# Impact of the Abbreviated Suicide Crisis Syndrome Checklist on Clinical Decision Making in the Emergency Department

Ethan Karsen, MD; Lisa J. Cohen, PhD; Betsy White, LCSW; Gabriele P. De Luca, MD; Inna Goncearenco; Igor I. Galynker, MD; and Frederick E. Miller, MD, PhD

## Abstract

**Objective:** The suicide crisis syndrome (SCS), an acute negative affect state predictive of near-term suicidal behavior, is currently under review for inclusion as a suicide-specific diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). While the predictive validity of the SCS for near-term suicidal behavior is well documented, its real-world clinical utility has yet to be evaluated. As such, this study evaluated how implementation of a novel assessment tool, the Abbreviated SCS Checklist (A-SCS-C), into the electronic medical records (EMRs) influenced disposition decisions in the emergency departments (EDs) of a large urban health system.

**Methods:** Logistic regression analyses evaluated the impact of SCS diagnosis on 212 admission/discharge decisions after accounting for chief complaints of suicidal ideation (SI), suicidal behavior (SB), and psychosis/agitation.

**Results:** The A-SCS-C was concordant with 86.9% of all non-psychotic disposition decisions. In multivariable analysis, the A-SCS-C had an adjusted odds ratio (AOR) of 65.9 (95% confidence interval: 18.79–231.07) for inpatient admission, whereas neither suicidal ideation nor behavior was a significant predictor. The effect size remained very high in 3 sensitivity analyses, the first using information from a different section of the EMR, the second in patients younger than 18 years, and the third in males and females separately (AORs > 30).

**Conclusions:** SCS diagnosis, when implemented in ED EMRs alongside SI and SB, was strongly predictive of clinician decision making with regard to admission/discharge, particularly in non-psychotic patients, while SI and SB were noncontributory. Overall, our results show that the SCS, as a diagnostic entity, demonstrates robust clinical utility and may reduce the limitations of relying on self-reported SI as a primary basis of suicide risk assessment.

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*Author affiliations are listed at the end of this article.*

Suicide was the 10th leading cause of death in the United States (US), accounting for 1 death every 11 minutes in 2019.[1] Despite ongoing suicide assessment and prevention efforts, suicide rates increased dramatically in the US—up 33% between 1999 and 2019.[2] Although such increases did not occur in many other countries, suicide still accounts for over 700,000 deaths globally each year and was the 17th leading cause of death in 2019.[3,4] Clearly, current risk assessment methods are insufficient and there is pressing need for novel approaches. In this context, there has been increasing interest in the notion of a suicide-specific syndrome that can indicate imminent suicidal risk.[5–7] Specifically, the suicide crisis syndrome,[8] a novel pre-suicidal diagnosis that has been robustly associated with near-term suicidal behavior, is currently under review for inclusion in ongoing updates to the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition, Text Revision (*DSM-5-TR*). The purpose of this article is to establish the clinical utility of the SCS with regard to psychiatric admission/discharge decisions in a large urban hospital system. To the extent that the SCS can guide clinical decision making in a real-world, high-risk setting, it will offer significant potential for dissemination into the community and far-reaching benefits for public health.

The SCS is an acute pre-suicidal syndrome with 5 components: criterion A plus criterion B, which includes 4 symptom domains (Table 1). Criterion A is an intense

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## Clinical Points

- Despite many years of suicide research, it is still very difficult to predict acute suicidal risk.
- The suicide crisis syndrome (SCS), an acute negative affect state robustly associated with near-term suicidal risk, offers a novel risk assessment framework.
- The SCS can be successfully integrated into emergency department risk assessment procedures.

and persistent feeling of frantic hopelessness/entrapment, defined as an urge to escape a perceived inescapable life situation.[8,9] The 4 components of criterion B include affective disturbance (B1), loss of cognitive control (B2), hyperarousal (B3), and acute social withdrawal (B4).[10–12] For a diagnosis of the SCS, patients must meet criterion A and have 1 or more symptoms from each of the 4 domains of criterion B. One benefit of the SCS is that it is not reliant on self-reported SI for risk assessment, as SI has been shown to be an unreliable indicator of imminent suicidal risk due to a number of factors, including intentional concealment,[13] frequent malingering,[14] a short time interval between onset of SI and suicidal action,[15] or the lack of explicit SI prior to an attempt.[16–18]

Accumulating research demonstrates the reliability and concurrent, incremental, and predictive validity of tools that measure the SCS with regard to suicidal thoughts and behavior (STB).[8,19–26] In particular, the SCS tools have shown concurrent validity in relation to recent and lifetime suicidality,[8,24,27,28] incremental validity over self-reported SI in predicting near-term suicide attempts,[24] and predictive validity with regard to 1 month post-discharge SI,[25] STB,[26,29] and suicide attempts.[8,24,30,31] Nonetheless, while the predictive validity of the SCS to imminent suicidal behavior is well documented, the clinical utility of the SCS diagnosis in a real-world clinical setting has yet to be evaluated. Of note, the predictive validity of the SCS has not yet been evaluated for suicide deaths, although this research is currently underway. Nonetheless, there is evidence linking acute negative affect states to suicide deaths. In a Norwegian study of suicide deaths among psychiatric inpatients (N = 7,000), acute depressed mood predicted suicide within 1 week post-admission, whereas suicidal ideation, recent suicidal attempt, and diagnosis of major depressive disorder did not.[32]

