

The Columbia Lighthouse Project/Center for Suicide Risk Assessment

The Columbia Suicide Severity Rating Scale (C-SSRS)

Supporting Evidence

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

Table 1: Studies Supporting Specific Psychometric Properties

<u>Psychometric Property</u>		<u>Studies</u>
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 ^{*^} ; Gunes et al. 2015 [^] ; Pai et al. 2015 [*] ; Madan et al. 2016 [*]
Reliability (inter-rater; multi-method agreement)		Kerr et al., 2013 [^] ; Brent et al., 2009 [^] ; Gunes et al. 2015 [^] ; 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 [^] ; Gunes et al. 2015 [^] ; 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 [^] ; Gunes et al. 2015 [^]
Cross-Cultural Validation		Danish (Conway et al. 2016 [^]); Turkish (Gunes et al. 2015 [^]); Korean (Pai et al. 2015 [*]); Spanish (Al-Halabi et al ., 2016ab [*])

* studies include adult samples; [^] studies include pediatric samples

Table 2: Psychometric Properties of Specific C-SSRS Predictors with Coefficients

Predictive Validity - Suicidal Ideation			
	Predictor	Criterion	Coefficients
Greist et al. 2014	<i>None Reported</i>	Actual, interrupted or aborted attempts	<u>All patients</u> : 0.8% incidence rate, N=4975 <u>Psychiatric patients</u> : 1.1% incidence rate, N=3184
	<i>Wish to Be Dead</i>	Actual, interrupted or aborted attempts	OR= 6.21, 95% CI = 4.18 – 9.23, p <0.001 OR= 4.99, 95% CI = 3.29 – 7.56, p <0.001
	<i>Non-Specific Active Thoughts</i>	Actual, interrupted or aborted attempts	OR= 6.69, 95% CI = 4.16 – 10.76, p <0.001 OR= 5.53, 95% CI = 3.38-9.04, p <0.001
	<i>Active with any methods (not plan) w/o intent to act</i>	Actual, interrupted or aborted attempts	OR= 11.16, 95% CI = 7.43-16.76, p <0.001 OR= 8.36, 95% CI = 5.44-12.84, p <0.001
	<i>Active with Some Intent to Act, without specific plan</i>	Actual, interrupted or aborted attempts	OR= 19.27, 95% CI = 12.97 – 28.63, p <0.001 OR= 15.24, 95% CI = 10.07-23.09, p <0.001
	<i>Active with specific plan and intent</i>	Actual, interrupted or aborted attempts	OR= 25.53, 95% CI = 16.94 – 38.47, p <0.001 OR= 18.70, 95% CI = 12.16 – 28.76, p <0.001
Posner et al. 2011 (TASA study N=124, ages 12-18)	<i>Baseline worst-point</i>	Attempts	OR=1.45, 95% CI=1.07-1.98, p=0.02
		Actual, interrupted and aborted attempts	OR=1.34, 95% CI=1.05-1.70, p=0.02
	<i>Lifetime severity</i>	Attempts	OR=1.43, 95% CI=0.99-2.05, p=0.05
	<i>Severity 4-5 (any intent to act)</i>	Attempts	OR=3.26, 95% CI=1.02-10.45, p=0.047
Actual, interrupted and aborted attempts		OR= 3.26, 95% CI=1.07-7.12, p=0.036	
Horwitz et al. 2015 (N=473, ages 15-24)	<i>Ideation severity 1 to 5</i>	Attempt	OR= 1.51, 95% CI= 1.24-1.84, p<0.001
Arias et al. 2016	<i>Current ideation severity 4 or 5 (with intent to die)</i>	Actual attempt or suicide 6 weeks post-ED visit	OR=1.70 95% CI 1.18-2.44, p =.004
		Actual, interrupted, aborted attempts, suicide or preparatory behavior	OR =1.52 95%CI 1.23-1.86 p <. 001

