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:

<table>
<thead>
<tr>
<th>PROCEDURE:</th>
<th>Question</th>
</tr>
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<tbody>
<tr>
<td>Level 4/5</td>
<td>Yes to question 4 or 5</td>
</tr>
<tr>
<td>Level 3</td>
<td>Yes to question 3 (and no to question 4 and 5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 4/5</td>
<td>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</td>
</tr>
<tr>
<td>Level 3</td>
<td>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</td>
</tr>
</tbody>
</table>
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.
**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

**Urgent psychiatric assessment:** Face-to-face by mental health professional before patient leaves clinic OR send to ER if not possible

**WISH TO DIE:** Over the past MONTH, have you wished you were dead or wished you could go to sleep and not wake up?
- Y
- N

**IDEATION:** Over the past MONTH, have you had any thoughts of killing yourself?
- Y
- Y
- N

**RECENT METHOD:** Have you been thinking about how you might kill yourself?
- Y
- N

**RECENT INTENT:** Have you had any intention of acting on these thoughts?
- OR

**INTENT W/ A SPECIFIC PLAN:** Have you worked out or started to work out the details of how to kill yourself and intend to act on this plan?
- Y
- N

**ACTUAL, INTERRUPTED OR ABORTED (SELF-INTERRUPTED) ATTEMPTS or PREPARATORY BEHAVIORS:** Have you ever done anything, started to do anything, or prepared to do anything to end your life? ex: 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.
- Y
- N

**TIMING:** When?
- Within last week
- Within last three months
- Within last year
- More than one year ago

**Decision whether to continue outpatient assessment or refer for urgent psychiatric evaluation depends on balance of additional risk factors for suicide v. protective factors**

**Return to Initial Algorithm:** assess severity of depression. Or, if not depressed, proceed with comprehensive psychiatric assessment

* 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.
### MILITARY SETTINGS – MEDCOM

#### Suicide Ideation Questioning and Prompts:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Prompt</th>
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<tbody>
<tr>
<td>1. What do you think? (Repeat for thoughts about death or not taking care of yourself)</td>
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<tr>
<td>2. Suicidal Thoughts</td>
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<tr>
<td>General nature of thoughts ranging from extreme to mild and worst nature</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>These thoughts tend to occur when you feel upset or anxious or even when you feel good and restful</td>
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<td></td>
<td></td>
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<tr>
<td>These thoughts can be influenced by a variety of factors such as stress, trauma, or other life events</td>
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<td></td>
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<tr>
<td>These thoughts may increase or decrease over time depending on your mood and situation</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions: 1, 3, 4, and 5. If NO to 2, go directly to question 6.</td>
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<td></td>
<td></td>
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<tr>
<td>3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act)</td>
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<tr>
<td>How likely is it to your best knowledge of yourself, that you have or have had thoughts of ending your life, even if you do not want to die immediately?</td>
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<tr>
<td>4. Suicidal Thoughts with Specific Plan</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>How likely is it to your best knowledge of yourself, that you have or have had thoughts of ending your life, even if you do not want to die immediately?</td>
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</tbody>
</table>

### Policy Specifics:

An ideation severity 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 any suicidal behavior:

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

<table>
<thead>
<tr>
<th>In the past 30 days about how often did you feel...</th>
<th>NONE</th>
<th>A LITTLE</th>
<th>SOME</th>
<th>MOST</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ...nervous?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. ...hopeless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. ...restless or fidgety?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. ...so depressed that nothing could cheer you up?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. ...that everything was an effort?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. ...worthless?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTAL SCORE FOR 1-6 =**  
**Column Total =**

**In the past month:**

7. ...have you wished you were dead, or wished you could go to sleep and not wake up? (If NO to Question 8, SKIP to Question 12)

8. ...have you actually had any thoughts of killing yourself?

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  \(\rightarrow\) ROUTINE REFERRAL  
2. If the total of 1 thru 6 = 13 to 17  \(\rightarrow\) URGENT REFERRAL  
3. If the total of 1 thru 6 >= 18  \(\rightarrow\) EMERGENT REFERRAL

**Questions 7-13**

4. If item 7 = YES  \(\rightarrow\) ROUTINE REFERRAL  
5. If item 8 or 9 = YES  \(\rightarrow\) URGENT REFERRAL  
6. If item 10 or 11 = YES  \(\rightarrow\) EMERGENT REFERRAL  
7. If item 12 = More than one year ago  \(\rightarrow\) ROUTINE REFERRAL  
8. If item 12 = 3 month to 1 year ago  \(\rightarrow\) URGENT REFERRAL  
9. If item 12 = Within past month  \(\rightarrow\) EMERGENT REFERRAL  
10. If item 13 = 2 or more  \(\rightarrow\) 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  \(\rightarrow\) EMERGENT referral.  
9. In all cases, use best judgment to refer – no matter the answers to the questions.

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**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-SSRS suicidal ideation severity
  - (Yes, No, Not sure)
- Current suicidal thoughts
  - Have you recently had any thoughts of ending your life?
- Suicidal thoughts
  - Have you recently thought about ending your life?
- Suicide intent
  - Have you formulated a plan to end your life?
- Intent and Means
  - Have you attempted suicide or planned to do so?
- C-SSRS suicide behavior
  - Have you ever done anything, attempted, damaged property, or anything similar to suicidal behavior?

Examples: Collected pills, obtained a gun, gave away valuables, wrote will or note, took out policies, but did not follow through, focused on how to kill self, tried to hurt self, cut self, self-harmed.

Current and past psychiatric history:
- Major Depressive
- Alcohol or substance abuse disorder
- Bipolar disorder
- PTSD
- E,B,D
- O.T.B.
  - Obsessive-compulsive disorders (OCD)
- Schizophrenia

Presenting Symptoms:
- Agitation
- Suicidal
- Unusual behavior
- Aggression
- Anxiety
- Depression
- Hallucinations
- Psychosis

Family History:
- Suicide
- Substance abuse
- Severe mental health disorders requiring hospitalization

Preventative measures:
- Triggers events leading to disturbance, harm, and/or harm (e.g., loss of relationship, financial or health status)
- Contingency planning (i.e., loss of relationship, financial or health status)
- Social isolation
- Overload

Change in treatment:
- Increase in medications
- Change in therapy or medication, e.g., increased dose
- Hospitalization
- Homelessness
- Emergency contacts
- Legal protection

Step 2: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

- Assessment of patient’s mental stability
- Observation status
- Education
- Bodily/medical management
- Pharmacological treatment
- Family significant-other engagement
- Psychosocial/behavioral treatment
- Psychosomatic training
- Psychopharmacological treatment
- Safety Plan
- Telephone follow-up upon discharge

High Risk
- Suicide-related events 1 month prior to present
- Suicide within past 3 months
- Suicide-related events

Moderate Risk
- Suicide-related events 1 month prior to present
- Suicide-related events within past 3 months
- Suicide-related events

Low Risk
- Suicide-related events
- Suicide-related events within past 3 months
- Suicide-related events

Referral to mental health professional to evaluate risk factors and determine appropriate treatment setting

Possible Interventions
- Pharmacological treatment
- Psychosocial/behavioral treatment
- Psychosomatic training
- Safety Plan
- Telephone follow-up upon discharge
- Psychosocial/behavioral treatment
- Psychosomatic training
- Safety Plan
- Telephone follow-up upon discharge
- Outpatient

Provide information about warning signs
- Provide National Suicide Prevention Lifeline card and local emergency contacts
- Wellness Recovery Action Planning (WRAP)
- Risk assessment plan review