The American Psychological Association defines clinical utility as "reflect[ing] the extent to which the intervention will be effective in the practice setting where it is to be applied, regardless of the efficacy that may have been demonstrated in the clinical research setting."[33] Thus, a diagnosis might have low user acceptability in clinical practice despite its proven validity and thereby fail to inform clinical decisions.[34] Likewise, improving clinical utility has been named as a top priority for the *DSM* revisions.[35] Similarly, the World Health Organization includes usefulness in making clinical management decisions as a feature of clinically useful constructs.[36] As such, establishment of the clinical utility of the SCS diagnosis is a necessary step to support its inclusion in *DSM-5-TR*. In the present study, we examine the impact of a novel suicide risk assessment tool, the Abbreviated SCS Checklist (A-SCS-C), on clinical decision making in the emergency departments (EDs) of a large, urban hospital system.

Hospital EDs represent one of the highest acuity areas of suicide risk assessment. In 2019 in the US, more than 490,000 patients presented to EDs with deliberate self-harm. Such patients had an almost 60-fold higher suicide mortality risk compared to demographically similar controls in the year following their ED visit.[37] Nonetheless, multiple barriers hinder the utility of assessment instruments. Indeed, EDs are high-intensity, complex, and chaotic clinical environments where clinicians are exposed to high levels of stress.[38–40] To be effective, assessment tools must be brief, easy to use, and accurate. As such, the ED provides an ideal real-world setting to test the clinical utility of the SCS.

## METHODS

### Participants

The initial sample included 229 consecutive patient encounters (217 unique patients) receiving psychiatric evaluation in 4 community EDs at NorthShore University Health System (located in the metropolitan area of Chicago, Illinois) between December 1, 2020, and December 31, 2020. Seventeen cases were excluded from further analysis; 9 were admitted to medicine, 3 were released to police custody, 2 were deceased, and 3 had missing data. In the final sample (N = 212), there were 112 (52.8%) females and 100 (47.2%) males, as classified by legal gender. Mean patient age was 31.89 ± 17.3 years; range, 7–99 years. Eleven (5.2%) patient encounters were for patients identified as Asian, 38 (17.9%) as Black/African American, 117 (55.2%) as Caucasian, 19 (9.0%) as Hispanic/Latino, and 26 (12.3%) as other/non-Hispanic; 1 patient declined to respond.

### Admission Procedure

When patients arrive at the ED, they are triaged by a nurse who determines if the patient requires further psychiatric assessment. If so, they are referred by the ED physician to a master's-level crisis worker who administers the suicide risk assessment tool (see below) and documents their clinical presentation. Disposition decisions are made by the on-call psychiatrist and the ED physician in collaboration with the crisis worker.

**Table 1.**
**Proposed Diagnostic Criteria for the Suicide Crisis Syndrome**

| | |
|---|---|
| **Criterion A** | **Frantic hopelessness/entrapment:** A persistent or recurring overwhelming feeling of urgency to escape or avoid an unacceptable life situation that is perceived to be impossible to escape, avoid, or endure |
| **Criterion B** *(at least 1 symptom from each subgroup)* | **1. Affective disturbance:** *Manifested by at least 1 of the following:*<br>• Emotional pain<br>• Rapid spikes of negative emotions or extreme mood swings<br>• Extreme anxiety that may be accompanied by dissociation or sensory disturbances<br>• Acute anhedonia (ie, a new or increased inability to experience or anticipate interest or pleasure)<br>**2. Loss of cognitive control:** *Manifested by at least 1 of the following:*<br>• Ruminations—an intense or persistent rumination about one's own distress and the life events that brought on distress<br>• Cognitive rigidity—an inability to deviate from a repetitive negative pattern of thought<br>• Ruminative flooding—an experience of an overwhelming profusion of negative thoughts, impairing ability to process information or make a decision<br>• Failed thought suppression—repeated unsuccessful attempts to suppress negative or disturbing thoughts<br>**3. Hyperarousal:** *Manifested by at least 1 of the following:*<br>• Agitation<br>• Hypervigilance<br>• Irritability<br>• Insomnia<br>**4. Acute social withdrawal:** *Manifested by at least 1 of the following:*<br>• Withdrawal from or reduction in scope of social activity<br>• Evasive communication with close others |
| **Criterion C** | **Exclusion criteria:** *Mental states solely due to these criteria are excluded.*<br>• Mental states of delirium or confusion<br>• Mental states preceding suicides as a political statement<br>• Mental states preceding physician-assisted suicides |

## Materials

**NorthShore Suicide Risk Assessment Tool.** In March 2020, NorthShore implemented a novel suicide risk assessment tool in their EDs. The tool combined the A-SCS-C, adapted from the full SCS Checklist,[41] with questions from the Columbia-Suicide Severity Rating Scale (C-SSRS)—Screening Version[42] (see Supplementary Figure 1). In this tool, all patients were screened using 2 questions from the A-SCS-C and 3 ratings from the C-SSRS. Any positive response prompted further assessment using the full A-SCS-C and C-SSRS Screen. Clinicians using the tool were free to use their own questions to elicit responses to the items; there was no structured interview. An additional 21 risk factors were grouped under activating events (eg, pending incarceration or homelessness) and clinical status (eg, hopelessness, major depressive episode).

