Mindful
Continuing Education

Suicide Risk Assessment, Prevention,and Intervention

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Introduction

Managing a client who is at high risk for suicide can be worrying, emotionally demanding, and challenging for the mental health clinician. Therefore, it is essential to learn how to identify, assess, and intervene during times of acute crisis. Social workers play a pivotal role in suicide prevention. As a crucial member of the healthcare team, social workers are well-trained to identify those who may be at risk of suicide and are able to provide or link those at risk with the care they so desperately need. We also know that those who die by suicide frequently had contact with the healthcare provider in the weeks and months prior to their death. The team needs to be alert and attentive to possible risk factors, warning signs, and reports of symptoms from their clients. All members of the healthcare team need to have a concrete understanding of suicide prevention, assessment, intervention, safety planning, local resources, and how to make referrals.

Section 1: Myths and Facts

Let's take a look at some common myths and facts related to suicide. The National Alliance on Mental Health (NAMI) (n.d.) identifies some of the most common myths and facts about suicide.

1. **Myth:** Suicide only affects individuals with a mental health condition.

   Fact: Many individuals with mental illness are not affected by suicidal thoughts, and not all people who attempt or die by suicide have mental illness. Relationship problems and other life stressors such as criminal/legal matters, persecution, eviction/loss of home, death of a loved one, a devastating or debilitating illness, trauma, sexual abuse, rejection, and recent or impending crises are also associated with suicidal thoughts and attempts.

2. **Myth:** Once an individual is suicidal, he or she will always remain suicidal.

   Fact: Active suicidal ideation is often short-term and situation-specific. Studies have shown that approximately 54% of individuals who have died by suicide did not have a diagnosable mental health disorder. Furthermore, for those with mental illness, the proper treatment can help to reduce symptoms.

   The act of suicide is often an attempt to control deep, painful emotions and thoughts an individual is experiencing. Once these thoughts dissipate, so will the suicidal ideation. While suicidal thoughts can return, they are not permanent. An individual with suicidal thoughts and attempts can live a long, prosperous life.

3. **Myth:** Most suicides happen suddenly without warning.

   Fact: Warning signs—verbally or behaviorally—precede most suicides. Therefore, it is important to learn and understand the warning signs associated with suicide. Many individuals who are suicidal may only show warning signs to those closest to them. These loved ones may not recognize what is going on, which is why it may seem like the suicide was sudden or without warning.

4. **Myth:** People who die by suicide are selfish and take the easy way out.

   Fact: Typically, people do not die by suicide because they do not want to live—people die by suicide because they want to end their suffering. These individuals are suffering so deeply that they feel helpless and hopeless. Individuals who experience suicidal ideations do not do so by choice. They are not simply "thinking of themselves," but rather, they are going through very serious mental health symptoms due to either mental illness or a difficult life situation.

5. **Myth:** Talking about suicide will lead to and encourage suicide.

   Fact: There is a widespread stigma associated with suicide, and as a result, many people are afraid to speak about it. Talking about suicide not only reduces the stigma but also allows individuals to seek help, rethink their opinions, and share their stories with others. We all need to talk more about suicide.

   When talking with clients about suicide, debunking common myths about suicide can hopefully allow individuals to look at suicide from a different lens and dispel the stigmas.

Section 2: Terminology

Using appropriate terminology is very important when it talks about the sensitive issues related to suicide. It may also help reduce the stigma that is associated with seeking help. Appropriate use of language also demonstrates respect and sensitivity to the experiences of those who have been affected by suicide, especially a family member or significant other. They are also consistent with how society describes types of death. For example, if someone would say that they died in a car accident, we would also say that someone may have died by suicide.

The language used to describe suicide can impact stigma and increase social isolation—the International Association for Suicide Prevention (IASP) (2023). Specific language can be problematic when discussing suicide. The language guide below provides some examples of problematic language and suggests safer alternatives.

PROBLEMATIC	PREFFERED
'committed suicide' or 'commit suicide'	'died by suicide' or 'took their own life' or 'suicide death'
'unsuccessful suicide' or 'failed suicide'	'suicide attempt' or 'non-fatal suicide attempt'
'successful suicide attempt'	'A fatal suicide attempt'
'suicide victim'	'Those who die by suicide'

Avoid sharing details of suicide method and location

Research shows that public communication that includes descriptions of suicide method or location has been associated with increased rates of suicide behaviour and imitation of the suicide method/location.

PROBLEMATIC	PREFFERED
Detail about method or location of suicide	No details of method or location. If needed, use general terms instead of specific details.
Images that show method or location of a suicide	No photos, illustrations, diagrams or video that show suicide method or location.

Source: https://www.iasp.info/wp-content/uploads/IASP-Language-Guidelines-2022-1.pdf

It is recommended to use "**death by suicide**," "**died by suicide**," "**suicide**," or "**suicide death**," as these terms reduce stigma (IASP, 2023).

- Use the term "**suicide attempt**" to clarify when suicidal behaviors have not resulted in a fatality (IASP 2023).
- **Suicidal behaviors** include talking about suicide or taking action to end one's life. They can include suicide attempts as well as preparations to die by suicide. Suicidal behaviors are not "gestures" (IASP, 2023).

Words related to "**success**" (e.g., failed or unsuccessful suicide attempts) are unwarranted and should be avoided (IASP, 2023). Stigmatizing language includes:

- **Committed suicide** - The word commit is also used to describe criminal offenses such as murder or suicide, but it is not a criminal act.
- "**Failure**" implies that not dying by suicide is negative. The word "failed" can worsen a person's hopeless or depressed state, especially if they already believe they are a failure. It can also dismiss the person's pain and downplay the severity of their symptoms.
- "**Suicidal gesture**" is a term some people use to describe suicidal behaviors that have a low potential for lethality or do not result in death. The term should be avoided because it is dismissive and conveys a lack of seriousness toward suicidal behavior. It suggests the person was simply attention-seeking or manipulative.

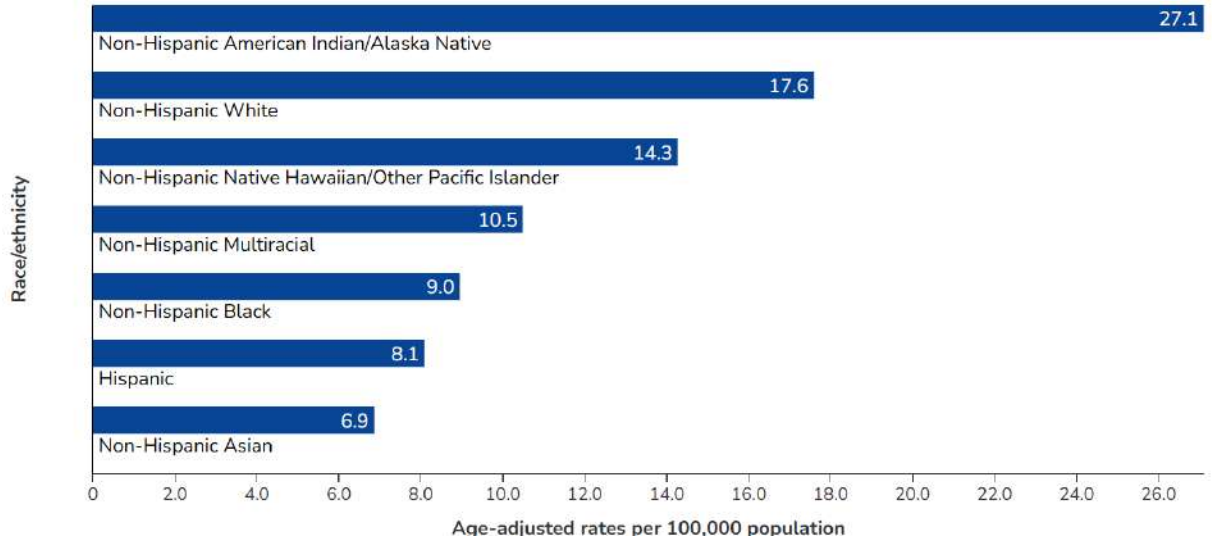
Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need (World Health Organization: WHO, 2024). Stigmatizing language can increase isolation and discourage seeking help. Using non-stigmatizing terms universally can help prevent further problems. Advocacy related to a universal language approach to suicide terms needs to occur on the federal level, in the media, and in research.

Section 3: Prevalence

To understand the impact of suicide on everyone, let us take a look at the prevalence. The World Health Organization (WHO, 2024) identifies that suicide is a serious public health problem that requires a public health response. Their latest research indicates:

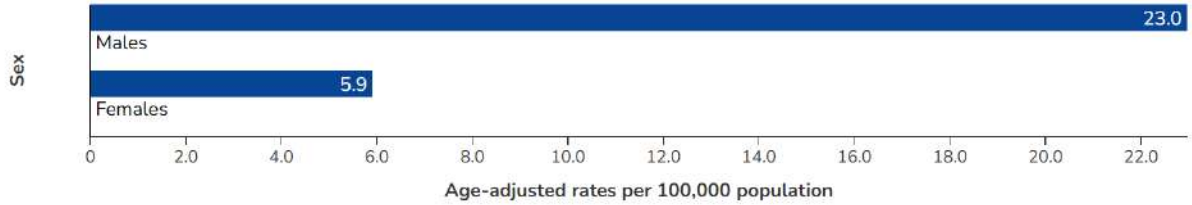
- More than 720,000 people die due to suicide every year.
- Suicide is the third leading cause of death among 15–29-year-olds.
- Seventy-three percent of global suicides occur in low- and middle-income countries.
- The reasons for suicide are multi-faceted, influenced by social, cultural, biological, psychological, and environmental factors present across the life course.
- The link between suicide and mental disorders (in particular, depression and alcohol use disorders) and a previous suicide attempt is well established in high-income countries.
- Experiencing conflict, disaster, violence, abuse, or loss, and a sense of isolation are strongly associated with suicidal behavior.
- Suicide rates are also high among vulnerable groups who experience discrimination, such as refugees and migrants; Indigenous peoples; lesbian, gay, bisexual, transgender, (LGBTQ+) persons; and prisoners.
- For every suicide, there are many more people who attempt suicide. A prior suicide attempt is an important risk factor for suicide in the general population.

