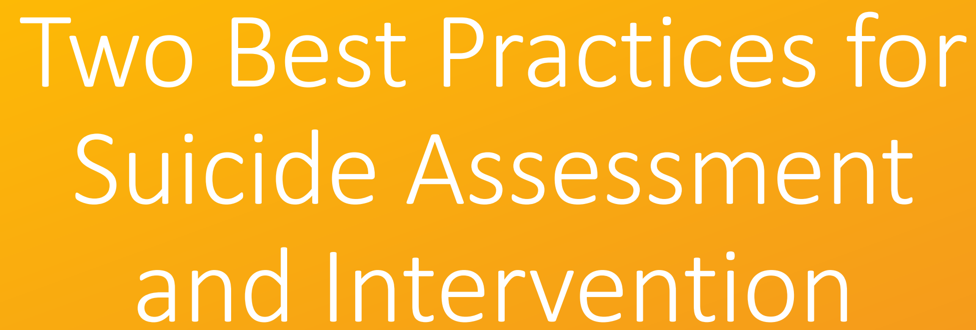

Two Best Practices for Suicide Assessment and Intervention

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Workshop Objectives

1. Integrate Columbia Suicide Severity Rating Scale (C-SSRS) into comprehensive suicide assessment.
2. Utilize C-SSRS results and additional contextual information to identify appropriate level of care for individuals with suicidal ideation.
3. Apply Safety Planning Intervention (SPI) in context of counseling relationship.
4. Identify safety considerations for telehealth context

Introductions

- Our roles
- Confidence
- Personal & professional connections

Understanding Suicide

The Words We Use

- Suicide
- Suicide attempt
- Active suicidal ideation
- Passive suicidal ideation
- Non-suicidal self-injury
- Instrumental suicide-related behavior

Terminology

- Self-inflicted
- Intent to die
- Actual harm to self
- Desired appearance and response

Is It Related to Suicide?

Protective Factors against Suicide (SPRC)

- Effective behavioral health care
- Connectedness to individuals, family, community, and social institutions
- Life skills (i.e., problem solving and coping skills, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide

Risk Factors for Suicide (SPRC)

- Prior suicide attempt(s)
- Misuse and abuse of alcohol or other drugs
- Mental disorders, particularly mood
- Access to lethal means
- Knowing someone who died by suicide, particularly family
- Social isolation
- Chronic disease and disability
- Lack of access to behavioral health care

Suicide Warning Signs (AAS)

- **I**deation
- **S**ubstance use

- **P**urposelessness
- **A**nxiety
- **T**rapped
- **H**opelessness

- **W**ithdrawal
- **A**nger
- **R**ecklessness
- **M**ood change

Consensus Youth Suicide Warning Signs

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Severe or overwhelming emotional pain or distress
- Worrisome behavioral cues or marked changes in behavior. Especially,
  - *Withdrawal from or changing in social connections*
  - *Changes in sleep*
  - *Anger or hostility that seems out of character or out of context*
  - *Recent increased agitation or irritability*

Common Misperceptions

- Someone who talks about it is not serious
- Talking about it will increase risk
- Suicide talk is about attention-seeking
- Suicide happens without warning
- Suicidal people want to die / can't stop
- Crazy, mentally ill, insane
- Danger reduced after crisis

Building Relationships & Opening Conversations

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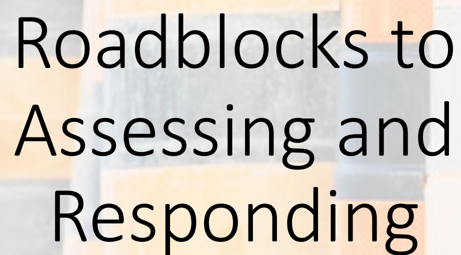


Roadblocks to Assessing and Responding

- What client beliefs or experiences may get in the way of open and honest talk?
- What counselor beliefs and experiences may get in the way of open and honest talk?

