**CLINICAL TRIAGE AND WORKFLOW GUIDELINES FOR THE C‐SSRS**

Answers on the C‐SSRS provide the information needed 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.

The C-SSRS has operationalized thresholds for imminent risk. No matter where the Columbia is being used, the imminent risk answers are the same. Those answers are a “yes” to items 4 or 5 for ideation severity (There is intent to act) within the past month or a “yes” to having any behavior in the past 3 months.



These high-risk answers require patient safety precautions until a mental health professional can evaluate the individual for possible hospitalization. Other answers on the Columbia only require referral to outpatient providers and crisis hotlines

This first level screening can be done by anyone (nurses, teachers, clergy, lawyers, parents, etc.) or by self-report.

Below and attached are some examples of workflow.





**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 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).

**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 the most severely emergent clinical situation.*

**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.



**HOSPITAL SETTINGS FOR THE JOINT COMMISSION REQUIREMENT**

**A Sample Intervention Matrix**

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| **Suicide Screening****Decision Support Tool** |
| **Screening** | **CSSRS Screening Answers** | **IMMEDIATE GOAL** | **POSSIBLE RESOURCES & INTERVENTIONS\*** |
| **High Risk**Suicidal ideation with intent or with intent and plan in past month (C-SSRS ideation # 4 or #5) ***And/Or***Suicidal Behavior within past 3 months (C-SSRS suicidal behavior)**Defined as:** Suicidal Ideation with intent or intent with plan in the past month and/or suicidal behavior within the past three months | #1, #2 and #3 = YES or NO#4 and #5 = NO#6 lifetime = YES#6 past 3 mos. = YES**-and/or-**#1 = YES or NO#2 = YES#3 = YES or NO#4 or #5 = YES#6 lifetime = YES or NO#6 past 3 mos. = NO | **Immediate notification to provider to assess and determine ultimate disposition. Provide safe environment.**  | **Provider to assess and determine disposition. Provide appropriate safe environment per Aurora policy.** **Consider the following support for decision-making:** **AMBULATORY RESOURCES:*** Contact Behavioral Health Call Center: 414-454-6777 for questions, or assistance in next step decision making.
* Contact local hospital Behavioral Health Intake for assistance, if available (Phone #).
* Send patient to ED via ambulance.
* Collaborative completion of Stanley Brown Patient Safety Plan
* If the patient declines further evaluation, elects to leave, and is believed to be a danger to themselves or others, call 911.  *(Patients cannot be legally detained against their will except by police through placement on an emergency detention status.)*

**EMERGENCY DEPT RESOURCES:*** Complete ED Nursing Psych Assessment
* Enter Consult Order to BH Intake
* Utilize Tele-Intake services, if onsite Intake unavailable
* Contact Local Crisis Team (Phone #) for evaluation of involuntary detention or diversion service (crisis group home, community safety plan)
* Complete Lifetime/Clinical Columbia Scale, if available
* Collaborative completion of Stanley Brown Patient Safety Plan

**MED/SURG RESOURCES:*** Initiate Care Plan for Suicide Risk/Depression
* Complete RN Mental Status Assessment
* Enter Psych/Psych Specialist Consult
* Contact Local Crisis Team (Phone #) for evaluation of involuntary detention or diversion service (crisis group home, safety plan)
* Enter consult to CM/SW
* Consider transfer to BH-specific unit
* Complete Lifetime/Clinical Columbia Scale, if available
* Collaborative completion of Stanley Brown Patient Safety Plan
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| **Medium Risk**Suicidal ideation WITH method, WITHOUT plan or intent in past month. (C-SSRS ideation #3)***And/Or***Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior)**Defined as:** Suicidal ideation with method, without plan or intent, and/or suicidal behavior more than three months ago | #1 = YES or NO#2 = YES#3 = YESand #4 and #5 = NO#6 lifetime = NO**-and/or-**#1 = YES or NO#2 = YES or NO#3, #4 and #5 = NO#6 lifetime = YES#6 past 3 mos. = NO | **Provider to assess and determine disposition. Provider has option to provide safe environment, per clinical judgement and assessment. (Provide policy link here). Obtain or complete further assessment. Behavioral Health Consult, if available.** | **Consider the following support for decision-making:** **AMBULATORY RESOURCES:*** Contact Behavioral Health Call Center: 414-454-6777 for questions, or assistance in next step decision making.
* Contact local hospital Behavioral Health Intake (Phone #) or local Aurora
* Contact Local Crisis Team (Phone #) for evaluation of involuntary detention or diversion service (crisis group home, safety plan)
* Outpatient Behavioral Health Center (Phone #) for guidance and/or scheduling assistance*.*
* Collaborative completion of the Stanley Brown Patient Safety Plan
* Consider scheduling follow-up appt. with:
	+ Behavioral Health **and/or**
	+ Primary Care Physician
* Provide patient “What to Do in a Crisis” FYWB and crisis phone numbers (Krames)