According to the U.S. Centers for Disease Control (2024), suicide is one of the leading causes of death in the United States. Some groups have disproportionately high rates of suicide. The racial/ethnic groups with the highest rates in 2022 were non-Hispanic American Indian and Alaska Native people and non-Hispanic White people (Centers for Disease Control and Prevention, Suicide Prevention, 2024).



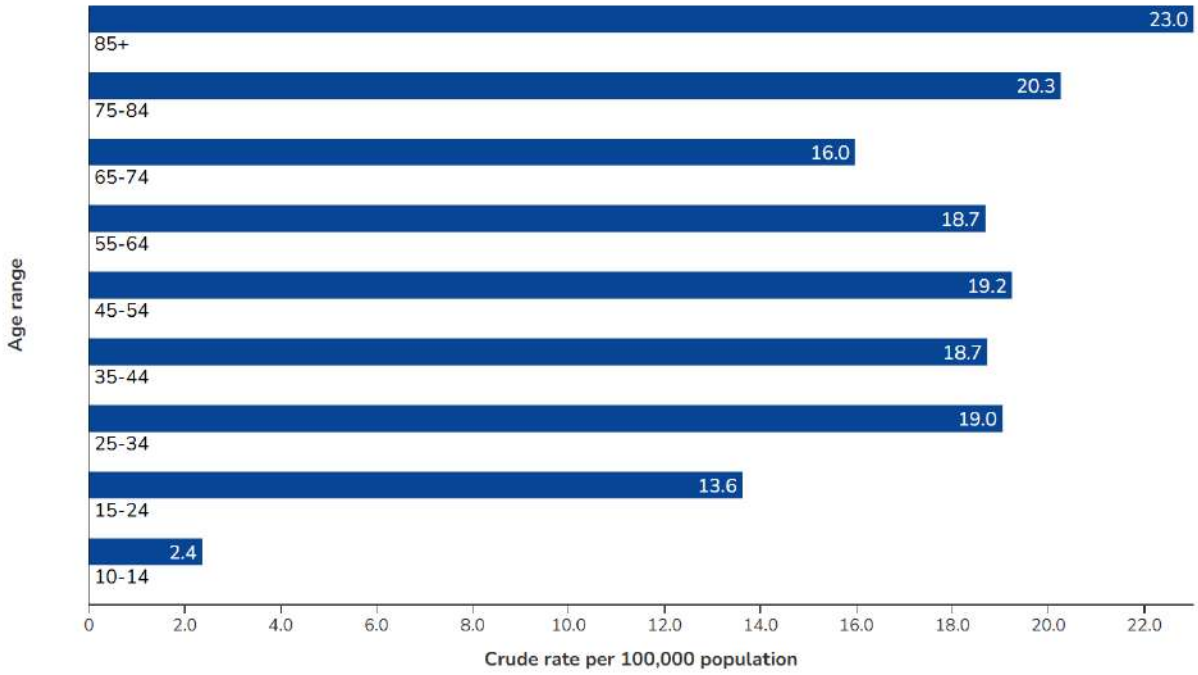
(Source: [Suicide Data and Statistics | Suicide Prevention | CDC](#))

The suicide rate among males in 2022 was approximately four times higher than the rate among females. Males make up 50% of the population but nearly 80% of suicides.



(Source: [Suicide Data and Statistics | Suicide Prevention | CDC](#))

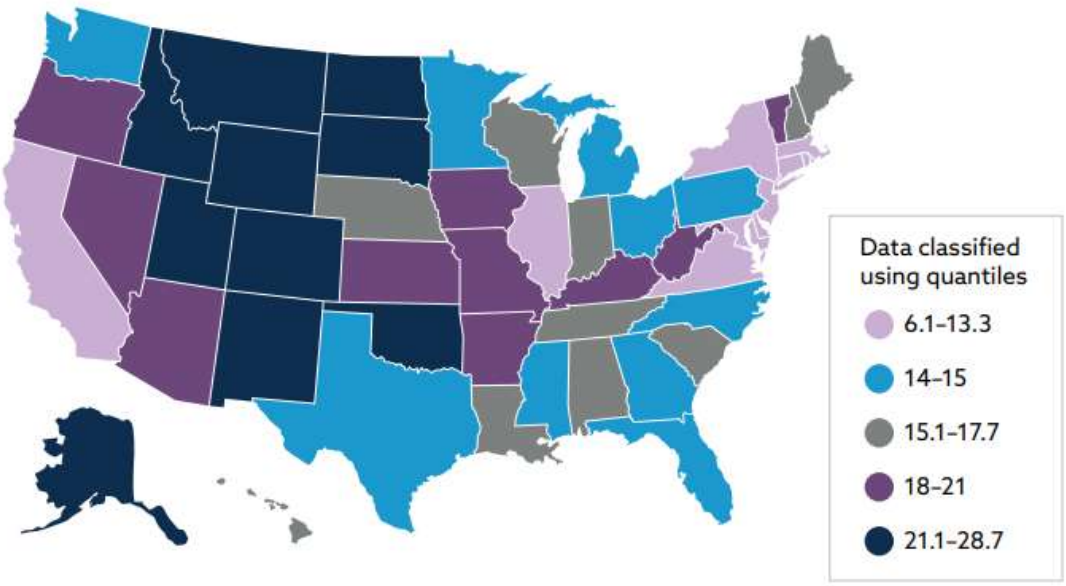
People ages 85 and older had the highest rates of suicide in 2022.



(Source: [Suicide Data and Statistics | Suicide Prevention | CDC](#))

Suicide rates across the United States by state highlight geographic disparities. For example, rates in 2022 ranged from 6.1 per 100,000 in Washington, D.C., to 28.7 per 100,000, in Montana.

The following figure details age-adjusted suicide rate per 100,000 for the United States by state of residence.



(Source: Suicide Data and Statistics | Suicide Prevention | CDC)

Firearms are the most common method used in suicides. Firearms were used in more than 50% of suicides in 2022.

(Source: Suicide Data and Statistics | Suicide Prevention | CDC)

Other populations disproportionately impacted by suicide include, for example:

- Individuals who have served in the armed forces. According to the most recent annual report released by the U.S. Department of Veterans Affairs (VA), the unadjusted suicide rate for Veterans increased 45%, from 23.3 per 100,000 in 2001 to 33.9 per 100,000 in 2021.
- Among non-Veteran U.S. adults, the suicide rate increased about 33%, from 12.6 per 100,000 in 2001 to 16.7 per 100,000 in 2021 (U.S. Department of Veterans Affairs, 2023).
- Some Veteran groups are at increased risk of suicide. Between 2020 and 2021, the age-adjusted suicide rate among female Veterans increased 24.1%. Male rates increased by 6.3% in the same period (U.S. Department of Veterans Affairs, 2023).
- Among recent users of Veteran's Health Administration (VHA) health care services experiencing homelessness, the suicide rate increased 38.2% to 112.9 per 100,000 in 2021 (U.S. Department of Veterans Affairs, 2023).
- American Indian and Alaskan Native Veterans have the highest rate of suicide based on race and ethnicity (46.3 per 100,000) and American Indian and Alaskan Native Veterans also saw the sharpest increase between 2020 and 2021 (51.8%) (U.S. Department of Veterans Affairs, 2023).
- Certain civilian occupational groups. Men in construction and extraction (65.6/100,000) and women in installation, maintenance, and repair (26.6/100,000) had the highest suicide rates by major occupational group (Sussell et al., 2023).

More about Firearms

The U.S. Centers for Disease Control (2024) defines a **firearm injury** as a wound or penetrating injury from a weapon that uses a powder charge to fire a projectile. Weapons that use a powder charge include handguns, rifles, and shotguns. Injuries from air- and gas-powered guns, BB guns, and pellet guns are not considered firearm injuries. This is because these types of guns do not use a powder charge to fire a projectile.

There are many types of firearm injuries, which can be fatal or nonfatal Centers for Disease Control and Prevention, Firearm Injury and Death (2024):

- **Intentionally self-inflicted:** suicide or nonfatal self-harm injury from a firearm.
- **Unintentional:** fatal or nonfatal firearm injuries that happen while someone is cleaning or playing with a firearm or other incidents of accidental firing without evidence of intentional harm.
- **Interpersonal violence:** homicide or nonfatal assault injury from a firearm.
- **Legal intervention:** firearm injuries inflicted by the police or other law enforcement agents acting in the line of duty. For example, firearm injuries that occur while arresting or attempting to arrest someone, maintaining order, or ensuring safety.
- **Undetermined intent:** firearm injuries where there is not enough information to determine whether the injury was intentionally self-inflicted, unintentional, the result of legal intervention, or from an act of interpersonal violence.

Research indicates that among people who made serious suicide attempts, many thought about suicide for as little as 5 to 10 minutes before they acted (Simon et

al., 2001; Deisenhammer et al., 2009). This suggests that suicide attempts can be impulsive, so safe and secure storage of lethal means can mean the difference between life and death among people at risk. Even if people have considered suicide in the past, the decision to act can take place in just minutes. Research suggests that when one means of suicide is unavailable or not accessible, people rarely substitute a different means of suicide. In the case of firearms, if any other means are substituted, the likelihood of death from the alternative means will be reduced since firearms are the most lethal method of suicide (U.S. Department of Health and Human Services, 2024).

If someone is seriously considering suicide, an important intervention is to put time and distance between the person and the lethal means of carrying out an attempt. Lethal means safety interventions are some of the most successful strategies in suicide prevention

Section 4: Suicide Prevention

Kris is a client who started feeling depressed 1 year ago when he lost his job. He recently attempted suicide by overdose.

Kris states, *"This is not like me, I've always been able to bounce back."*

Throughout childhood, Kris and his mother were physically abused by his father. Kris states that his mother did not leave the domestic violent relationship for financial reasons. One was that she could not afford to raise Kris on her own. When he was 10 years old, his mother was able to access services and resources through the help of a domestic violence shelter. Eventually, they were able to rent an apartment. Kris' mother worked two jobs to support them. Kris' father went to prison. Kris indicates that he and his mother did not discuss the trauma throughout his childhood and had her own mental health concerns. He mainly

coped by playing with his friends and working when he was old enough to get a job.

According to Kris, *"I had to grow up fast. I never felt like I fit in."*

Immediately after graduating high school, one of his friends died in a car accident. Kris struggled to make sense of his friend's death. He attempted to cope with the grief by working more.