Preparing for Conversations

(Shea, 2002)

- Be direct – kill, suicide
- Tune in to hesitancy
- Investigate "not really"
- Look for nonverbals
- Get out from behind the clipboard
- Tune in to own responses
- Take your time
- Prepare to be persistent and creative

Key Elements of Suicide Risk Assessment

Context

- Precipitating events
- Stressors
- Triggers

Nature of Ideation

- Ideation
- Plan
- Means
- Intent

Supporting Assessments

- Warning signs
- Prior history
- Risk factors
- Protective factors

Columbia Suicide Severity Rating scale (C-SSRS)

http://cssrs.columbia.edu

See website for

- Setting-specific versions
- Additional details and manuals
- Formal training and demonstration videos

Why the C-SSRS

- Simple design appropriate for variety of professionals
- Efficient identification regarding level of care
- Evidence of suicide reduction following implementation
- Free
- Universal – across ages (created for children, effective with adults), populations, settings, 100+ languages
- Evidence-supported

Adopted as protocol by multiple state DoEs including TN, GA, NY

The Columbia Suicide Severity Rating Scale (C-SSRS): Psychometric Evidence

Table 1: Studies Supporting Specific Psychometric Properties

Psychometric Property		Studies
Clinical Utility	Predictive and/or Incremental Validity	Brent et al., 2009^; Posner et al., 2011*^; Gipson et al., 2015^; Conway et al. 2016^; Horwitz et al., 2015^; Mundt et al., 2013*; Arias et al. 2013*; Greist et al. 2014*; Brown et al., 2015*; Arias et al., 2016*; Madan et al. 2016*
	Sensitivity to Change	Posner et al., 2011*^; Ionescu et al., 2016*
	Sensitivity and Specificity	Posner et al., 2011*^; Mundt et al., 2013*; Viguera et al. 2015*; Madan et al. 2016*
	Positive and Negative Predictive Value (PPV & NPV)	Mundt et al 2013*; Viguera et al 2015*
Reliability (internal consistency)		Posner et al., 2011*^; Kilincaslan et al. 2018^; Pai et al. 2015*; Madan et al. 2016*
Reliability (inter-rater; multi-method agreement)		Kerr et al., 2013^; Brent et al., 2009^; Kilincaslan et al. 2018^; Hesdorffer et al., 2013*; Arias et al., 2013*; Brown et al. 2015*
Internal Structure (Factor Analysis)		Al-Halabi et al., 2016b*; Madan et al. 2016*
Convergent Validity & Accuracy		Posner et al., 2011*^; Kerr et al., 2013^; Kilincaslan et al. 2018^; Pai et al. 2015*; Youngstrom et al. 2015*; Brown et al., 2015*; Madan et al.2016*
Divergent & Discriminant Validity		Posner et al., 2011*^; Kerr et al., 2013^; Kilincaslan et al. 2018^
Cross-Cultural Validation		Danish (Conway et al. 2016^); Turkish (Kilincaslan et al. 2018^); Korean (Pai et al. 2015*); Spanish (Al-Halabi et al ., 2016ab*)

* studies include adult samples; ^ studies include pediatric samples

Screener Demo

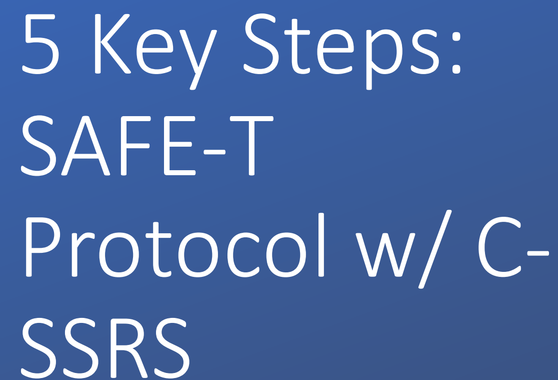
School-Based Screener w/ Triage

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Schools

	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
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?*** e.g. "*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.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**Lifetime**	
Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.		
	Past 3 Months	
If YES, ask: ***Was this within the past 3 months?***		

