CLINICAL TRIAGE GUIDELINES USING THE C-SSRS

Answers on the C-SSRS provide the information needed in order to classify someone's suicidal ideation and behavior, and when combined with clinical judgment, can help determine levels of risk and aid in making clinical decisions about care.

Severity of Ideation Subscale - consists of 5 questions that reflect five types of ideation of increasing severity:

- A positive answer to Question 4 or 5 indicating presence of ideation with at least some intent to die in the past one month indicated a severe risk and clear need for further evaluation and clinical management (e.g., triggers immediate referral to mental health services and patient safety precautions).

4 – Active Suicidal Ideation with Some Intent to Act, Without Specific Plan (e.g., I would hang myself [method] and I can't guarantee that I won't do it [intent]).

5 – Active Suicidal Ideation with Specific Plan and Intent (e.g., tomorrow at 1:00pm when I know no one will be home [plan], I am going to [intent] take a handful of Tylenol that I have in my medicine cabinet).

Suicidal Behavior Subscale - includes questions about 4 suicidal behaviors and non-suicidal self-injurious behavior.

- Presence of ANY suicidal behavior (suicide attempt, interrupted attempt, aborted attempt and preparatory behavior) in the past 3 months indicates a severe risk and clear need for further evaluation and clinical management (e.g., triggers immediate referral to mental health services and patient safety precautions).

***Note:** *Endorsement of other questions on the scale could also indicate a need for further evaluation or clinical management depending on population or context, however a positive answer to Question 4 or 5 in the past month or any behavior in the past 3 months indicate a more emergent clinical situation.*

Additional sections on the Full C-SSRS and not on the Screener version

Intensity of Ideation Subscale - includes 5 questions about the Frequency, Duration, Controllability, Deterrents, and Reasons for Ideation for the most severe level of ideation endorsed on the Severity subscale (i.e., highest endorsed from 1 to 5).

- The total score ranges from 2 to 25, with a higher number indicating more intense ideation and greater risk.

Suicidal Behavior Lethality inquires about the level of actual medical damage or potential for it

- Greater lethality or potential lethality of the behavior (endorsed on the Behavior subscale) indicates increased risk.

EXAMPLES OF TRIAGE/ALERT RULES IN DIFFERENT CARE SYSTEMS

COMMUNITY CARE SETTINGS (CENTERSTONE, the largest non-profit provider of community-based behavioral health services in the nation)

Alert and Monitoring System

The Electronic Health Record (EHR) is designed to offer assistance to providers assessing service recipients for high suicide risk. Based on information collected in the applicable Columbia SSRS tool, a service recipient can be identified as being at high risk for suicide. Those who will be considered at high risk for suicide will have a positive endorsement of **either** of the following (research found these to be highly predictive of completed suicides):

a. A positive endorsement, relative to the past 30 days, in the **"Suicidal Thoughts" section of item # 4** (Have you had these thoughts and had some intention of acting on them?) **or item # 5** (Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?).
b. A positive endorsement, relative to the past 90 days, in the **"Suicide Behavior" section of item # 6** (Have you ever done anything, started to do anything, or prepared to do anything to end your life?).

