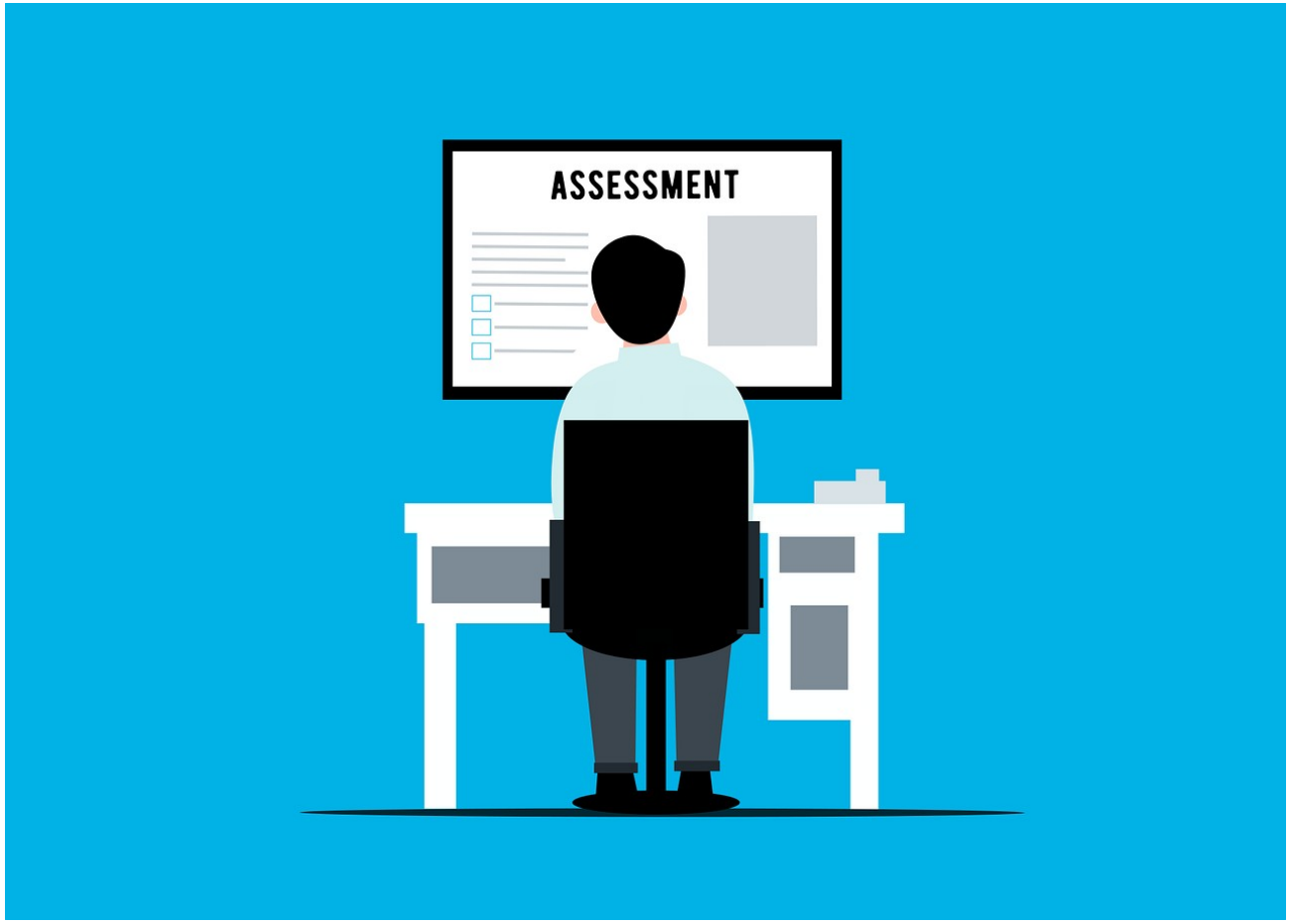
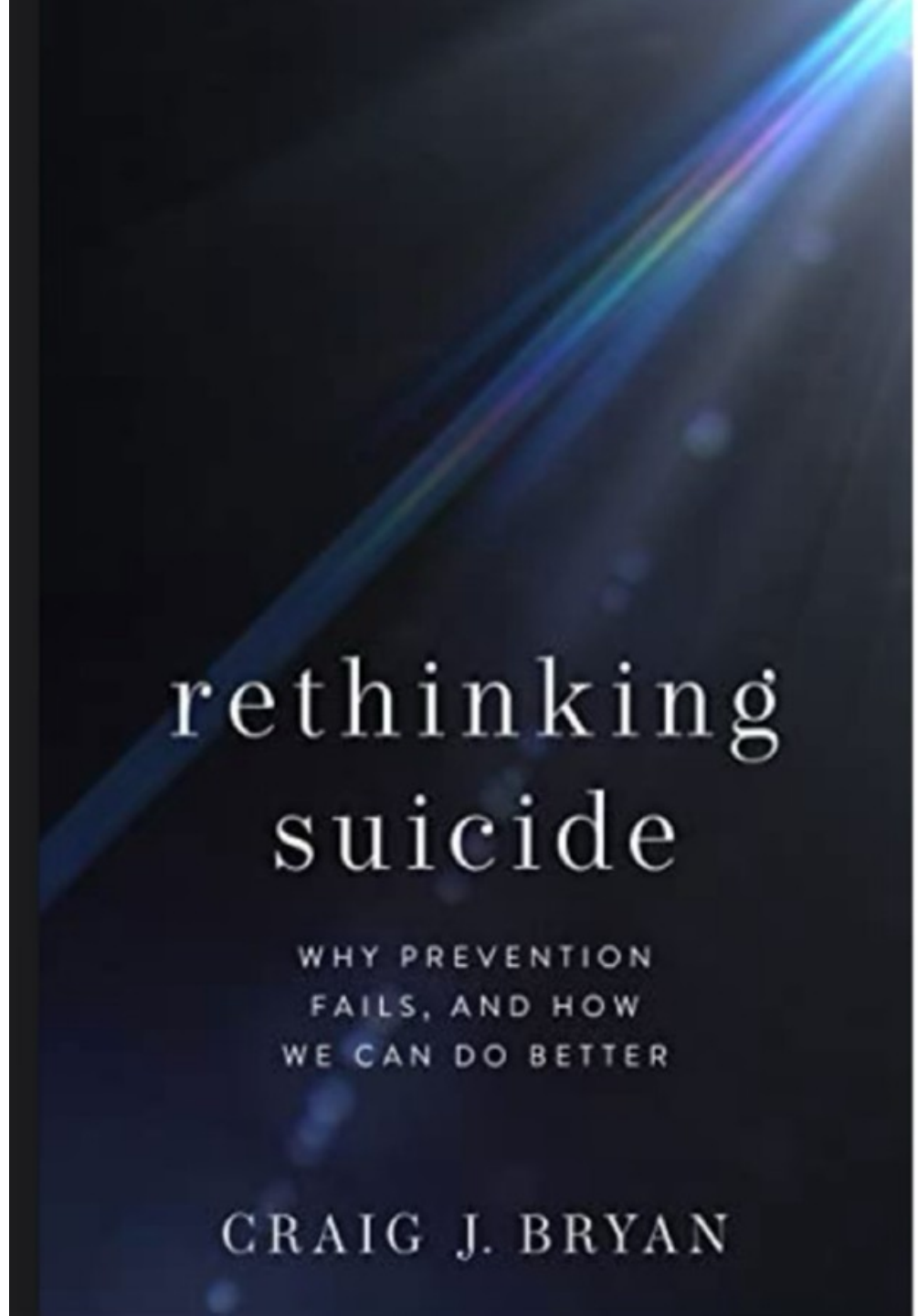
The Suicide Continuum Unmasked: Understanding Suicide Through a New Lens



