Student Suicide Risk Management Protocol

- ☐ (Optional) Contact the 24-Hour Washtenaw CMH Crisis Team to seek support or consultation (734-544-3050)
- ☐ Complete the Columbia SSRS
- ☐ Determine if a referral to PES is needed (seek consultation as needed)
- ☐ If yes, complete the top half of the referral worksheet
- ☐ Contact the family (unless contraindicated)
- ☐ Call PES (734-936-5900) and alert them that you are referring a student and will be faxing a school referral and communication worksheet
- ☐ Fax the worksheet to PES (734-763-7204)

Columbia-Suicide Severity Rating Scale and Scoring Instructions

Suicide Ideation Definitions and Prompts

Questions are highlighted in grey boxes and italicized.

Ask questions 1 and 2.

	Past Month	
	Yes	No

1. **Wish to be Dead:**
   Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

   Have you wished you were dead or wished you could go to sleep and not wake up?

2. **Suicidal Thoughts:**
   General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself," even if thoughts about ways to kill oneself, methods, intent, or plan are not present.

   Have you actually had any thoughts of killing yourself?

If YES to question 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3. **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**
   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 worked 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."

   Have you been thinking about how you might kill yourself?

4. **Suicidal Intent (without Specific Plan):**
   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."

   Have you had these thoughts and had some intention of acting on them?

5. **Suicide Intent with Specific Plan:**
   Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

   Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

	Past 3 Months	
	Yes	No

6. **Suicide Behavior Question:**

   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, ask:

   How long ago did you do any of these?

   - ☐ Over a year ago?
   - ☐ Between three months and a year ago?
   - ☐ Within the last three months?

Administration and Triage Guidelines for the C-SSRS Screener

Item 1 (Wish to be dead)

Ask item 1 and then move on to item 2 regardless of response.

Item 2 (Suicidal thoughts)

A negative answer to item 2:

- Go directly to item 6

A positive answer to item 2:

- Ask all remaining items: 3, 4, 5, and 6

Item 3 (Method)

A positive answer to question 3:

- Use clinical judgment - consider context, supports in place, and seek consultation
- Follow up with student within 1 week

Item 4 (Intention without specific plan)

A positive answer to question 4:

- Refer immediately to mental health services and take safety precautions

Item 5 (Intention and plan)

A positive answer to question 5:

- Refer immediately to mental health services and take safety precautions

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Item 6 (Past suicidal behavior)

A positive answer to question 6 in the past three months:

- Refer immediately to mental health services and take safety precautions

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

PES Referral and Communication Worksheet

A completed Columbia-Suicide Severity Rating Scale should be provided to the hospital along with this referral form.

Student and School Information and Primary Concerns Date: _____

Student Name: _____ Grade level: _____

School: _____

Primary concerns (check all that apply):

- ☐ Self-report of attempted suicide
- ☐ Self-report of a planned suicide
- ☐ Third person report of an attempted or planned suicide
- ☐ Severe and persistent suicidal ideation
- ☐ Suicidal or severe self-harm behavior
- ☐ Homicidal plan or intent

Further details/information: _____

Referring school professional(s): _____

Daytime contact phone: _____ After-hours contact phone: _____

Contact fax: _____ ☐ May receive confidential health information Email: _____

Consulted w/ 24-hour Washtenaw Community Mental Health Crisis Team (734-544-3050): ☐ Yes ☐ No

If yes, name of Crisis Team contact: _____ Phone: _____

UM Psychiatric Emergency Services: Phone: 734-936-5900, Fax: 734-763-7204
UM Emergency Dept: 1500 E Medical Dr., Ann Arbor, MI 48109

St. Joe's Hospital: Phone: 734-712-3000
5301 McAuley Dr., Ypsilanti, MI 48197

PES Recommendations Date: _____

- ☐ Admitted to inpatient unit – further information to follow at discharge
- ☐ Enroll in a partial day program. Referral made to: _____
- ☐ Follow up with outpatient mental health care provider
  - ☐ Referral provided to family for new outpatient treatment
    Agency/Provider name: _____ Date of scheduled appointment: _____
  - ☐ Continue with established provider
    Provider name: _____ Phone: _____
- ☐ Review safety plan with a school counselor or school mental health care provider
  Copy of plan provided to: ☐ Family ☐ School
- ☐ Referral to school-based CBT (if available)
  ☐ Primary depression ☐ Primary anxiety ☐ Other: _____
- ☐ Family declined recommended admission, hospitalization, or partial day treatment program

PES / UMHS contact name: _____

Contact phone: _____ Email: _____

Signature below indicates that this form may be sent by a medical provider to the referring school professional(s) or to the appropriate school staff member listed below for coordination of care and follow up.

School District	Contact	Fax
Ypsilanti Community Schools	Assistant Superintendent	734-221-1214

Parent/Guardian Signature: _____ Date: _____

Last edited: 01/30/2020