The tool was embedded into the ER Epic Workflow, a flowsheet created by the hospital's information technology department. Items were scored with radio buttons and drop-down menus. Clinicians received approximately 3 hours of training, consisting of readings and a posttest format, lecture and discussions, and a demonstration with health information technology staff. Usage of the tool was monitored via chart audits by the clinical supervisor.

As the dataset used for analysis was extracted from a preexisting database and entirely deidentified, the study was given exempt status from institutional review board approval with no need for informed consent forms.

**Abbreviated SCS Checklist.** The A-SCS-C was adapted from the SCS Checklist[8] (see Table 1 for SCS criteria). There are 2 screening items: "Do you feel trapped with no good options left?" and "Are you overwhelmed or have you lost control by negative thoughts filling your head?" Three additional items are administered when either of the screening questions are answered positively. The first item is a clinician rating of entrapment (SCS criterion A), rated as yes, no, or extreme. The second item assesses the 4 domains of SCS criterion B: affective disturbance, loss of cognitive control, hyperarousal, and social withdrawal. This item is rated yes if the patient exhibits 1 or 2 of the domains and extreme if the patient exhibits 3 or 4. A final rating is recorded as *positive* if both criteria A and B are rated as yes and as *extreme* if both criteria are scored extreme. A positive or extreme score in the final rating reflects a positive SCS diagnosis.

**Epic Workflow suicidal ideation.** The C-SSRS rating of suicidal ideation (SI) in the past 3 months from the Epic Workflow was included as a measure of SI. For ease

Table 2.

**Descriptive Statistics for Predictor and Outcome Variables**

| Variable | n (%) |
|---|---|
| **Admitted to inpatient unit** | 122 (57.5) |
| **Discharged from emergency room** | 90 (42.5) |
| **SCS positive/extreme** | 79 (37.26) |
| **Chief complaint** | |
| No suicidal ideation or behavior | 107 (50.5) |
| Suicidal ideation | 83 (39.1) |
| Suicidal behavior | 22 (10.4) |
| Psychosis/agitation | 59 (28) |
| Substance abuse | 6 (2.8)[a] |
| Depression | 6 (2.8)[a] |
| Mania | 2 (0.94)[a] |
| Anxiety | 9 (4.2)[a] |
| Aggression/behavioral disturbance/homicidal ideation | 18 (8.4)[a] |
| Other | 13 (6.1)[a] |
| **Epic Workflow risk assessment** | |
| Suicidal ideation—past month | 117 (55) |

[a]Variable not included in the analyses.
Abbreviation: SCS = suicide crisis syndrome.

of analysis, the original 5-point scale of SI severity was collapsed into a binary yes/no variable. Any positive response to the query on SI was scored as yes.

### Chief Complaint

The chief psychiatric complaint that led to the ED visit was recorded in the electronic medical record (EMR) by the master's level crisis worker. For this analysis, 54 different chief complaints were grouped into 9 categories (SI, suicidal behavior [SB], psychosis/agitation, substance abuse, depression, mania, anxiety, aggression/behavioral disturbance/homicidal ideation, and other). A single complaint was coded for each patient. When more than 1 chief complaint was listed, SB had precedence; if both SI and SB were listed, the chief complaint was coded as SB. Psychosis/agitation was coded next and had precedence over all other non-suicidal chief complaints (see Supplementary Table 1).

After initial analysis of the chief complaints, only psychosis/agitation, SI, and SB variables were selected as predictor variables in subsequent analyses. These were the most common chief complaint categories (28% psychosis, 50% SI or SB) and represent the most severe conditions and the patients most likely to be admitted.[43–45]

### Disposition Decision

The outcome variable was disposition decisions (admission to the inpatient service vs discharge from ED) for patients evaluated in the ED over a 1-month period approximately 9 months after the introduction of the A-SCS-C into the EMR.

### Statistical Analyses

In order to test the clinical utility of the A-SCS-C, we first conducted a 2-step multiple logistic regression model, with disposition decision as the outcome variable. The chief complaints of SI, SB, and psychosis/agitation were entered in step 1 and A-SCS-C diagnosis in step 2.

To test whether the model differed using SI information extracted from the C-SSRS rating in the Epic Workflow (rather than the chief complaint), we performed a sensitivity analysis using another 2-step multiple logistic regression model. SI from C-SSRS was entered in step 1; A-SCS-C diagnosis, in step 2.

We then calculated the sensitivity and specificity of the A-SCS-C diagnosis alone and then of each statistical model listed above. Analyses were performed with IBM SPSS v28.

Finally, we performed 2 more sensitivity analyses, the first in pre-adult patients, under age 18, and the second in male and female subsamples (identified by legal gender) analyzed separately.