Possible Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Referral
Item 4 Student Safety Precautions and psychiatric evaluation by crisis team/EMT/Emergency room
Item 5 Student Safety Precautions and psychiatric evaluation by crisis team/EMT/Emergency room
Item 6 Behavioral Health Referral
Item 6 3 months ago or less: Student Safety Precautions and psychiatric evaluation by crisis team/EMT/Emergency room



5 Key Steps: SAFE-T Protocol w/ C-SSRS

1. **Identify risk factors**
   - C-SSRS suicidal ideation severity
   - C-SSRS suicidal behavior
   - Current and past psychiatric diagnoses
   - Presenting symptoms
   - Family history
   - Precipitants/stressors
   - Change in treatment
   - Access to legal means
2. **Identify protective factors**
3. **C-SSRS suicidal ideation intensity**
4. **Determine level of risk**
5. **Documentation**

Bridging to "The Question" and Assessment

Summarize situation and reflect feelings

Use owning statements

Be very direct

Affirm choice to share

Give room to tell why

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?*	Low
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	Low
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	Moderate
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	High
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?*	High
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** Moderate **Past 3 Months** High

Ideation Demo

Behavior Demo

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?*	Low
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	Low
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	Moderate
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	High
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?*	High
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** Moderate **Past 3 Months** High

Activating Events:

- □ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- □ Pending incarceration or homelessness
- □ Current or pending isolation or feeling alone

Treatment History:

- □ Previous psychiatric diagnosis and treatments
- □ Hopeless or dissatisfied with treatment
- □ Non-compliant with treatment
- □ Not receiving treatment
- □ Insomnia

Other:

- □ ___________________
- □ ___________________
- □ ___________________

Clinical Status:

- □ Hopelessness
- □ Major depressive episode
- □ Mixed affect episode (e.g. Bipolar)
- □ Command Hallucinations to hurt self
- □ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- □ Highly impulsive behavior
- □ Substance abuse or dependence
- □ Agitation or severe anxiety
- □ Perceived burden on family or others
- □ Homicidal Ideation
- □ Aggressive behavior towards others
- □ Refuses or feels unable to agree to safety plan
- □ Sexual abuse (lifetime)
- □ Family history of suicide

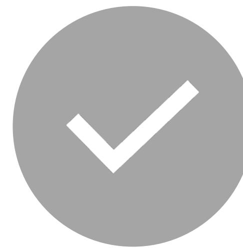
□ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: ☐ Fear of death or dying due to pain and suffering ☐ Identifies reasons for living ☐ ____________________ ☐ ____________________	**External:** ☐ Belief that suicide is immoral; high spirituality ☐ Responsibility to family or others; living with family ☐ Supportive social network of family or friends ☐ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior) If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent for comprehensive behavior/lethality assessment.	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	**Month**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	
Total Score	

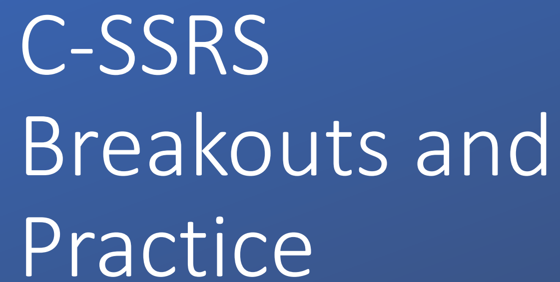
Additional Implementation Resources

FREE MATERIALS AND SCHOOL-BASED KITS AVAILABLE AT [HTTP://CSSRS.COLUMBIA.EDU](http://cssrs.columbia.edu)



FREE ADMINISTRATION TRAINING AVAILABLE [HTTP://CSSRS.COLUMBIA.EDU/TRAINING/TRAINING-OPTIONS/](http://cssrs.columbia.edu/training/training-options/)

C-SSRS Breakouts and Practice



- Establish scenario
- Warm up quickly. At the very minimum, work through C-SSRS suicidal ideation and behavior questions. Try to get through the SAFE-T Framework

From Assessment to
Intervention

Risk Formulation Guidelines

	C-SSRS Level	Risk Factors	Protective Factors	Suicide History
Low	1 or 2	Modifiable	Strong	None reported
Moderate	3	Multiple	Few	Behavior more than 3 months ago
High	4 or 5			Behavior within past 3 months

Confounds to the "Risk Grid"

- Provider/client relationship
- Perceived pain
- Perceived resources
- Previous attempts
- Mental health history & disorders
- Balance of warning signs, risk factors, and protective 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."

