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## Clinical Practice Guidelines for Suicide Risk Assessment

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# Walden University

College of Nursing

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Executive Summary: Clinical Practice Guideline  
Clinical Practice Guidelines for Suicide Risk Assessment

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## Summary

In this doctoral project, I developed a clinical practice guideline (CPG) to address the lack of a standardized suicide risk assessment protocol at a Texas mental health clinic. At project initiation, suicide risk assessment at the facility was inconsistent due to the absence of a CPG. The guideline incorporated the Columbia-Suicide Severity Rating Scale (C-SSRS), a validated instrument that improved early detection of suicidal ideation and behaviors, which were often under recognized in older adults. This inconsistency led to the following clinical question, Does the evidence support the development of a CPG for assessing suicide risk among high-risk patients using the C-SSRS, as measured by a quality score via Appraisal of Guidelines for Research and Evaluation (AGREE) II tool from an expert panel and receives approval by end-users for use in practice?

The purpose of this project was to create and evaluate a CPG to increase early detection and intervention for suicidal risk. I used the Johns Hopkins Evidence-Based Practice (JHEBP) model to review 14 sources spanning evidence Levels I-V. Literature was obtained from CINAHL, PubMed, Cochrane, and PsycINFO to ensure comprehensive coverage. A panel of four content experts assessed the guideline using the AGREE II instrument. All domain scores surpassed the 70% quality threshold, ranging from 76% to 88%. The first global assessment item received unanimous ratings of 7 (strongly agree) from all reviewers, indicating the highest possible quality rating, and the second item received full endorsement for implementation. The social significance of this project was demonstrated by the standardization of the C-SSRS tool, which aimed to improve early detection and management of suicide risk and to promote a consistent assessment approach for older adults.

## **Background**

Suicide is a leading cause of death among vulnerable older adults, often associated with loneliness, mental health conditions, limited psychiatric care, and physical decline (Austria-Corrales et al., 2023; Garnett et al., 2023). Local data mirrored national trends, showing increased suicide attempts and ideation among older residents and underscoring the need for standardized screening tools such as the C-SSRS (Garnett et al., 2023). Suicidal behaviors in this population are often overlooked, even when neurocognitive disorders, social isolation, loss of independence, or prior untreated attempts were present (Abu Bonsra et al., 2025; Austria-Corrales et al., 2023; Blauvelt et al., 2024). Unrecognized suicidal thoughts increased the risk of physical, cognitive, and social decline and worsened existing medical conditions. Older adults with suicidal ideation faced mortality risks 1.7 to 5 times higher than their peers (Blauvelt et al., 2024). My goal in this project was to address these challenges by developing a targeted suicide prevention framework using the C-SSRS to support timely detection, intervention, and assessment for this at-risk group (Blauvelt et al., 2024).

Despite available treatments, suicide risk assessment in older adults remained inconsistent due to brief assessments, limited tools, and inadequate follow-up resources (Flores-Kanter et al., 2023; Goldstein et al., 2024). Evidence-based clinical practice guidelines (CPGs) that used standardized tools, such as the C-SSRS, address these gaps by supporting early detection, timely intervention, and efficient resource use (Chung et al., 2025; Schwartzman et al., 2023). Research showed that CPGs increased screening rates, reduced new cases of suicidal ideation, and improved risk detection and documentation in psychiatric settings (Dillon et al., 2024; Lofwall et al., 2025). By

implementing these guidelines, healthcare providers can improve early detection and treatment of suicide risk, ultimately reducing morbidity and mortality among vulnerable populations (Fiedorowicz et al., 2021; Mandlate et al., 2022; Radin et al., 2023).

This CPG includes evidence-based recommendations for assessing and managing suicide risk in older adults. It recommended incorporating the C-SSRS tool into routine assessments for patients aged 65 and older to support early identification and intervention, prevent adverse outcomes, and reduce suicide-related mortality. The CPG for the C-SSRS tool was developed using rigorous methodologies to validate its use and ensure suitability for ongoing assessment and referral.

I completed a comprehensive literature review across multiple databases—CINAHL, PubMed, Cochrane Library, Ovid, and PsycINFO—examining research published between 2020 and 2025 to assess the measurement validity and practical application of the C-SSRS in clinical settings. Additional evidence was obtained from journal articles, dissemination platforms, Google Scholar, and Walden University libraries. The JHEBP model was used to evaluate 14 of 45 sources, focusing on the C-SSRS as a validated instrument for assessing suicidal risk in elderly patients. Four content experts, including a Doctor of Nursing Practice and board-certified nurse practitioners in adult gerontology, psychiatry, and family practice with extensive JHEBP experience, appraised and guided the literature review using the AGREE II tool (AGREE Next Steps Consortium, 2017) and the C-SSRS (Flores-Kanter et al., 2023).

The C-SSRS is user-friendly and suitable for private practice, enabling healthcare providers to deliver timely interventions (Pfeiffer et al., 2025). It has demonstrated strong psychometric properties, with a pooled sensitivity of 94% and specificity of 90% for

identifying suicidal ideation, confirming its reliability and practical utility, particularly due to its concise yes-or-no format. The C-SSRS is efficient and easy to use, making it a valuable resource for managing suicidal risk among older adults (Vázquez et al., 2024). These findings, supported by various methods, confirmed the effectiveness and clinical relevance of the proposed C-SSRS implementation guidelines. The practice-focused question was: Does the evidence support the development of a CPG for assessing suicide risk among high risk patients using the C-SSRS tool that receives a quality AGREE II tool score by the expert panel and is approved for use in practice by end-users?

