

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

Psychometric Property		Studies
Clinical Utility	Predictive and/or Incremental Validity	Brent et al., 2009 [^] ; Posner et al., 2011 ^{*^} ; Mundt et al., 2013 [*] ; Arias et al. 2013 [*] ; Greist et al. 2014 [*] ; Gipson et al., 2015 [^] ; Horwitz et al., 2015 [*] ; Brown et al., 2015 [*] ; Arias et al., 2016 [*] ; Conway 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 ⁶ ; Brent et al., 2009 [^] ; Hesdorffer et al., 2013 [*] ; Arias et al., 2013 [*] ; Brown et al. 2015 [*] ; Gunes 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 [^]); Korean (Pai et al. 2015 [*]); Turkish (Gunes 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	<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	<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 hospitalization within 6 month post initial hospitalization	$r = .125, p < .05, N=275$

Predictive Validity - Suicidal Behavior

	Predictor	Criterion	Coefficients
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
Horwitz et al. 2015	<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	<i>NSSIB item</i>	Return ER visit	OR = 1.52; 95% CI, 1.08-2.12, p<.05
		Attempt	$\chi^2 = 4.131, df = 1, p = 0.04$

See also: Conway et al 2016.

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
Brown et al. (2015): psychiatric ER patients (N=250)	<ul style="list-style-type: none"> 18% (n=23) of patients with a <u>suicide attempt</u> in the past week misclassified or missed by clinical assessment. Agreement with clinical assessment for <u>suicide attempts</u> (K=0.76, p<.001) Agreement with clinical assessment of <u>non-suicidal self-injurious behavior</u> (K=0.72, p<.001)
Horwitz et al. (2014): Young adult psychiatric emergency patients (N=473)	<ul style="list-style-type: none"> Suicidal ideation added incremental validity to the prediction of future suicide attempts beyond the past suicide attempt, $X^2(1) = 7.54, p = .006$
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 <u>suicide attempts</u> compared to chart reviews (59% vs. 18%, difference of 41%, 95% CI= 28-55, p<0.001)

See also: Conway et al 2016.

Reliability - Suicidal Ideation (inter-rater and multi-method agreement)		
Study	Ideation Type	Coefficients
Brent et al. (2009)	<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

Youngstrom et al. (2015)	Accuracy calibrated against “missing gold standard” latent class-derived ideation and behavior categories	$\kappa > 0.7$
Gunes et al. (2015)	Inter-rater reliability for the <u>most severe ideation scores</u> in the last month and lifetime were good	Lifetime $\kappa = 0.91$ Recent $\kappa = 0.76$
Hesdorffer et al. (2013)	Agreement between the MINI, C-SSRS and eC-SSRS for lifetime <u>suicidal ideation</u>	$\kappa = 0.80$, 95% CI = 0.72-0.89
Reliability - Suicidal Behavior		
Brown et al. (2015)	Agreement with clinical assessment for <u>attempts</u>	$\kappa = 0.76$, $P < .001$
	Agreement with clinical assessment for <u>non-suicidal self-injurious behavior</u>	$\kappa = 0.72$, $P < .001$
Youngstrom et al. (2015)	Accuracy of <u>attempt</u> : calibrated against latent class-derived categories	$\kappa > 0.8$
Brent et al. (2009)	Inter-rater reliability for a rating of <u>suicidal behavior, ranging from 0 to 5</u> (no behavior to multiple attempts during the assessment period) using the Columbia Classification Algorithm of Suicide Assessment	100% agreement
Kerr et al. (2013)	Inter-rater agreement for distinction among <u>actual, aborted, interrupted attempts, preparatory acts and any other act</u>	$\kappa = 0.88$
Hesdorffer et al. (2013)	Agreement between the MINI, C-SSRS and eC-SSRS for lifetime <u>suicidal behavior</u>	$\kappa = 0.67$, 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