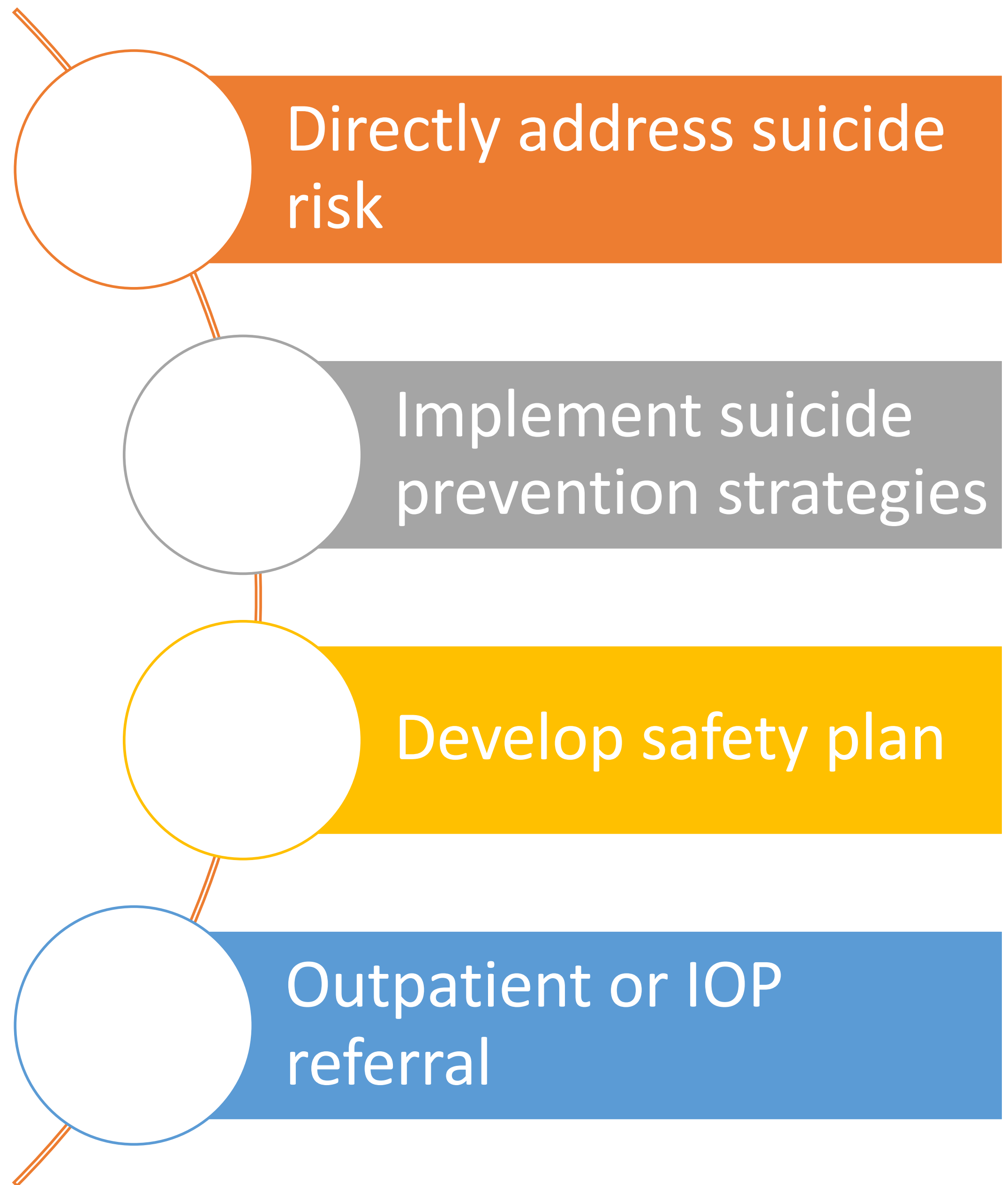
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