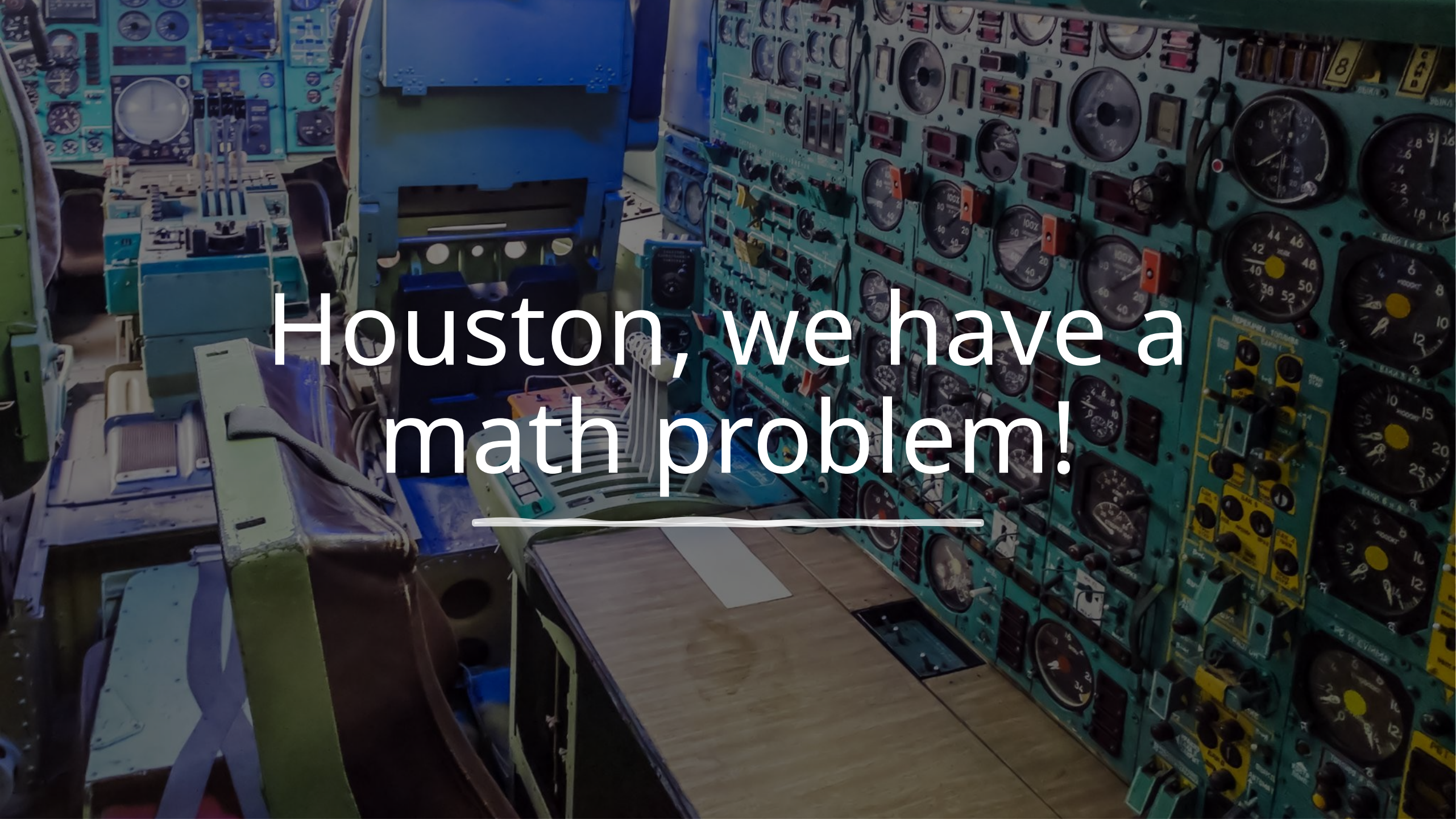
Agenda

- Reframing Risk Assessment to Needs Based Care
- Understanding Suicide Risk
- Screening and Assessment
- Triage Levels and Interventions
- 10 Tips for Reframing Suicide Risk

Reframing Risk Assessment to Needs Based Care


rethinking
suicide
WHY PREVENTION
FAILS, AND HOW
WE CAN DO BETTER
CRAIG J. BRYAN

Understanding Suicide Risk


Houston, we have a
math problem!