He states, *"Looking back, I probably should have talked to someone."*

After 1 year of feeling depressed, Kris decided to end his life. He compiled every medication he could find and then drove to an empty parking lot to die by overdose.

"I didn't want my mom to find me. I didn't want anyone to find me. But somebody saw my car and was suspicious, and they called the police."

Could Kris have received the help needed before he attempted suicide?

Kris likely would have died if a stranger did not intervene to prevent his suicide. Interrupting a suicide crisis to save someone's life is one method of suicide prevention. But could something have been done sooner?

What if the following prevention occurred and Kris

- Did not have access to the medications he used to attempt suicide?
- Was assessed and treated for depression at some point in the last two years?
- Talked to someone about his grief, even a friend or his mom?
- Received trauma-focused treatment during his childhood?

- Learned how to talk to trusted adults and supportive friends about his feelings?
- Had better access to resources and support throughout his childhood, who would have intervened in the physical abuse?
- Felt safe and protected from his dad?

You can likely identify a number of occasions where prevention efforts could have helped Kris. A healthcare professional, teacher, co-worker, friend, or his mom could have identified Kris' risk and intervened. Perhaps interventions could have occurred much sooner. That's where prevention starts with education.

United States Efforts to Prevent Suicide

The United States (U.S.) Department of Health and Human Services (2024) recently published the National Strategy for Suicide Prevention to promote a coordinated and comprehensive approach to suicide prevention in communities across the country and at every level of government.

The new 2024 National Strategy for Suicide Prevention (National Strategy) is meant to address gaps in the field and to guide, motivate, and promote a more coordinated and comprehensive approach to suicide prevention in communities across the country. The comprehensive approach addresses the many factors associated with suicide, with the recognition that there is no single solution. It seeks to prevent suicide risk in the first place (upstream prevention), identify and support people with increased risk through treatment and crisis intervention (downstream prevention), prevent reattempts, promote long-term recovery and support survivors of suicide loss. Carrying out the comprehensive approach relies on collaboration with public and private sector partners, people with suicide-centered lived experience, and people in populations disproportionately affected by suicide and suicide attempts. The foundation of comprehensive prevention includes a strong suicide prevention infrastructure at all levels, a competent and well-trained workforce, the use of quality data to help drive decision-making, and a strong science base, as laid out in the new strategy.

This plan is designed to increase accountability for suicide prevention efforts and to increase federal infrastructure. Federal agencies committed to specific, short-term actions related to the goals and objectives included in the Strategy that they will carry out over the next three years (U.S. Department of Health and Human Services, 2024).

Strategic Direction 1: Community-Based Suicide Prevention

- **Goal 1:** Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.

- **Goal 2:** Support upstream comprehensive community-based suicide prevention.
- **Goal 3:** Reduce access to lethal means among people at risk of suicide.
- **Goal 4:** Conduct postvention and support people with suicide-centered lived experience.
- **Goal 5:** Integrate suicide prevention into the culture of the workplace and into other community settings.
- **Goal 6:** Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.
- **Goal 7:** Implement research-informed suicide prevention communication activities in diverse populations using best practices from communication science.

Strategic Direction 2: Treatment and Crisis Services

- **Goal 8:** Implement effective suicide prevention services as a core component of health care.
- **Goal 9:** Improve the quality and accessibility of crisis care services across all communities.

Strategic Direction 3: Surveillance, Quality Improvement, and Research

- **Goal 10:** Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.
- **Goal 11:** Promote and support research on suicide prevention.

Strategic Direction 4: Health Equity in Suicide Prevention

- **Goal 12:** Embed health equity into all comprehensive suicide prevention activities.
- **Goal 13:** Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.
- **Goal 14:** Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.
- **Goal 15:** Improve and expand effective suicide prevention programs for populations disproportionately impacted by suicide across the life span through improved data, research, and evaluation.

The comprehensive approach calls for communities to select, implement, and evaluate a range of strategies to address the many factors associated with suicide at the individual, relationship, community and societal levels. The following strategies from the Centers for Diseases Control and Prevention's (CDC) Suicide Prevention Resource for Action (CDC, 2022):

- Strengthening economic supports
- Creating protective environments (e.g., lethal means safety and workplace prevention)
- Improving access and delivery of suicide care
- Promoting healthy connections
- Teaching coping and problem-solving skills

- Identifying and supporting people at risk
- Lessening harms and preventing future risk (e.g., postvention)

The National Guidelines for Behavioral Health Crisis Care outlines the three core services noted above in this way:

- Clinically staffed crisis call centers meeting the 988 Suicide and Crisis Lifeline standards provide real-time access to someone to talk to 24/7/365.
- Mobile crisis response teams for community-based responses meet someone where they are.
- Crisis receiving and stabilizing facilities within the community provide a place to go for mental health and substance use care (SAMHSA, 2020)

Social-Ecological Model

The Center for Diseases Control and Prevention, Violence Prevention (2024) uses a four-level social-ecological model to better understand violence and the effect of potential prevention strategies. This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand the various factors that put people at risk for violence or protect them from experiencing or perpetrating violence. The overlapping rings in the model illustrate how factors at one level influence factors at another level.

(Source: https://www.cdc.gov/violence-prevention/about/index.html)

The model also suggests that preventing violence requires simultaneous action across multiple levels. This approach is more likely to sustain prevention efforts over time and achieve an impact on the population as a whole (The Center for Diseases Control and Prevention, Violence Prevention, 2024). The levels are described below:

Individual

The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include conflict resolution and life skills training, social-emotional learning, safe dating, and healthy relationship skill programs.

Relationship

The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle-

peers, partners and family members-influences their behavior and contribute to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring and peer programs designed to strengthen parent-child communication, promote positive peer norms, problem-solving skills and promote healthy relationships.

Community

The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level focus on improving the physical and social environment in these settings (e.g., by creating safe places where people live, learn, work, and play) and by addressing other conditions that give rise to violence in communities (e.g., neighborhood poverty, residential segregation, and instability, high density of alcohol outlets).

Societal

The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society. Prevention strategies at this level include efforts to promote societal norms that protect against violence as well as efforts to strengthen household financial security, education and employment opportunities, and other policies that affect the structural determinants of health.

Adverse childhood experiences (ACEs)

Going back to Kris, we could identify that he experienced some adverse childhood experiences. ACEs include traumatic, destabilizing, or stressful events that occur in youth. Examples include (CDC, 2019b):

- Abuse or neglect
- Community violence
- Parental death or incarceration
- Poverty
- Family members with substance use or mental health disorders

ACEs are linked to many unhealthy symptoms and behaviors, including increased suicide risk. One study assessed participants over the course of twenty-two years and found that adults with more ACEs were more likely to consider or attempt suicide. Findings strongly suggest that decreasing adversity in childhood will prevent suicide throughout the lifespan (Thompson & Kingree, 2022).

Preventing Adverse Childhood Experiences

The Centers for Disease Control and Prevention (2019) publication: *Preventing adverse childhood experiences: Leveraging the best available evidence* suggests that we can prevent ACEs through:

- Bolstering financial security and family-friendly work policies
- Promoting social norms that oppose violence
- Providing children with high-quality childcare and early education
- Engaging children in safe and stimulating environments

- Teaching life and relationship skills (e.g., SEL, dating, parenting)
- Connecting youth to activities and trusted adults
- Intervening to lessen the harm of ACEs (e.g., treatment, victim services)

Strategies that prevent ACEs reduce suicide risk, making them an effective prevention method.

Positive Childhood Experiences

Researchers have also studied the ways positive childhood experiences can impact the effects of ACEs on adult mental health. Proactive promotion of positive childhood experiences can improve resilience and reduce the risk of depression and other behavioral health issues in adulthood (Bethell et al., 2019). Children are more likely to develop resilience when they have positive childhood experiences such as:

- Talking to family about emotions
- Feeling like their family stands by them during challenging times
- Participating in and enjoying traditions in their community
- Experiencing a sense of belonging in school
- Feeling supported by peers
- Having two or more adults (not parents) who are genuinely interested in them
- Feeling safe and protected by the adults with whom they live

A wholesome home environment and positive childhood experiences can moderate the effects of ACEs on suicide risk. Kris had the following adverse childhood experiences:

- Abuse of his father
- Parental incarceration of his father
- Poverty
- Mother struggling with mental health concerns

If Kris's mom, school, or other family and community members could have identified these ACEs he was experiencing, some intense positive childhood experiences could have occurred. Especially when a child experiences trauma or overwhelming stress, it is encouraged that the family talk about their feelings, and the child feels supported to talk about their fears or worries.

Section 5: Suicide Risk

It is important for all healthcare providers, including social workers who have clients who are at risk for suicide, to remain up to date on the latest evidence resources continuously and practice guidelines. Social, psychological, cultural, and other factors can interact to increase the

risk of suicidal behavior. Remember that just because the client presents with the risk factor, this does not mean they are contemplating suicide. At the same time, a person contemplating suicide does not mean that they will attempt to die by suicide. The number of risk factors in combination with the protective factors are important to consider when determining an individual's life full of suicide risk. Reminder: It is possible that people who are severely contemplating dying by

suicide or actively concealing some more obvious warning signs. It is also important to note prevalence in different populations.

Recommendation estimate risk by using clinical judgment, along with consultation with the healthcare team. Remember, if many risk factors are present, the role of protective factors may be diminished at the point of crisis, this may not be relied upon to prevent a death by suicide. An approach is to recognize the many factors associated with suicide at the individual, relationship, community, and societal levels, as mentioned above in the Social Ecological Model.