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**

Strategy for Low Risk

- Facilitate outpatient referral
- Coordinate systemic supports
- Notify caregiver
- Provide Lifeline
- Consider Safety Planning Intervention (CBM says do it)

Strategy for Moderate Risk



Strategy for High Risk

- Initiate psychiatric admission
- Provide continuous supervision
- Follow-up and document evaluation outcome

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

- ☐ Your Clinical Observation
- ☐ Relevant Mental Status Information
- ☐ Methods of Suicide Risk Evaluation

- ☐ Brief Evaluation Summary
  - ☐ Warning Signs
  - ☐ Risk Indicators
  - ☐ Protective Factors
  - ☐ Access to Lethal Means
  - ☐ Collateral Sources Used and Relevant Information Obtained
  - ☐ Specific Assessment Data to Support Risk Determination
  - ☐ Rationale for Actions Taken and Not Taken

- ☐ Provision of Crisis Line 1-800-273-TALK(8255)
- ☐ Implementation of Safety Plan (If Applicable)

If you or someone you know needs support now,

CALL OR TEXT: 988

CHAT: 988lifeline.org

988

Improves access to crisis services by making it easier to connect to crisis counselors through calls, texts and chats. A network of trained counselors is ready to listen, support and help. Most crises are resolved over the phone, reducing in-person response.

911

An emergency and public safety dispatch system of Emergency Medical Services, fire, and police.

Hello... Contact CARE Line

Calling 911 for a mental health crisis typically results in a police dispatch.

Calling 988 provides a mental health response and reduces strain on community resources.

Hello... Contact CARE Line

Safety Planning Intervention (SPI)

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19,* 256-264

Treatment manual and resources:

https://suicidesafetyplan.com/

SPI Context

Intended for low-moderate levels of risk

Brief intervention tested in Emergency Departments

Identified as SPRC, AFSP, and Zero-Suicide best practice

Can be used as stand-alone or within context of ongoing care

Collaborative process results in written, personalized safety plan

Distinctly different from no-suicide contract

SPI Overview: 6-step, Sequential Plan

Warning signs

Internal coping strategies

Socialization strategies for distraction and support

Social contacts for direct assistance

Professional and agency contacts

Means restriction

SPI Overview: For Each Step

COLLABORATIVE IDENTIFICATION IN CLIENT'S OWN WORDS

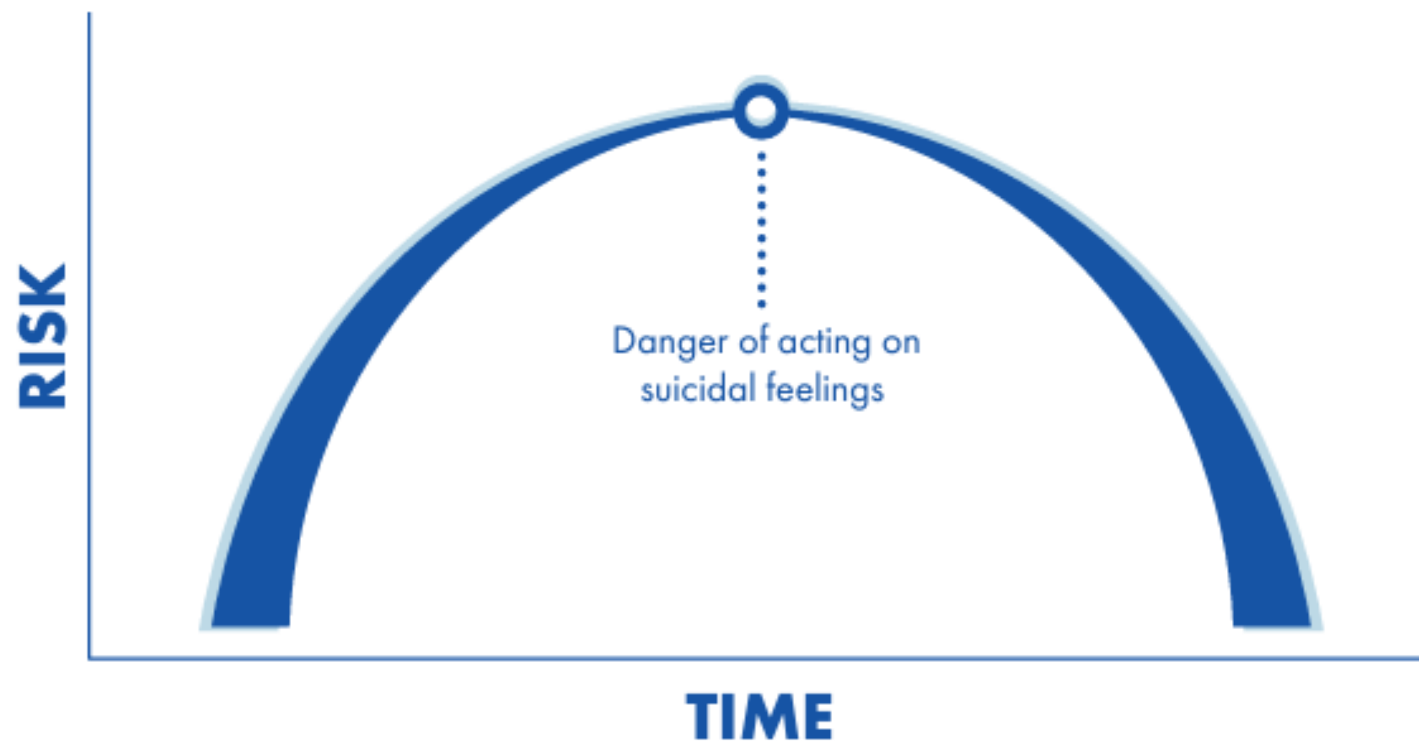
DISCUSSION ABOUT **LIKELIHOOD**

HOW LIKELY DO YOU THINK YOU WOULD BE ABLE TO DO THIS STEP DURING A TIME OF CRISIS?

PROBLEM-SOLVING OF **ROADBLOCKS OR DIFFICULTIES**

WHAT MIGHT STAND IN THE WAY OF YOU [SUMMARIZE STEP]?

SUICIDE RISK CURVE



Step 1: Recognition of Warning Signs

- Identify situations, images, thinking styles, moods, or behaviors that precede suicidal crisis

How will you know when the safety plan should be used?

What do you experience when you start to think about suicide or feel extremely depressed?

Demo

Safety Planning Intervention

Part 1

Step 2: Internal Coping Strategies

- Identify what can do, without assistance of another, should they become suicidal again

What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?

Demo

Step 3: Socialization Strategies for Distraction and Support

- Identify opportunities for socializing with others in natural environment who may help to distract
- Encourage visiting healthy social settings

Who or what social settings help you take your mind off your problems at least for a little while?

Who helps you feel better when you socialize with them?

Demo

Step 4: Social Contacts for Assistance in Resolving Suicidal Crises

- Identify prioritized list of family members or friends to inform and directly request assistance in coping with the crisis
- Practice how to share what they need

Among your family or friends, who do you think you could contact for help during a crisis?

Who is supportive of you and who do you feel that you can talk with when you're under stress?

Step 5: Professional and Agency Contacts to Help Resolve Suicidal Crises

- Clinicians' names and phone numbers
- 24-hour emergency treatment facility or team
- NSPL 800-273-TALK

Who are the mental health professionals that we should identify to be on your safety plan?

Are there other health care providers?

How will you contact them?

Step 6: Means Restriction

- Focus on ensuring a safe environment
- Firearms restriction for all (even if not in plan)
- Restricting access to elements of plan

What do we need to do to help make sure your environment is safe?
Do you own a firearm, such as a gun or rifle?
What other means do you have access to and may use to attempt to kill yourself?
How can we go about developing a plan to limit your access to these means?