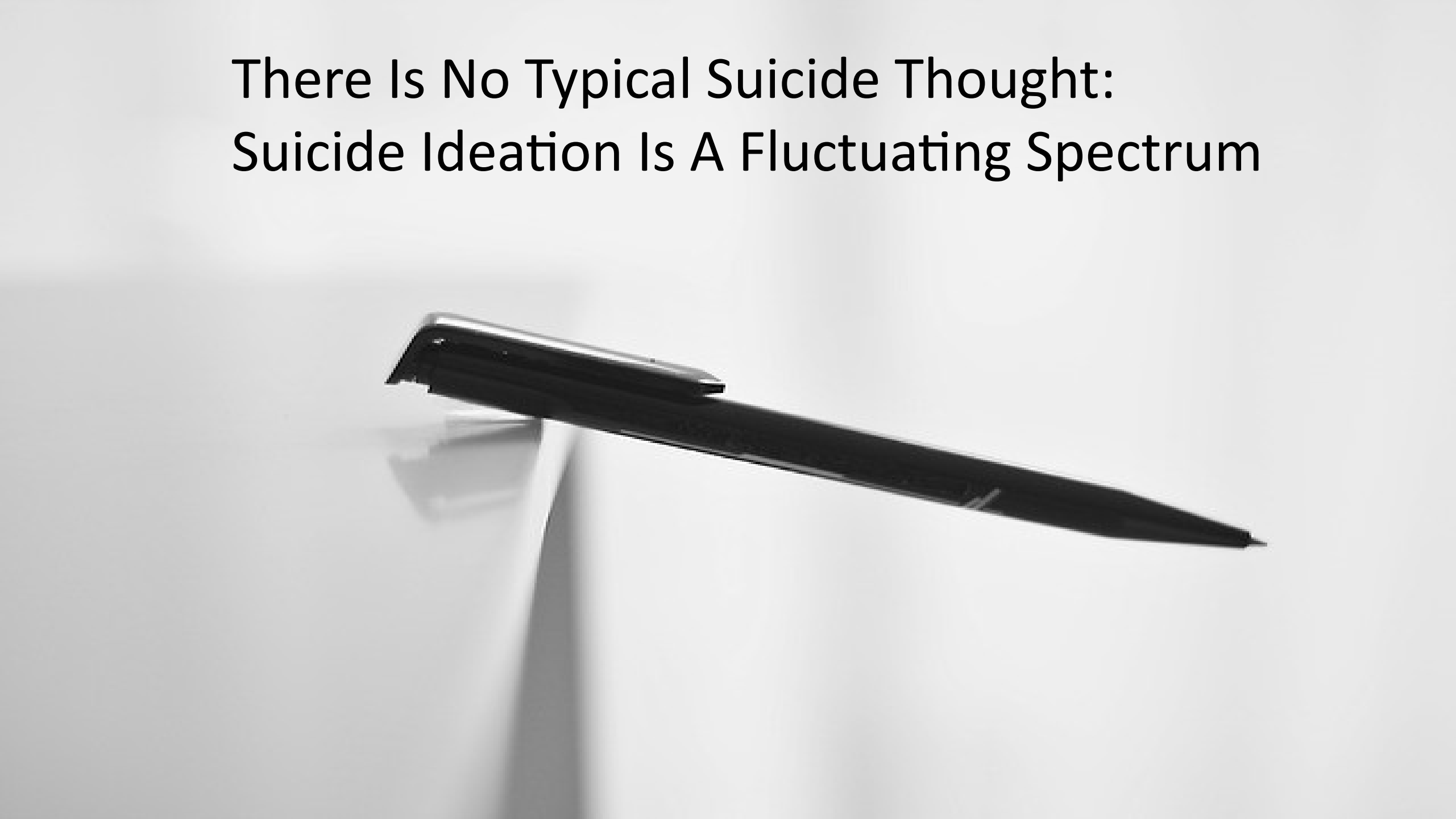
A Test That IDs Suicide 90% (Sensitivity)

1. 90% Sensitivity (ID’s 90% of those at imminent risk. Pretty Good!
2. 5% False positive rate – misidentifies only 5% Amazing
3. Let’s say base 14.3/100,000 (2022 data)
4. True positives: 12 (we identify 12 of the 14 deaths!)
5. But we similarly identify 4999 FALSE POSITIVES
6. We have no way to separate the 12 from the 4999!

Understanding Base Rate Fallacy

- Base rate fallacy affects our judgment in probability.
- Often leads to misinterpretation of statistical information.
- Awareness can improve decision-making processes.