Decrease in Suicide Rate: C-SSRS as Intervention	Out-Patient Mental Health Esposito, 2015	<ul style="list-style-type: none"> Centerstone - the largest provider of community-based outpatient mental health care in the U.S. The C-SSRS administered to every client at every service delivery point as part of a comprehensive Zero Suicide prevention program. In the first 20 months post-implementation, the Tennessee facilities saw a nearly 65 % reduction in the suicide rate, from 3.1 to 1.1 per 10,000 clients.
	Active Duty: US Marines Seck, 2015	<ul style="list-style-type: none"> Following training of all support staff in the C-SSRS at 16 USMC installations and implementation of mandatory C-SSRS screening by the non-healthcare personnel, including legal services, suicides in the USMC dropped by 22%, from 45 in 2013 to 34 in 2014.
	States: Utah US: UT Dept. of Human Services, 2015	<ul style="list-style-type: none"> For the first time reversed the rising suicide trend since implementing the C-SSRS as part of the comprehensive Zero Suicide program in 2015.
	Active Duty: US Army Adam Walsh, CIV DODHRA DSPO (US), (2015, personal communication)	<ul style="list-style-type: none"> At the end of 2-4 months of treatment for PTSD in active duty soldiers (N=1206), those with greater improvement in PTSD had fewer suicidal ideation symptoms on the C-SSRS.

Table 3: (Continued)

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. (2014) (suicide analyses in preparation)	<ul style="list-style-type: none"> Preliminary analyses show higher prevalence of suicidal ideation and behavior among the Vets with Bipolar Disorder than Schizophrenia. Different patterns of association with medical, psychiatric disorders and demographic characteristics between BP and SZ groups
	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

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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 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 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.

Ages 7-17

Strawn, J. R., Prakash, A., Zhang, Q., Pangallo, B. A., Stroud, C. E., Cai, N., & Findling, R. L. (2015). A randomized, placebo-controlled study of duloxetine for the treatment of children and adolescents with generalized anxiety disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(4), 283-293.

Emslie, G. J., Prakash, A., Zhang, Q., Pangallo, B. A., Bangs, M. E., & March, J. S. (2014). A double-blind efficacy and safety study of duloxetine fixed doses in children and adolescents with major depressive disorder. *Journal of child and adolescent psychopharmacology*, 24(4), 170-179.

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 7-17

Prakash, A., Lobo, E., Kratochvil, C. J., Tamura, R. N., Pangallo, B. A., Bullok, K. E., ... & March, J. S. (2012). An open-label safety and pharmacokinetics study of duloxetine in pediatric patients with major depression. *Journal of child and adolescent psychopharmacology*, 22(1), 48-55.

Ages 10-18

Scott, M., Underwood, M., & Lamis, D. A. (2015). Suicide and Related-Behavior Among Youth Involved in the Juvenile Justice System. *Child and Adolescent Social Work Journal*, 32(6), 517-527.

Ages 11-17

Goodyer, I. M., Tsancheva, S., Byford, S., Dubicka, B., Hill, J., Kelvin, R., ... & Wilkinson, P. (2011). Improving mood with psychoanalytic and cognitive therapies (IMPACT): a pragmatic effectiveness superiority trial to investigate whether specialised psychological treatment reduces the risk for relapse in adolescents with moderate to severe unipolar depression: study protocol for a randomised controlled trial. *Trials*, 12(1), 175.

Ages 12-17

Findling, R. L., Cutler, A. J., Saylor, K., Gasior, M., Hamdani, M., Ferreira-Cornwell, M. C., & Childress, A. C. (2013). A long-term open-label safety and effectiveness trial of lisdexamfetamine dimesylate in adolescents with attention-deficit/hyperactivity disorder. *Journal of child and adolescent psychopharmacology*, 23(1), 11-21.

Findling, R.L., A. Robb, and A. Bose, *Escitalopram in the treatment of adolescent depression: a randomized, double-blind, placebo-controlled extension trial.* J Child Adolesc Psychopharmacol, 2013. 23(7): p. 468-80.

Ages 7-18 (for pediatric sub-sample; paper also included studies with adults)

Gibbons, R. D., Brown, C. H., Hur, K., Davis, J. M., & Mann, J. J. (2012). Suicidal thoughts and behavior with antidepressant treatment: reanalysis of the randomized placebo-controlled studies of fluoxetine and venlafaxine. *Archives of general psychiatry*, 69(6), 580-587.

Ages 12-17.5

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.

Ages 12-18

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., ... & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, 168(12), 1266-1277.

Ages 12-18

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Ages 12-17

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Cross-Cultural Settings

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