greenspace

Columbia-Suicide Severity Rating Scale (C-SSRS)

SUICIDE IDEATION DEFINITIONS AND PROMPTS	SINCE LAST CONTACT	
Ask questions that are 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 on acting on them?** As opposed to "I have thoughts, but I definitely will not do anything about them"		
5) **Have you started to work or worked out the details of how to kill yourself and do you intend to carry out this plan?**		
6) **Have you 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.		

Scoring: The C-SSRS does not provide a numerical score but categorizes risk levels based on responses:
No or Low Risk: No suicidal ideation or behaviors reported.
Moderate Risk: Suicidal thoughts with some intent or planning but no action taken.
High Risk: Suicidal ideation with intent, plan, or recent suicidal behaviors.
The patient is at low risk if they answer YES solely to questions 1 or 2. The patient is at moderate risk if they answer YES to question 3. If the patient answers YES to question 4, 5, or 6, they are at high risk of suicidality.