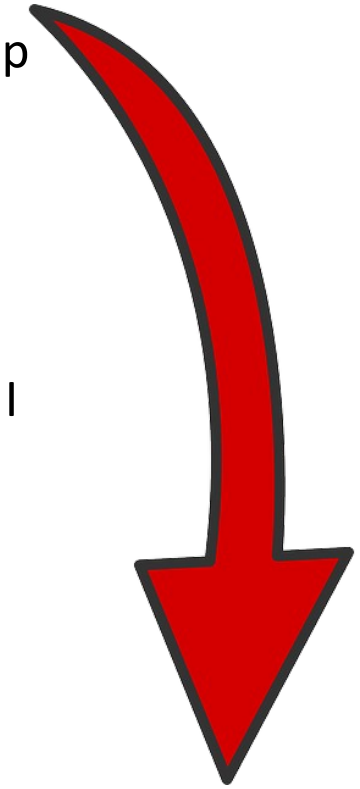
There Is No Typical Suicide Thought: Suicide Ideation Is A Fluctuating Spectrum



Spectrum of Suicide Thoughts

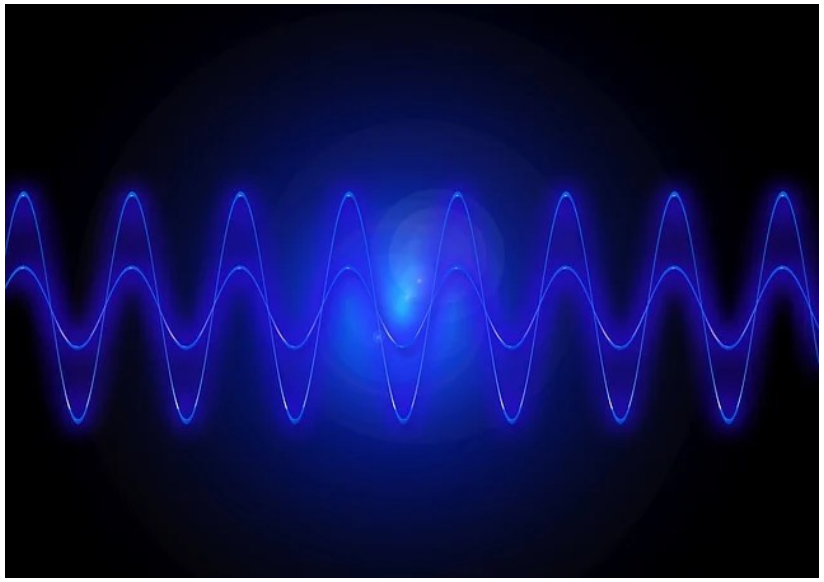
Suicide ideation start with a desire to get away from pain:

1) **Escapist**: I just want this to end/stop/can't take this
2) **Premorbid**: I just want to go away and never come back/sleep and never wake up, not be here anymore
3) **Morbid**: I wish I were dead, I keep thinking about death, I would be better off dead – BUT NOT ACTIVELY THINKING OF TAKING ACTION OR PLACING SELF IN HARMS WAY
4) **Ambivalent:** Not sure if they want to live or die
5) **Passive**: I wouldn't move if a car was coming towards me, or I will stop taking my insulin (medication required for living) – WILLINGNESS TO LET HARM HAPPEN
6) **Active:** Is thinking about taking direct action to end life

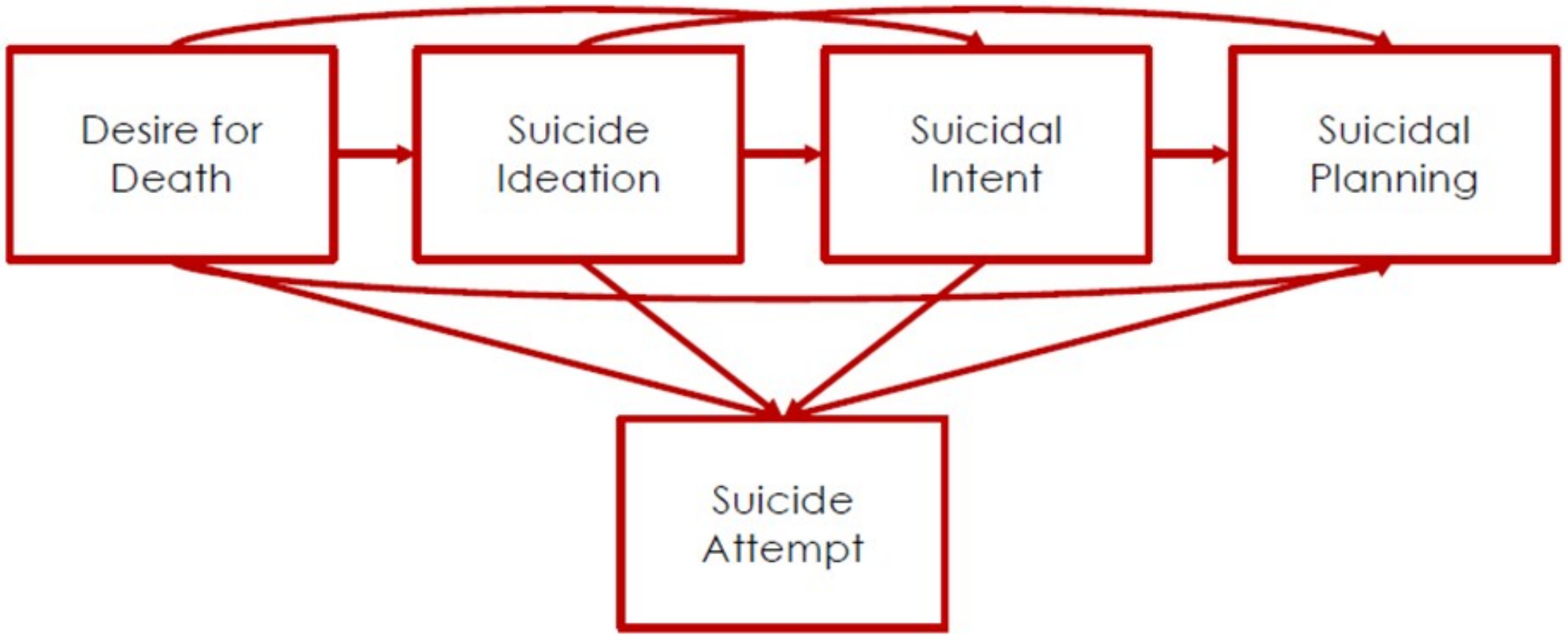


People think suicide is like this, but

IT’S LIKE THIS



From Craig Bryan, September 2024 Mt. Sinai Hospital Presentation



AND: Why don't folks disclose?

