The Columbia Suicide Severity Rating Scale (C-SSRS)

Supporting Evidence

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

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<th>Psychometric Property</th>
<th>Studies</th>
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<tr>
<td>Predictive and/or Incremental Validity</td>
<td>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^</td>
</tr>
<tr>
<td>Sensitivity to Change</td>
<td>Posner et al., 2011^; Ionescu et al., 2016^</td>
</tr>
<tr>
<td>Sensitivity and Specificity</td>
<td>Posner et al., 2011^; Mundt et al., 2013^; Viguera et al. 2015^; Madan et al. 2016^</td>
</tr>
<tr>
<td>Positive and Negative Predictive Value (PPV &amp; NPV)</td>
<td>Mundt et al 2013^; Viguera et al 2015^</td>
</tr>
<tr>
<td>Reliability (internal consistency)</td>
<td>Posner et al., 2011^; Kilincaslan et al. 2018^; Pai et al. 2015^; Madan et al. 2016^</td>
</tr>
<tr>
<td>Reliability (inter-rater; multi-method agreement)</td>
<td>Kerr et al., 2013^; Brent et al., 2009^; Kilincaslan et al. 2018^; Hesdorffer et al., 2013^; Arias et al., 2013^; Brown et al. 2015^</td>
</tr>
<tr>
<td>Internal Structure (Factor Analysis)</td>
<td>Al-Halabi et al., 2016^; Madan et al. 2016^</td>
</tr>
<tr>
<td>Convergent Validity &amp; Accuracy</td>
<td>Posner et al., 2011^; Kerr et al., 2013^; Kilincaslan et al. 2018^; Pai et al. 2015^; Youngstrom et al. 2015^; Brown et al., 2015^; Madan et al.2016^</td>
</tr>
<tr>
<td>Divergent &amp; Discriminant Validity</td>
<td>Posner et al., 2011^; Kerr et al., 2013^; Kilincaslan et al. 2018^</td>
</tr>
<tr>
<td>Cross-Cultural Validation</td>
<td>Danish (Conway et al. 2016^); Turkish (Kilincaslan et al. 2018^); Korean (Pai et al. 2015^); Spanish (Al-Halabi et al., 2016^)</td>
</tr>
</tbody>
</table>

* studies include adult samples; ^ studies include pediatric samples
Table 2: Psychometric Properties of Specific C-SSRS Predictors with Coefficients