## RESULTS

Of the 212 patient encounters in the study, 122 (57.5%) resulted in admissions to the inpatient unit. Seventy-nine patient encounters (37.26%) received positive or extreme A-SCS-C ratings (positive SCS diagnosis). Of the chief complaints, 83 (39%) involved SI, 22 (10.4%) SB, and 59 (28%) psychosis or agitation (Table 2). Overall, SCS diagnosis was concordant with 73.1% (N = 151) of admission/discharge decisions. When patients with a chief complaint of psychosis/agitation were excluded, the proportion of SCS-concordant admission/discharge decisions increased to 86.9% (N = 133).

### Relationship Between SCS Diagnosis and SI and SB Ratings and Psychosis

SCS status overlapped with SI in both the chief complaint ($\phi$ coefficient = 0.564, $P < .001$) and C-SSRS ratings ($\phi$ coefficient = 0.596, $P < .001$), but the concordance was not complete. While 94.7% of patients *without* chief complaints of either SI or SB were negative for SCS, 37% of those *with* SI only and 25% of those with SB were also SCS negative. By C-SSRS, the findings were similar. Of those *without* SI, 94.7% had no SCS diagnosis, but neither did 36.8% of those *with* SI. Psychosis and SCS co-occurred in only 9 (4%) of the patients.

### Logistic Regression Analyses Using Chief Complaints as Predictors

In the first logistic regression analysis, disposition decisions were regressed against SCS status and 3 categories of chief complaint: SI, SB, and psychosis/agitation (Table 3). In step 1, when excluding the SCS, the presence of SB yielded the highest adjusted odds ratio (AOR) of admission to the inpatient unit when compared to the absence of either SI or SB, followed by the presence of psychosis/agitation versus its absence. In step 2, SCS diagnosis was included in the model and

Table 3.

**Logistic Regression Analysis: Chief Complaint Predictors to Admission/Discharge Decisions**

| Predictor | Admitted, n (%) | Discharged, n (%) | Regression coefficient | Standard error | Adjusted odds ratio | 95% CI | *P* value |
|---|---|---|---|---|---|---|---|
| **Step 1** | | | | | | | |
| Suicidal ideation | 49 (59.0) | 34 (41.0) | 0.962 | 0.353 | 2.616 | 1.311–5.222 | .006 |
| Suicidal behavior | 18 (81.8) | 4 (18.2) | 2.186 | 0.620 | 8.896 | 2.640–29.978 | < .001 |
| No suicidal ideation/ behavior (ref) | 55 (51.4) | 52 (48.6) | ... | ... | ... | ... | ... |
| Psychosis/agitation | 42 (71.2) | 17 (28.8) | 1.507 | 0.392 | 4.515 | 2.095–9.728 | < .001 |
| No psychosis/agitation (ref) | 80 (52.3) | 73 (47.7) | ... | ... | ... | ... | ... |
| **Step 2** | | | | | | | |
| Suicidal ideation | 49 (59.0) | 34 (41.0) | −1.230 | 0.614 | 0.292 | 0.088–0.974 | .045 |
| Suicidal behavior | 18 (81.8) | 4 (18.2) | 0.248 | 0.872 | 1.281 | 0.232–7.08 | .776 |
| No suicidal behavior (ref) | 55 (51.4) | 52 (48.6) | ... | ... | ... | ... | ... |
| Psychosis/agitation | 42 (71.2) | 17 (28.8) | 1.748 | 0.431 | 5.745 | 2.469–13.369 | < .001 |
| No psychosis/agitation (ref) | 80 (52.3) | 73 (47.7) | ... | ... | ... | ... | ... |
| SCS | 72 (91.1) | 7 (8.9) | 4.188 | 0.640 | 65.906 | 18.79–231.07 | < .001 |
| No SCS (ref) | 50 (37.6) | 83 (62.4) | ... | ... | ... | ... | ... |

Abbreviations: ref = reference category, SCS = suicide crisis syndrome.

Table 4.

**Logistic Regression Analysis: Epic Workflow Predictors to Admission/ Discharge Decision**

| Predictor | Admitted, n (%) | Discharged, n (%) | Regression coefficient | Standard error | Adjusted odds ratio | 95% CI | *P* value |
|---|---|---|---|---|---|---|---|
| **Step 1** | | | | | | | |
| SI | 77 (65.8) | 40 (34.2) | 0.760 | 0.283 | 2.14 | 1.23–3.73 | .007 |
| No SI (ref) | 45 (47.4) | 50 (52.6) | ... | ... | ... | ... | ... |
| **Step 2** | | | | | | | |
| SI | 77 (65.8) | 40 (34.2) | −1.002 | 0.414 | 0.37 | 0.16–0.87 | .016 |
| No SI (ref) | 45 (47.4) | 50 (52.6) | ... | ... | ... | ... | ... |
| SCS | 72 (91.1) | 7 (8.9) | 3.505 | 0.529 | 33.28 | 11.81–93.78 | < .001 |
| No SCS (ref) | 50 (37.6) | 83 (62.4) | ... | ... | ... | ... | ... |

Abbreviations: ref = reference category, SCS = suicide crisis syndrome, SI = suicidal ideation inclusive of thoughts, intent, plan, attempt, and nonsuicidal self-injury.

yielded by far the highest AOR for admission (AOR = 65.9), exceeding the other variables by a large margin. Furthermore, while the AOR of psychosis/agitation remained largely the same (AOR = 5.75), the AOR from SB lost statistical significance and the presence of SI *reduced* the likelihood of admission by over 70% (AOR = 0.29).