**EMERGENCY DEPT RESOURCES:*** Enter consult Order to BH Intake
* Utilize Tele-Intake services, if onsite Intake unavailable (Phone #)
* Contact Local Crisis Team (Phone #) for evaluation of involuntary detention or diversion service (crisis group home, safety plan)
* Contact Behavioral Health Call Center: 414-454-6777 for questions, or assistance in next step decision making.
* Contact local Behavioral Health Center for disposition to PHP, day treatment or for guidance and assistance (phone #)
* Collaborative completion of the Stanley Brown Patient Safety Plan
* Consider scheduling follow-up appt. with:
	+ Behavioral Health **and/or**
	+ Primary Care Physician
* Provide patient with “What to Do in a Crisis” FYWB and crisis phone numbers (Krames)

**MED/SURG RESOURCES:** * Initiate Care Plan for Suicide Risk/Depression
* Complete RN Mental Status Assessment
* Enter Psych/Psych Specialist Consult
* Enter consult to CM-SW
* Contact Local Crisis Team (Phone #) for evaluation of involuntary detention or diversion service (crisis group home, safety plan)
* Collaborative completion of Stanley Brown Patient Safety Plan
* Consider scheduling follow-up appt. with:
	+ Behavioral Health **and/or**
	+ Primary Care Physician
* Provide patient with “What to Do in a Crisis” FYWB and crisis phone numbers (Krames)
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| **Low Risk**Wish to die (C-SSRS Ideation #1) no method, plan, intent or behavior***Or*** Suicidal ideation (C-SSRS Ideation #2) WITHOUT method, plan, intent or behavior. ***Or*** Modifiable risk factors and strong protective factors. ***Or*** No reported history of suicidal ideation or behavior.**Defined as**: Wish to die, no method, plan, intent, or behavior and/or suicidal ideation, no method, plan, intent, or behavior or modifiable risk factors and strong protective factors, or no reported history of suicidal ideation or behavior | #1 and #2 = YES or NO#3 and #4 and #5 = NO# 6 lifetime = NO | **Provide education and resources.** | **Consider the following support for decision-making:** **AMBULATORY RESOURCES:*** Provider may inquire if patient would like any information: crisis information, Coping with a Crisis FYWB, depression ‘what to look for” FYWB, numbers to obtain behavioral health assistance. (Krames)
* Collaborative completion of Stanley Brown Patient Safety Plan
* Consider:
	+ Referral to Behavioral Health **and/or**
	+ Follow up with Primary Care Physician
* Contact Behavioral Health Call Center: 877-666-7223 for assistance scheduling

**HOSPITAL-WIDE RESOURCES:** * Provider may inquire if patient would like any information: crisis information, Coping with a Crisis FYWB, depression ‘what to look for” FYWB, numbers to obtain behavioral health assistance
* Collaborative completion of Stanley Brown Patient Safety Plan
* Consult with local BH Intake team, tele-intake, or Behavioral Health Call Center, if more guidance needed.
* Consider at discharge:
	+ Referral to Behavioral Health **and/or**
	+ Follow up appt with Primary Care Physician
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**A Sample Intervention Plan**