Category	Risk factors	Protective factors

Individual	• History of:
	  ◦ Suicide attempt(s)
	  ◦ Depression
	  ◦ Other mental illness
	  ◦ Substance use
	  ◦ Adverse childhood experiences
	  ◦ Violence (as victim, perpetrator, or both)
	• Negative life stress:
	  ◦ Severe illness
	  ◦ Chronic pain
	  ◦ Criminal and/or legal problems
	  ◦ Financial loss or instability
	  ◦ Job problem or loss
	  ◦ Intergenerational trauma
	• Experiences of:
	  ◦ Hopelessness
	  ◦ Impulsivity
	  ◦ Aggression
	  ◦ Social isolation
	  ◦ Loneliness
		• Beliefs in:
		  ◦ Reasons for living
		  ◦ Cultural identity
		• Effective life skills:
		  ◦ Coping

Relationship	• Negative life events:
	  ◦ Family or loved one's suicide
	  ◦ Loss of relationship(s)
	• Negative relationships:
	  ◦ High conflict or violent relationships
	  ◦ Bullying
	  ◦ Social exclusion
	  ◦ Interpersonal racism and discrimination
		• Connection:
		  ◦ Social support
		  ◦ Close relationships with positive peers, parents, family, significant others
		  ◦ Variety of relationships and frequency of interactions

Category	Risk factors	Protective factors

Community	• Traumatic history:
	  ◦ Historical trauma
	  ◦ Suicide cluster
	• Risk environment
	  ◦ Community violence
	  ◦ Discrimination
	• Disconnection:
	  ◦ Stress of acculturation
	  ◦ Lack of access to health care
		• Healthy environment:
		  ◦ Accessible and affordable high-quality health care (physical and behavioral)
		• Connection to:
		  ◦ School
		  ◦ Community
		  ◦ Social institutions

Societal	• Negative stereotypes about:
	  ◦ Help-seeking
	  ◦ Mental illness
	• Risk environment:
	  ◦ Unsafe media portrayals
	  ◦ Easy access to lethal means of suicide among people at risk
	  ◦ Systemic or institutional racism and discrimination
		• Objections to suicide from:
		  ◦ Culture
		  ◦ Morals
		  ◦ Religious beliefs
		• Reduced access to lethal means of suicide

(Source: https://www.hhs.gov/sites/default/files/national-strategy-suicide-prevention.pdf)

All health systems have critical roles in supporting responsive suicide prevention care. There are critical opportunities to identify risks early and to get people the care that explicitly addresses suicidal thoughts and plans. Not all health care systems have standardized and routine screening and assessment for suicide. Health care settings can support people at risk by creating standard protocols for recognizing and addressing suicide risk.

(Source: https://www.hhs.gov/sites/default/files/national-strategy-suicide-prevention.pdf)

The Department of Health and Human Services (2024) strategy identifies that individuals with increased risk for suicide who enter the health care system would receive high-quality care aligned with best practices in suicide prevention. Regardless of where an individual might connect within a health care setting (e.g., primary care office, emergency department), they would receive services that matched their current situation. They would:

- Receive a full assessment to determine their suicide risk.
- Collaborate on creating a safety plan.
- Engage in conversations around lethal means safety.
- Receive evidence-based care specific to suicide.

Let's go back to Kris. There are many points in Kris' life where he could have met with a health care provider or learned something at school that prevented his suicide attempt in adulthood. Kris's risk factors include depression, adverse childhood experiences, and a history of witnessing abuse and violence. Following the recent loss of his friend's death, that led to social isolation and loneliness.

Prevention strategies can occur before, during, and even after a suicide crisis occurs. All three approaches to intervention are essential for effective suicide prevention. When Kris' friend died, he did not have the coping strategies to process grief. When feeling depressed and later suicidal, he did not have the ability to recognize that he needed help nor the willingness to seek it.

Zero Suicide

The widely implemented Zero Suicide framework generated successful examples of health care settings that adopted a systematic approach. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. When it comes to patient safety, the most fundamental responsibility of health care, the only acceptable number of losses due to errors in quality of care is zero. Zero Suicide applies that life-saving mindset to preventing suicide. The Zero Suicide model operationalizes the core components necessary for healthcare systems to transform suicide care into seven elements. (Education Development Center, 2024).

(Source: https://zerosuicide.edc.org/toolkit/zero-suicide-toolkit)

Zero Suicide Elements

LEAD

Lead system-wide culture change committed to reducing suicides. Acknowledge that top leadership commitment and dedicated front line champions are both necessary for success. Leadership must both convince staff to see and believe that

suicide can be prevented and provide tangible supports in a safe and blame-free environment—what is known as a just culture.

TRAIN

Train a competent, confident, and caring workforce.

Interactions with staff are a critical part of any patient experience. This is doubly true for many suicidal individuals who have had experiences with health care providers or interventions where their needs were not met, their suicidality not reduced, and worse, where they were stigmatized or traumatized. For many people at risk, this is their first encounter with the behavioral health care system. Any door must be the right door – through which the staff, both clinical and non-clinical, engage people at risk by encouraging them to believe treatment can work, that the staff care about them, instilling a commitment to come back to the next appointment. Understanding that ambivalence, the desire to find a solution to the intense pain they feel versus the innate human desire to live—is essential for any clinician working with a patient at risk of suicide.

IDENTIFY

Identify individuals with suicide risk via comprehensive screening and assessment.

For those who screen positive, the use of a standardized risk assessment tool and risk formulation needs to be conducted to determine the course of treatment and next steps. People should be screened at every visit with a health care professional and all health care providers need to be comfortable asking about suicide directly and without judgment.

ENGAGE

Engage all individuals at-risk of suicide using a suicide care management plan.

Talk with individuals openly about their suicide risk and the treatment available to address it. Those who screen positive for suicide should develop a collaborative safety plan with a clinician or health care worker before going home. The safety plan, also called a wellness plan or crisis response plan, needs to address means safety. Individuals at risk for suicide should understand their suicide care management plan which includes what to expect from treatment, the placement on a high-risk pathway, and what that means both for ongoing appointments as well as for missed appointments. It is the organization's responsibility to keep the patient engaged in and coming to care by being patient-centered, committed to quality, safe, timely, and culturally relevant treatment and care.

TREAT

Treat suicidal thoughts and behaviors directly using evidence-based treatments.

Research in the last 10 to 15 years has emerged to suggest that suicide can be targeted directly through treatments that focus explicitly on the suicide risk, both to keep patients safe and to help them to thrive. Randomized controlled trials have found that Cognitive Therapy for Suicide Prevention (CT-SP), dialectical behavior therapy (DBT), and the Collaborative Assessment and Management of Suicide (CAMS) all reduce suicide and suicidal behaviors. Even brief interventions delivered during single in-person encounters are effective at reducing suicide behaviors. It is essential that clinicians apply these techniques that are known to reduce suicide, but they must be trained in these modalities.

TRANSITION

Transition individuals through care with warm hand-offs and supportive contacts.

Patients are at the highest risk for suicide in the immediate aftermath of a psychiatric hospitalization. There is a clear need for universal and continuing interventions and support following discharge. Despite the evidence that it is

critical for safety, only about half of patients receive any outpatient care during the first week after psychiatric hospital discharge, and one-third receive no mental health care at all during the first month after discharge. Linkages to providers through warm handoffs must be created as well as more support and helping patients understand what to expect from care is necessary. Providers should routinely use caring contacts, appointment reminders, and bridge appointments to ensure that patients went to appointments and plan to keep on going.

IMPROVE

Improve policies and procedures through continuous quality improvement.

Collect and examine data routinely, and maintain fidelity to the processes established for the system. Specifying all aspects of suicide care in the clinical workflow and monitored in an electronic health record will provide necessary data to identify successes and failures in care. However, continuous quality improvement can only be effectively implemented in a safety-oriented, "just" culture free of blame for individual clinicians when a patient attempts or dies by suicide, which would include supporting clinicians and staff following the suicide death of a patient.

The Columbia Protocol

Columbia University, the University of Pennsylvania, and the University of Pittsburgh — supported by the National Institute of Mental Health (NIMH) developed the screening tool for a 2007 NIMH study of treatments to decrease suicide risk among adolescents with depression. The Columbia Protocol, based on more than 20 years of scientific study, filled an urgent need for suicide research and prevention: a better way to uniformly and reliably identify people who are at risk. In 2011, the Centers for Disease Control and Prevention adopted the protocol's definitions for suicidal behavior and recommended the use of the

Columbia Protocol for data collection. In 2012, the Food and Drug Administration declared the Columbia Protocol the standard for measuring suicidal ideation and behavior in clinical trials (The Columbia Lighthouse Project, 2016.)

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		High Risk

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

(Source: https://cssrs.columbia.edu/wp-content/uploads/Columbia_Protocol.pdf)

A positive Columbia scale should have an additional assessment implemented. A licensed independent provider (LIP), including social workers, should be the one implementing the further assessment. The goal of the initial screen and assessments are to allow the client to share their narrative around suicidal thoughts, plans, and any past suicide thoughts or behavior. The LIP elicits to hear their story and obtain a person-centered, clinical conceptualization of risk so the LIP understands why this person is wanting to die by suicide. The information provided in the client's story can then be used to diagnose acute and chronic risk and then identify risk mitigation strategies that map those levels of risk. Precipitating factors should also be explored. Precipitating factors are elements that cause or contribute to the occurrence of thoughts or behaviors of suicide. Protective factors enhance resilience and may serve to counterbalance risk factors.

The ASQ

The Ask Suicide-Screening Questions (ASQ) tool is a brief validated tool for use among both youth and adults. The Joint Commission approves the use of the ASQ for all ages. The ASQ is a set of four screening questions that takes 20 seconds to administer (National Institute of Mental Health, n.d.). There are two separate tool kits for both adults and youth that are organized by the medical setting in which they will be used: emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics.

Ask the patient:

1. In the past few weeks, have you wished you were dead? Yes No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
3. In the past week, have you been having thoughts about killing yourself? Yes No
4. Have you ever tried to kill yourself? Yes No
   If yes, how?

   When?

   If the patient answers yes to any of the above, ask the following question:
5. Are you having thoughts of killing yourself right now? Yes No
   If yes, please describe:

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen)*.
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - "**Yes**" to question #5 = **acute positive screen** (imminent risk identified)

- Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
- Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

- "**No**" to question #5 = **non-acute positive screen** (potential risk identified)
  - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/ guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.
  - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Clinical Care Pathway for Suicide Risk Screening

The Suicide Risk Screening clinical pathway material was generated by the American Academy of Child and Adolescent Psychiatry (AACAP) Pathways for Clinical Care (PaCC) workgroup to assist hospitals, emergency departments, and inpatient medical/surgical units with the implementation of suicide risk screening pathways for pediatric patients.

The suicide risk clinical pathway provides guidance for screening pediatric patients for suicide risk in medical settings using the Ask Suicide-Screening Questions (ASQ) and effectively managing patients who screen positive. The pathway proposes a three-tiered approach to screening: 1) screening for suicide risk with

the ASQ (≈ 20 seconds), 2) a brief suicide safety assessment (BSSA) to conduct a more in-depth suicide risk assessment for patients who screen positive on the ASQ (≈ 10 minutes), and if deemed necessary by the brief suicide safety assessment, 3) a full suicide safety assessment that includes a broader mental health assessment (Brahmbhatt, et al., 2019).