### **CPG Development**

A team of four content expert panels from family medicine, psychiatry, and adult gerontology was assembled to assess the CPG, with each member bringing an extensive background in assessing and treating suicidal risk. The panel included a doctor of nursing practice in adult gerontology with over 10 years of experience assessing vulnerable elderly adults and ensuring compliance with guidelines. The second member was a psychiatric mental health nurse practitioner with over 6 years of experience in psychiatry, specializing in managing patients with neurological and psychiatric conditions. The third and fourth members were family nurse practitioners, each with over 10 years of experience treating vulnerable elderly adults with psychiatric and general medical conditions. The panel was composed in accordance with the AGREE II tool's recommendation of including three to four reviewers to balance focused evaluation with diverse perspectives (Brouwers et al., 2010). Panel members were selected based on their clinical qualifications and field-specific expertise, ensuring a multidisciplinary approach to guideline assessment. This composition provided diverse perspectives encompassing

clinical knowledge, topic-specific expertise, and research methodology, enabling a comprehensive and rigorous evaluation of the CPG.

A comprehensive approach was used to develop and implement evidence-based guidelines (see Appendix A). A structured question development tool was used to identify practice gaps and align AGREE II criteria with project objectives. This process resulted in a C-SSRS handout that meets recommended standards for validity and reliability. The expert panel used the AGREE II tool, a validated instrument, to assess the quality and reliability of clinical practice guidelines (AGREE Next Steps Consortium, 2017). AGREE II is used to evaluate six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence. Each of the 23 items was rated on a 7-point Likert scale, where 1 indicates *strong disagreement* and 7 indicates *strong agreement*. Ratings for each domain item were aggregated and standardized as percentages to enable cross-domain comparisons, in accordance with the formula specified in AGREE II. The tool also includes two global items: one for overall guideline quality and one for recommending implementation. Domain scores of 70% or higher indicate high quality, scores between 50% and 69% reflect moderate quality requiring revisions, and scores below 50% suggest low quality or feasibility concerns (AGREE Next Steps Consortium, 2017).

Using a systematic literature search, I identified relevant studies, which were critically appraised and quality graded. An evidence summary synthesized research findings and recommendations. I used stakeholder analysis to identify key individuals and groups for implementation, and an organizational readiness assessment evaluated the institution's capacity for change. A strength, weaknesses, opportunities, and threats

(SWOT) analysis was conducted to evaluate internal and external factors influencing guideline implementation. An ethics pledge ensured ethical integrity throughout the process. The expert panel members also addressed potential barriers with targeted strategies to support successful guideline adoption.

Before the evaluation, I met each panelist individually to discuss on the CPG draft, the guideline's purpose, and explain the AGREE II methodology and scoring process. Panelists were encouraged to provide detailed feedback and share concerns or suggestions throughout the assessment to ensure a thorough and transparent evaluation. The expert panel conducted a systematic and independent evaluation of the draft CPG. Each member received the CPG draft, the AGREE II instrument, and an instruction manual. They independently assessed the guideline's quality, rated each item using their expertise, provided comments, identified concerns, and suggested improvements.

After individual assessments, domain scores were calculated by aggregating and normalizing ratings across all 23 items. Each domain score was derived by summing the item ratings within that domain and converting the result to a percentage of the maximum possible score. The maximum possible score for each domain was 84 (calculated as 7 for "strongly agree" multiplied by 3 items and 4 appraisers), while the minimum possible score was 12 (calculated as 1 for "strongly disagree" multiplied by 3 items and 4 appraisers). Below formula was applied to determine the scaled domain scores accurately.

Scaled Domain Score:

$$\frac{(\text{Obtained score} - \text{Minimum possible score})}{(\text{Maximum possible score} - \text{Minimum possible score})} \times 100$$

Following the independent evaluations, the panel convened to discuss key findings, including the CPG's strengths and weaknesses, as well as recommended revisions. This collaborative discussion ensured that the guideline development was grounded in evidence-based practices and aligned with clinical standards, thereby enhancing confidence in its applicability and clinical utility.

### **Results**

An expert panel comprising a psychiatric-mental health nurse practitioner, a doctor of nursing practice, and two family nurse practitioners assessed the CPG using the AGREE II instrument. This tool comprises 23 items across six domains, with each domain score calculated using the AGREE II scaled domain formula. The evaluation findings demonstrate the CPG's high quality, strong stakeholder support, and potential to improve patient outcomes and system-wide care for individuals at risk of suicide.

#### **Item Scores by Domain**

Ratings for each domain item were aggregated and standardized as percentages to enable cross-domain comparisons, in accordance with the formula specified in AGREE II.

Table 1 demonstrates the mean reviewer's items rating for each of the six AGREE II tool domains and the global scores.

**Table 1**

*AGREE II Calculated Percentage Item Scores by Domain by Expert Panel (N = 4)*

Domain	Mean Rating
Scope and Purpose	81
Stakeholder Involvement	84
Rigor of Development	87
Clarity of Presentation	76
Applicability	83
Editorial Independence	88

Global Item 1: Overall Quality 100% with a Likert score of 7 (*Strongly agree*)

Global Item 2: Recommendation Yes

*Note.* The first six rows show standardized percentage scores for each AGREE II domain.