Madan et al. 2016: (N=1,055 adult psych in-patients)	<i>Most severe ideation within 72 hours of hospitalization</i>	Any suicide behavior within 6 months post hospitalization	$r = .165, p < .01, N=275$
		Psychiatric re-hospitalization within 6 months	$r = .125, p < .05, N=275$
Conway et al. 2016: (N=85 adolescents, age < 18, mean age=16.2)	Severity of ideation (1-5)	Any type of suicidal behavior at follow-up	OR= 1.66, 95% CI= 1.13-2.44, $p < 0.05$
	Ideation with intent to act (4 or 5)		OR= 7.76, 95% CI= 1.66-36.23, $p < 0.01$
	Ideation intensity total score		OR= 1.27, 95% CI= 1.04-1.54, $p < 0.05$

Predictive Validity - Suicidal Behavior

	Predictor	Criterion	Coefficients
Horwitz et al. 2015: (N=473, ages 15-24)	<i>Attempt</i>	Attempt	OR=4.80, 95% CI = 2.23-10.32, $p < 0.001$
	<i>NSSIB item</i>	Attempt	OR=3.12, 95% CI = 1.36-7.19, $p < 0.01$
Gipson et al. 2014 (N=178, ages 13-17)	<i>NSSIB item</i>	Return ER visit	OR = 1.52; 95% CI, 1.08-2.12, $p < .05$
		Attempt	$\chi^2 = 4.131, df = 1, p = 0.04$
Conway et al. 2016 (N=85, age < 18, mean age=16.2)	<i>Attempts</i>	Re-attempt [short-term]	OR= 11.50, 95% CI= 1.66-79.65, $p < 0.05$
Greist et al. 2014	<i>Attempt</i>	Actual, interrupted or aborted attempts	OR=4.57, 95% CI = 3.6-5.7, $p < 0.001$
	<i>Interrupted Attempt</i>	Actual, interrupted or aborted attempts	OR=5.55, 95% CI = 4.4-7.0, $p < 0.001$
	<i>Aborted Attempt</i>	Actual, interrupted or aborted attempts	OR=5.09, 95% CI = 4.1-6.4, $p < 0.001$
	<i>Preparatory behavior</i>	Actual, interrupted or aborted attempts	OR=5.69, 95% CI = 4.3-7.5, $p < 0.001$

Incremental Validity and Accuracy

Brent et al., (2009): Treatment resistant, depressed adolescent suicide attempters (N=334, ages 12-18)	<ul style="list-style-type: none"> Higher rates of suicidal (20.8% vs. 8.8%, chi squared= 9.18, df=1, p<0.002) and non-suicidal self-injury (17.6% vs. 2.2%, chi squared= 23.47, df=1, p<0.001) detected with systematic monitoring
Horwitz et al. (2015): Young adult psychiatric emergency patients (N=473, ages 15-24)	<ul style="list-style-type: none"> Suicidal ideation added incremental validity to the prediction of future suicide attempts beyond the past suicide attempt, $X^2(1) = 7.54, p = .006$
Brown et al. (2015): psychiatric ER patients (N=250)	<ul style="list-style-type: none"> 18% (n=23) of patients with a suicide attempt in the past week misclassified or missed by clinical assessment. Agreement with clinical assessment for suicide attempts (K=0.76, p<.001) Agreement with clinical assessment of non-suicidal self-injurious behavior (K=0.72, p<.001)
Arias et al. (2013): 497 ER adult patients with suicidal thoughts or attempt(s)	<ul style="list-style-type: none"> 41% increase in the detection of suicide attempts compared to chart reviews (59% vs. 18%, difference of 41%, 95% CI= 28-55, p<0.001)

Reliability - Suicidal Ideation (inter-rater and multi-method agreement)

Study	Ideation Type	Coefficients
Brent et al. (2009) (N=334, ages 12-18)	<i>suicidal ideation ranging from 0 to 5 (from no ideation to suicidal ideation with intent and a clear plan) monitored weekly</i>	ICC = .09, p< 0.001
Gunes et al. (2015) (N=211, ages 12-18)	<i>Inter-rater reliability for the <u>most severe ideation scores</u> in the last month and lifetime were good</i>	Lifetime $\kappa = 0.91$ Recent $\kappa = 0.76$
Youngstrom et al. (2015)	<i>Accuracy calibrated against "missing gold standard" latent class-derived ideation and behavior categories</i>	$\kappa > 0.7$