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Criterion</th>
<th>Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Greist et al. 2014</strong></td>
<td>Actual, interrupted or aborted attempts</td>
<td>All patients: 0.8% incidence rate, N=4975 Psychiatric patients: 1.1% incidence rate, N=3184</td>
</tr>
<tr>
<td>None Reported</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR= 6.21, 95% CI = 4.18 – 9.23, p &lt; 0.001 OR= 4.99, 95% CI = 3.29 – 7.56, p &lt; 0.001</td>
</tr>
<tr>
<td>Wish to Be Dead</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR= 6.69, 95% CI = 4.16 – 10.76, p &lt; 0.001 OR= 5.53, 95% CI = 3.38-9.04, p &lt; 0.001</td>
</tr>
<tr>
<td>Non-Specific Active Thoughts</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR= 6.69, 95% CI = 4.16 – 10.76, p &lt; 0.001 OR= 5.53, 95% CI = 3.38-9.04, p &lt; 0.001</td>
</tr>
<tr>
<td>Active with any methods (not plan) w/o intent to act</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR= 11.16, 95% CI = 7.43-16.76, p &lt; 0.001 OR= 8.36, 95% CI = 5.44-12.84, p &lt; 0.001</td>
</tr>
<tr>
<td>Active with Some Intent to Act, without specific plan</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR= 19.27, 95% CI = 12.97 – 28.63, p &lt; 0.001 OR= 15.24, 95% CI = 10.07-23.09, p &lt; 0.001</td>
</tr>
<tr>
<td>Active with specific plan and intent</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR= 25.53, 95% CI = 16.94 – 38.47, p &lt; 0.001 OR= 18.70, 95% CI = 12.16 – 28.76, p &lt; 0.001</td>
</tr>
<tr>
<td><strong>Posner et al. 2011</strong> (TASA study N=124, ages 12-18)</td>
<td>Baseline worst-point Attempts</td>
<td>OR=1.45, 95% CI=1.07-1.98, p=0.02</td>
</tr>
<tr>
<td>Baseline worst-point</td>
<td>Actual, interrupted and aborted attempts</td>
<td>OR=1.34, 95% CI=1.05-1.70, p=0.02</td>
</tr>
<tr>
<td>Lifetime severity Attempts</td>
<td>OR=1.43, 95% CI=0.99-2.05, p=0.05</td>
<td></td>
</tr>
<tr>
<td>Severity 4-5 (any intent to act) Attempts</td>
<td>OR=3.26, 95% CI=1.02-10.45, p=0.047</td>
<td></td>
</tr>
<tr>
<td>Severity 4-5 (any intent to act) Actual, interrupted and aborted attempts</td>
<td>OR= 3.26, 95% CI=1.07-7.12, p=0.036</td>
<td></td>
</tr>
<tr>
<td><strong>Horwitz et al. 2015</strong> (N=473, ages 15-24)</td>
<td>Ideation severity 1 to 5 Attempt</td>
<td>OR= 1.51, 95% CI= 1.24-1.84, p&lt;0.001</td>
</tr>
<tr>
<td><strong>Arias et al. 2016</strong></td>
<td>Current ideation severity 4 or 5 (with intent to die) Actual attempt or suicide 6 weeks post-ED visit</td>
<td>OR=1.70 95% CI 1.18-2.44, p =.004</td>
</tr>
<tr>
<td>Current ideation severity 4 or 5 (with intent to die) Actual, interrupted, aborted attempts, suicide or preparatory behavior</td>
<td>OR =1.52 95% CI 1.23-1.86 p &lt;. 001</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Predictor Description</td>
<td>Criterion Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Madan et al. 2016:</td>
<td>Most severe ideation within 72 hours of hospitalization</td>
<td>Any suicide behavior within 6 months post hospitalization</td>
</tr>
<tr>
<td>(N=1,055 adult psych in-patients)</td>
<td></td>
<td>Psychiatric re-hospitalization within 6 months</td>
</tr>
<tr>
<td>Conway et al. 2016:</td>
<td>Severity of ideation (1-5)</td>
<td>Any type of suicidal behavior at follow-up</td>
</tr>
<tr>
<td>(N=85 adolescents, age &lt; 18, mean age=16.2)</td>
<td>Ideation with intent to act (4 or 5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ideation intensity total score</td>
<td></td>
</tr>
</tbody>
</table>

### Predictive Validity - Suicidal Behavior

<table>
<thead>
<tr>
<th>Study</th>
<th>Predictor</th>
<th>Criterion</th>
<th>Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horwitz et al. 2015:</td>
<td>Attempt</td>
<td>Attempt</td>
<td>OR = 4.80, 95% CI = 2.23-10.32, p &lt; .001</td>
</tr>
<tr>
<td>(N=473, ages 15-24)</td>
<td>NSSIB item</td>
<td>Attempt</td>
<td>OR = 3.12, 95% CI = 1.36-7.19, p &lt; .01</td>
</tr>
<tr>
<td>Gipson et al. 2014</td>
<td>NSSIB item</td>
<td>Return ER visit</td>
<td>OR = 1.52; 95% CI, 1.08-2.12, p &lt; .05</td>
</tr>
<tr>
<td>(N=178, ages 13-17)</td>
<td></td>
<td>Attempt</td>
<td>$X^2 = 4.131, \text{df} = 1, \text{p} = 0.04$</td>
</tr>
<tr>
<td>Conway et al. 2016</td>
<td>Attempts</td>
<td>Re-attempt [short-term]</td>
<td>OR = 11.50, 95% CI = 1.66-79.65, p &lt; .05</td>
</tr>
<tr>
<td>(N=85, age &lt; 18, mean age=16.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greist et al. 2014</td>
<td>Attempt</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR = 4.57, 95% CI = 3.6-5.7, p &lt; .001</td>
</tr>
<tr>
<td></td>
<td>Interrupted Attempt</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR = 5.55, 95% CI = 4.4-7.0, p &lt; .001</td>
</tr>
<tr>
<td></td>
<td>Aborted Attempt</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR = 5.09, 95% CI = 4.1-6.4, p &lt; .001</td>
</tr>
<tr>
<td></td>
<td>Preparatory behavior</td>
<td>Actual, interrupted or aborted attempts</td>
<td>OR = 5.69, 95% CI = 4.3-7.5, p &lt; .001</td>
</tr>
</tbody>
</table>
## Incremental Validity and Accuracy