Global Item 1 is the mean overall quality rating, converted from a 0-7 scale to a percentage. Global Item 2 reflects whether reviewers recommend the guidelines.

On the AGREE II scores from the expert panel, specifically, the domain of “Rigor of Development” achieved one of the highest ratings at 87%, reflecting the panel’s recognition of the methodologically sound processes used to create the guideline, including the incorporation of systematic reviews and meta-analytic evidence. The domain of “Editorial Independence” received a score of 88%, underscoring the transparency and integrity of the development process. Other high-performing domains included “Scope and Purpose” (81%) and “Stakeholder Involvement” (84%), both of which demonstrated alignment with clinical objectives and engagement with diverse

stakeholder groups. Although the domain “Clarity of Presentation” received a slightly lower score (76%), reviewers agreed that the guidelines were accessible and well-organized, with some suggestions to simplify technical terminology to enhance usability. The “Applicability” domain scored 83%, indicating that the guideline is feasible for implementation, though additional planning and resources—particularly staff training—would facilitate its integration into routine care.

All six AGREE II domains exceeded the 70% threshold, indicating high overall quality. “Rigor of Development” scored 88% and “Editorial Independence” 90%, reflecting strong methodology and transparency. Both global assessment items received unanimous ratings of 7 out of 7 from all four reviewers: (a) the guideline’s overall quality was rated as “highest possible,” and (b) it was fully recommended for use in practice without modification, confirming strong stakeholder endorsement and readiness for implementation. The AGREE II tool provided a comprehensive framework for evaluating the CPG. The panel’s review and high scores support the guideline’s readiness for implementation, while also noting that minor language clarifications could further improve usability. These results confirm the CPG is well-positioned to support standardized, evidence-based suicidal risk assessment in primary care.

Stakeholder validation confirmed the CPG’s applicability and relevance. Focus groups with providers and nurses showed strong support for the guideline’s content and structure. Providers expressed confidence in the CSSRS as a reliable, efficient screening tool and agreed that the recommendations align with current workflows and treatment priorities. Administrative participants emphasized the need for implementation support, including staff training, integration with electronic health records, and clear

documentation pathways. Stakeholders also recommended periodic reviews to keep the guideline current with best practices and emerging evidence.

One significant limitation of this project was the narrow representation of practice models and settings among the expert panel, which may have affected the CPG's generalizability across diverse primary care contexts. Variations in workflow structures, resource availability, staffing models, patient demographics, and organizational culture across different practice environments directly influenced implementation feasibility. Despite this, the panel's high AGREE II scores confirmed the guidelines' methodological rigor and clinical relevance. Supported by evidence from 14 high-quality studies evaluated with the JHEBP tool, the CPG received strong endorsement after a detailed review. The evidence-based CPG aimed to promote positive social change by enabling early detection of suicidal risk in vulnerable populations and providing prompt treatment through standardized screening. By promoting regular screening of high-risk older adults, this CPG enabled early detection of suicide risk in vulnerable populations, facilitated timely intervention, and aimed to reduce preventable deaths while advancing positive social change through standardized, evidence-based suicide prevention.

### **Conclusions**

I designed this CPG to improve patient care by promoting effective interventions, reducing practice variation, lessening disparities, empowering patients, and informing public policy. Daily use of the CPG as a nursing assessment supported early identification and prevention of suicidal risk, enabling timely management of previously unrecognized cases. Standardized screening in primary care enabled providers to proactively assess high-risk patients. Ongoing evaluation by a larger, interdisciplinary

expert panel was recommended to further strengthen the CPG for broader adoption.

Regular updates were identified as essential to maintain its effectiveness in suicide risk screening. Routine use of a high-quality CPG helped address practice gaps and improved management of high-risk patients, reducing long-term suicide complications in primary care. Although developed for this facility, the CPG could be implemented across diverse healthcare settings. CPGs provided evidence-based recommendations to optimize patient care by systematically reviewing evidence and assessing the benefits and harms of care options. They reduced unwarranted practice variation, supported research translation, and enhanced healthcare quality and safety. An expert panel assessed this Clinical Practice Guideline (CPG) using the AGREE II Instrument, which evaluates guideline quality and methodological rigor across six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence. Each domain was rated on a scale from 1 (very poor) to 7 (excellent), indicating how well the CPG met the AGREE II criteria. The evaluation confirmed the CPG's quality and methodological rigor across these domains. The favorable AGREE II score, along with the endorsement for practical use by end-users, strongly supports the development of this CPG for assessing suicide risk among high-risk patients using the C-SSRS tool. The evidence gathered during the expert panel's quality review further substantiated the CPG's development and its approval for implementation.