1. They may literally not be experiencing suicidal thoughts when we ask!!! Suicide is indeterminant and complex/ (Bryan, 2021)
   a. Indeterminant – infinite paths to suicide, even if some of the paths are more common than others, these more common pathways are still not particularly predictive
   b. Complex and irreducible -Suicide behavior is an emergence of dynamic systems. Factors interact with each other and change over time; small changes in one factor can lead to HUGE changes in the system – disproportionate responses. We may not like it, but someone can move from low to high risk very, very quickly
2. Concern about impact of disclosing – there are valid fears about impact of disclosing thoughts*
   a. Shame, guilt, fear of hospitalization, breaches of confidentiality
   b. Recent study found that youth who had a history of inpatient psychiatric treatment or had screened positive in primary care clinic were 2x as likely to report a 0 on item 9 of PHQ one month before attempt

*Flores JP, et al, Adolescents Who Do Not Endorse Risk via the Patient Health Questionnaire Before Self-Harm or Suicide. JAMA Psychiatry. 2024 Jul 1;81(7):717-726

NO DOESN'T MEAN NO

- **Research: 50-75% of people who die of suicide DENY suicide thoughts when asked shortly before death.***
- **Many reasons make it difficult to disclose thoughts or they may not have thoughts at time.**
- **Trust your gut and rely on other cues, person's story, non-verbal behaviors, etc.**

***Berman, A.L. Suicide (2018) Risk Factors Proximate to Suicide and Suicide Risk Assessment in the Context of Denied Suicide Ideation. *Life Threat Behavior* Jun;48(3):340-352**

Utilizing the Columbia Suicide Severity Rating Scale in a Veteran Population: Efficacy and Clinical Implications

thors & Affiliations:
by E. Beatty, John Richardson, Sonja Batten
op Soldier Suicide

ROGER STOP SOLDIER SUICIDE

ACKGROUND

"Accurate and timely screening can uncover suicide risk and create an opportunity for the delivery of life-saving interventions"

This study evaluates the efficacy of the Columbia-Suicide Severity Rating Scale (CSSRS) when used as an initial web-based or telephone screener among veterans seeking mental health support.

CSSRS leads to risk categorization of minimal, low, moderate or high risk.
a. Often informs need for followup assessment
b. Moderate and high risk individuals typically receive follow-up care

ow often are at-risk individuals unwilling to disclose thoughts of suicide on the web-based CSSRS?

ETHODS

Collected all CSSRS screenings completed in 2024 through the Stop Solider Suicide online Help Request Form.
a. Positive screening defined by a low, moderate, or high risk assignment on the CSSRS.

Collect all interview-based intake risk designations for corresponding CSSRS screenings (n = 719).
a. Positive assessment at intake defined by High or Moderate Acute Risk Level, History of Chronic Ideation, or a History of Attempts.

Isolate individuals who screened negative on CSSRS (n = 305) but were later assessed positive during interview-based intake (n = 125).

Use descriptive analysis and linear models to identify patterns in individuals who may be likely to screen negative during web-based CSSRS screening and later divulge risk of suicide.

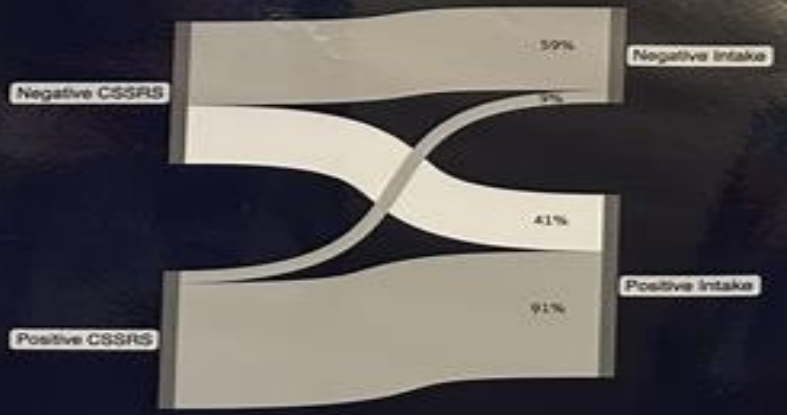
Table 1: Demographic breakdown of individuals who screen negative on the CSSRS.

Demographic	Category	Sample Size	Demographic	Category	Sample Size
Race	Black or African American	120	Branch	Army	136
	White or Caucasian	148		Coast Guard	6
	Other or Mixed Race	30		Navy	68
Ethnicity	Hispanic or Latino	27		Air Force	28
	Not Hispanic or Latino	256		Marines	34
Age	18-24	11		Multiple	6
	25-34	69	Service Status	Active Duty	12
	35-44	110		Discharged	226
	45-54	50		Discharged (National Guard)	5
	55-64	41		Discharged (Reserve)	1
	65+	19		National Guard	8
Gender	Men	201		Reserve	10
	Women	79		Retired	20

KNOWLEDGMENTS:
th Hootie and the ROGER Wellness Center Team

41%

of veterans and service members who screen negative on the CSSRS are assessed as positive for suicidal thoughts and behaviors during interview-based intake.



RESULTS: Of Individuals who screened negative on the CSSRS....

There were no statistically significant differences in the percentage of participants whose risk level increased within each of the demographic categories.