Demo

SPI Ensuring Implementation

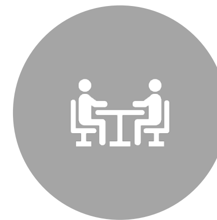
Must be personalized, collaborative

Assess reactions to plan

Ask to identify most helpful aspects of plan

Assess likelihood would use plan

Identify and problem-solve potential obstacles and difficulties



Discuss where to keep and how will retrieve when needed

SPI Breakouts & Practice

- Same scenario as last round but assess risk to be low-moderate
- Summarize what you heard about risk and plan – then bridge to SPI practice
- At the very minimum, introduce suicide risk curve and work through SPI 6 steps as a team

Telehealth Considerations

Conceptual Considerations

- Suicidal individuals historically excluded from telehealth
- COVID-19 pandemic transformed approach
- Basic guidelines need to be enacted within organizational plan

- Key resources:
  - https://zerosuicide.edc.org/resources/resource-database/sp-tie-telehealth-suicidal-clients-during-covid-19-crisis

Basic Action Steps

Request current location at start of session

Ensure emergency contact information on file

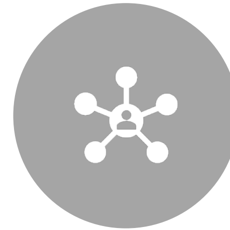
Have contact plan in place (e.g., phone backup)

Add impact of pandemic to standard risk assessment

Add inquiry about increased access to lethal means

Adaptations to Management and SPI

Increased clinical contact or brief check-ins



Identify individuals in environment to monitor and support; have direct contact with those individuals

Initiate active rescue if absolutely needed

Ensure SPI Form can be used (e.g., screen share, e-mail, or text)

SPI Adaptations in Social Isolation

- **Daily internal coping**
  - Importance of a plan and regular schedule
  - Importance of outdoors/fresh air
  - Use of news

- **Social contacts for distraction are limited**
  - Virtual activities – tours, concerts, meet-up, hang-outs, interactive online games
  - Current social environment
  - Parks or outside areas

- **Social supports**
  - Seek permission and initiate contact with 1-2 specific people
  - May need to include virtual/distance options

Any Questions

TLPCA 2024
Two Best Practice for Suicide Assessment and Intervention

Scenarios

SCENARIO 1
Jamie is a sophomore at Local High School whom you have seen for issues related to bullying, absenteeism related to bullying, and plummeting grades. They appear increasingly hopeless, and you've noticed a recent decline in self-care as well. You've also noticed some scratches on Jamie's hands and that they've been wearing long-sleeve shirts even in hot weather, leading you to wonder about whether they may be self-injuring. When you ask how things are going at school, Jamie says "about as well as they are at home." When you ask about home, Jamie looks down and says "Not good. My parents don't know how to deal with a kid like me. They keep looking to church – as if that will fix it." It's really not worth talking about.

SCENARIO 2
Maria is a young adult who initially comes to counseling wanting to figure out whether her relationship is healthy for her. She spends a number of sessions sharing about the importance of marrying and having children within her culture and religion. She is closely connected to her family and faith community, and she finds purpose in her work with animal fostering. Maria senses that her inability to settle may be a disappointment to her family. She's also been grappling with whether she can "fix" some of the "warning signs" she sees in her partner – knowing that he will not attend counseling with her. Maria presents to your fourth session looking tired and dejected, noting that a recent disagreement "got physical," she doesn't think she can talk to any of her friends or family members about this, and she feels at a loss of what to do.

SCENARIO 3
Frank recently started attending virtual classes at the community college and reports feeling isolated and alone. He misses his high school friends who have all moved away to residential schools, and he is struggling to find meaning in his job in fast food service. He's started feeling hopeless about the situation and has increased use of marijuana as the pandemic wears on. He tells you he uses to mellow himself out because he finds himself increasingly irritable and agitated over little things, like his parents complaining about messes he leaves around the house. More and more, he's holing himself up in his bedroom wanting to "sleep away" the pandemic.