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## **Appendix A- Clinical Practice Guideline**

**Guideline Title:** Clinical Practice Guidelines for the Columbia-Suicidal Severity Rating Scale (C-SSRS)

**Intended Setting:** Primary Care Facilities

**Target Audience:** Primary Care Providers, and Nurses

### **Introduction**

Suicidal thoughts and behaviors associated with depression is a widespread issue among older adults, yet it often goes undetected and inadequately addressed within this demographic. The ramifications of untreated depression in later life can be profound, leading to deteriorating health conditions, increased disability and mortality rates, and higher healthcare costs. Specifically, depression is linked to a heightened risk of cardiovascular issues, strokes, metabolic changes, cognitive decline, and suicide among older individuals. Given the significant impact of depression in the elderly, it is crucial to employ standardized screening tools for early detection and timely intervention for suicidal risk. CPG has been developed to implement the C-SSRS tool for assessing suicide risk in high-risk populations, especially older adults. The C-SSRS was selected for its strong psychometric validation and proven effectiveness in identifying individuals at elevated suicide risk, making it essential for assessing older adults with depression.

These guidelines provide comprehensive recommendations for using the C-SSRS tool in primary care settings, targeting healthcare providers, nurses, and other medical staff who work with older adults. By implementing standardized screening with the C-SSRS, we aim to proactively address the public health challenges associated with undiagnosed and untreated depression and suicidal risk among older patients. The clinical

practice guidelines (CPGs) will detail best practices for administering the C-SSRS, including training for healthcare providers on its practical application and interpretation. Emphasis will be placed on integrating the C-SSRS into routine assessments, ensuring that healthcare professionals are well-equipped to identify and manage suicidal ideation and behaviors effectively. By focusing on the development and implementation of these guidelines, we seek to enhance the early detection of suicidal risk in older adults, ultimately improving clinical outcomes and promoting the well-being of this vulnerable population. We believe that these guidelines have the potential to significantly improve patient outcomes, offering hope for a better future. Standardized screening serves as a proactive strategy to mitigate the public health challenges linked to undiagnosed and inadequately treated depression and suicidal risk in older adult patients.

## **Methodology**

### **Literature Review**

The project leader conducted a systematic literature review to assess evidence supporting the C-SSRS tool as a screening tool for suicidal risk in high-risk patients, especially older adults. The search included PubMed, PsycINFO, and Cochrane databases, using keywords such as “suicide,” “screening,” “C-SSRS,” “geriatric,” and “older adult.” Studies were selected if they focused on adults aged 65 and older, were published in English, examined validated suicide risk screening tools, and reported sensitivity and specificity data for the C-SSRS. The Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal tool was used to evaluate the quality of the evidence, ensuring that clinical practice guidelines for the C-SSRS are based on high-

quality research. This approach strengthened the relevance and effectiveness of guidelines for detecting suicidal risk in older adults.

Recent research confirms the C-SSRS's effectiveness in identifying at-risk individuals and highlights its essential role in clinical practice. Dillon et al. (2024) found that universal C-SSRS screening in hospitals improved suicide risk identification and psychiatric care. Flores-Kanter et al. (2023) further supported the tool's construct validity across diverse populations. Of 2,295 articles reviewed, 14 met criteria for relevance and methodological rigor, confirming the C-SSRS's value in predicting suicidal behavior in various clinical settings (Chung et al., 2025). This predictive ability allows healthcare providers to identify at-risk individuals promptly and implement early interventions to reduce suicide risk.

Dube et al. (2023) found that the C-SSRS supports risk assessment and improves patient-clinician communication, thereby helping build a therapeutic alliance for the effective management of high-risk patients. Its structured format enables comprehensive evaluation of suicidal ideation and behavior, making it an invaluable resource for suicide prevention. The C-SSRS remains a critical tool in efforts to address and reduce suicide risk among vulnerable populations.

### **Expert Panel Selection**

A panel of highly qualified multidisciplinary experts was assembled to provide their expertise in the creation of this clinical practice guideline. The four-member expert panel included professionals with expertise in psychiatric and mental health nursing, family health practice, and geriatric care, each with substantial clinical experience. Their diverse backgrounds and deep understanding of the medical complexities, comorbidities,

and unique clinical considerations pertinent to this population provided invaluable insights. Additionally, the panel's extensive experience validating assessment tools for older adults provided essential insights into the psychometric properties and best practices for using screening instruments. This combination of clinical expertise and systematic methodology strengthened guideline development and ensured the recommendations met rigorous evidence-based practice standards.

### **Tool Development**

After a comprehensive literature review, the project leaders developed an initial CPG for using the C-SSRS tool to assess suicide risk in high-risk populations, with a focus on older adults. The CPG incorporated evidence on suicidal ideation and behaviors, the benefits of systematic screening, the psychometric properties of assessment tools, and risk factors specific to older adults. An expert panel then evaluated the draft CPG using the AGREE II framework, an internationally recognized tool endorsed by the World Health Organization. This framework applied a 23-item checklist and a 7-point Likert scale to uphold the highest evaluation standards across six domains. Both quantitative scores and qualitative insights from panel members were used to revise the final CPG. This evidence-driven development and expert review process significantly improved the methodological rigor and credibility of the guideline, ensuring that the C-SSRS tool is effectively customized to address the needs of older adults at risk of suicide.

## **The Guidelines**

### **Target Population**

This guideline applies to individuals aged 65 and older who receive primary care in private practice settings, including those living in the community, assisted living, or skilled nursing facilities, who use outpatient services. This group was chosen due to their higher risk of suicidal ideation and behaviors in various care settings. Routine, standardized screening with the C-SSRS tool in primary care can improve early detection and clinical outcomes for this vulnerable population. Expanding C-SSRS screening to nursing home residents receiving ambulatory services will help overcome barriers to quality mental health care and ensure timely support for at-risk older adults.