Demographic	Category	Increased Risk	Demographic	Category	Increased Risk
Race	Black or African American	38%	Branch	Army	46%
	White or Caucasian	42%		Coast Guard	17%
	Other or Mixed Race	37%		Navy	38%
Ethnicity	Hispanic or Latino	48%		Air Force	37%
	Not Hispanic or Latino	42%		Marines	35%
Age	18-24	36%		Multiple	17%
	25-34	43%	Service Status	Active Duty	36%
	35-44	47%		Discharged	41%
	45-54	39%		Discharged (National Guard)	40%
	55-64	28%		Discharged (Reserve)	0%
	65+	37%		National Guard	13%
Gender	Men	41%		Reserve	40%
	Women	46%		Retired	40%

In individuals where negative CSSRS screenings shifted to a positive risk assessment, interview-based intakes times were longer on average ($p < 0.001$).

CONCLUSION

The Problem

- WE confirm that a large proportion of those who screen negative on the CSSRS may still be experiencing suicidal thoughts and behaviors.
- CSSRS has many strengths as a screening tool, yet individuals with a negative screen may still benefit from an additional assessment.

Characteristic Profile

- **There is no clear demographic profile for those individuals who are likely to withhold suicide risk on the web-based CSSRS and disclose during interview-based intake.**

What can we do?

- Personalized interview-based intake can aid in accuracy of assessment
- Consider trust building prior to suicide screening
- Ensure sufficient time for a thorough assessment
- Field must explore additional markers of risk and clinical priority beyond current suicide screeners.

STOP SOLDIER SUICIDE

Desire = Escape From Pain

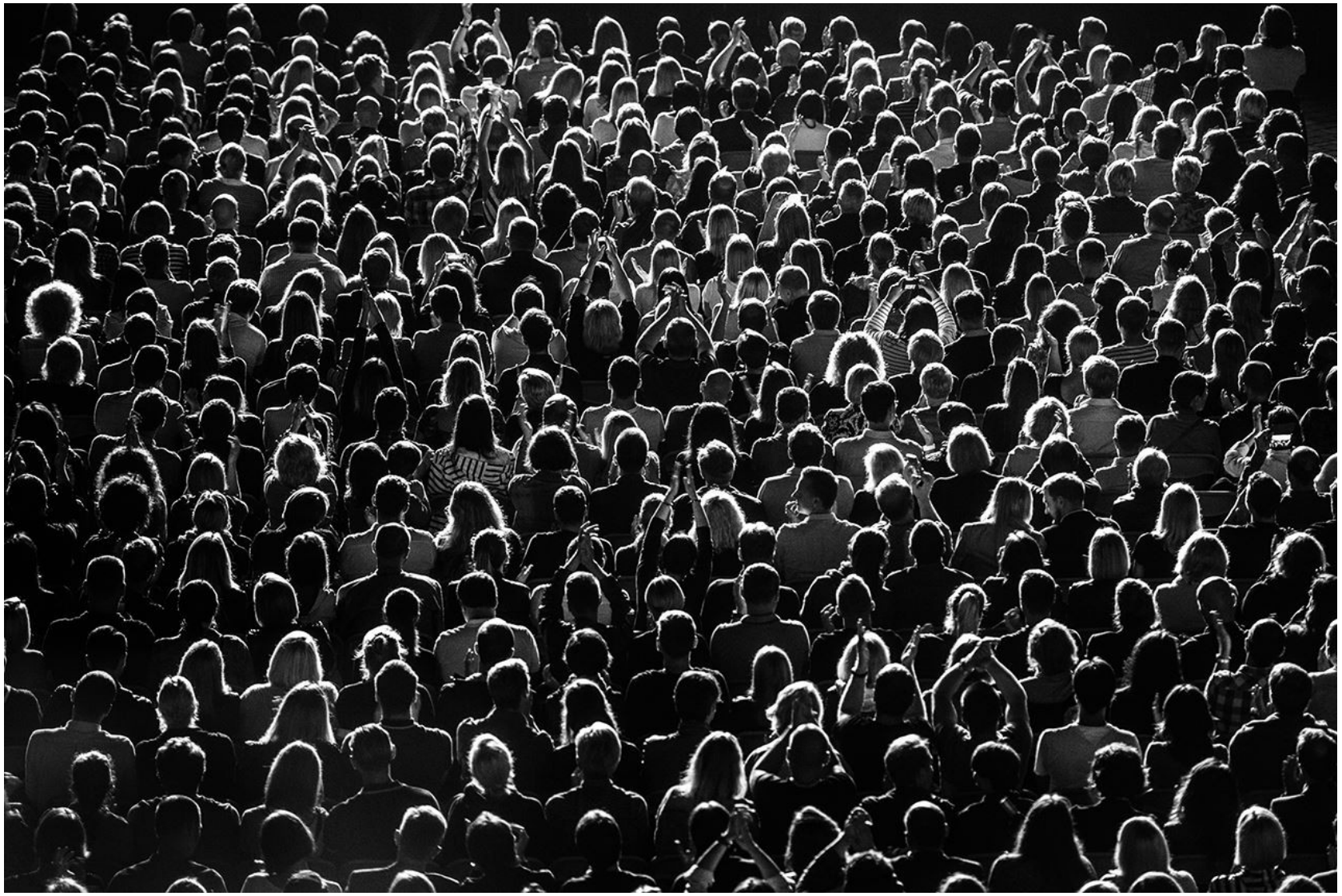
- Thoughts about suicide/death/dying
  - Passive thoughts/death focus just as predictive of suicide as active thoughts
- Hopelessness/helplessness
- Psychological pain
- Perceived burdensomeness
- Trapped/cornered ideation

Suicide Desire By Any Other Name Is Just As Dangerous

- Severe depression
- Intense psychological pain
- Expressed hopelessness or helplessness
- Statements of finality – i.e. nothing matters, what's the point
- Escapist/premorbid/morbid ideation
  - I want this all to stop, it's too much, I need a break
  - I can't take it anymore, I just don't want to be here
  - I want to go to sleep and not wake up
  - I would be better of dead, I think of death a lot, it would be better for others if I wasn't here

If any of these are present, we should attempt full assessment and develop proactive safety plans even if person is denying active suicide thoughts

Everyone Is At Risk (Or Not)



Screening and Assessment

Screening (988):

Are you currently (or recently) experiencing any thoughts of suicide or have you taken any action to harm yourself?