HOSPITAL SETTINGS FOR THE JOINT COMMISSION REQUIREMENT

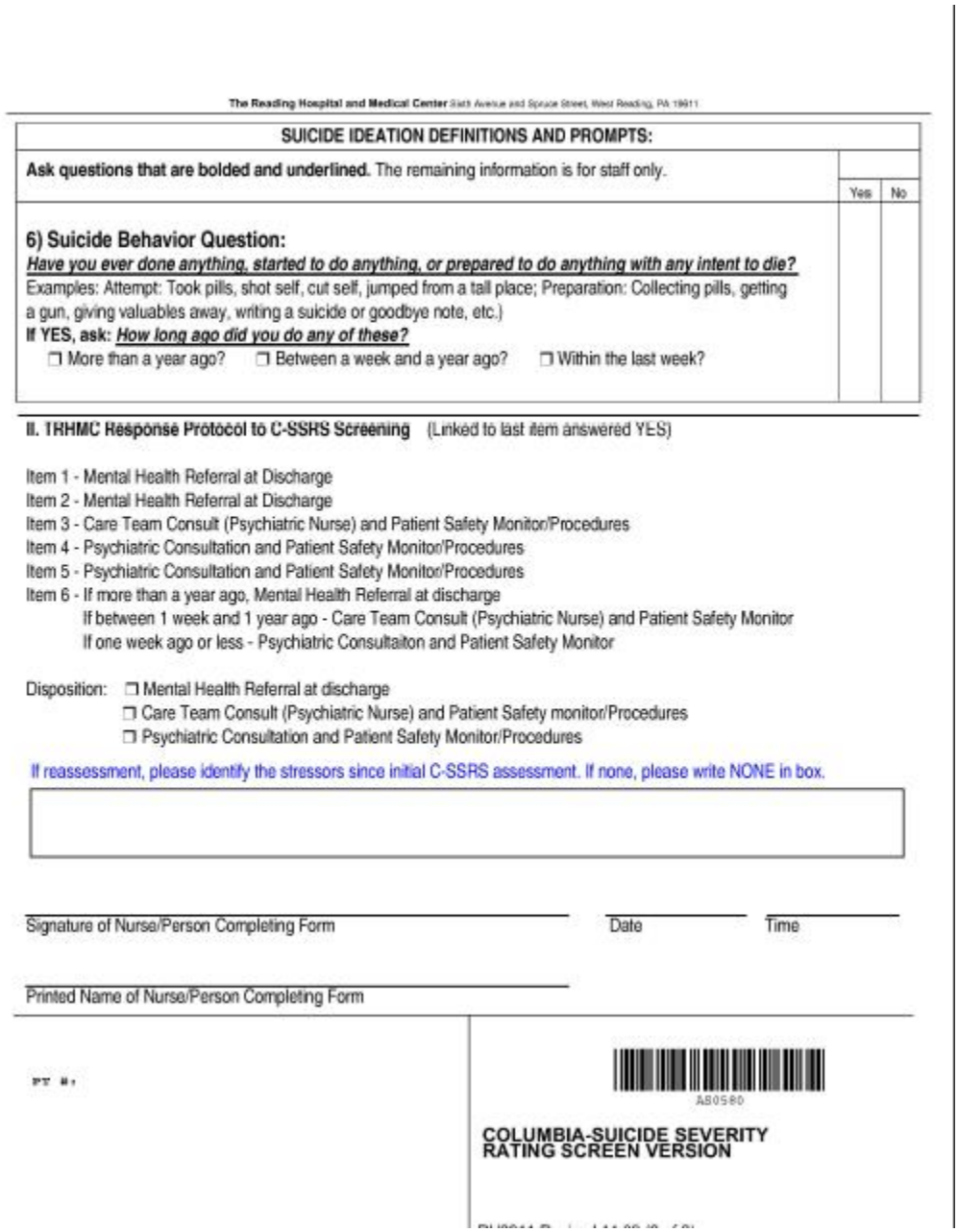
This example from the **Reading Hospital** policy shows types of clinical disposition corresponding to the level of ideation severity in the last month:

PROCEDURE:

Question	Trigger
Level 4/5 Yes to question 4 or 5	• Nursing Order to call MD for Psych Consult • Nursing Interventions (print on Kardex): • Pt Safety Monitor – 1:1 Observation • Pt Safety Monitor – Within arm's reach at all times • Complete Self Harm Safety Assessment every shift • Affix Suicide Risk Magnet to door • Revise Diet order to Safe tray • Alerts to ATC, Nutrition Services, Environmental Services and Security • Progress note for chart
Level 3 Yes to question 3 (and no to question 4 and 5)	• Consult to Care Team • Nursing Interventions (prints on kardex): • Pt Safety Monitor – 1:1 Observation • Pt Safety Monitor – Within arm's reach at all times • Complete Self Harm Safety Assessment every shift • Affix Suicide Risk Magnet to door • Revise Diet order to Safe Tray • Alerts to ATC, Nutrition Services, Environmental Services, Spruce Facilitator and Security • Progress note for chart

The triage plan shows that **endorsing ideation** of 1 or 2 results in a mental health referral at discharge, 3 results in a consult by a psychiatric nurse and 4 or 5 results in psychiatric consultation and patient safety monitoring.