## EPIC Workflow Risk Assessment Model

Analyses were repeated with C-SSRS SI replacing the chief complaint suicidal variables (Table 4). Overall, results were similar to the previous model, with the AOR for admission to the inpatient unit of the SCS diagnosis far exceeding that of C-SSRS SI rating in step 2 (SCS AOR = 33.28 vs SI AOR = 0.37). As in the previous model, after accounting for co-occurring SCS, patients presenting with SI in the ED were 63% *less* likely to be admitted than patients without SI.

## Co-Occurring SCS and SI/SB

As the high overlap with SCS and SI and SB raised the potential for multicollinearity, we investigated the disposition patterns of patients with and without SCS who also had SI or SB. Of patients with SI but not SCS (N = 31), 6.5% were admitted and 93.5% were discharged. Of those with SI and SCS (N = 52), 90.4% were admitted and 9.6% were discharged ($\chi^2 = 16.6$, $P < .001$). Of those with SB and not SCS, (N = 5), 20% were admitted and 80% were discharged. Of those with both SB and SCS (N = 17), 100% were admitted and 0% were discharged ($\chi^2$ not done due to empty cell). These results suggest that the study findings are not attributable to collinearity between the SCS and SI/SB.

## Sensitivity and Specificity

We calculated the sensitivity and specificity of the SCS diagnosis alone as well as that of the other models

Table 5.

**Sensitivity and Specificity of Different Models for Admission vs Discharge Decisions**

| Model | Sensitivity (proportion true positives) | Specificity (proportion true negatives) |
|---|---|---|
| SCS positive or extreme | 0.59 | 0.92 |
| Chief complaint step 1 (SIB, psychosis/agitation) | 0.85 | 0.40 |
| Chief complaint step 2 (SIB, psychosis/agitation, SCS) | 0.87 | 0.76 |
| SCS and psychosis/agitation alone | 0.88 | 0.76 |
| Epic Workflow step 1 (SI) | 0.63 | 0.56 |
| Epic Workflow step 2 (SI, SCS) | 0.59 | 0.92 |

Abbreviations: SCS = suicide crisis syndrome, SI = suicidal ideation, SIB = suicidal ideation or behavior.

tested (Table 5). When assessed in isolation, SCS status had very high specificity (0.92) but sensitivity barely above chance. Although almost all patients with a SCS diagnosis were admitted, so were many patients without this diagnosis. For step 1 from the first logistic regression with SI, SB, and psychosis/agitation as predictors, both sensitivity and specificity were inadequate, either slightly above or even lower than chance. Both sensitivity (0.87) and specificity (0.76) increased markedly in step 2, however, when SCS status was added to the model. Our results were similar when looking at the C-SSRS SI together with the A-SCS-C. Step 1 of this model had 63% sensitivity and 56% specificity. In step 2, specificity rose to 92%, although sensitivity remained low, likely due to the absence of psychosis/agitation from the model.

### Sensitivity Analysis With Pre-Adult Patients

Because of the substantial presence of minors in this sample (N = 60), a sensitivity analysis of the relationship between SCS status and admit/discharge decision was performed only in patients under age 18 (14.82 ± 2.079; range, 7–17). The relationship was significant ($\chi^2_1 = 29.418$, $P < .001$), and SCS status accounted for 82.9% of total admission/discharge decisions.

### Sensitivity Analyses With Regard to Sex

To determine if the clinical utility of the A-SCS-C was consistent across sex, we repeated the primary analysis separately for males and females (as classified by legal gender). Consistent with prior analyses, after controlling for SI, SB, and psychosis/agitation, SCS status was highly associated with admission decision, for both males (N = 100; AOR = 32.59; 95% CI, 6.0–178.4) and females (N = 112; AOR = 152.46; 95% CI = 17.1–1356.5). Of note, as the confidence intervals overlap, the difference between sexes is not statistically significant.

## DISCUSSION

The purpose of our study was to evaluate the real-world applicability of the suicide crisis syndrome (SCS), a novel suicide-specific diagnostic entity currently under review by the *DSM-5-TR* Scientific Review Committee. Specifically, we measured how much determination of SCS status influences admission versus discharge decisions in the EDs of a large, urban hospital system. Further, we compared the impact on clinical decision making of the SCS to that of patients' self-reported suicidal ideation.