The following are components of the three-tiered approach to screening:

Conducting the ASQ Screening:

- **When to screen:** It is important to share educational material with parents/ guardians about screening, such as a parent/guardian informational flyer to be distributed at the beginning of the visit. Generally, PaCC recommends that patients presenting with psychiatric or behavioral health chief complaints be screened for suicide risk at the triage phase of the emergency department visit. For patients presenting with chief physical health complaints, it is acceptable to screen once they are in an exam room during the initial nursing assessment. For inpatient medical units, it is recommended that screening occur during the initial nursing assessment during patient admission to the unit.

- **Privacy:** Screening is most often conducted by nursing staff, but this may vary by institution or depend on workflow. The nurse (or other trained screener) asks the parent/guardian to briefly "step out" of the exam room or "step away" (from triage) while the screening is conducted. This is important because the patient may be less likely to give frank responses if the parent/guardian is present during screening. The screener should not "ask" if it is okay for a parent/guardian to leave the room, but instead make it standard practice to ask parents to step out. However, if the parent/ guardian refuses to leave the room or the patient makes a special request that the parent/guardian stay, then screening should proceed with the

parent/guardian present. During this “private” interaction, the screener can also inquire about other sensitive questions meant to be asked in private, such as abuse/neglect/substance abuse/sexuality, etc. If the parent/guardian disagrees with performing the evaluation, the medically responsible provider should be alerted and the refusal managed in the same manner as any other medical procedure that is refused.

- **How to initiate screening:** After the parent/guardian leaves the room, (or with the parent/guardian present if necessary), the screener should begin with, “Now I’m going to ask you a few questions.” Tell the patient they may respond with “yes” or “no” and then, while making good eye contact, ask the first four ASQ questions verbatim, exactly as they are written. It should take approximately 20 seconds to administer all four questions. If the patient refuses to answer the questions, this should be noted as “refused to answer,” which will require further evaluation. The ASQ screen has been validated by means of a live person administering the questions; however, some centers have used tablets and self-reports as ways of administering the scale.

- **Assessment:** Assessing answers to the ASQ should happen immediately while in the patient’s room. Importantly, if the child answers in a way that, in the clinical judgment of the screener, suggests there is reason for concern, the screener can override a negative screen and request the positive screen protocol be followed. Screening results should be interpreted as follows:

    a. **Negative Screen:** If the patient answers “no” to questions 1 through 4, screening is complete (NEGATIVE SCREEN), and it is not necessary to ask question number 5. No intervention is necessary.

b. **Positive Screen:** If the patient answers “yes” to any of questions #1-4, or refuses to answer any one of the questions, they are considered a POSTIVE SCREEN for suicide risk. At this point, the nurse should ask question #5, “Are you having thoughts of killing yourself right now?” This is done in order to assess clinical acuity in the ED.

   There are two ways to screen positive for suicide risk: acute and non-acute.

   i. **Acute Positive Screening:** If the patient answers “yes” to question #5, they are considered an acute positive screen, and possibly at imminent risk for suicide. The screener should explain the results and next steps as per the script in the Appendix. The patient should then be treated per standard of care for suicidal patients in the ED. The patient requires an emergent full-safety evaluation (see below for more details). The Patient cannot leave the ED until evaluated thoroughly for safety. If a parent denies or declines further evaluation of safety after screening positive, the attending physician should be alerted. This matter should be treated according to the same rules of the institution as when a parent/guardian declines what is considered urgent medical care for other life-threatening conditions. Safety precautions, such as direct observation of the patient, and environmental precautions (e.g., removal of all dangerous objects from the room and patient’s belongings) should be followed. The medically responsible provider should be alerted.

   ii. **Non-acute Positive Screening:** If the patient answers “yes” to any of the questions #1-4, but answers “no” to question #5, they are considered a non-acute positive screen, meaning that potential suicide risk has been identified and requires further evaluation. The

patient requires a brief suicide safety assessment (BSSA) to determine whether or not a full safety assessment is needed. The patient cannot leave the emergency department until evaluated for safety. If a parent denies or declines further evaluation of safety after screening positive, the attending physician should be alerted. This matter should be treated according to the same rules of the institution as when a parent/guardian declines what is considered urgent medical care for other life-threatening conditions. The medically responsible provider should be alerted.

Essential to the success of suicide screening implementation is a three-tiered approach that includes a BSSA. When screening with the ASQ yields a non-acute positive screen, a brief safety assessment should be conducted in order to determine whether or not a full suicide safety assessment and safety measures are required in the emergency department. This BSSA should typically be conducted by a trained mental health or medical provider and usually takes less than 10 minutes.

Not every patient who screens positive on the ASQ initial screen will require intensive safety precautions or a full safety evaluation. Using the BSSA optimizes mental health resources and ensures a viable screening program.

General principles of a BSSA

1. The BSSA is utilized when the initial screening with ASQ is a NONACUTE POSITIVE SCREEN.
2. The purpose of this assessment is to determine whether a more thorough, full, mental health/safety assessment is needed.

3. The BSSA should typically be a 10-minute or less evaluation conducted by a trained mental health provider (for example an MD/DO, NP, PA, LCSW or other mental health provider).
4. The PaCC recommends using standardized questionnaires as a guide for assessing risk and the need for further intervention, i.e., the ASQ BSSA or the Columbia Suicide Severity Rating Scale (C-SSRS)
5. After the BSSA is completed, the trained mental health provider must determine level of risk (imminent, high, low) to decide next steps.

More details about the suicide assessment and recommendations from the PaCC will be discussed in the next section.

Section 6: What is a suicide assessment?

Prevention begins with an in-depth evaluation of the risk of suicide. Suicide assessment is about gathering information about the risks and the protective factors to help determine how likely they are to die by suicide. Risk factors can overlap with warning signs, the difference is risk factors are what is found in research to increase the likelihood somebody will engage in suicidal self-directed violence. A client's specific warning signs can include histories of hospitalization and access to lethal means.

The intervention process begins during an assessment and continues throughout the assessment process. It is essential to demonstrate empathy, compassion, and respect to help establish the rapport needed to build with that client. It also includes information related to the clients, personal and medical history, suicide plans, current level of suicidal ideation, and quality of their support networks.

Assessment is based on reviewing warning signs and risks, protective factors, personal and medical history, any mental health and substance abuse concerns, or any other major life crisis. What does the assessment process look like? While the presence of risk factors indicates a higher possibility of suicide, it is important to know, however, that the large majority of people living with mental illness or risk factors for suicide do not necessarily engage in suicide behaviors. The risk of suicide can be high, even in the absence of intent or thoughts of suicide. It is possible that people who are actively contemplating dying by suicide may be concealing some otherwise obvious warning signs. The risk of suicide tends to be highest when someone is living with several risk factors that displayed at the same time risk factors may also predispose someone to a higher risk of suicide. However, the majority of people with mental illness or other risk factors do not engage in suicidal behaviors. When trying to determine the level of suicide risk, it is important also to consider the protective factors that may balance risk factors.

Considering how high of a risk an individual is for attempting or contemplating suicide, the number and interaction of these risk factors, in conjunction with protective factors, often determine the level of risk. Some different intervention goals include relationship and rapport building with care, compassion, and concern. This reduces the client's shame and guilt, which perpetuates the stigma of suicide. Social workers need to practice with a nonjudgmental, empathetic, and respectful perspective.

Consider the following when asking about suicide and reasons for living during an assessment:

Open-ended questions

- Use open-ended questions to collect information non judgmentally.
- Starting with open-ended questions will help you elicit more information.

- Examples of open-ended questions:
    - What do your suicidal thoughts look like?
    - How do you know when you're thinking about suicide?

Closed-ended questions

- Elicit single word (e.g., yes/no) responses and are most useful when clarifying information.
- Examples of closed-ended questions:
    - Are you having thoughts of wanting to kill yourself?
    - Have you made preparations to kill yourself?

Summarize

- Summarize the Client's comments using their language.
- Summary statements with reflections reinforce that you are listening and are prepared to collaboratively understand the Client's experience.
- Additionally, summarizing may facilitate more trust and dialogue with the Client.
- Examples of summary statements:
    - I hear you saying that you are feeling hopeless and have been feeling down.
    - What does it mean for you to feel down?

Validate Experience

- The Client's experience of their psychological pain is valid and important to acknowledge.

- This applies to any experience they have, including suicidal ideation and behavior.
- Validation underscores the importance of the Client's experience without judging their behavior.
- While the Client's experience of their pain is valid, their pattern of responding to the psychological pain may not be consistent with their values and long-term goals, i.e., it does not support their well-being.

Directly Ask about Suicide

- Be direct and ask the Client specifically about their experience.
- While being direct with the Client, maintain a collaborative style, for example:
- Use the client's language for reflective statements and in documentation of the evaluation
- Work as a team with the client to evaluate suicide risk, e.g., "could you help me fill in the gaps between getting in a fight with your wife and attempting suicide?"

Responding to Information About Suicide

At the beginning of your work together, let the client know how you will respond to the information they may give to you, e.g., confidentiality discussion and when confidentiality will need to be broken. For instance, express to the client that if they tell you about suicidal thoughts alone it does not necessarily warrant hospitalization.

Let the client know that you would consider hospitalization only when there is concern about imminent risk of harm to themselves or others. This means they have imminent intent to act on suicidal or homicidal thoughts. If you work with the client routinely, it is not necessary to have the conversation about confidentiality in every meeting, but at least at the start of your work together.

Full Suicide Safety Assessment

Brahmbhatt et al. (2019) indicate that a full suicide safety assessment is completed when there is an acute positive screen from the ASQ or high or imminent risk from the BSSA (ASQ or CRRS). The following provides additional guidance on conducting assessments for youth:

The purpose of a full suicide safety assessment is to:

1. Further assess suicide safety risk and determine interventions needed to keep patient safe such as:
    a. Need for the patient to be under direct observation.
        i. Level of safety precautions (such as restrictions on access to sharps, electronics, specific articles of clothing, cords, etc) that need to be in place.
        ii. Need for hospitalization in an inpatient psychiatric setting for ongoing suicide safety monitoring and treatment of the underlying cause.
    c. Develop an initial differential diagnosis.
    d. Formulate the case according to the biopsychosocial model.
    e. Develop a treatment plan in collaboration with the youth and the parent/guardian.