Having any behavior : within the past week results in an MD consult, within the past month results in a Care Team consult, within the past year results in a mental health referral at discharge.



The Reading Hospital and Medical Center 6th Avenue and Spruce Street, West Reading, PA 19611

SUICIDE IDEATION DEFINITIONS AND PROMPTS:

Ask questions that are bolded and underlined. The remaining information is for staff only.

	Yes	No
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything with any intent to die?*** Examples: Attempt: Took pills, shot self, cut self, jumped from a tall place; Preparation: Collecting pills, getting a gun, giving valuables away, writing a suicide or goodbye note, etc.) **If YES, ask:** ***How long ago did you do any of these?*** ❒ More than a year ago? ❒ Between a week and a year ago? ❒ Within the last week?		

II. TRHMC Response Protocol to C-SSRS Screening (Linked to last item answered YES)

Item 1 - Mental Health Referral at Discharge
Item 2 - Mental Health Referral at Discharge
Item 3 - Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/Procedures
Item 4 - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 5 - Psychiatric Consultation and Patient Safety Monitor/Procedures
Item 6 - If more than a year ago, Mental Health Referral at discharge
If between 1 week and 1 year ago - Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor
If one week ago or less - Psychiatric Consultaiton and Patient Safety Monitor

Disposition: ❒ Mental Health Referral at discharge
❒ Care Team Consult (Psychiatric Nurse) and Patient Safety monitor/Procedures
❒ Psychiatric Consultation and Patient Safety Monitor/Procedures

If reassessment, please identify the stressors since initial C-SSRS assessment. If none, please write NONE in box.

Signature of Nurse/Person Completing Form Date Time

Printed Name of Nurse/Person Completing Form

PT #:

AB0580

COLUMBIA-SUICIDE SEVERITY RATING SCREEN VERSION

HARVARD PARTNERS HEALTHCARE/MASS GENERAL – C-SSRS WITH RISK AND PROTECTIVE FACTORS

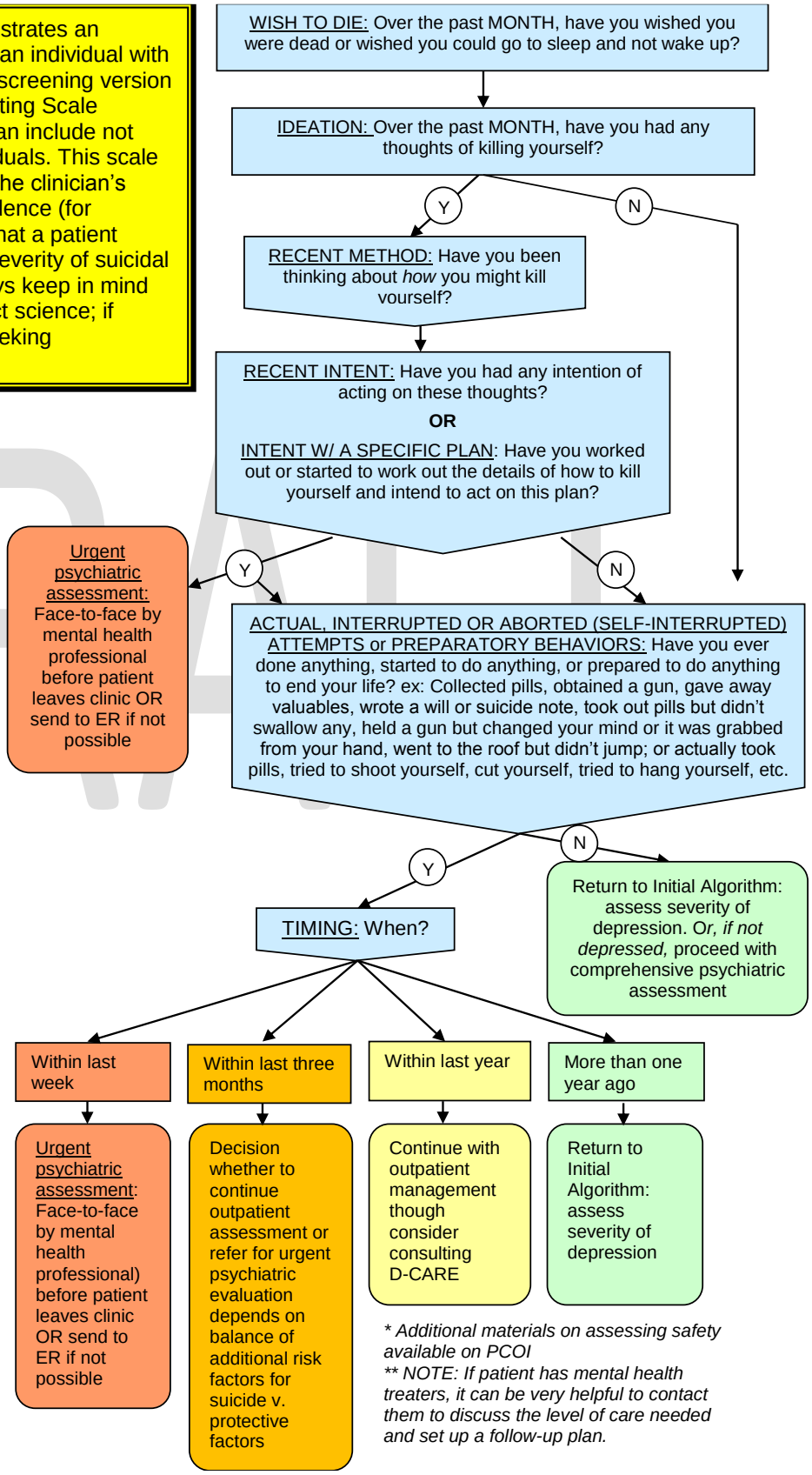
INSTRUCTIONS: This flow chart illustrates an approach to assessing the safety of an individual with suicidal thoughts. It is based on the screening version of the Columbia Suicide Severity Rating Scale (C-SSRS). Sources of information can include not only the patient but also other individuals. This scale can guide decision-making, though the clinician's judgment should always take precedence (for example, if there is reason to think that a patient might be reluctant to report the full severity of suicidal thinking). The clinician should always keep in mind that suicide prediction is not an exact science; if worried, best to err on the side of seeking consultation.

Risk Factors

- ☐ Can't enjoy anything
- ☐ Anxiety and/or panic
- ☐ Insomnia
- ☐ Hopelessness or despair
- ☐ Homicidal ideation
- ☐ Psychotic disorder or command hallucinations
- ☐ Personality Disorder (e.g. borderline, narcissistic)
- ☐ Mood disorder
- ☐ PTSD or Hx of abuse or trauma
- ☐ EtOH or substance use/abuse or withdrawal
- ☐ Impulsivity, aggression or anti-social Bx
- ☐ Ongoing medical illness (e.g. CNS, TBI, chronic pain)
- ☐ FHx of suicide, Recent or anticipated loss (relationship, financial, health, place to live) or event with despair, humiliation, or shame
- ☐ Lack of social support and/or increasing isolation
- ☐ Perceived burden on others
- ☐ Legal issues, incarceration
- ☐ Local suicide cluster or exposure to one via media
- ☐ Access to lethal means, e.g., firearms, stockpile
- ☐ Non-compliant or not in treatment