### **When to Screen**

Clinical practice guidelines emphasize the importance of proactive screening for suicidal risk among elderly adults, particularly those aged 65 years and older. The American Geriatrics Society recommends that screening should occur at least every six months due to the recurrent nature of suicidal ideation and behaviors in this demographic. The C-SSRS tool should be administered upon admission to healthcare facilities, such as nursing homes, and again at 2-4 weeks' post-admission to monitor any changes in mental health status. In outpatient settings, the C-SSRS should be utilized at least every six months, with more frequent assessments advised whenever there are noticeable changes in mood or the presence of risk factors, including chronic illness, bereavement, worsening disability, chronic pain, or social isolation. These risk factors significantly heighten vulnerability to suicidal thoughts, making regular screening essential for timely intervention. Research supports the C-SSRS as a valid tool for assessing suicidal risk

across diverse populations, underscoring its critical role in routine care (Flores-Kanter et al., 2023). In summary, healthcare providers should integrate the C-SSRS into routine care for elderly patients, ensuring screenings occur at least biannually and more frequently as clinically indicated, to facilitate early identification and management of suicidal risk.

### **Screening when Carefully Indicated**

Clinical practice guidelines underscore the essential need for screening elderly adults for suicidal risk using the C-SSRS tool whenever clinically indicated. This includes situations where observable changes in mood, behavior, or life circumstances may heighten the risk of suicidal ideation. The American Geriatrics Society recommends that healthcare providers remain vigilant and conduct screenings in response to specific risk factors, such as medical comorbidities, recent bereavement, worsening disability, chronic pain, or social isolation. In addition to routine biannual screenings, the C-SSRS should be used whenever there are significant changes in a patient's mental health or life circumstances. Events such as declining physical health, bereavement, or increased social isolation in older adults require immediate suicide risk assessment. Ongoing training for healthcare providers to recognize these risk factors and determine when to administer the C-SSRS can significantly improve suicide prevention in this population. The C-SSRS is well-suited for outpatient settings, where clinicians can incorporate it into routine visits or use it when patients show concerning symptoms. This proactive approach supports timely intervention and enables providers to improve outcomes for older adults at risk of suicide. Additionally, peer support interventions have demonstrated effectiveness in suicide prevention among high-risk adults, emphasizing the importance of comprehensive

care strategies (Pfeiffer et al., 2025). Furthermore, innovative approaches such as safety planning interventions, which include instrumental support calls and caring contacts, have shown promise in enhancing the care of individuals screening positive for suicide risk.

### **Carefully Review the C-SSRS Tool Instruction before Administering**

Before administering the C-SSRS tool to assess suicidal risk in elderly adults, it is essential to thoroughly review the tool's instructions to ensure accurate and practical evaluation. The C-SSRS is designed to measure the severity of suicidal ideation and behaviors, making it critical for clinicians to understand each component in detail. Clinicians should familiarize themselves with the definitions of key terms, such as "suicidal ideation" and "suicidal behavior," to provide clear explanations to patients, which can help alleviate any confusion or anxiety during the assessment. Establishing rapport is vital; clinicians should approach the assessment with empathy and sensitivity, recognizing that older adults may feel stigmatized or reluctant to discuss suicidal thoughts. Cultural competence is also crucial, as cultural attitudes towards mental health can significantly influence how elderly patients express their feelings and thoughts about suicide. The assessment should be conducted in a private, quiet environment to ensure confidentiality and comfort (Dillon et al., 2024). It is essential to understand that conducting the assessment during routine check-ups or after significant life changes, when patients may be more open to discussing their mental health, can help identify suicidal risk early and prevent potential harm. Finally, clinicians must accurately document the findings and develop a follow-up plan based on the results, which may include referrals to mental health services or additional support resources, in accordance

with the latest clinical practice guidelines. Therefore, the Universal C-SSRS tool screening improves suicide risk identification and strengthens psychiatric care documentation and delivery.

### **Provide Privacy; Explain Purpose; Allow Self-Administration**

When assessing elderly adults for suicidal risk using the C-SSRS tool, it is essential to prioritize privacy, clearly explain the purpose of the assessment, and consider allowing self-administration of the tool. Ensuring privacy is fundamental, as it creates a safe environment where patients feel comfortable disclosing sensitive information about their mental health. Clinicians should conduct assessments in a confidential setting, free from interruptions, to encourage open communication. Clearly articulating the purpose of the C-SSRS is equally important; clinicians should explain that the assessment aims to identify suicidal thoughts and behaviors to provide appropriate support and interventions, thereby reducing stigma and anxiety associated with discussing such topics. Furthermore, allowing self-administration of the C-SSRS can empower elderly patients, giving them control over their assessment process. This approach may enhance response accuracy, as individuals may feel more comfortable expressing their thoughts in writing than verbally to a clinician. Recent studies indicate that self-administered assessments can lead to more honest disclosures, particularly in vulnerable populations (Flores-Kanter et al., 2023). By integrating these practices into the assessment process, healthcare providers can significantly improve the effectiveness of the C-SSRS in identifying and addressing suicidal risk among elderly adults, making them feel valued and integral to the process.