2. The full suicide safety assessment is typically completed by a licensed mental health provider such as a psychiatrist, psychologist, psychiatric nurse practitioner, physician assistant, MSW/LCSW, or other trained mental health professional.

3. During the full suicide safety assessment, at least a portion of the time should be spent interviewing the patient and caregivers separately

4. It is important to obtain collateral information when possible since many children and adolescents may not to share all pertinent information.

Components of a full suicide safety assessment:

1. Interview process:

    a. Speak to medical team to clarify consultation question and review the medical record

    b. Introduction and explanation of the purpose of the interview should be provided to the parents/guardians and the youth together

    c. Ideally, at least part of the interview with the youth should be conducted without the presence of family members/visitors

    d. At least part of the interview with parents/guardians should be conducted without the presence of the patient

2. If possible, collect collateral information to facilitate a comprehensive assessment. Collateral information can include outpatient mental health providers, school staff, child protective services, department of children and family services, correction officers, and pharmacies

3. Complete assessment based on a bio-psycho-social model including clear identification of risk as well as protective factors

a. Assess for more details regarding suicidal ideation and intent

b. Collect information regarding past suicide attempts and non-suicidal self-injury

c. Evaluate for additional risk and protective factors that may influence the desire to attempt suicide:

    i. Common risk factors may include feelings of hopelessness, evidence of major depressive disorder or severe anxiety, ongoing acute stressors, substance use, history of non-suicidal self-injury.

    ii. Common protective factors may include a strong support network, a strong belief system, and active engagement in treatment.

c. Obtain information about past psychiatric and medical histories, family history and social history.

d. Evaluate for potential contributing psychiatric conditions such as major depressive disorder, bipolar affective disorder, substance use disorders, and anxiety disorders.

e. Evaluate current mental status.

4. Recommendations

    a. Should be communicated to both parent/guardian and the youth together and clearly communicated to the medical team

    b. If psychiatric hospitalization is recommended, the following should be completed:

        i. The patient remains in as secure an environment as possible. A secure environment includes but is not limited to: close supervision, removing dangerous objects from the room, decreasing attachment

points potentially used for strangulation, removal of personal items including communication devices, and careful consideration of visitor list.

ii. Information about the hospitalization and process should be communicated to the youth and family.

iii. Safety precautions should continue until transfer takes place and ensured during transfer.

d. If the patient is felt to be safe to discharge home (upon medical clearance), a safety plan should be completed with the patient and their family. The safety plan typically includes restriction of means such as removing firearms from home and securing all medicines in home including over-the-counter medicines. The safety plan can also include coping strategies, provide crisis resources, and an outline of a follow-up plan for mental health care.

i. Creating a safety plan if patient will be discharged:

- Warning signs of a crisis that may be developing: e.g., increasing isolation, increasing irritability, suspicious behavior, increased feelings of loneliness or sadness, etc.
- Restriction of Means: e.g., locking up medications including over the counter medications
- Secure weapons including guns in the home are removed or locked away and not accessible
- Identify internal coping strategies and distractions such as listening to music, physical activity, relaxation techniques or distress tolerance skills, calling a friend

- Identify who to contact if a crisis arises: parent, friend, clinician, urgent care/emergency department
- Provide National Crisis Hotline: 988.

Section 7: Risk Stratification

Therapeutic risk management is based on clinical risk management that is patient-centered, supportive of the treatment process and maintains the therapeutic alliance. It is a model for achieving therapeutic risk management of the suicidal client that involves augmenting clinical risk assessment with structured instruments, stratifying risk in terms of both severity and temporality, and developing and documenting a safety plan (Wortzel, et.al., 2013). These elements are readily accessible to and deployable by mental health clinicians in most disciplines and treatment settings, and they collectively yield a suicide risk assessment and management process.

To understand a client's level of risk for suicide during an assessment, it is important to classify their acute and chronic risk levels. According to (Wortzel et.al., 2013), risk stratification improves understanding and communication of the client's current circumstances, strengthens documentation, and improves treatment planning. When stratifying risk, both acute and chronic risk for suicide should be assessed separately. Therapeutic risk management of the suicidal patient is highly nuanced, with various clinical situations and treatment settings mandating specific considerations; therapeutic risk management is necessarily tailored to both the individual and the treatment environment.

A two-dimensional (accounting for severity and temporality) risk stratification that identifies low acute risk with high chronic risk more accurately depicts the individual's actual risk for suicide and better facilitates clinical decision-making

(e.g., that the patient is safe and appropriate for outpatient care but needs to have a safety plan in place in anticipation of future suicidal crises). It also eliminates the double-edged sword of choosing between discharging a “high-risk” patient or having to explain erroneous “low-risk” designation if or when that individual goes on to engage in self-directed violent behavior in the weeks or months ahead (Wortzel, et.al., 2013).

Acute Risk

To determine the level of acute risk, assess:

- Current suicidal ideation
- Plan
- Intent
- Behavior
- Access to lethal means

Based on the information gathered, determine whether the acute risk level is low, intermediate, or high:

- **High acute risk:** The essential features of high acute risk for suicide involve both suicidal ideation with the intent to die by suicide and the inability to maintain safety independent of external support or help. Various warning signs and/or risk factors are likely to be present in such scenarios, such as plans to die by suicide; access to the means needed to execute a suicide plan; recent or ongoing preparatory behaviors and/or suicide attempt; acute psychiatric illness, such as an active major depressive episode, acute psychosis, and/or drug or alcohol relapse; exacerbation of a personality disorder, such as increased behaviors associated with a borderline

personality disorder; and acute psychosocial stressors such as job loss, dissolution of a relationship, or incarceration. High acute risk for suicide typically mandates psychiatric hospitalization to maintain safety and aggressively target the modifiable factors driving the acute spike in suicide risk. Individuals at high acute risk for suicide require direct observation until they are in a secure psychiatric unit, and they should be maintained in an environment with limited access to lethal means (e.g., no access to sharps, cords/tubing, or toxic substances).

- **Intermediate acute risk:** Client may have suicidal ideation and a plan to die by suicide, but can maintain safety independently. The essential feature of intermediate acute risk is the perceived ability to maintain safety independent of external support or help. Needless to say, the determination as to whether or not the patient can independently maintain safety will involve a clinical judgment based on the totality of available clinical data. Patients at intermediate acute risk for suicide may present in a manner that is quite similar to those deemed to be at high acute risk for suicide, and they frequently share many of the same clinical features. The only difference may be a lack of intent, based on an identified reason for living (e.g., children) and the ability to abide by a safety plan and maintain safety independently. Recent preparatory behaviors are likely to be absent in such clinical scenarios. It is, of course, prudent to consider psychiatric hospitalization for these individuals. Hospitalization may address suicidal thoughts and/or behaviors, especially if pertinent modifiable factors driving suicide risk are amenable to treatments best accomplished in an inpatient setting (e.g., acute psychosis warranting aggressive medication management/adjustment). Outpatient management should be intensive, with frequent contact, regular reassessment of suicide risk, and a well-articulated safety plan.

- **Low acute risk:** There is no current intent to die by suicide. If a plan for suicide is present, it is likely to be vague and without preparatory behaviors. Client can maintain safety independently. Low acute risk typically involves clinical presentations in which current suicidal intent, a suicide plan, and preparatory behaviors are all absent. There should be high collective confidence (e.g., patient, clinician, and family members) in the ability of the patient to independently maintain his or her own safety. It is important to recognize that persons at low acute risk for suicide may still have suicidal ideation, but it will be without associated intent or plan. If a suicide plan is present, the plan is general and/or vague, without any associated preparatory behaviors, and/or is contingent on some potential eventuality (e.g., "I'd shoot myself if things ever got bad enough, but I don't have a gun"). Collective confidence regarding the ability to independently maintain safety will typically be associated with commensurate ability in the individual to engage in appropriate coping strategies and the person's willingness and ability to utilize a safety plan in the event of future heightened suicidal intent.

Chronic Risk

To determine the level of chronic risk, assess:

- History of suicidal behavior over an individual's lifetime
- Reasons for living
- Access to coping skills
- Persistent psychosocial stressors (e.g., relationship, occupational, financial)
- Chronic medical conditions

Based on the information gathered, determine whether the chronic risk level is low, intermediate, or high:

- **High chronic risk:** There is a history of suicide attempt(s), presence of chronic conditions that elevate risk (e.g., substance use, chronic pain), few coping skills, limited reasons for living, and significant chronic psychosocial stressors (e.g., persistent relationship distress or financial and housing stressors). A variety of risk factors are typically associated with high chronic risk for suicide. Examples include chronic major mental illness and/or personality disorder, history of prior suicide attempt(s), history of substance abuse/dependence, chronic pain, chronic suicidal ideation, chronic medical illness, limited coping skills/abilities, unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment), and limited ability to identify reasons for living. Conceptually, these are individuals who are at chronic risk for becoming acutely suicidal, typically in the context of unpredictable albeit often inevitable situational contingencies (e.g., job loss, relationship turmoil/dissolution, drug or alcohol relapse). Hence, these patients require routine mental health follow-up, a well-articulated safety plan, and routine screening regarding risk for suicide. Means restriction should be part of their management/ safety planning (e.g., no access to guns, limited medication supplies). Development of coping skills and augmentation of protective factors are important components in efforts to mitigate chronic suicide risk.

- **Intermediate chronic risk:** Individuals at intermediate chronic risk for suicide may present with many of the same factors associated with high chronic suicide risk, such as diagnoses of major mental illnesses and/or personality disorders, substance abuse/ dependence, and/or chronic medical conditions or pain. However, in these individuals, the relative balance of protective factors, coping skills, reasons for living, and

psychosocial stability suggests an enhanced ability to endure future crises without resorting to self-directed violence and/or suicidal behaviors. Such patients will require routine mental health care in an effort to optimize their psychiatric condition and maintain or enhance their coping skills and protective factors. A safety plan should be in place. The client may have a history of chronic conditions that elevate the risk for suicide (e.g., depression, substance use, chronic pain); risk factors are balanced with access to coping skills and the ability to endure crisis using these skills, reasons for living, and engagement in care.