Indeed, our hypothesis was confirmed, such that diagnosis of the SCS was powerfully predictive of admission and discharge decisions in the ED. When considering the SCS in conjunction with chief complaints of suicidal ideation (SI), suicidal behavior, and psychosis/agitation, SCS overwhelmingly increased the odds of admission from the ED to the inpatient unit (AOR = 65.91). This dramatic effect size was replicated in the first sensitivity analysis, using a separate rating of SI drawn from a different section of the EMR (AOR = 33.28). Additional sensitivity analyses showed that these results were equally applicable in a pre-adult subsample and in males and females analyzed separately.

Although at first glance and in the absence of the SCS suicidal ideation appears to drive admission decisions, this changes after adding the SCS to the model, at which point SI actually reduces the likelihood of admission. Thus, while many patients that exhibited suicidal ideation were admitted, the data indicate that almost all who were admitted presented with comorbid SCS. Further, patients who presented with SI in the absence of the SCS were *less* likely to be admitted. In fact, of the 31 patients with SI (but no SB) who were also SCS negative, 93.5% (N = 29) were discharged. It appears such patients were deemed at lower risk, possibly due to suspicions of malingering or to displays of emotional lability or dysfunctional interpersonal behavior without significant suicidal risk. Indeed, such clinical presentations are typical reasons for discharge from the ED, even in the context of suicidal ideation.[14,46] Additionally, some patients may have presented with chronic SI in the absence of the SCS and were deemed not to be at acute risk. This suggests that assessment of the SCS in the ED supported clinicians' judgments as to when patients presenting with SI did and did not pose acute suicidal risk. Given that SI is one of the most common reasons for ED visits,[43] these findings suggest that risk assessment with the SCS has the potential to reduce unnecessary hospitalizations for patients with SI.

Indeed, when the SCS, SI, suicidal behavior, and psychosis/agitation were considered together, sensitivity and specificity were both elevated. Looking at SCS and SI without taking into account psychosis, however, increased specificity but not sensitivity. Most people presenting this way were likely to be admitted, but many people without SCS or SI were also admitted, largely because patients

presenting with psychosis/agitation but not SCS/SI were also highly likely to be admitted (AOR = 5.74). Thus, the impact of psychosis on admission/discharge decisions appears to be largely independent of SCS and SI.

There is robust evidence for the reliability and internal consistency as well as the concurrent, predictive, and incremental validity of the SCS with regard to suicidal thoughts and behavior in multiple settings.[19–23,28,47] Given these findings, there appears to be significant value to including the SCS as a suicide-specific diagnosis in the *DSM-5-TR*. Numerous authors have considered the benefits of a suicide-specific diagnosis,[6,8,48–52] although others have raised objections to this notion.[53]

The criteria for the SCS, however, unlike other suicide-specific diagnoses, are not reliant on self-reported SI or SB for risk assessment. The limits of SI alone as a marker of imminent suicide risk are well established.[13,14,16–18,46,54] Indeed, our findings show that ED clinicians behave in accordance with this position. Rather than serving as the centerpiece of risk assessment, therefore, a more appropriate use of SI might be alongside the SCS diagnosis.

Overall, our results show that the SCS, as a diagnostic entity, demonstrates robust clinical utility and further reduces the limitations of relying on self-reported SI as a primary basis of suicide risk assessment. Future research can replicate and expand upon these findings.

It is important to note, however, that evidence of the predictive validity and clinical utility of the SCS does not obviate the need for a full suicide risk assessment for patients presenting to the ED, taking into account numerous psychosocial, familial, circumstantial, and comorbid psychiatric factors as well as the mental health resources available to the patient. Indeed, the NorthShore assessment tool incorporated many additional features beyond the SCS. As such, a holistic approach adapted for the individual patient is still recommended.[55] What the SCS can offer, however, is a powerful tool to aid in and potentially even focus a broad assessment, as the use of numerous risk factors can lead to confusion as to which factors to prioritize.[56] Future research can evaluate the optimal way to integrate the SCS into a broader suicide risk assessment.

## Limitations

This study is not without limitations and should be considered in the context of them. For one, the time frame of the study was only 1 month, so we cannot determine how well the clinical utility of the SCS is sustained over time, nor whether or how often there will be need for training refreshers. As this study is currently ongoing, future research can address these questions. Further, the relationship between the SCS and SI will need replication as the base rate between patients with SI but without SCS was low (N = 31). Additionally, the generalizability of these finding to other clinical settings beyond the ED has yet to be evaluated. Assessment of clinical utility in the ED was fairly simple with a binary outcome, admission vs discharge. In outpatient or other clinical settings, the decision making triggered by a positive SCS diagnosis may be less straightforward, although it is likely to involve some form of intensification of treatment or monitoring. As such, future research can investigate the optimal use of the SCS in diverse clinical settings.

Relatedly, it is important to note that in the hospital setting where our study took place, implementation of the A-SCS-C had support at the highest levels of leadership. The measure was placed into the electronic medical record and its use made mandatory. Adequate training and preparation were also provided. Nonetheless, the relative ease and low cost of adoption should facilitate dissemination of the A-SCS-C or similar SCS-based assessment tools to other clinical settings.