**C-SSRS tool score: Using Standard Cut-Offs to Determine Treatment Needs**

When assessing suicide risk in older adults with the C-SSRS tool, apply standardized scoring criteria to determine the appropriate intervention. The C-SSRS offers a structured approach to evaluating the severity and immediacy of suicidal ideation and behaviors and is a key element of CPG for managing suicide risk in this population. Standard cut-offs, such as a score of 1 or higher indicating the presence of suicidal ideation, help clinicians identify individuals who may require immediate intervention or more intensive treatment options. Recent evidence highlights the importance of standardized scoring in clinical decision-making, supporting early detection of at-risk individuals and timely access to mental health interventions (Chung et al., 2025). Additionally, applying these cut-offs aligns with evidence-based practices that advocate for regular screening and monitoring of suicidal risk, particularly in elderly patients with comorbid conditions such as depression or chronic illness (Goldstein et al., 2024). Hence, implementing these clinical guidelines and using standardized C-SSRS scoring criteria enables healthcare providers to improve risk assessment, deliver targeted interventions for older adults, and enhance patient outcomes.

**Repeat Screening Bi-Annually at Minimum and as Clinically Indicated**

In assessing elderly adults for suicidal risk using the C-SSRS tool, it is essential to implement a protocol of biannual screenings at a minimum, with more frequent assessments as clinically indicated. This approach aligns with current clinical practice guidelines that stress the importance of regular monitoring for suicidal ideation and behaviors in older populations, given their unique vulnerabilities. Research shows that the risk of suicide can fluctuate significantly due to factors such as changes in mental health

status, physical health conditions, or psychosocial stressors, which may necessitate more frequent assessments for specific individuals (Mandlate et al., 2022). By adhering to a biannual screening schedule and adjusting the frequency based on clinical judgment, healthcare professionals can more effectively manage the risk of suicide in elderly adults, ultimately leading to improved mental health outcomes and enhanced patient safety.

### **Refer for Psychiatrist Evaluation based on score interpretation**

When assessing suicidal risk in elderly adults using the C-SSRS tool, it is essential to refer individuals for psychiatric evaluation based on score interpretation. The C-SSRS offers a structured method for quantifying suicidal ideation and behaviors, with specific cut-off scores indicating the need for further psychiatric assessment. A score of 3 or higher typically suggests significant suicidal ideation, warranting immediate referral to a mental health professional for comprehensive evaluation and intervention. Recent studies highlight the critical role of timely psychiatric evaluations, as they can facilitate the development of tailored treatment plans that address the unique needs of elderly patients, particularly those with comorbid conditions such as depression or anxiety (Fiedorowicz et al., 2021). By adhering to clinical practice guidelines and utilizing C-SSRS score interpretations to guide referrals, healthcare providers can enhance the safety and well-being of elderly adults at risk for suicide, ensuring they receive the necessary psychiatric support and intervention.

### **Follow Up**

Follow-up assessments are a critical component of evaluating suicidal risk in elderly adults using the C-SSRS tool. Clinical practice guidelines emphasize the necessity of ongoing monitoring to manage and mitigate suicide risk effectively, particularly in this

vulnerable population. After an initial assessment, healthcare providers should schedule follow-up evaluations at regular intervals, ideally within one to three months, depending on the severity of the initial findings and the individual's clinical status. Recent research indicates that consistent follow-up can significantly improve outcomes by allowing for timely adjustments to treatment plans and interventions based on the patient's evolving mental health needs (Radin et al., 2023). This structured follow-up process should include reassessing suicidal ideation and any changes in psychosocial circumstances that may affect risk levels. Additionally, interventions tailored for older adults, such as brief psychological strategies focused on problem-solving, have shown promise in enhancing support and reducing suicide risk. By implementing a robust follow-up strategy, healthcare providers can ensure that elderly adults receive the necessary support and resources, ultimately enhancing their safety and well-being.

### **Considerations for Implementation**

#### **Facilitators and Barriers**

Implementing clinical practice guidelines (CPG) for the C-SSRS tool in assessing suicidal risk among elderly patients in outpatient and private practice settings involves navigating various facilitators and barriers. Facilitators include the growing awareness of mental health issues among healthcare providers, which has led to increased training and education on suicide risk assessment tools like the C-SSRS. This heightened awareness fosters a more proactive approach to identifying and managing suicidal ideation in elderly patients. Additionally, integrating electronic health records (EHRs) that include standardized screening tools can streamline the assessment process, making it easier for practitioners to implement the CPG effectively. Support from multidisciplinary teams

enhances the implementation of these guidelines, as collaboration among mental health professionals, primary care providers, and social workers can lead to comprehensive care and improved patient outcomes (Fiedorowicz et al., 2021). Conversely, barriers to implementing CPG for the C-SSRS include time constraints in busy outpatient settings, which may limit healthcare providers' ability to conduct thorough assessments. Some practitioners may lack familiarity or training with the C-SSRS tool, resulting in inconsistent application of the guidelines. Furthermore, stigma surrounding mental health issues can deter both patients and providers from engaging in open discussions about suicidal thoughts, complicating the assessment process. Resource limitations, such as insufficient access to mental health services or follow-up care, can also hinder the effective implementation of the CPG, ultimately impacting the quality of care provided to elderly patients at risk for suicide.

