C-SSRS TRIAGE PLAN FOR F-M COMMUNITY PROVIDERS

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 person administering the screener's judgment should always take precedence. The person administering should always keep in mind that suicide predication is not an exact science; if worried, best to err on the side of seeking consultation.

	YES	NO
1. Over the past MONTH, have you wished you were dead or wished you could go to sleep and not wake up? Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.	**Go to #2**	**Go to #2**
2. Have you actually had any thoughts of killing yourself? General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself"* without specific thoughts of ways to kill oneself/associated methods, intent, or plan.	**Go to #3-6**	**Go to #6**
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.		
3. Have you been thinking about how you might do this? 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 work ed 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.*"	**M**	**L**
4. Have you had these thoughts and had some intention of acting on them? Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."	**H**	**L**
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? Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.	**H**	**L**

6.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.	**HIGH RISK (H)** Yes within past 3 months	**MODERATE RISK (M)** Yes >3 months	**LOW (L)** No

Triage Level = The highest risk level determined from any C-SSRS question.

Make sure the person is not left alone until an adequate handoff has occurred.

High Risk

Emergent psychiatric assessment needed. Do not leave alone

North Dakota option if cooperative:

24/7 call 2-1-1 and request Southeast Human Services Center for a risk assessment.

Option if uncooperative:

Transport by safest route (FM Ambulance or PD). Place hold as necessary

Moderate Risk – Not @ imminent risk to self.

- Assess for coping skills and scene stressors/dangers to determine response.
- Encourage person to follow up with or help them connect with their primary physician or mental health professional for comprehensive psychiatric assessment.
- Help person connect with First Link at 2-1-1 for a list of resources and suicide hotline.

Low Risk

- Assess for coping skills and scene stressors/dangers to determine response.
- Help person connect with First Link at 2-1-1 for a list of resources and suicide hotline, if necessary.