COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version with Triage Points for HealthReach Practices

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past week**	**Past month**	
Ask questions that are in bolded and underlined.	**Yes/No**	**Yes**	**NO**
Ask Questions 1 and 2			
1) Wish to be Dead: ***Have you wished you were dead or wished you could go to sleep and not wake up?***			
2) Suicidal Thoughts: ***Have you had any actual thoughts of killing yourself?***			
If YES to 2: Ask Question 3			
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): ***Have you been thinking about how you might kill yourself?***			
If NO to 2 or NO to 3, skip to Question 6 and stop there **If YES to Question 3, ask Question 4, 5 and 6**			
4) Suicidal Intent (without Specific Plan): ***Have you had these thoughts and had some intention of acting on them?***			
5) Suicide Intent with Specific 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?***			

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?
- ☐ Within the past week?

Notes:

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II. Response Protocol to C-SSRS Screening

(Linked to last item answered YES, within the past month; item 6 is independent of the others)

These triage points are suggested responses to increasing levels of risk and cannot be considered as inflexible. Clinical judgment, availability of in-house and regional resources, and mediating circumstances must be taken into consideration. If uncertain, triage must opt to a higher risk level rather than a lower risk.

Item 1 – Thoughts of death but no suicidal ideation:
Consider Behavioral Health referral & medication management evaluation and follow-up

Item 2 – Suicidal Ideation w/o plan; no attempt history within 1 year:
Behavioral Health Referral and f-up within 7 days; evaluate for medication management

Item 3 – Suicidal Ideation with identified method but no preparation or specific plan:
Consult with provider team, Safety plan and close monitor/follow-up procedures

Item 4 – Suicidal ideation with specific accessible plan but no intention to act on the plan:
Crisis Assessment & Safety plan and close monitoring and follow-up

Item 5 – Suicidal ideation with detailed accessible plan and intention to act; clear level of distress:
Crisis Assessment & consideration of higher LOC; Safety plan & close monitoring and follow-up

Item 6 – History of suicidal preparatory behavior or suicide attempts:

- If over a year ago, and 3, 4, 5 are no, ***Behavioral Health Referral and follow-up plan***
- If between 1 week and 1 year ago and 4 and 5 are no: -***Consider crisis assessment; do safety planning and close follow-up plan***
- If one week ago or less- ***Crisis Consultation/Assessment and Safety planning and close follow-up. May need higher level of care.***

Disposition/referrals: (Check all that apply)

- ☐ Behavioral Health Referral
- ☐ Safety Plan developed
- ☐ Evaluation for medication management
- ☐ Plan made for follow-up (Time Frame ________________________________)
- ☐ Crisis Assessment
- ☐ Transferred to ED for safety and Assessment
- ☐ Other___________________________________
- ☐ Consulted with:____