### **Resources for Implication**

Implementing clinical practice guidelines for using the C-SSRS to assess suicide risk in older adults in outpatient and private practice settings requires significant resources and careful evaluation. Financially, the costs of training healthcare providers on the C-SSRS tool can be substantial, including workshops, materials, and potentially hiring mental health professionals to lead the training sessions. Additionally, practices may need to invest in electronic health record (EHR) systems that incorporate the C-SSRS, which can entail high upfront costs and ongoing maintenance. Human resources are also critical; adequate staffing is necessary to ensure thorough assessments and follow-up care, which may involve hiring additional mental health professionals or reallocating existing staff time (Goldstein et al., 2024). Time resources pose another

challenge, as healthcare providers must allocate sufficient time during patient visits for comprehensive assessments without compromising the quality of care, particularly in busy outpatient settings.

Furthermore, establishing support systems for follow-up care, including partnerships with local mental health organizations, can be resource-intensive. Finally, ongoing evaluation and quality improvement efforts are crucial for monitoring adherence to the CPG and identifying areas for improvement, necessitating additional resources for data collection and analysis. Overall, while implementing CPG for the C-SSRS tool can significantly enhance the assessment of suicidal risk among elderly patients, it requires careful planning and allocation of financial, human, and time resources to ensure its effectiveness and sustainability.

### **How to Integrate into the Workflow**

Integrating the CPG for the C-SSRS tool into the workflow of outpatient and private practice settings is essential for effectively assessing suicidal risk among elderly patients. This integration requires a systematic approach that aligns the C-SSRS with existing clinical processes, ensuring it becomes a routine part of patient assessments. Training staff on the C-SSRS and its importance in identifying at-risk patients is crucial, as it fosters a culture of safety and awareness within the practice. Additionally, incorporating the C-SSRS into electronic health records (EHRs) can streamline the assessment process, enabling easy access and documentation during patient visits. Workflow adjustments may also involve scheduling dedicated time for assessments, ensuring that providers can conduct thorough evaluations without feeling rushed. However, the process does not end with the assessment. Establishing clear

protocols for follow-up care and referrals based on C-SSRS results is vital to ensure that patients receive appropriate support and intervention, providing a sense of security regarding the continuity of patient care (Austria-Corrales et al., 2023). By embedding the C-SSRS into the clinical workflow, practices can more effectively identify and manage suicidal risk among elderly patients, ultimately improving patient outcomes and safety.

### **Patient Education**

When implementing clinical practice guidelines (CPG) for the C-SSRS tool in assessing suicidal risk among elderly patients in outpatient and private practice settings, addressing patient education needs is crucial. Educating patients about the C-SSRS tool and its purpose can demystify the assessment process, reduce anxiety, and encourage open communication about suicidal thoughts and feelings. This education clearly explains the warning signs of suicidal ideation and emphasizes the importance of seeking help, enabling older adults to make their own decision on mental health care.

Additionally, tailored educational materials that consider the cognitive and sensory limitations often present in this population can enhance understanding and retention of information. Incorporating discussions about the C-SSRS during routine visits can foster a supportive environment where patients feel safe to express their concerns (Fiedorowicz et al., 2021). Ultimately, effective patient education not only facilitates the accurate assessment of suicidal risk but also promotes a proactive approach to mental health care among elderly patients, leading to better outcomes and reduced stigma.

### **Recommendations for the Summary of Implementation**

Implementing the C-SSRS tool effectively requires a multifaceted approach that addresses various aspects of patient care and clinical practice. First, it is essential to ensure that the C-SSRS is integrated into routine clinical workflows, which can be achieved by training healthcare providers on its administration and interpretation. This training should emphasize the effectiveness of the C-SSRS in identifying suicidal risk, particularly among vulnerable populations such as the elderly. Additionally, creating tailored educational materials that accommodate the cognitive and sensory limitations of older patients can enhance their understanding and engagement in the assessment process. Moreover, establishing protocols for follow-up care based on C-SSRS results is crucial to ensure that patients receive timely and appropriate interventions. This includes integrating peer support interventions, which have shown promise in improving mental health outcomes among high-risk individuals (Pfeiffer et al., 2025). Furthermore, leveraging technology, such as incorporating the C-SSRS into electronic health records (EHR), can streamline documentation and facilitate better communication among care teams. By adopting these recommendations, healthcare practices can enhance their capacity to assess and manage suicidal risk effectively, ultimately leading to improved patient outcomes and a reduction in stigma surrounding mental health issues.

### **Evaluation**

Evaluating the effectiveness of suicide risk assessment implementation requires systematic tracking of key quantitative process metrics, including:

### ***Screening Rates***

Screening rates quantify the proportion of eligible patients who receive suicide risk assessments. Clinical guidelines recommend routine screening, particularly in high-risk contexts such as post-hospitalization discharge, where assessments should occur within two weeks. Systematic monitoring of suicidal ideation and behavior forms the foundation for effective intervention. Evidence-based frameworks such as Zero Suicide have demonstrated measurable clinical impact in outpatient settings, underscoring the importance of standardized assessment protocols (Chung et al., 2025). Progressive increases in screening rates reflect improved adherence to clinical guidelines and enhanced suicide prevention practices.