Protective Factors

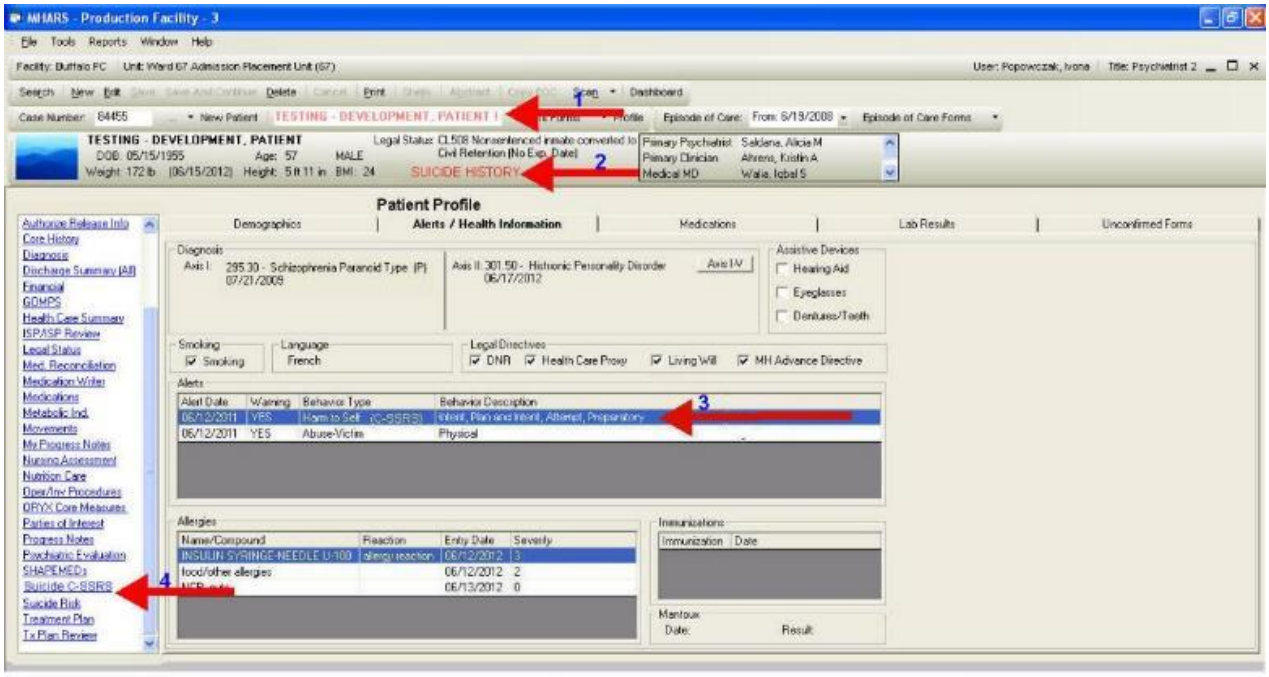
- ☐ Ability to cope with stress or frustration
- ☐ Sense of responsibility to others
- ☐ Social support
- ☐ Has a reason to live
- ☐ Religious beliefs
- ☐ Positive therapeutic relationship
- ☐ Engaged in work or school
- ☐ Fear of death
- ☐ Cultural, spiritual or moral attitudes against suicide



** Additional materials on assessing safety available on PCOI*
*** NOTE: If patient has mental health treaters, it can be very helpful to contact them to discuss the level of care needed and set up a follow-up plan.*

