Columbia-Suicide Severity Rating Scale and Scoring Instructions

Suicide Ideation Definitions and Prompts

Questions are highlighted in grey boxes and italicized.

Ask questions 1 and 2.

1. **Wish to be Dead:**
   Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
   
   *Have you wished you were dead or wished you could go to sleep and not wake up?*

2. **Suicidal Thoughts:**
   General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself,” even if thoughts about ways to kill oneself, methods, intent, or plan are not present.
   
   *Have you actually had any thoughts of killing yourself?*

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

3. **Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**
   Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…. and I would never go through with it.”
   
   *Have you been thinking about how you might kill yourself?*

4. **Suicidal Intent (without Specific Plan):**
   Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.”
   
   *Have you had these thoughts and had some intention of acting on them?*

5. **Suicide Intent with Specific Plan:**
   Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.
   
   *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*

If YES, ask:

6. **Suicide Behavior Question:**
   
   *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*
   
   Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

   If YES, ask:
   
   *How long ago did you do any of these?*
   
   - Over a year ago?
   - Between three months and a year ago?
   - Within the last three months?
Administration and Triage Guidelines for the C-SSRS Screener

**Item 1 (Wish to be dead)**
Ask item 1 and then move on to item 2 regardless of response.

**Item 2 (Suicidal thoughts)**
A negative answer to item 2:
- Go directly to item 6
A positive answer to item 2:
- Ask all remaining items: 3, 4, 5, and 6

**Item 3 (Method)**
A positive answer to question 3:
- Use clinical judgment - consider context, supports in place, and seek consultation
- Follow up with student within 1 week

**Item 4 (Intention without specific plan)**
A positive answer to question 4:
- Refer immediately to mental health services and take safety precautions

**Item 5 (Intention and plan)**
A positive answer to question 5:
- Refer immediately to mental health services and take safety precautions

**Item 6 (Past suicidal behavior)**
A positive answer to question 6 in the past three months:
- Refer immediately to mental health services and take safety precautions