Hesdorffer et al. (2013)	<i>Agreement between the MINI, C-SSRS and eC-SSRS for lifetime <u>suicidal ideation</u></i>	$\kappa = 0.80$, 95% CI = 0.72-0.89
Gwaltney et al. (2017) (N=86, ages >18)	<i>Equivalence analyses between IVR (interactive voice response) and tablet text-based eC-SSRS for <u>most severe lifetime ideation</u></i>	Correlation: 0.87, $p < 0.001$ ICC: $\kappa = 0.89$, $p < 0.001$
	<i>Equivalence analyses between IVR (interactive voice response) and tablet text-based eC-SSRS for <u>most severe ideation in past 6 months</u></i>	Correlation: 0.69, $p < 0.001$ ICC: $\kappa = 0.79$, $p < 0.001$
Reliability - Suicidal Behavior		
Gwaltney et al. (2017) (N=86, ages >18)	<i>Equivalence analyses between IVR (interactive voice response) and tablet text-based eC-SSRS for <u>Actual attempts (lifetime)</u></i>	$\kappa = 0.81$, $p < 0.001$
	<i>Actual attempts (recent-last 2 yrs)</i>	$\kappa = 0.73$, $p < 0.001$
	<i>Number of lifetime actual attempts</i>	$\kappa = 0.81$, $p < 0.001$
	<i>Interrupted attempts (lifetime)</i>	$\kappa = 0.78$, $p < 0.001$
	<i>Interrupted attempts (recent-last 2 yrs)</i>	$\kappa = 0.762$, $p < 0.001$
	<i>Aborted attempts (lifetime)</i>	$\kappa = 0.54$, $p < 0.001$
	<i>Aborted attempts (recent-last 2 yrs)</i>	$\kappa = 0.74$, $p < 0.001$
	<i>Preparatory behaviors (lifetime)</i>	$\kappa = 0.77$, $p < 0.001$
	<i>Preparatory behaviors (recent-last 2 yrs)</i>	$\kappa = 0.89$, $p < 0.001$
	<i>Non-suicidal, self-injurious behavior</i>	$\kappa = 0.73$, $p < 0.001$

Brent et al. (2009) (N=334, ages 12-18)	<i>Inter-rater reliability for a rating of <u>suicidal behavior</u>, ranging from 0 to 5 (no behavior to multiple attempts during the assessment period) using the Columbia Classification Algorithm of Suicide Assessment</i>	100% agreement
Kerr et al. (2014a,b) (N=155, ages 13-17)	<i>Inter-rater agreement for distinction among <u>actual, aborted, interrupted attempts, preparatory acts and any other act</u></i>	$\kappa = 0.88$; $\kappa = .91$
Brown et al. (2015)	<i>Agreement with clinical assessment for <u>attempts</u></i> <i>Agreement with clinical assessment for <u>non-suicidal self-injurious behavior</u></i>	$\kappa = 0.76$, $P < .001$ $\kappa = 0.72$, $P < .001$
Youngstrom et al. (2015)	<i>Accuracy of <u>attempt</u>: calibrated against latent class-derived categories</i>	$\kappa > 0.8$
Hesdorffer et al. (2013)	<i>Agreement between the MINI, C-SSRS and eC-SSRS for lifetime <u>suicidal behavior</u></i>	$\kappa = 0.67$, 95% CI = 0.53-0.80

The Columbia Suicide Severity Rating Scale (C-SSRS): Impact in Public Health and Diagnostic and Treatment-Monitoring Effectiveness

Table 3: C-SSRS as Intervention and Measure of Diagnosis and Treatment

C-SSRS as an Effective Measure for Diagnosis & Treatment	Veterans Legarreta et al., 2015	<ul style="list-style-type: none"> The association of specific PTSD symptoms with suicidal ideation and behavior suggested individual PTSD symptoms as treatment target for reducing suicidal outcomes.
	Veterans Harvey et al., 2018	<ul style="list-style-type: none"> A lifetime history of suicidal ideation and behavior was higher among the Vets with Bipolar Disorder (82.3%, N=5414) than Schizophrenia (69.9%, N=3942) The highest risk was found for patients with multiple psychiatric comorbidities (OR = 2.61 for ideation; OR = 3.82 for behavior). Clinical factors (e.g., psychiatric comorbidity) contributed more of the variance in the predictive model than demographic factors.
	Medication Treatment Ionescu et al. (2016) Prakash et al. (2012)	<ul style="list-style-type: none"> Ketamine treatment effective for suicidal ideation (SI) in adults SI severity improved <u>independent</u> of acute decrease in depression and SI intensity improved <u>even if SI severity un-remitted</u> Duloxetine was effective in treating suicidal ideation among children ages 7-17 with major depression Distinguished children with improvement and deterioration

References for Psychometric Evidence and Clinical Outcomes

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Representative Publications for C-SSRS Use:

Demographic and Clinical Populations, Settings, Treatment Efficacy and Assessment Guidelines

Pediatric Populations by Age Group

Ages 5-11

Glennon, J., Purper-Ouakil, D., Bakker, M., Zuddas, A., Hoekstra, P., Schulze, U., ... & Coghill, D. (2014). Paediatric European Risperidone Studies (PERS): context, rationale, objectives, strategy, and challenges. *European child & adolescent psychiatry, 23*(12), 1149-1160. [also includes 12-17.5 age group]

Proskurina, T., Mykhailova, E., Matkovska, T., Reshetovska, N., & Matkovska, A. (2016). Clinical and psychopathological risk factors for the development of recurrent depression in children at puberty. *European Psychiatry, 33*, S145-S146.

Ages 6-12

Buchanan, J., Burke, T., Camacho, K., Yershova, K., Lazzaretto, D., Posner, K. (2013) Preschool Bullying and Victimization as Predictors of Suicidal Ideation in School Age: 6-year Follow-Up of the Preschool Attention Deficit/Hyperactivity Disorder Treatment Study (PATS). *1st Annual Meeting of the International Academy for Suicide Research*, Montreal, Canada.

Ages 6-17

Glennon, J., Purper-Ouakil, D., Bakker, M., Zuddas, A., Hoekstra, P., Schulze, U., ... & PERS Consortium. (2014). Paediatric European Risperidone Studies (PERS): context, rationale, objectives, strategy, and challenges. *European child & adolescent psychiatry, 23*(12), 1149-1160.

Sangal, R. B., Blumer, J. L., Lankford, D. A., Grinnell, T. A., & Huang, H. (2014). Eszopiclone for insomnia associated with attention-deficit/hyperactivity disorder. *Pediatrics, 134*(4), e1095-e1103.

Ages 6-18

Wigal, S. B., Nordbrock, E., Adjei, A. L., Childress, A., Kupper, R. J., & Greenhill, L. (2015). Efficacy of Methylphenidate Hydrochloride Extended-Release Capsules (Aptensio XR™) in Children and Adolescents with Attention-Deficit/Hyperactivity Disorder: A Phase III, Randomized, Double-Blind Study. *CNS drugs, 29*(4), 331-340.

Ages 7-13

Weinstein, S. M., Henry, D. B., Katz, A. C., Peters, A. T., & West, A. E. (2015). Treatment moderators of child-and family-focused cognitive-behavioral therapy for pediatric bipolar disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(2), 116-125.

Ages 7-17

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Emergency Departments: Identification of Risk and Prediction of Suicidal Behavior in Pediatric and Adult Patients

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In-Patient Psychiatric Settings: Identification of Risk and Prediction of Suicidal Behavior in Pediatric and Adult Patients

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