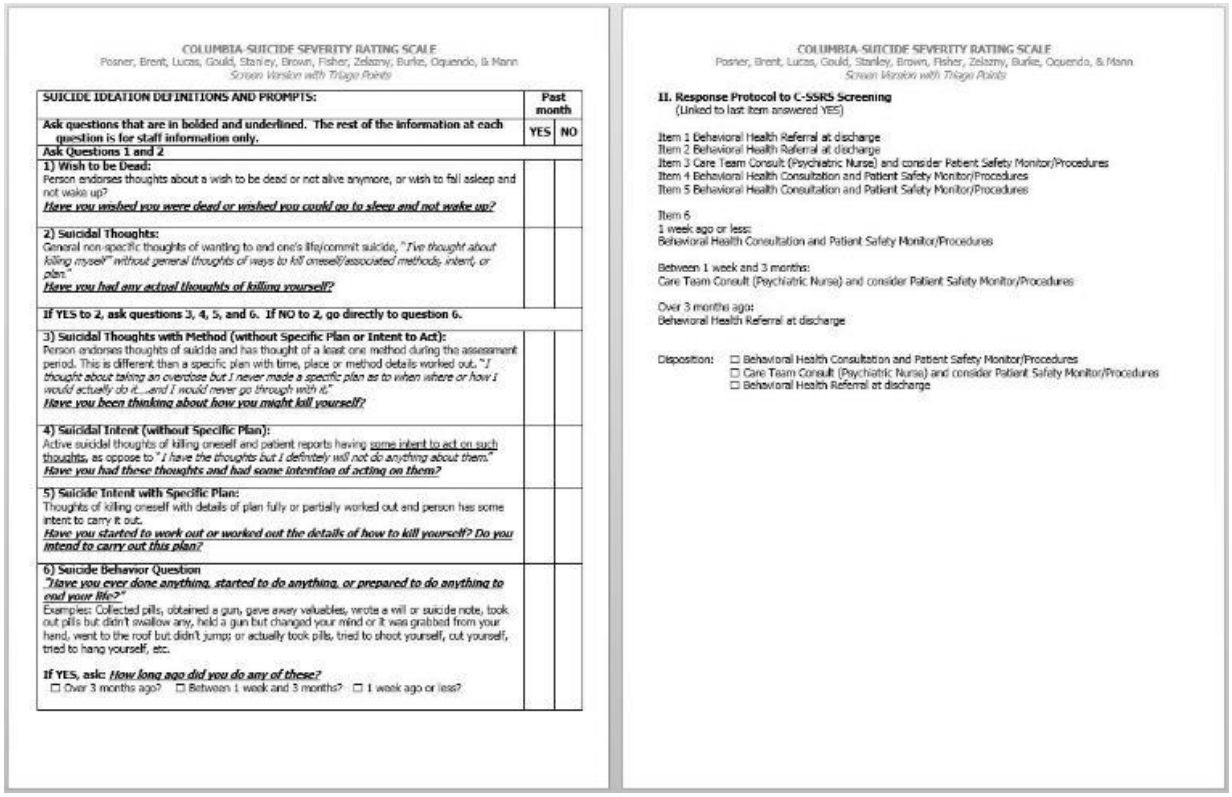
STATE-WIDE ELECTRONIC MEDICAL RECORD SYSTEM
(used by the New York State Office of Mental Health facilities with outpatient services)

The system automatically adds a **RED SUICIDE WARNING ALERT** to the patient's record for endorsing a "4 or 5" in the past month or a behavior in the past 3 months; and an **ORANGE SUICIDE HISTORY ALERT** if there is any lifetime history of ideation severity of "4 or 5" or any suicidal behavior.



1. This is the current functionality in MHARS that will show the patient's name in red with an exclamation point, if there is a warning for this patient. Applies to all warnings, not just suicide risk.
2. This is our new suggestion to show the agreed upon text if the patient has a current alert based off the C-SSRS. There will be a hover that will state, "Go to Suicide: C-SSRS under MHARS Links on the left hand side."
3. The description will show all the behaviors that have been selected for this patient throughout their lifetime. If they have a Warning, 'YES' will be displayed in the Warning column.
4. To get more details, the user would select the C-SSRS icon on the left hand side. This would bring them to the C-SSRS main page. See other mockup for further details.

MILITARY SETTINGS – MEDCOM



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bolded and underlined. The rest of the information at each question is for staff information only.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.* ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** ☐ Over 3 months ago? ☐ Between 1 week and 3 months? ☐ 1 week ago or less?		