C-SSRS Practice

1. The goal is to get practice and build up confidence using the C-SSRS for mild-moderate risk (our most common experience). If a scenario lands close to home, DO NOT play the client role for that scenario. Opt out and select another. This guideline stands even if you feel like it was a long time ago and is healed and resolved now.
2. **Counselor** - Reflect your understanding of the scenario and use it to bridge right away to a reflection and ask about suicide. Work your way through the SAFE-T Protocol with C-SSRS. If you get stuck, call a time-out and ask the observer to help you.
3. **Client** - Engage based on the role play scenario. You can hesitate a bit, but be sure to make your scenario about suicide. Do not make your responses go any higher than a 3 on the C-SSRS. Make sure you have some risk and protective factors. Keep it workable.
4. **Feedback observer -** use the C-SSRS feedback checklist to formulate feedback. If counselor calls a time-out and asks for your support getting unstuck, do your best to engage them. Provide direct and honest feedback at the end.
5. **Call for help** if you get really stuck.

Feedback Checklist

- Counselor used reflective skills to smoothly introduce the question
- Counselor used reflective skills to maintain the process
- Counselor asked all 5 C-SSRS ideation questions in order
- Counselor asked the C-SSRS suicide behavior question
- Counselor explored ideation intensity using provided questions
- Counselor clarified or explored additional assessments
- Counselor responded to client concerns with care
- Counselor refrained from making promises unable to keep

SPI Practice

1. Pick up where you left off with the C-SSRS cases. You've determined your client is mild-moderate risk, so you decide to bridge into an SPI.
2. **Counselor** - Reflect your understanding of the scenario and use it to bridge to both the hopes you hear as well as the risks related to suicide. Let the client know you want to work together to help them create a plan to stay safe from suicide, even when things are hard. Introduce the suicide risk curve. Then, work your way through the 6-step SPI. If you get stuck, call a time-out and ask the feedback observer to help you.
3. **Client** - Engage based on the role play scenario. You can have doubts or hesitate, but make it workable.
4. **Feedback observer -** use the SPI feedback checklist to formulate honest feedback for the counselor. If counselor calls a time-out and asks for your support getting unstuck, do your best to engage them. Provide direct and honest feedback at the end of the 10 min practice.
5. **Call for help** if you get really stuck.

Feedback Checklist

- Counselor used reflective skills to smoothly introduce the SPI
- Counselor used reflective skills to maintain the process
- Counselor addressed all 6 areas in order
- Counselor helped client troubleshoot implementation
- Counselor ensured appropriate supports identified
- Counselor responded to client concerns with care
- Counselor refrained from making promises unable to keep

Suicide Assessment and Intervention Resource Bank

C-SSRS

General CSSR-S Website https://cssrs.columbia.edu
SAFE-T Protocol with C-SSRS https://cssrs.columbia.edu/documents/safe-t-c-ssrs/
CSSR-S Evidence Base https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/evidence/
CSSR-S Official Training https://cssrs.columbia.edu/training/training-options/

Safety Planning Intervention

Stanley-Brown SPI Main https://suicidesafetyplan.com/
Blank Safety Plan http://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf
Suicide Risk Curve Infographic http://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Suicide-risk-curve-8-6-21.pdf
SPI Demo Videos https://suicidesafetyplan.com/training/

Open-access 90-minute SPI webinar https://deploymentpsych.org/content/cdp-presents-safety-planning-intervention-reducing-suicide-risk-20-sept-adobe-connect
Safety Planning Quick Guide https://sprc.org/online-library/safety-planning-guide-a-quick-guide-for-clinicians/

Telehealth and Suicide https://zerosuicide.edc.org/resources/resource-database/sp-tie-telehealth-suicidal-clients-during-covid-19-crisis

General Suicide Resources

- **988 Suicide and Crisis Lifeline** https://988lifeline.org/
- **American Association of Suicidology** https://suicidology.org/
- **American Foundation for Suicide Prevention** https://afsp.org/
- **Suicide Prevention Resource Center** https://sprc.org/
- **Zero Suicide Initiative** https://zerosuicide.edc.org/