Further, the admission rate in this sample appears to be higher than that found in many other hospital settings, which typically have an admission rate below 50%.[57,58] One explanation for this discrepancy is that the NorthShore system is located in a fairly affluent and well-resourced area, such that outpatient care is readily available for patients with milder conditions, resulting in higher acuity in the ED. Additionally, patients are triaged before the suicide risk assessment tool is administered, such that patients with anxiety disorders or substance use disorders may have already been referred to outpatient care. Finally, data were collected at the beginning of the COVID pandemic, which might have dissuaded patients with milder conditions from presenting to the hospital. Future research can test the generalizability of the current findings to other ED settings.

Additionally, although the AORs for SCS status were remarkably high, the accompanying 95% CIs were large for all multivariate analyses, possibly due to a relatively small sample size. This suggests that the exact effect size cannot be specified from this dataset. However, that the AORs were significant and represented very large effect sizes across both the primary and all sensitivity analyses (AORs > 30) adds confidence to the general robustness if not exactitude of the findings.

A further consideration involves potentially different predictors to voluntary versus involuntary admissions.[59] Future research could evaluate the clinical utility of SCS status across both types of admissions.

It must also be reiterated that the SCS has not been evaluated yet for its ability to predict suicide deaths. Such research is currently underway. Nonetheless, as SI and SAs are highly correlated with suicide deaths[60] and also merit clinical attention on their own, we believe the current results are still highly relevant to assessment of suicidal risk.

Finally, the A-SCS-C differs from the original measures of the SCS and thus lacks evidence of reliability and predictive validity for suicide risk. Whether a full SCS assessment offers advantages over the A-SCS-C

needs to be examined in future research. Likewise, the clinical utility of other assessment formats, such as the 15-item SCS Checklist, has yet to be tested.

## CONCLUSION

Within the context of its limitations, this study provided compelling evidence of the clinical utility of the SCS with regard to actual clinical decision making (ie, admission vs discharge decisions) in an acute, real-world setting. The SCS appears to offer significant value as a central component of suicide risk assessment in the ED and may even reduce the limitations of relying on self-reported SI as a primary basis of such assessment. Future research can replicate and expand upon these findings.

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**Author Affiliations:** Department of Psychiatry, NorthShore University Health System, Evanston, Illinois (Karsen, White, Goncearenco, Galynker, Miller); Carl Icahn School of Medicine/Mount Sinai Beth Israel, New York, New York (Cohen); Department of Psychiatry, Faculty of Medicine and Psychology, University of Rome Sapienza, Rome, Italy (De Luca).

**Corresponding Author:** Lisa J. Cohen, PhD, Bernstein Pavilion, 7B-07, Mount Sinai Beth Israel, 10 Nathan Perlman Pl, New York, NY 10003 (LisaJ.Cohen@mountsinai.org).

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# Supplementary Material

**Article Title:** Impact of the Abbreviated Suicide Crisis Syndrome Checklist on Clinical Decision Making in the Emergency Department

**Authors:** Ethan Karsen, MD; Lisa J. Cohen, PhD; Betsy White, LCSW; Gabriele P. De Luca, MD; Inna Goncearenco; Igor I. Galynker, MD; and Frederick E. Miller, MD, PhD

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## List of Supplementary Material for the article

1. Table 1 — Grouping of Chief Complaints Not Classified Under Psychosis/Agitation or Suicidal Ideation and Behavior
2. Figure 1 — NorthShore University Health System's Emergency Department Workflow for the Assessment of Suicide Risk, Using the A-SCS-C and Questions Adapted from the C-SSRS

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This Supplementary Material has been provided by the author(s) as an enhancement to the published article. It has been approved by peer review; however, it has undergone neither editing nor formatting by in-house editorial staff. The material is presented in the manner supplied by the author.

**Supplementary Table 1: Grouping of Chief Complaints Not Classified under Psychosis/Agitation or Suicidal Ideation and Behavior**

| Predictor Group | Original Predictor | N (%) | Group N (%) |
|---|---|---|---|
| Substance abuse | Ethanol intoxication | 1 (1.9) | 6 (11.3) |
| | Malingering/drug use | 1 (1.9) | |
| | Subs. abuse, aggression | 2 (3.7) | |
| | substance abuse w Bipolar | 1 (1.9) | |
| | substance abuse w/anxiety | 1 (1.9) | |
| Depression | Depressed mood | 1 (1.9) | 6 (11.3) |
| | Depression | 2 (3.7) | |
| | Depression and anxiety | 2 (3.7) | |
| | Depression/mood swings | 1 (1.9) | |
| Mania | Mania | 1 (1.9) | 2 (3.7) |
| | Pressured Speech | 1 (1.9) | |
| Anxiety | Anxiety | 4 (7.4) | 9 (16.7) |
| | anxiety/depression | 1 (1.9) | |
| | anxiety/headaches/insomnia | 1 (1.9) | |
| | anxiety/impaired functioning | 1 (1.9) | |
| | anxiety/insomnia | 1 (1.9) | |
| | anxious | 1 (1.9) | |
| Aggression/Behavioral Disturbance/Homicidal Ideation | aggression | 1 (1.9) | 18 (33%) |
| | Aggressive behavior | 10 (18.5) | |
| | Autism/aggression | 1 (1.9) | |
| | Behavioral dyscontrol | 1 (1.9) | |
| | behavioral dysregulation | 2 (3.7) | |
| | Destructive bx | 1 (1.9) | |
| | Homicidal ideation | 1 (1.9) | |
| | Impulsive behavior | 1 (1.9) | |
| Other | Accidental overdose | 1 (1.9) | 13 (24.7) |
| | Delirium | 1 (1.9) | |
| | Domestic Disturbance | 1 (1.9) | |
| | Eating Disorder | 1 (1.9) | |
| | Fire Setting | 1 (1.9) | |
| | Insomnia | 1 (1.9) | |
| | Malingering | 1 (1.9) | |
| | Mood disorder/autism | 1 (1.9) | |
| | Nightmares | 1 (1.9) | |
| | OCD | 1 (1.9) | |
| | Poor sleep | 1 (1.9) | |
| | PTSD/TBI/aggression | 1 (1.9) | |
| | Unable to care for self | 1 (1.9) | |
| Total | | 54 (100) | 54 (100) |

