SCREENING and ACTIONS

Patient presents with mental health concern or clinical suspicion of suicidal ideation present

**SCREEN for suicide risk using the C-SSRS Quick Screen**

- **Q1:** Have you wished you were dead or wished you could go to sleep and not wake up?
  - [y1, n2]
  - **no to 1, yes to 2 OR yes to both**

- **Q2:** Have you actually had any thoughts of killing yourself?
  - [y2, n2]

- **Q3:** Have you been thinking about how you might kill yourself?
  - [y3, n3]

- **Q4:** Have you had these thoughts and had some intention of acting on them?
  - [y4, n4]

- **Q5:** Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
  - [y5, n5]

- **Q6:** Have you ever done anything, started to do anything, or prepared to do anything to end your life?
  - [y6, n6]

**ACTIONS based on positive responses (respond based on highest level of risk)**

- **LOW risk**
  - • Continue with plan of care
    - **Note:** Patient response to question 6 may increase risk and result in additional steps.

- **MODERATE risk**
  - • Continue with plan of care
  - • Initiate nursing interventions

- **HIGH risk**
  - • Notify charge nurse/shift coordinator & attending physician
  - • Assess need for 1:1
  - • Initiate nursing interventions
  - • Administer C-SSRS Lifetime/Recent Assessment

**If in the past 4 weeks:**
- Notify change nurse/shift coordinator & attending physician; assess need for 1:1; initiate nursing interventions

**If 1–12 months ago:**
- Assess risk factors & consider referral to MHI or BH provider; nursing interventions

**If ≥1 year ago:**
- Consider referral to MHI or BH provider & patient education

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Not intended to replace physician judgment with respect to individual variations and needs.
### ADDITIONAL SCREENING TOOLS

**Columbia Suicide Severity Rating Scale (C-SSRS)**

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<tr>
<th>C-SSRS version</th>
<th>Description</th>
<th>Who administers?</th>
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| **Adult/Adolescent (≥12 years) Quick Screen** | Used in primary care and EDs to quickly screen patients for suicidal thoughts and behaviors; 3–6 questions (depending on patient responses). Assesses *past month.* | Any clinician can administer this screen. At Intermountain, the Quick Screen is used by:  
- Primary care providers (PCPs)  
- Emergency department (ED) triage nurses  
- Clinicians (nurses, MDs, etc.) on BH units and inpatient units |
| **Pediatric (≤11 years) Quick Screen** | | |
| **Adult/Adolescent (≥12 years) Lifetime/Recent Assessment** | Used for full assessment during initial visit; 2-page assessment (number of questions varies based on patient responses). Assesses *lifetime and past month.* |  
- PCPs treating patients at low risk  
- Any MD  
- Mental health specialists  
- Trained MHI team members (care managers, health advocates, etc.)  
- ED crisis workers  
- Other trained clinicians |
| **Pediatric (≤11 years) Lifetime/Recent Assessment** | | |
| **C-SSRS — Adult/Adolescent (≥12 years) Since Last Visit Version** | Used to assess patient at follow-up visits; same questions as the Lifetime/Recent versions. Assesses *since last visit or since last assessment.* | |
| **Pediatric (≤11 years) Since Last Visit Version** | | |
| **Suicide Prevention — Risk Assessment Tool** | Used to assess the patient’s level of risk during initial visit and over time; 1-page list of suicide risk and protective factors. Assesses *current risk.* | |