<table>
<thead>
<tr>
<th>Study</th>
<th>Ideation Type</th>
<th>Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent et al. (2009): Treatment resistant, depressed adolescent suicide attempters (N=334, ages 12-18)</td>
<td>Higher rates of suicidal (20.8% vs. 8.8%, chi squared = 9.18, df=1, p&lt;0.002) and non-suicidal self-injury (17.6% vs. 2.2%, chi squared = 23.47, df=1, p&lt;0.001) detected with systematic monitoring</td>
<td></td>
</tr>
<tr>
<td>Horwitz et al. (2015): Young adult psychiatric emergency patients (N=473, ages 15-24)</td>
<td>Suicidal ideation added incremental validity to the prediction of future suicide attempts beyond the past suicide attempt, ( \chi^2 (1) = 7.54, p = .006 )</td>
<td></td>
</tr>
</tbody>
</table>
| Brown et al. (2015): psychiatric ER patients (N=250) | • 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) | • 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)*

<table>
<thead>
<tr>
<th>Study</th>
<th>Ideation Type</th>
<th>Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brent et al. (2009) (N=334, ages 12-18)</td>
<td><em>suicidal ideation ranging from 0 to 5 (from no ideation to suicidal ideation with intent and a clear plan)</em> monitored weekly</td>
<td>ICC = .09, p&lt; 0.001</td>
</tr>
</tbody>
</table>
| Kilincaslan et al. 2018 (N=213, ages 12-18) | *Inter-rater reliability for the most severe ideation scores in the last month and lifetime were good* | Lifetime \( \kappa = 0.92 \)  
Recent \( \kappa = 0.88 \) | |
<p>| Youngstrom et al. (2015) | <em>Accuracy calibrated against “missing gold standard” latent class-derived ideation and behavior categories</em> | ( \kappa &gt; 0.7 ) |</p>
<table>
<thead>
<tr>
<th>Hesdorffer et al. (2013)</th>
<th>Agreement between the MINI, C-SSRS and eC-SSRS for lifetime suicidal ideation</th>
<th>$\kappa = 0.80, 95% \text{ CI} = 0.72-0.89$</th>
</tr>
</thead>
</table>
| Gwaltney et al. (2017)  | **Equivalence analyses/multi-method agreement between IVR (interactive voice response) and tablet text-based eC-SSRS for most severe lifetime ideation** | Correlation: 0.87, $p<0.001$  
ICC: $\kappa = 0.89, p<0.001$ |
|                         | *Equivalence analyses between IVR (interactive voice response) and tablet text-based eC-SSRS for most severe ideation in past 6 months* | Correlation: 0.69, $p<0.001$  
ICC: $\kappa = 0.79, p<0.001$ |

**Reliability - Suicidal Behavior**

<table>
<thead>
<tr>
<th>Gwaltney et al. (2017)</th>
<th><strong>Equivalence analyses/multi-method agreement between IVR (interactive voice response) and tablet text-based eC-SSRS for lifetime Actual attempts</strong></th>
<th>$\kappa = 0.81, p&lt;0.001$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of lifetime actual attempts</td>
<td>$\kappa = 0.81, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Actual attempts (recent-last 2 yrs)</td>
<td>$\kappa = 0.73, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Interrupted attempts (lifetime)</td>
<td>$\kappa = 0.78, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Interrupted attempts (recent-last 2 yrs)</td>
<td>$\kappa = 0.762, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Aborted attempts (lifetime)</td>
<td>$\kappa = 0.54, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Aborted attempts (recent-last 2 yrs)</td>
<td>$\kappa = 0.74, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Preparatory behaviors (lifetime)</td>
<td>$\kappa = 0.77, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Preparatory behaviors (recent-last 2 yrs)</td>
<td>$\kappa = 0.89, p&lt;0.001$</td>
</tr>
<tr>
<td></td>
<td>Non-suicidal, self-injurious behavior</td>
<td>$\kappa = 0.73, p&lt;0.001$</td>
</tr>
<tr>
<td>Study</td>
<td>Description</td>
<td>Results</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Brent et al. (2009)</td>
<td>Inter-rater reliability for a rating of suicidal behavior, ranging from 0 to 5 (no behavior to multiple attempts during the assessment period) using the Columbia Classification Algorithm of Suicide Assessment</td>
<td>100% agreement</td>
</tr>
<tr>
<td>Kerr et al. (2014a,b)</td>
<td>Inter-rater agreement for distinction among actual, aborted, interrupted attempts, preparatory acts and any other act</td>
<td>κ = 0.88; κ = .91</td>
</tr>
<tr>
<td>Brown et al. (2015)</td>
<td>Agreement with clinical assessment for attempts</td>
<td>κ = 0.76, P &lt; .001</td>
</tr>
<tr>
<td></td>
<td>Agreement with clinical assessment for non-suicidal self-injurious behavior</td>
<td>κ = 0.72, P &lt; .001</td>
</tr>
<tr>
<td>Youngstrom et al. (2015)</td>
<td>Accuracy of attempt: calibrated against latent class-derived categories</td>
<td>κ &gt; 0.8</td>
</tr>
<tr>
<td>Hesdorffer et al. (2013)</td>
<td>Agreement between the MINI, C-SSRS and eC-SSRS for lifetime suicidal behavior</td>
<td>κ = 0.67, 95% CI = 0.53-0.80</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>C-SSRS as an Effective Measure for Diagnosis &amp; Treatment</th>
<th>Studies</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veterans</strong> Legarreta et al., 2015</td>
<td></td>
<td>• The association of specific PTSD symptoms with suicidal ideation and behavior suggested individual PTSD symptoms as treatment target for reducing suicidal outcomes.</td>
</tr>
<tr>
<td><strong>Veterans</strong> Harvey et al., 2018</td>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td><strong>Medication Treatment</strong> Ionescu et al. (2016)</td>
<td></td>
<td>• Ketamine treatment effective for suicidal ideation (SI) in adults</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SI severity improved independent of acute decrease in depression and SI intensity improved even if SI severity un-remitted</td>
</tr>
<tr>
<td></td>
<td>Prakash et al. (2012)</td>
<td>• Duloxetine was effective in treating suicidal ideation among children ages 7-17 with major depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Distinguished children with improvement and deterioration</td>
</tr>
</tbody>
</table>
References for Psychometric Evidence and Clinical Outcomes