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
Screen Version with Triage Points

II. Response Protocol to C-SSRS Screening
(Linked to last item answered YES)

Item 1 Behavioral Health Referral at discharge
Item 2 Behavioral Health Referral at discharge
Item 3 Care Team Consult (Psychiatric Nurse) and consider Patient Safety Monitor/Procedures
Item 4 Behavioral Health Consultation and Patient Safety Monitor/Procedures
Item 5 Behavioral Health Consultation and Patient Safety Monitor/Procedures

Item 6
1 week ago or less:
Behavioral Health Consultation and Patient Safety Monitor/Procedures

Between 1 week and 3 months:
Care Team Consult (Psychiatric Nurse) and consider Patient Safety Monitor/Procedures

Over 3 months ago:
Behavioral Health Referral at discharge

Disposition: ☐ Behavioral Health Consultation and Patient Safety Monitor/Procedures
☐ Care Team Consult (Psychiatric Nurse) and consider Patient Safety Monitor/Procedures
☐ Behavioral Health Referral at discharge

Policy specifics:

An <u>ideation severity</u> of:

- 1 or 2 results in a routine behavioral health referral.
- 3 results in a review by the care team
- 4 or 5 results in **EMERGENT ACTION – patient safety monitoring and psychiatric consult**

Presence of <u>any</u> suicidal behavior:

- <u>over 3 months ago</u> results in a routine behavioral health referral
- <u>within the past 3 months</u> results in a review by the care team
- <u>within the past week</u> results in **EMERGENT ACTION – patient safety monitoring and psychiatric consult**

PRISON MENTAL STATUS EXAM

ASU SCREENING QUESTIONNAIRE

The following six questions ask about how you have been feeling. For each question tell me if you have felt this way NONE of the time, A LITTLE of the time, SOME of the time, MOST of the time, or ALL of the time.

In the past 30 days about how often did you feel...	NONE	A LITTLE	SOME	MOST	ALL
1. ...nervous?	0	1	2	3	4
2. ...hopeless?	0	1	2	3	4
3. ...restless or fidgety?	0	1	2	3	4
4. ...so depressed that nothing could cheer you up?	0	1	2	3	4
5. ...that everything was an effort?	0	1	2	3	4
6 ...worthless?	0	1	2	3	4
TOTAL SCORE FOR 1-6 = ____ Column Total =					

In the past month:	YES	NO
7. ...have you wished you were dead, or wished you could go to sleep and not wake up?		
8. ...have you *actually* had any thoughts of killing yourself?		
If NO to Question 8, SKIP to Question 12		
9. ...have you been thinking about how you might do this?		
10. ...have you had these thoughts and had some intention of acting on them?		
11. ...have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
12. Have you ever done anything, started to do anything, or prepared to do anything with any intent to die? (*For example collected pills or a razor blade, made a noose, given things away, or written a goodbye or suicide note.*)		

If YES, ask: How long ago did you do any of these things?

- ☐ More than one year ago?
- ☐ Between three months and one year ago?
- ☐ Within the past month?

13. If YES, ask: How many times have you done any of these things? ☐ times

Scoring Rules

1. If the total of 1 thru 6 = 8 to 12 → ROUTINE REFERRAL
2. If the total of 1 thru 6 = 13 to 17 → URGENT REFERRAL
3. If the total of 1 thru 6 >= 18 → EMERGENT REFERRAL

Questions 7-13

4. If item 7 = YES → ROUTINE REFERRAL
5. If item 8 or 9 = YES → URGENT REFERRAL
5. If item 10 or 11 = YES → EMERGENT REFERRAL
6. If item 12 = More than one year ago → ROUTINE REFERRAL
7. If item 12 = 3 month to 1 year ago → URGENT REFERRAL
8. If item 12 = Within past month → EMERGENT REFERRAL
9. If item 13 = 2 or more → URGENT REFERRAL

Instructions

1. Ask ONLY non-MHSDS inmates
2. Ask all questions just as they are written.
3. All questions (except 12) apply to the last 30 days.
4. Repeat questions as necessary.
5. Score questions 1-6 by totaling the numbers in the boxes.
6. Questions 7-12 are YES/NO.
7. Use the scoring rules to determine need for referral for further evaluation.
8. If the inmate refuses → EMERGENT referral.
9. In all cases, use best judgment to refer – no matter the answers to the questions.