- Columbia Suicide Severity Rating Scale (CSSRS)
- Ask Suicide-Screening Questions (ASQ)
- I no longer recommend PHQ as a screener*

*Huttle, A., Rombola, C., Ortin-Peralta, A., Abramson, E. L., Waseem, M., & Miranda, R. (2025). Differences in reporting suicide ideation and attempt: Implications for suicide risk screening in pediatric primary care. Academic Pediatrics, 25(4), 102795. https://doi.org/10.1016/j.acap.2025.102795

1. NO doesn’t mean “no suicide risk,” it means we just don’t know much about suicide risk

2. YES means we are obligated to do a full assessment

3. And we can and should do a full assessment when we obtain a “no’ but there are other indications we should assess further

Suicide Assessment: what needs are not being met?

Suicide assessment is less about predicting likelihood of suicide behavior and more about identifying what needs are present that we need to meet/address or mitigate to increase safety. Remember we cannot eliminate all safety threats, nor do we need to try but we should identify key elements that will help us triage to appropriate levels of care and build appropriate intervention plans

- Capability for suicide, past attempts
- Level of judgment
- Social connectedness – who is available, who should we avoid, what new connections can we make
- Presence of substance use or mental health challenges
- Current access to care and is care meeting the client's needs, are they willing to re-engage with existing care or establish new care
- Does person have plan, means and intent
- Are they able to identify reasons for living and engage in collaborative safety planning
- What are their reasons for dying, what is driving them towards suicide
- What is high-level level of uncertainty/ambivalence
- Presence of severe symptoms like depression, mania, psychosis, debilitating psychological pain or anxiety
- Are they their own guardian, do we need to involve responsible parties

While this list is not exhaustive, it is a high level overview of some of the key aspects needed for thorough assessment

Triage Levels and Interventions

Triage Levels

1. **No obvious suicide risk elevations present**. This is not the same as low or no risk, in fact, these categories don't exist. We have no reliable, evidence-based tools to draw this conclusion. Instead, what we are saying as we are not seeing any clinically reliable indicators of elevated risk.
2. **Elevated risk, not imminent.** This means we have had a positive screen supported by a completed assessment (including our clinical judgement that risk is elevated even when the client denies active suicide risk) but the client's judgment is intact, and there is no indication of imminency (no plan, means or intent) and we don't have justification for involuntary methods based on client's presentation and our assessment
3. **Imminent risk:** we have clear evidence of impaired judgment with risk elevation or clear evidence of plan, intent and means that indicate that if we do not mitigate the risk with voluntary (or involuntary) interventions, objective evaluators would deem potential for suicide as imminent without taking immediate action

Matching Interventions to Triage Level


mm/inch
OFF
ON
ZERO
mm
RISK

We need to have an honest conversation about what we do and do not know about evaluating suicide risk:

1. We are ethically obligated to do the following on all contacts:
   - screen for suicide risk
   - if screening is positive, complete risk assessment
   - formulate the presence of risk and its imminence
   - mitigate risk using best practices (de-escalate and reduce distress, develop collaborative safety plan, link with appropriate services or ensure immediate safety when imminent)
2. But we don’t have compelling research that accurately distinguishes between risk levels like low, medium or high nor is there any research that provides standardized tools to accurately predict suicide
3. This means we must acknowledge the inherent uncertainty of our task
   - it is never black and white, but many shades of gray
   - despite this uncertainty, we can proceed with confidence and compassion
   - in many ways, this uncertainty is more comforting than the alternative

1. No obvious suicide risk elevations present.

1. Whereas we cannot say that there is no or low risk, when we have screened and assessed appropriately find no elevation, we do not have an ethical or clinical obligation to do suicide specific intervention and/or safety planning
   - Identify key presenting problems
   - Provide appropriate crisis intervention/de-escalation and problem solving
   - Assist with re-engaging or connecting to care as appropriate
   - Normalize that sometimes things can get worse, and we want to are available 24/7 if/when person needs us or things escalate
   - If clinically appropriate, offer mobile outreach or service linkage to address non-suicide related crises
   - You can always do the “You and I have been talking a there, and you’ve helped me understand what is going on and I just want to make sure I am not missing anything… is there anything we haven’t discussed or some things going on that may be hard to talk about”
2. In these situations, we don’t want to add problems that are not there, but we want to make sure we are keeping the door open for the client to tell is if things may be worse than they are ready to disclose
3. Pro-active education/suicide safety planning

2. Elevated risk, not imminent.

1. We must attempt to do collaborative safety planning and mitigate identified needs driving the crisis
   - Offer outreach/urgent care linkage whenever possible
   - Provide appropriate crisis intervention/de-escalation and problem solving and check in to see if this was helpful in reducing distress or focus on suicide
   - Aggressively but collaboratively assist with re-engaging or connecting to care as appropriate
   - Offer and initiate contacts with available support whenever possible
   - Always connect with available follow-up services when eligible
   - Implement means safety procedures
   - Ensure the safety plan is collaborative and addresses unmet needs
     - Ask client if they believe this plan will keep them safe?
     - Ask if we are missing anything or of there are additional needs or aspects of situation we still need to address
     - Reassess client's reported level of suicidality
     - Explore/problem-solve potential challenges to current safety plan
2. In these situations, if there is no imminency and client doesn't want to develop a safety plan, THEY DO NOT HAVE TO. Explore other options that may help the caller address the challenges they are currently facing.
3. Remember, collaborative safety planning is never coerced

It’s Fuzzy

I wish I could say it is always super clear which triage level we are on with our clients. And, sometimes, it is!

