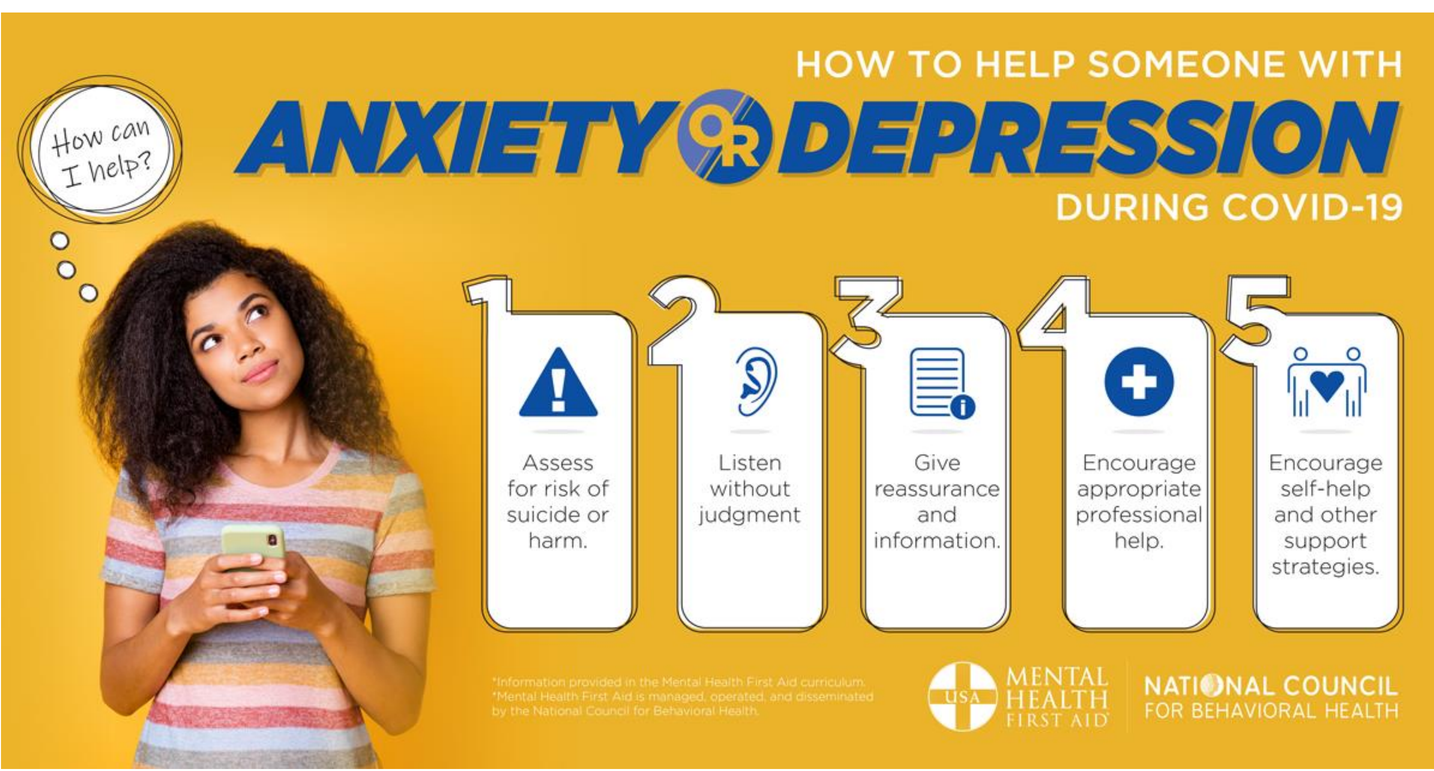
Quick Guide: CLINICAL TRIAGE GUIDELINES USING THE C-SSRS

Please remember that these calls are meant to be social in nature, you are not operating in a clinical capacity, however, if your older adult does talk about thoughts of death, wanting to die, euphemisms (“sad,” “feeling blue,” “lonely,” “I’m ready to go”) or anything that is concerning to you below are some steps to guide you with an appropriate response.

Also, remember that some of these statements are normal for older adults or people who are dealing with a crisis like the pandemic, you can validate their response “It is ok for people to verbalize anxiety or depression, we would expect that”.

You can ask them more about it. Depending on what they are saying, you can or should ask them more about it. Follow your gut instinct, if it sounds off track then follow up.

Use the steps below to determine the level of risk and what your appropriate response should be.



Please be familiar with the full length resources provided that include protective factors and suggested responses to address suicidal thoughts.

Triage protocol for suicidal thoughts verbalized

1- If detect suicidal ideations then use the CSSRS screen (below), let them know you are concerned and would like to ask some additional questions. Let them know you are a mandated reporter and are required to follow up accordingly:

   a. If low risk, then after your phone call ends call the faculty on call
      i. Use resources to engage older adult in coping skills, increasing support, and reasons to live
   b. If medium risk then call the faculty on call while your still on the phone, if faculty is not available try the next faculty on the list on call
      1. Safety plan:
         a. if older adult is medium risk ask questions to find out if they are seeing a mental health provider and encourage them to call them. Ask them if they are willing to provide the mental health provider's phone number to you so you can call on their behalf
         b. ask if there is anyone around (at home, nearby) ensure they are not alone
         c. Use resources to engage older adult in coping skills, increasing support, and reasons to live
         d. Review protective factors
   c. If high risk (danger to self)
      i. ask if someone is with them, a family member, friend or caregiver, etc. and ask to talk to them. Let them know they should call 911 because the older adult is in immediate danger to self
      ii. if the older adult is alone and high risk, has ideations, intent, plan and means an urgent intervention is required, call 911 then also let them know that you care about their well-being and will be sending someone to look in on them, and that "they are coming to help you". Obtain their address, use your conference calling option on your phone, keep your older adult on the phone when you call 911.
      iii. After the situation has resolved immediately contact the faculty member on call

SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity	Month
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 do this?*	
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. If "YES" Was it within the past 3 months?	Lifetime Past 3 Months

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 ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

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
High Suicide 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)	☐ Initiate local psychiatric admission process ☐ Stay with patient until transfer to higher level of care is complete ☐ Follow-up and document outcome of emergency psychiatric evaluation
Moderate Suicide Risk ☐ Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** ☐ Multiple risk factors and few protective factors	☐ Directly address suicide risk, implementing suicide prevention strategies ☐ Develop Safety Plan
Low Suicide Risk ☐ Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ Discretionary Outpatient Referral

Suicide Prevention Line

The 988 Lifeline

988 is now active across the United States. This new, shorter phone number will make it easier for people to remember and access mental health crisis services. (Please note, the previous 1-800-273-TALK (8255) number will continue to function indefinitely.)