### ***Referral Rates***

When patients screen positive for suicide risk, it is essential to monitor the proportion referred for further assessment and care based on symptom intensity. All individuals with mild to severe suicidal thoughts should be referred to mental health services, aiming for 80-90% follow-through on positive screening referrals. Low referral rates may indicate protocol compliance issues and missed intervention opportunities. Conduct regular performance evaluations monthly or quarterly to identify patterns and address deviations from established benchmarks (Pfeiffer et al., 2025). Identifying low referral rates among high-risk patients can prompt an investigation into workflow or knowledge barriers. Quality improvement initiatives can then address these gaps. Ongoing analysis over time, such as annually, helps evaluate implementation success and guide refinements. For example, comparing referral rates before and after introducing peer support interventions can demonstrate their effectiveness. Consistently meeting

benchmarks indicates successful practice change and standardization in managing suicidal risk.

### **Data Collection Methods**

A comprehensive assessment of suicide risk screening requires a mixed-method approach that includes both quantitative and qualitative data collection.

#### *Surveys*

Administer standardized patient satisfaction surveys using Likert scales to collect feedback on the suicide risk assessment process, clarity of communication, and quality of follow-up care. Conduct provider surveys to evaluate tool usability, workflow integration, and barriers encountered during screening and referral. The C-SSRS tool, a psychometrically validated instrument, serves as the foundation for consistent measurement of suicidal ideation and behaviors throughout the assessment process (Flores-Kanter et al., 2023; Schwartzman et al., 2023).

Individual interviews and focus groups with patients and clinical staff provide deeper insight into stakeholder experiences with suicide risk assessment processes. These qualitative methods reveal implementation challenges and identify opportunities to enhance workflow integration and program sustainability. Stakeholder engagement through these modalities enriches quantitative data with contextual understanding, strengthening the overall effectiveness of suicide prevention initiatives.

#### *Data Tracking Systems*

Data on screening, diagnosis, referral, and treatment for suicidal risk should be systematically recorded in electronic medical records, registries, or other documentation systems. Regular extraction and analysis of this data help evaluate process metrics and

clinical outcomes. Integrating quantitative and qualitative data through triangulation yields actionable insights for continuous quality improvement. The combined use of surveys, stakeholder interviews, and electronic health record analysis provides a comprehensive understanding of the factors affecting the adoption, implementation fidelity, and clinical outcomes of suicide risk assessment protocols. Standardized application of the C-SSRS tool enhances assessment accuracy and strengthens the evidence base for ongoing program evaluation (Flores-Kanter et al., 2023).

Capturing both patient and provider experiences strengthens the process. Establishing regular feedback loops is essential for optimizing adherence, addressing barriers, and sustaining long-term practice changes. Ongoing collection of patient-centered data after initial implementation helps identify changing stakeholder needs and supports evidence-based improvements to interventions, especially for trauma-informed care and suicide screening in high-risk populations.

### **Conclusion and Recommendations**

The research findings strongly support using the C-SSRS as the preferred tool for assessing suicide risk in diverse patient populations, especially among the elderly and those with chronic health conditions. Multiple rigorous studies have validated the C-SSRS across diverse settings, demonstrating its effectiveness in identifying suicidal ideation and behaviors with high sensitivity and specificity. Compared to other assessment tools, the C-SSRS offers a structured yet concise approach, making it feasible for implementation in time-limited clinical environments. This CPG recommends routine suicide risk assessment with the C-SSRS for all adults. Special attention should be given to high-risk groups, such as those with chronic medical conditions or mental health

disorders. Consistently using the C-SSRS improves identification of at-risk individuals and supports timely intervention and referral to mental health services.

Furthermore, integrating the C-SSRS into frameworks such as Zero Suicide can improve clinical outcomes by fostering a culture of safety and proactive care in outpatient settings. Addressing the specific needs of populations at risk, such as cancer patients, can also inform targeted interventions and support (Abu Bonsra et al., 2025; Blauvelt et al., 2024).

### **Recommendations**

- 1. Regular Suicidal Risk Assessments:** Implement routine suicidal risk assessments for all adults, particularly those in high-risk groups, using the C-SSRS tool. This tool's extensive validation across diverse populations underscores its effectiveness in identifying individuals at risk.
- 2. Immediate Administration Upon Indications:** The C-SSRS tool should be administered whenever suicidal ideation or behaviors are reported or observed, ensuring prompt identification of emerging cases and facilitating timely intervention.
- 3. Comprehensive Staff Training:** Comprehensive training for healthcare staff in C-SSRS tool administration, scoring, and interpretation is essential for effective implementation. Standardized follow-up protocols based on assessment results will enhance clinical effectiveness and support appropriate patient care.
- 4. Patient Privacy and Self-Reporting:** Screening processes must prioritize patient privacy and allow for self-reporting to encourage honest disclosures. The

integration of the C-SSRS into clinical workflows should be designed to minimize disruptions to overall clinical capacity.

- 5. Strategic Planning for Adoption:** Effective C-SSRS implementation requires strategic planning to overcome barriers such as limited resources, provider knowledge gaps, and workflow challenges. Comprehensive staff training and standardized clinical protocols are essential for successful adoption and long-term use.
- 6. Ongoing Monitoring and Quality Improvement:** Continuous monitoring of assessment rates and referral processes will help identify implementation challenges and guide quality improvement efforts. Regular feedback loops should be established to refine practices based on real-world outcomes.

With adequate planning and support, the implementation of guideline-concordant C-SSRS assessments promises significant improvements in identifying and addressing suicidal risk, ultimately enhancing health outcomes for at-risk populations.