Representative Publications for C-SSRS Use:

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

Pediatric Populations by Age Group

Ages 5-11


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


Ages 6-18


Ages 7-13

**Ages 7-17**


**Ages 7-18 (for the pediatric sub-sample; also includes studies with adults)**


**Ages 8-12**


**Ages 10-18**


**Ages 11-17**


**Ages 12-17**


Ages 12-17.5

Ages 12-18

Ages 13-17

Ages 13-19
**Ages 14-19**


**Studies with Adolescents and Young Adults**

**Ages 13-25**


**Ages 14-39**


**Ages 15-20**


**Ages 15-24**


**Ages 20-22**

School Protocols

Medical Specialties
Neurology


Oncology

Psoriasis

Psychiatric Conditions
Alzheimer’s


**ADHD**


**Alcoholism**

**Autism**

**Bipolar Depression**


**Complicated Grief**
Generalized Anxiety Disorder (GAD)

Perinatal/Postpartum Depression


Psychosis/Schizophrenia


PTSD

Sleep

Healthcare Systems

Outpatient Settings
Outpatient Psychiatry

Juvenile Justice


Integrated Primary Care

Veterans


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


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


**Mobile Crisis**


**Telemedicine**


**Treatment Efficacy for Suicidal Outcomes**


**Guidelines for Treatment & Assessment of Suicidal Outcomes**


**Reviews of Suicide Risk Assessment Tools**


**Linguistic and Psychometric Validation of Translations**


*Al-Halabi, S., Fernández-Peláez, AD, Burón, P., Riesco, E., Rodríguez-Revuelta, J. Posner, K. Oquendo, M., García-Portilla, MP, Saiz., P. and Bobes, J (September, 2016). In Search of the Internal Structure of the Columbia Suicide Severity Rating Scale (C-SSRS): A Confirmatory Factor Analysis Approach. 16th European Symposium on Suicide Suicidal Behavior, Oviedo, Spain. [Spanish]*


Cross-Cultural Settings

**Latin America (Spanish)**

**Australia**

**China**

**Croatia**

**Ethiopia**

**France**

**Germany**

**Hungary**

**Indonesia**

**India**

**Korea**


**Spain**


**Sri Lanka**


**Ethnic Groups**

**Asian Americans**


**C-SSRS Training Program Evaluations**


Columbia Suicide Severity Rating Scale Versions

C-SSRS Clinical Practice Screener:


Omolewa, P., & Tribble, K. L. The Impact of C-SSRS (Columbia-Suicidal Severity Rating Scale) Usage on Quality of Care in John George Psychiatric Hospital (San Leandro, CA): a Medical Care Evaluation Study.

C-SSRS Self-Report:


