Columbia Suicide Risk Assessment Procedure

Revision Date: 03/2026

Procedure:

A. If a client is in imminent risk of serious self-harm, consult with the program manager or clinical specialist, and call the Mobile Support Team (MST) Crisis Call Center at 1-800-746-8181.

B. Direct service providers are to inform the program manager or clinical specialist for support, clinical consultations, and next steps, as appropriate for the situation, when completing a Columbia-Suicide Severity Rating Scale (C-SSRS) assessment.

1. The Mobile Support Team (MST), Crisis Stabilization Unit (CSU), Crisis Assessment, Prevention and Education (CAPE) staff, and any other staff designated as crisis response staff by a section manager should refer to their own policies and procedures regarding suicide risk assessments and consultation.

2. If a client refuses to complete a risk assessment or Safety/Crisis Plan, direct service providers shall stay in contact with the client and bring in the clinical specialist, program manager, or Mobile Support Team (MST) as support.

C. Suicide Risk Assessment:

1. All direct service providers trained in suicide risk assessment (except CAPE, CSU, & MST staff) must use a C-SSRS assessment under the following circumstances:

   a. A client is a potential danger to self/suicidal and/or engaging in suicidal behavior based on self-report or collateral information.

   b. A client is displaying verbal or behavioral indicators of suicide risk as defined in suicide risk assessment training.

   c. A client scores a 2 or 3 on the California Integrated Practice (CANS) or Standard Adult Needs and Strengths Assessment (ANSA) Comprehensive 3.0 under the “Suicide Risk” item at time of assessment or reassessment.

   d. A client scores a 3 (Severe) or 4 (Very Severe) on the Emotional, Behavioral, or Cognitive Conditions domain of the American Society of Addiction Medicine (ASAM) Criteria, and required Licensed Practitioner of the Healing Arts (LPHA) consult reveals concurrent suicide risk factors.

   e. At the time of post-hospitalization contact, when the hospitalization was for danger to self.

f. Use of a C-SSRS assessment is not limited to the above scenarios; staff may utilize the form in non-crisis situations when clinically indicated.

2. Documentation

a. Document the completion of a C-SSRS assessment in the *Intervention* section of the service note.

b. Note any significant findings in the *Response* section of the progress note and refer to the C-SSRS assessment.

c. Attach the C-SSRS assessment document to the applicable service note.

d. Include the time spent conducting the assessment and completing the document in the appropriate duration fields of the service note.

e. Code as “Crisis Intervention,” or, if completed on the same day as an assessment, use the applicable assessment procedure code based on the scope of practice.

f. Clinical documentation should describe the response or intervention provided to mitigate risks identified through screening, including but not limited to: actions taken and clinical decisions made; safety planning and crisis support measures; options considered and rejected, along with the rationale for those decisions; and any consultations that occurred.

D. Risk Identification and Triage

1. C-SSRS is run by the Columbia Lighthouse Project, which disseminates the C-SSRS and has formulated a risk level rating scale. Use this tool to help determine the level of risk and appropriate response.

2. How it works:

a. Risk identification using the Columbia Protocol is directive enough that you can immediately determine the level of risk, but flexible enough that interventions can be modified using clinical judgement.

b. The “score” is either Low, Moderate, or High risk depending on where there are affirmative answers. The most concerning responses are the same in all settings and are **a recent (past month) “yes” to question 4 or 5 on ideation severity and/or any recent (past 3 months) behavior.** Answers are color-coded for easy risk level identification (see Triage and Risk Identification - The Columbia Lighthouse Project).

c. Interventions can be adapted to reflect your individual setting/program.

3. Links to Lighthouse Project Support Documents:

a. https://cssrs.columbia.edu/

b. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/risk-identification/

c. SAFE-T-Protocol-w-C-SSRS-and-Columbia-Risk-and-Protective-Factors-Recent-2023b.doc

E. Risk Identification Grid

Answer Responses	Risk Level	Recommended Follow-up
Yes to **1.** Wish to be dead or **2.** Suicidal Thoughts and **No** to **6.** Suicide Behavior	**Lower Risk**	Complete Safety/Crisis Plan, Increase Support
Yes to **1.** Wish to be dead, **2.** Suicidal Thoughts, and/or **3.** Suicidal Thoughts with Method (without Specific Plan or Intent to Act) and **Yes** to **6.** Suicide Behavior – Not in the past 3 months	**Moderate Risk**	Complete Safety/Crisis Plan, Increase Support, Engage with program manager or clinical specialist for evaluation of support and follow up as determined to be appropriate for age and by team.
Yes to **6.** Suicide Behavior – In the past 3 months Or **Yes** to **4.** Suicidal Intent (without Specific Plan) or **5.** Suicidal Intent with Specific Plan	**High Risk**	Get immediate help for client: contact manager, clinical specialist, call MST, CSU, or 911 as recommended by program protocol. Staff should stay with the client until they are connected to crisis support.

F. Safety Plan

1. Complete the Safety Plan document in any of the following circumstances. If safety planning with a support person, complete the MHS 625 (Adult) or MHS 837 (Youth) Safety Support Plan form.

   a. After completing a C-SSRS assessment with risk indication of “Low” or above.

   b. Within 7 business days after client is discharged from a CSU or hospital immediately following an admission due to suicidal ideation or behavior.

   c. If the client has other clinical indicators of suicide risk, even if the C-SRRS screening is negative (no to all questions).

2. **Adult:** If the client is not hospitalized, complete the Safety Plan document in SmartCare.

    a. If the client has an identified support person (family member, friend, or helper) to participate in safety support planning, and a signed release of information (ROI), they can be included in the safety planning.

    b. Including support persons on the Safety Plan is optional for adult clients.

    c. Ensure there is a signed release of information (ROI) prior to discussing the plan with the support person.

3. **Youth**: If the client is not hospitalized, complete the Safety Plan document in SmartCare and complete MHS 837 Safety Support Plan in collaboration with the client's parent or guardian.

    a. Including parents/guardians on the Safety Plan is mandatory for youth clients, unless the youth is emancipated.

    b. Refer to Consents and Authorizations for Minors procedure for release of information (ROI) requirements.

4. Staff who initiate the Safety Plan should confirm the level of care and ensure the client is set up to receive appropriate follow-up support and services.

    NOTE: If at any time during safety support planning the client meets the criteria in section I, refer to the Crisis Stabilization Unit (CSU) or call 911.

Applicable Forms:

	Form	Type	Use-case
1.	C-SSRS Children's Baseline Screening	SmartCare	Initial screening for youth clients
2.	C-SSRS Adult Assessment (for adults)	SmartCare	Initial screening for adults during assessments
3.	C-SSRS Pediatric Since Last Visit	SmartCare	Follow-up screening for youth clients
4.	C-SSRS Adult Since Last Visit	SmartCare	Follow-up screening for adult clients
5.	C-SSRS Adult Screener	SmartCare	Initial screening for adults during mental health screening process
6.	Safety Plan	SmartCare	Safety planning with the client
7.	MHS 625 Adult Safety Support Plan	PDF	Safety planning with support person for an adult client
8.	MHS 837 Youth Safety Support Plan	PDF	Safety planning with support person for a youth client