_____ _____ _____

Signature of Person Completing Form | Date | Time

_____ _____

Printed Name of Person Completing Form | Inmate Name & CDCR Number

SAFE-T/C-SSRS TRIAGE TOOL FOR PSYCHIATRIC CARE/BEHAVIORAL HEALTH

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

New York State Office of Mental Health

Step 1: Identify Risk Factors

C-SSCS Suicidal Ideation Severity	48 hr	Months	Lifetime (Worst)
1) **Wish to be dead** *Have you wished you were dead or wished you could go to sleep and not wake up?*			
2) **Current suicidal thoughts** *Have you actually had any thoughts of killing yourself?*			
3) **Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*			
4) **Suicidal intent without Specific Plan** *Have you had these thoughts and had some intention of acting on them?*			
5) **Intent with Plan** *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*			
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	48 hr	3 Months	Lifetime

Current and Past Psychiatric Dx:
- ☐ Mood Disorder
- ☐ Psychotic disorder
- ☐ Alcohol/substance abuse disorders
- ☐ PTSD
- ☐ ADHD
- ☐ TBI
- ☐ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
- ☐ Conduct problems (antisocial behavior, aggression, impulsivity)
- ☐ Recent onset

Presenting Symptoms:
- ☐ Anhedonia
- ☐ Impulsivity
- ☐ Hopelessness or despair
- ☐ Anxiety and/or panic
- ☐ Insomnia
- ☐ Command hallucinations
- ☐ Psychosis

Family History:
- ☐ Suicide
- ☐ Suicidal behavior
- ☐ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:
- ☐ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Sexual/physical abuse
- ☐ Substance intoxication or withdrawal
- ☐ Pending incarceration or homelessness
- ☐ Legal problems
- ☐ Inadequate social supports
- ☐ Social isolation
- ☐ Perceived burden on others

Change in treatment:
- ☐ Recent inpatient discharge
- ☐ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
- ☐ Hopeless or dissatisfied with provider or treatment
- ☐ Non-compliant or not receiving treatment

☐ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or workplace or ease of accessing

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE	POSSIBLE INTERVENTIONS
High Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) Or ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	**Refer to Psychologist or Psychiatrist to evaluate for hospitalization** **Place on Facility High Risk List**	☐ Assessment of patient's medical stability ☐ Observation Status ☐ Elopement precautions ☐ Body/belongings search ☐ Pharmacological treatment ☐ Family/significant-other engagement ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Safety Plan ☐ Telephone Follow-up upon discharge **Safety needs to consider in the physical environment:** ☐ Assess the physical environment, focusing on limiting access to methods. The most common methods of suicide in hospitals are hanging, suffocation and jumping. **If risk assessment is conducted in outpatient setting:** ☐ Place individual in a room that is away from exits but close to staff where patient is observed at all times ☐ Beware of elopement risk if patient is against admission AND/OR wanting to be alone to follow through with plans of suicide
Moderate Risk ☐ Suicidal ideation **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #2 or #3) Or ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) Or ☐ Multiple risk factors and few protective factors	**Refer to mental health professional to evaluate risk factors and determine appropriate treatment setting**	☐ Pharmacological treatment ☐ Psychotherapy (CBT, DBT) ☐ Psychoeducation (coping skills, stress management, symptom management, etc.) ☐ Engagement with family-member or significant-other ☐ Safety Plan ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts
Low Risk ☐ Wish to die (C-SSRS Suicidal Ideation #1) **no plan, intent or behavior** Or ☐ Suicidal ideation more than 1 month ago **WITHOUT plan, intent or behavior** (C-SSRS screen #2 or #3) Or ☐ Modifiable risk factors and strong protective factors Or ☐ No reported history of Suicidal Ideation or Behavior	**Outpatient**	☐ Provide information about warning signs. ☐ Provide National Suicide Prevention Lifeline card and local emergency contacts ☐ Wellness Recovery Action Planning (WRAP) ☐ Re-assess at treatment plan review