**Supplementary Figure 1: NorthShore University Health System's Emergency Department Workflow for the Assessment of Suicide Risk, Using the A-SCS-C and Questions Adapted from the C-SSRS[42]**

## SCREENING

### 1. SUICIDE CRISIS SYNDROME

1.1 Do you feel trapped with no good options left? YES NO

1.2 Are you overwhelmed, or have you lost control by negative thoughts filling your head? YES NO

### 2. SUICIDAL THOUGHTS AND BEHAVIORS

2.1. Have you wished you were dead or wished you could go to sleep and not wake up? YES NO

2.2 Have you actually had any thoughts of killing yourself? YES NO

2.3 Have you done anything, started to do anything, or prepared to do anything to end your life? YES, Lifetime YES, Past 3 months NO

YES to ANY of the SCREENING questions above → FULL SUICIDE RISK ASSESSMENT REQUIRED

## FULL SUICIDE RISK ASSESSMENT

### 1. SUICIDE CRISIS SYNDROME (SCS) Diagnostic Criteria

#### *Entrapment*

Presents with a problem that they perceive as intolerable and unsolvable. May describe themselves as "trapped". "having no exit", or "having reached a dead end" YES NO EXTREME

#### *Associated Disturbances*

*Domains*

1. Affective Disturbance 2. Loss of Cognitive Control
3. Hyperarousal 4. Social Withdrawal

| | |
|---|---|
| | NO |
| *If exhibits 1 or 2 of the domains* | YES |
| *If exhibits 3 or 4 of the domains* | EXTREME |

#### *SCS Criteria Interpretation*

Meets criteria for SCS if scores YES or EXTREME for both Entrapment and Associated Disturbances sections POSITIVE EXTREME NEGATIVE

### 2. SUICIDAL THOUGHTS AND BEHAVIORS

#### *Suicidal Ideation*

*select most severe in LAST MONTH, leave blank if negative screen in Screening section 2*

- Wish to be dead
- Suicidal Thoughts
- Suicidal Thoughts with method but without specific plan or intent to act
- Suicidal Intent without specific plan
- Suicidal Intent with specific plan

## FULL SUICIDE RISK ASSESSMENT- continued

### 2. SUICIDAL THOUGHTS AND BEHAVIORS - continued

***Suicidal & Self-Injurious Behavior***

*select most severe in LAST THREE MONTHS*

- Actual suicide attempt
- Interrupted attempt
- Aborted or self-interrupted attempt
- Other preparatory acts to kill self
- Self-injurious behavior without suicidal intent

*select most severe in LIFETIME*

- Actual suicide attempt
- Interrupted attempt
- Aborted or self-interrupted attempt
- Other preparatory acts to kill self
- Self-injurious behavior without suicidal intent

***Risk Factors*** *- select all that apply*

| Activating Events (Recent) | Clinical Status |
|---|---|
| • Recent loss or other significant negative event (legal, financial, relationship, etc.)<br>• Pending incarceration or homelessness<br>• Legal problems<br>• Sexual or physical abuse<br>• Chronic pain<br>• Bullying/Discrimination (e.g., LGBTQ, gender, racial)<br>• Current or pending isolation or feeling alone | • Hopelessness<br>• Major depressive episode<br>• Mixed affective episode (e.g., Bipolar)<br>• Agitation or severe anxiety<br>• Command hallucinations to hurt self<br>• Highly impulsive behavior<br>• Substance abuse dependence (e.g., intoxication or withdrawal)<br>• Homicidal ideation<br>• Sleep disturbance<br>• Active eating disorder<br>• Has access to lethal means<br>• Perceived burden on family or others<br>• Chronic physical pain or other acute medical<br>• Aggressive behavior towards others |

### 3. RISK FORMULATION

3.1 Risk **STATUS -** compared to OTHER patients in the treatment setting

**HIGHER than** **SIMILAR to** **LOWER than**

3.1.1. Why? List the most important factors _____

3.2. Risk **STATE** – compared to THEIR OWN historic baseline

**HIGHER than** **SIMILAR to** **LOWER than**

3.2.1. Why? List the most important factors _____