If you are unsure, get CONSULTATION!

10 Tips for Reframing Suicide Risk

10 TIPS FOR REFRAMING SUICIDE RISK

1. Your primary focus: where is the person heading in this moment?

2. Are they in pain /distress/ experiencing loss or intense loneliness?

3.Are they feeling helpless or hopeless?

4. Are they experiencing any level of escapist ideation?

5. Don’t get comfortable about “NO.” No is mostly meaningless without the context

6. Assess and allow for ambivalence: Sometimes when someone is struggling, they are not sure if they want to live or not anymore… do you ever feel that way?

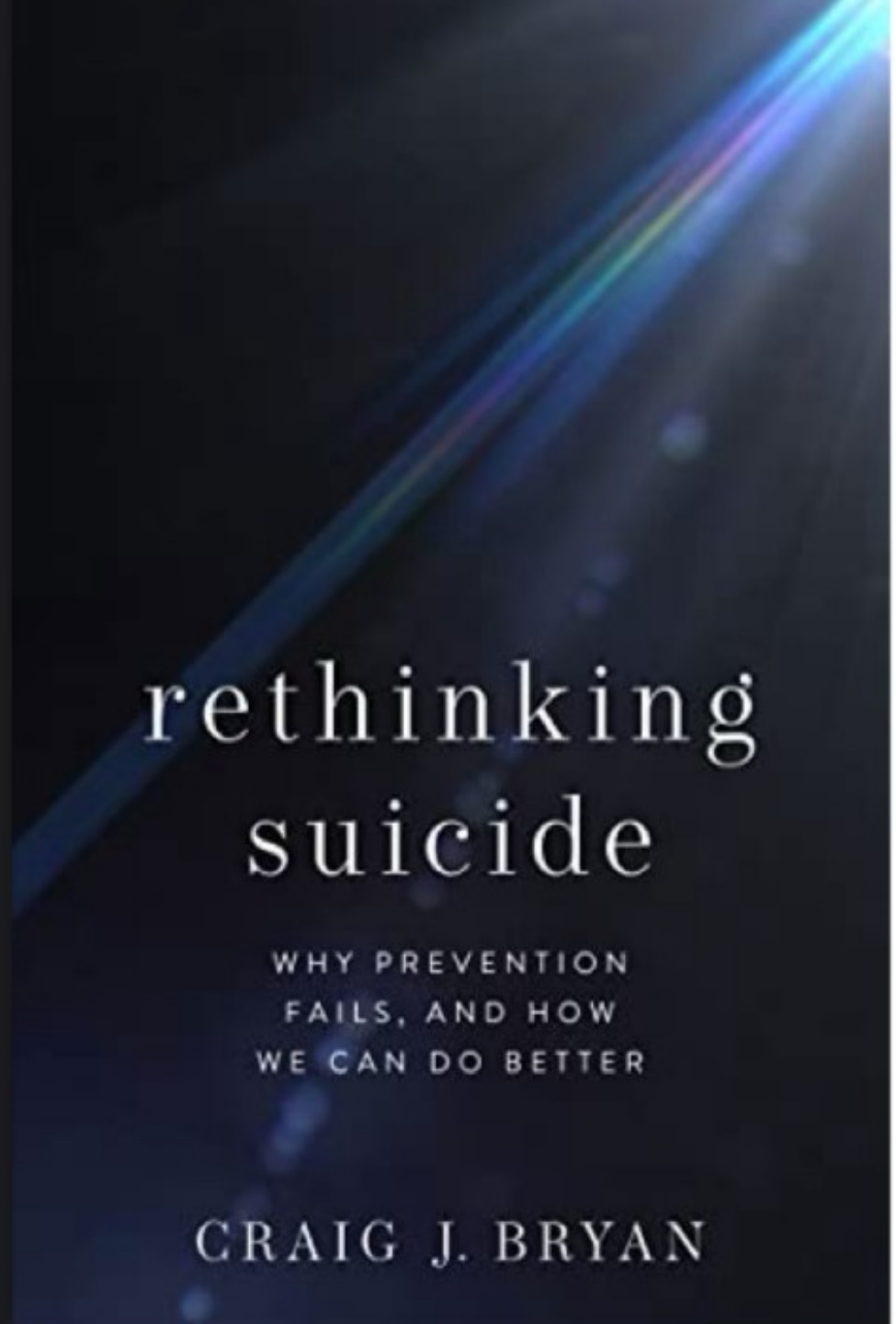
7. What are the persons reasons for living/life connections

8. Pain/distress/hopelessness/ trapped feelings combined with ambivalence about life are just as predictive of future suicide behavior as active thoughts.

9. SEE THE WHOLE PERSON, not just the answer to “Are you having suicidal thoughts?”

10. When someone is feeling helpless/hopeless/trapped is having any level of escapist ideation, they have SUICIDE DESIRE even if they deny active suicide thoughts.

- In these cases, normalize the situation and provide some education
- Right now, you are not having any suicide thoughts, but when people are feeling {fill in the blank} it is not unusual for suicide thoughts to occur
- Can we talk about making a plan to keep you safe just in case things get worse?



1. Accountability (vs. discipline)
2. Gratitude
3. Doing things for others
4. Mutual respect
5. Create & protect white space
6. Encourage secure firearm storage