

Columbia Suicide Severity Rating Scale (C-SSRS)

About the C-SSRS

What does it measure?

The Columbia Suicide Severity Rating Scale (C-SSRS) is a measure used to identify and assess individuals at risk for suicide. Questions are phrased for use in an interview format but can be completed as a self-report measure if necessary. The C-SSRS measures four constructs: the severity of ideation, the intensity of ideation, behavior, and lethality. It includes “stem questions,” which if endorsed, prompt additional follow-up questions to obtain more information. There are currently ten versions of the scale available specifically for military settings, including:

1. **Full Scale Lifetime/Recent** version, which allows practitioners to gather a lifetime history of suicidal ideation and/or behavior.
2. **Full Scale Since Last Contact** version, for assessment of suicidal thoughts and behaviors since C-SSRS was last administered.
3. **Screener Basic/Recent** version, a shortened version of the full form (3-6 questions) commonly used in clinical triage settings.
4. **Screener Basic Since Last Contact** version, for assessment of suicidal ideations and behaviors since last contact with triage groupings.
5. **Screener Recent Self Report** version, allows patients to complete for professional assessment over recent months.
6. **Screener Recent with Triage for Emergency Room Department** version, screening with color-coded risk levels and next steps for ER departments.
7. **Screener Recent with Triage for Primary Care Settings** version, specific to primary care settings with color-coded risk levels and next steps.
8. **Screener Since Last Asked Self-Report** version, shortened patient self-report.
9. **Risk and Protective Factors Page**, which provides a checklist of protective and risk factors of suicidality.
10. **Military Family Risk Factors** version, contains shortened questions on risk-factors specific to service members.

SECTIONAL IDEATION	Lifetime/Time Since Last Contact	Most Severe	Most Recent
<p>1. Wish to Die Thoughts of suicide that are not suicidal or suicidal but not suicidal (e.g., "I wish I could just stop existing, or wish I could just stop existing and not wake up." Have you wished you were dead or wished you could go to sleep and not wake up? If yes, describe: _____</p>			
<p>2. Non-Specific Active Suicidal Thoughts Thoughts of suicide that are not suicidal or suicidal but not suicidal (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself (method, means, or plan) during the assessment period. Have you actually had any thoughts of killing yourself? If yes, describe: _____</p>			
<p>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Thoughts of suicide that are not suicidal or suicidal but not suicidal (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself (method, means, or plan) during the assessment period. This is different than a specific plan with time, place or method, details noted (e.g., thought of method to kill self but not a specific plan). Includes persons who would say, "I thought about doing or wanting to do it but never made it specific plan or to when, where or how I could actually do it, and I could never go through with it." Have you ever thought about how you might do this? If yes, describe: _____</p>			
<p>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Thoughts of suicide that are not suicidal or suicidal but not suicidal (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself (method, means, or plan) during the assessment period. This is different than a specific plan with time, place or method, details noted (e.g., thought of method to kill self but not a specific plan). Includes persons who would say, "I thought about doing or wanting to do it but never made it specific plan or to when, where or how I could actually do it, and I could never go through with it." Have you ever thought about how you might do this? If yes, describe: _____</p>			
<p>5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of suicide that are not suicidal or suicidal but not suicidal (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself (method, means, or plan) during the assessment period. This is different than a specific plan with time, place or method, details noted (e.g., thought of method to kill self but not a specific plan). Includes persons who would say, "I thought about doing or wanting to do it but never made it specific plan or to when, where or how I could actually do it, and I could never go through with it." Have you ever thought about how you might do this? If yes, describe: _____</p>			
<p>INTENSITY OF IDEATION The following features should be noted with respect to the most severe type of ideation (i.e., 1-2 from above, with 1 being the least severe and 2 being the most severe). Ask about the feature you find the most suicidal.</p> <p>Lifetime - Most Severe Ideation _____ Severity _____ Duration of Ideation _____ Most Severe _____ Most Recent _____</p> <p>Recent - Most Severe Ideation _____ Severity _____ Duration of Ideation _____ Most Severe _____ Most Recent _____</p> <p>Frequency How many times have you had these thoughts? (1) Less than once a week (2) Once a week (3) 2-3 times a week (4) Daily or almost daily (5) Many times each day</p> <p>Duration When you have the thoughts how long do they last? (1) Less than 10 minutes (2) 10-30 minutes (3) 30-60 minutes (4) More than 60 minutes or continuous</p> <p>Controllability Could you stop thinking about killing yourself or wanting to die if you want to? (1) Easily with a conscious thought (2) Can control thoughts with little difficulty (3) Unable to control thoughts (4) Thoughts are automatic and uncontrollable</p> <p>Disinterest Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide? (1) Someone I personally respect (2) Someone I don't personally respect (3) Someone I don't respect (4) No one</p> <p>Reasons for Ideation What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling, the other would you couldn't go on living with this pain or how you were feeling or was it to get attention, revenge or a reaction from others? Or both? (1) To end the pain or stop the way you were feeling (2) To get attention, revenge or a reaction from others (3) Both (4) None of the above (5) Don't know</p>			

Availability

All four versions of the scale can be accessed from the Columbia University Medical Center's Center for Suicide Risk Assessment website at <https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.military.english>.

The C-SSRS is included in the battery of measures available within the Behavior Health Data Portal (BHDP). The BHDP is a software platform used to measure and examine patient-level clinical outcomes in military behavioral health clinics.

Scoring the C-SSRS

The C-SSRS is made up of ten categories, all of which maintain binary responses (yes/no) to indicate a presence or absence of the behavior. The ten categories included in the C-SSRS are as follows: Category 1 – Wish to be Dead; Category 2 – Non-specific Active Suicidal Thoughts; Category 3 – Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act; Category 4 – Active Suicidal Ideation with Some Intent to Act, without Specific Plan; Category 5 – Active Suicidal Ideation with Specific Plan and Intent; Category 6 – Preparatory Acts or Behavior; Category 7 – Aborted Attempt; Category 8 – Interrupted Attempt; Category 9 – Actual Attempt (non-fatal); Category 10 – Completed Suicide. A yes/no binary response is also utilized in assessing self-injurious behavior without suicidal intent. The outcome of the C-SSRS is a numerical score obtained from the ten categories.

What are the clinical cutoffs, if any?

There are no specified clinical cutoffs for the C-SSRS due to the binary nature of the responses to items. When an item is endorsed, the clinician must pose follow-up inquiries to obtain additional information. The following table can inform safety monitoring and treatment planning when patients endorse suicidal ideation, suicidal behavior, or both:

Outcome	Item Endorsement	C-SSRS Categories
Suicidal ideation	“Yes”	Categories 1-5
Suicidal behavior	“Yes”	Categories 6-10
Suicidal ideation & behavior	“Yes”	Categories 1-10

How should a provider interpret results?

Interpretation of the C-SSRS can take place on an itemized level, a categorical scale, or overall severity of suicidal ideation and behavior. Specific ratings can be derived from the C-SSRS, such as the suicidal behavior lethality scale, suicide ideation score, and the suicidal ideation intensity rating. Ultimately, interpretation will be derived from a thorough clinical assessment, client history, and clinical expertise.

Using the C-SSRS in Practice

How should providers use the results in treatment planning?

Providers should use the C-SSRS as a measure of suicidal ideation, intent, or plan, and past suicidal behavior. It can be used to guide appropriate therapeutic intervention and to facilitate safety monitoring and planning. In addition, the C-SSRS can be utilized to measure treatment progress over time and to assess continued difficulties with suicidality which should be targets of treatment.

References

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