- **Low chronic risk:** This designation will capture a broad range of individuals, from persons with little or no mental health or substance abuse problems to individuals dealing with significant mental illness but with a relative abundance of coping strengths and resources. Individuals with low chronic risk for suicide have a history of managing stressors without resorting to suicidal ideation. The following factors will typically be absent: history of self-directed violence, chronic suicidal ideation, a tendency toward highly impulsive, risky behaviors, severe, persistent mental illness, and marginal psychosocial functioning. The client has a history of managing life stressors without relying on suicidal ideation.

Interventions for clients who are considered high acute risk:

- May need to be directly observed in an environment with no access to lethal means until transferred to a secure unit.
- Psychiatric hospitalization to maintain safety.

The key is you want to make sure your risk dedication strategies and the action you're taking match the risk level you are choosing. In terms of high acute risk this is typically clients who are going to be psychiatrically hospitalized. These are

clients with suicidal ideation with the intent to act on a plan, unable to keep themselves safe outside of the hospital. These are the clients that the social worker or other mental health counselor should be really concerned about and referral for inpatient hospitalization. Those with acute risk may share some of the features of those at high acute, but the big difference is their ability to maintain safety outside of the hospital.

These clients may have reasons for living or other factors that are balancing out right now.

It is also recommended to be very concerned about these clients who are at intermediate acute risk and consider inpatient hospitalization. For intermediate acute risk, completing a lethal means assessment and a safety plan is essential. Also, to consider to make sure they have the crisis hotline number (988) and consider additional phone check-ins between sessions.

The development of precise risk dedication formulations that accurately reflect both short- and long-term suicide risk is essential for facilitating optimal clinical decision-making, particularly in determining the necessity of hospitalization and in balancing the ethical principles of autonomy, non-maleficence, and beneficence.

Section 8: Interventions

The intervention goal is to explore suicide when the client is not in crisis. Clients can think more clearly and realistically when they are not actively having thoughts of suicide. This helps to view the situation more openly and generate more options for resources. Inviting clients to explore their experiences with suicide when they are not in an active state of crisis may allow the client to see these crises are temporary and that they can be worked through. Suicide can be discussed through the safety lens of prevention. The patient will see the

prevention plan as a familiar resource that is readily accessible. The goal is to explore parts of itself that do not want to die. Invite the client to consider the part of them that does not want to die or that is unsure about dying. Another intervention goal is exploring and connecting with the clients. seek to comprehend what the client is expressing as an intervention goal in creating a safety plan.

Safety Plan

A Safety Plan is a prioritized written list of coping strategies and sources of support for patients who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, is in the patient's own words, and is easy to read. The Western Interstate Commission for Higher Education (2008) with funding from the Rural Health Policy, Health Resources and Services Administration (HRSA), developed the *Safety Planning Guide: A Quick Guide for Clinicians* that may be used in conjunction with the "Safety Plan Template." The following is a summary of the Quick Guide:

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

Step 1: Warning Signs

- Ask: “How will you know when the safety plan should be used?”
- Ask: “What do you experience when you start to think about suicide or feel extremely depressed?”
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient’s own words.

Step 2: Internal Coping Strategies

- Ask: “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- Assess the likelihood of use: Ask: “How likely do you think you would be able to do this step during a time of crisis?”
- If doubt about use is expressed, ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem-solving approach to address potential roadblocks and identify alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower the risk.
- Ask: “Who or what social settings help you take your mind off your problems, at least for a little while?”
- Ask: “Who helps you feel better when you socialize with them?”

- Ask for safe places they can go to be around people (i.e., coffee shops).
- Ask the patient to list several people and social settings in case the first option is unavailable.
- Assess the likelihood that the patient will engage in this step; identify potential obstacles and problem-solve as appropriate.

Remember, in this step, the goal is a distraction from suicidal thoughts and feelings.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve a crisis or lower the risk.
- Ask: "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you are under stress?"
- Ask patients to list several people in case one contact is unreachable.
- Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess the likelihood that the patient will engage in this step. Identify potential obstacles and problem-solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower the risk.

- Ask: “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
- List names, numbers, and/or locations of mental health provider(s), and local urgent care services.
- Assess the likelihood that the patient will engage in this step;
- Identify potential obstacles and problem solve them.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: “Do you own a firearm, such as a gun or rifle?” and “What other means do you have access to and may use to attempt to kill yourself?”
- Collaboratively identify ways to secure or limit access to lethal means:
- Ask: “How can we go about developing a plan to limit your access to these means?”
- For methods with low lethality, clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient’s access to a highly lethal method, such as a firearm, should be done by a designated, responsible person. This is usually a family member or close friend, or the police.

Remember: the safety plan is a tool to engage the patient and is only one part of a comprehensive suicide care plan.

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

(Source: https://988lifeline.org/wp-content/uploads/2017/09/Brown_StanleySafetyPlanTemplate1.pdf)

Many mental health professionals engage a “no-suicide contract” with their patient when identifying a client is at risk for suicide. Although some variability exists, a no-suicide contract (also referred to as a no-harm or suicide prevention contract) will typically entail the patient agreeing to not harm him or herself in a specified time period. “No-suicide contracts” may also provide some guidance regarding what the patient is to do (e.g., call the provider) if the person feels that he or she can no longer abide by the contract. In addition, no-suicide contracts tend to be used most frequently with highest risk patients (Rudd, 2007). Although there is no empirical support regarding the effectiveness of no- suicide contracts, research suggests that up to 79% of mental health professionals report that they use no-suicide contracts (Drew, 2001) The use of “no-suicide contracts” for suicide ideation and thoughts is not recommended for the following reasons:

- The no-suicide contract is not legally binding and does not offer protection from malpractice claims (Stanley et al., 2001).
- Patients who sign a no-suicide contract do not actually have any legal obligation to uphold their side of the agreement. Furthermore, it is erroneous to believe that a document such as the no-suicide contract can actually prevent a patient from killing him- or herself (Matarazzo et al., 2014).
- A no-suicide contract may have the unintended effect of providing mental health professionals with a false sense of relief regarding their concern for their patient and may lower their vigilance despite potentially not having any effect on the patient’s intent to die by suicide (Matarazzo et al., 2014).

Psychotherapy

Cognitive-behavioral therapy (CBT) decreases suicidal behavior risk in adults and adolescents with depression and in adults with borderline personality disorder,

and it halved suicide reattempt rates in patients presenting to an emergency department after a recent suicide attempt compared with treatment as usual (Mann, et at., 2021). CBT for suicidal individuals is designed to help high-risk individuals apply more effective coping strategies (e.g., cognitive restructuring) in the context of stressors and problems that trigger suicidal behaviors. CBT has been reported to reduce attempt frequency compared with treatment as usual in adolescents but not in adults. CBT may work by improving negative problem orientation and emotion regulation, reducing impulsiveness, and attenuating suicidal ideation.

Dialectical behavior therapy (DBT) for borderline personality disorder in adolescents, college students, and adults prevents suicide attempts and hospitalization for suicidal ideation. It lessens medical consequences of self-harm behaviors compared with treatment as usual. Treatment dose may be a factor because a single session of DBT was not found to reduce suicidal ideation, whereas most effective studies employed a 20-week DBT intervention (Mann et al., 2021).

Contact and/or active outreach following a suicide attempt or suicidal ideation crisis.

The period of greatest risk of suicidal behavior is after discharge from the emergency department or from an inpatient hospital unit. Eighty percent of suicide deaths following a nonfatal suicide attempt happen within 1 year. Follow-up contact interventions as simple as sending postcards prevented suicide attempt in two of four studies consistent with earlier studies that found a robust benefit for reducing suicidal behaviors intervention (Mann et al., 2021).

Enhancing treatment engagement and adherence after an emergency department visit or hospital stay through follow-up contact calls reduced attempts or ideation in four of five studies. These interventions are scalable, as shown by a

multinational study reporting that psychoeducation paired with telephone or in-person contact reduced the suicide rate over 18 months among suicide attempters (Mann et al., 2021)). Another study used a similar approach by sending caring text messages over 1 year to active military personnel who had reported a suicide attempt (half the sample) or suicidal ideation, but not in the context of discharge from the hospital or emergency department. The intervention lowered subsequent suicide attempts by almost half (Comtois et al, 2019). A cohort comparison study of safety planning interventions, administered in the emergency department with follow-up telephone contact, produced a 45% reduction in suicidal behaviors compared with treatment as usual (Stanley et al, 2018).

Section 9: Ethical Dilemmas

Part of the challenge derives from the fact that optimal management of a suicidal patient forces us to make tough choices, selecting between two of our highest-ranking guiding ethical principles: autonomy and beneficence. Typically, social workers respect the right to self-determination; allowing our patients to make informed choices for themselves.

The National Association of Social Work (NASW) defines self-determination: *"Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others," (2021)*

Especially when the client lacks decision-making capacity and when social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients (NASW, 2021). But sometimes beneficence, doing what is ultimately in the best interest of the client, will mandate making decisions to optimize patient safety that are contrary to the individual's wishes. For instance, the choice to involuntarily hospitalize a client who is judged to be at high acute risk for suicide is not without consequences.

Risk stratification should inform clinical decision-making in a manner that appropriately balances the medical ethical principles of autonomy, nonmaleficence, and beneficence (Gillon, 1994). It is important to recognize a suicidal crisis and hospitalize a patient who is otherwise not able to maintain his or her own safety. It is also necessary to consider that hospital admission, especially involuntary hospitalization, is not without consequences. An unwanted (and unnecessary) hospitalization may disrupt various psychosocial roles and relationships, such as a needed job or supportive familial bonds, and, in doing so, may actually threaten protective factors that mitigate suicide risk on a long-term basis (Wortzel et al, 2014). But, the social worker's primary responsibility is to promote the well-being of clients. In general, clients' interests are primary.

However, social workers' responsibility to the larger society or specific legal obligations may, on limited occasions, supersede the loyalty owed to clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.) (NASW Code of Ethics, 2021). Therapeutic relationships could be impaired by an involuntary admission, particularly one that is unwanted.

Efforts to avoid unnecessary and potentially disruptive involuntary admissions are a necessary component of practice. However, the consequences of failing to act in

the face of a genuine suicidal crisis are potentially catastrophic, possibly culminating in a death by suicide. Navigating these ethical dilemmas often should be done with consultation with supervisors or other licensed independent providers.

Section 10: Impact of a Suicide Loss

There is no one "correct" way to cope with a suicide, as each person's relationship with the deceased is unique. As a result, the impact of the loss will vary from person to person. Many will suggest that bereavement after a suicide is unlike any other kind of bereavement. Not all families need or want professional support, but those bereaved by suicide tend to seek support. Support interventions include individual or family face-to-face support, support groups, counseling, and specific therapy for traumatic bereavement.

The standard "grieving process" is further complicated by the inexplicable nature of suicide itself. Add notions of guilt and the pressures of stigma, and there is a potential risk for suicide for anyone experiencing complicated grief due to suicide. Reactions to a suicide loss will be different for every person.

Some of these reactions may include:

- Shock and numbness
- Deep sadness
- Anger and blame
- Guilt
- Shame
- Relief

- Denial
- Why questions
- Fear
- Depression
- Leaning on spiritual or religious beliefs
- Thinking about suicide
- Reaching out

It is important for relatives, friends, and the larger community to support people throughout the grief process. The Canadian Association For Suicide Prevention (2025) suggests the following on how to assist survivors directly:

- Respect the timing and pace of an individual's grief process. It is a difficult journey. Encourage them to make choices that are right for them.
- Offer compassionate listening, understanding, and patience.
- Reassure survivors that what they are feeling is normal.
- Find out what supports are available in the community regarding a suicide loss.
- Listen to, and follow the wishes of the family, avoiding making judgement or giving your own opinion about the person who died or what you think the family should be feeling.
- Use the language that the family is using, such as 'died by suicide.'
- Offer information about practical options and emotional support.
- Offer support with practical decision-making, if needed.

- Offer follow-up meetings or phone calls if appropriate and keep to any follow-up arrangements.

Helping clients find a suicide survivor support groups in their area can also help. Peer support can be an invaluable source of strength for people who have lost someone to suicide. Peer support can include face-to-face support groups, such as visits from an outreach team, loss survivor conferences, and telephone and online connections among people bereaved by suicide.

Suicide Loss of a Client

The suicide of a client or patient is a deeply feared result in mental health care. When this happens, the therapist must navigate multiple roles and responsibilities while managing personal emotional reactions. Common reactions can be self-doubt, feeling like a failure, shock, disbelief, and fear of malpractice. This can be a time to fulfill immediate duties and gradually address emotional responses in a way that fosters both personal and professional growth and accountability.

Jeffrey C. Sung, MD, a clinical instructor at the University of Washington Department of Psychiatry and Behavioral Sciences, has developed helpful guidelines for therapists following a client suicide. The suicide death of a client or patient is a dreaded potential outcome in mental health treatment. Such an event requires the clinician to respond in a manner that fulfills a number of roles and responsibilities while also attending to powerful emotions. The desired outcome of this painful process is the completion of immediate responsibilities and the gradual resolution of emotional responses that promote personal and professional growth and responsibility. Coping with violent death in the setting of social and professional isolation or stigmatization, confidentiality restrictions on discussion of the relationship with the deceased, and fears of wrongful death litigation can

understandably result in a circumstance that has been described as “the most profoundly disturbing event” of a clinician’s professional career (Sung, 2016).

Please note: the guidelines and recommendations outlined below are intended to help identify immediate responsibilities and potential resources and sources of support following a client's suicide. Since every case is unique and presents its own issues, these are intended only as general guidelines to be modified as appropriate for the individual situation in conjunction with a clinician’s risk management or legal counsel.

Summary of Recommendations

1. **Attend to immediate responsibilities**

    - Contact malpractice carrier and/or legal counsel for administrative support.
        - As a matter of routine clinical legal practice, notify your malpractice carrier or legal counsel immediately to begin planning a response.
        - For individual practitioners, a malpractice carrier functions to provide administrative support in a manner analogous to supervisory or management staff in an agency setting.
        - Follow any recommendations for maintaining confidentiality, seeking consultation or support from colleagues, contacting family members, completing the clinical record, and facilitating disclosure of the written clinical record to surviving family members (if needed).
        - In cases where an adversarial relationship has developed between the clinician and family, consultation with a malpractice carrier may help to guide contact with the family.

- Access immediate support from a colleague or supervisor
    - Learning of the suicide death of a client typically induces feelings of shock and disbelief. Seeking immediate assistance for emotional support can help to restore enough balance to attend to immediate responsibilities.
    - If the client's care was shared with another clinician (primary care provider, care manager, other psychiatrist or therapist, group therapist), call the other clinician to make a plan around how to proceed.
    - Balanced against a clinician's needs for support are the legal ramifications of discussing the client's treatment. That is, if any legal action results from the suicide death, discussions about the treatment with colleagues may be discoverable evidence that may be used against the clinician.
    - In consultation with peers, the clinician may wish to consider limiting the discussion to the emotional effects of the suicide death or seeking personal psychotherapy or legal counsel.
    - In the latter relationships, information that is discussed will have greater protection through therapist-client or attorney-client privilege, respectively.
    - The effects of professional stigma may exacerbate a clinician survivor's emotional distress, and consultation with a colleague or supervisor familiar specifically with the loss of a client by suicide is recommended.
- Cancel or re-schedule appointments to allow time to complete immediate tasks

- The death of a client by suicide may require the clinician to engage in immediate tasks. Cancelling or rescheduling appointments allows time for this.
- Furthermore, a clinician affected by the suicide of a client may be experiencing emotions that affect the ability to provide optimal care to other clients. Canceling or re-scheduling existing appointments allows time to engage in self-care in a manner that ensures safe care for other clients.

- Understand and respect client confidentiality
  - Privacy rights continue after the death of a client, and disclosures of protected health information about the deceased are still limited by HIPAA privacy regulations.
  - After the death of a client, privilege is the legal principle that determines who has the authority to lift the restrictions of confidentiality on a clinical record. Laws will differ from state to state regarding who holds the privilege to authorize disclosures of the clinical record. This individual may be a personal representative, executor of the estate or next of kin (spouse, adult child, parent).
  - Prior to contacting the surviving family, a clinician will need to consult with their malpractice carrier or legal counsel to determine state law regarding the hierarchy of who holds the privilege to authorize disclosures of the clinical record as well as how to prepare a consent form that will allow written authorization to lift confidentiality.
  - Until written consent from the person holding the privilege to authorize lifting of confidentiality is obtained, clinicians will need to explain with compassion and understanding to surviving family

members that disclosures about information discussed in treatment are limited by privacy laws.

- Clinicians will also need to describe the process by which an authorized representative can provide written consent to lift confidentiality in order to facilitate a more open, narrative discussion that includes information that was discussed in treatment.
- Prior to contacting the surviving family: - Clarify with legal counsel state law regarding who holds the privilege to lift confidentiality restrictions of a clinical record and it is recommended to have a list of resources for suicide survivors.
- Before confidentially is lifted, clinicians can still provide important information regarding suicide in general: risk and protective factors, relationship to mental illness, and normal patterns of grieving following suicide loss. Without disclosing information specific to the individual client's death, the clinician can still highlight general principles that are most relevant to the deceased client's particular circumstances.
- Balancing initial feelings of shock and disbelief, responsiveness to the grieving family's need for information, and respect for client confidentiality is difficult and may require consultation with colleagues and risk management.

- Contact surviving family
  - A clinician survivor's emotional pain, fear of litigation and direct legal counsel may all influence the likelihood of contact with surviving family members. Specifically in regard to a fear of litigation and in

contrast to a purely legalistic recommendation to restrict contact with surviving family members.

- An approach based on “compassion over caution” in choosing to proceed in manner guided by a desire to comfort and care for the surviving family members rather than only to protect the clinician from litigation.
- Format: The beginning of the call requires the clinician to identify himself or herself and then to express sympathy. The middle of the call is characterized by listening rather than talking as the clinician gathers information regarding the family’s needs. The call ends with the clinician providing contact information for the family. The clinician should also prepare a list of suicide survivor resources to give to the family if these are desired.
- Avoid any communications to suggest guilt or blame on the part of the family or treating clinician.
- Clinicians affected by a client’s suicide may be experiencing grief and guilt that may affect objective description of the work done with the client.
- Avoid engaging in therapeutic work with the family (i.e. grief counseling). If family members require mental health assistance, facilitate a referral for care. Engaging in therapeutic work with surviving family members creates a dual relationship that confounds an objective decision as to whether family members wish to pursue a claim of wrongful death.
- Offer to meet with family members to discuss any emotional responses and immediate needs for support. Arranging a meeting

within 1-3 weeks allows the family time to complete immediate arrangements, prepare questions and provide written consent for disclosure of the clinical record. The time between an initial call and meeting with the family also allows the supervisor/clinician to access emotional support and clarify confidentially laws. The purpose of this meeting is to hear and respond to the emotional needs of the grieving family. The focus is on the sadness of the death and the needs of the family rather than details of the treatment.

- Complete the written clinical record
    - Document that the client is deceased and include factual information obtained regarding how the client died, including the source of the information.
    - Do not alter or revise any previous documentation.
- Notify other patients if needed
    - If other clients were involved in treatment settings (i.e. group therapy) with your client, make a plan around disclosing the information regarding the suicide.
    - Guidelines for disclosing information:
        - A general guideline is to disclose only information that has been available through third-party, public sources – i.e. information that is not confidential protected health information, and/or only provide that information which had already been available to the other clients in the treatment setting and public sources.
        - While sharing no information whatsoever with other clients represents the most conservative approach to managing the

confidentiality of the deceased, failing to acknowledge factual information that is known to other clients through non-confidential sources may lead to distrust between clinicians and clients as well as a problematic situation where clients believe they can only speak with one another about the death.

- Discuss the death in factual terms without sensationalizing the events.
- In group settings, notify all clients individually before meeting as a group to avoid the need to repeat and discuss the information if clients arrive late for the group session.

- Clinical/therapeutic aspects:
  - Therapeutic role: Express genuine feelings while avoiding excessive displays of emotion that might convey that surviving clients must care for a distressed clinician.
  - Suicide risk management: Assess for increase in suicide risk in surviving clients.
  - Therapeutic aspects: For clients at risk of suicide, encountering the suicide death of another client risks a contagion effect that increases risk in survivors. This is especially the case if negative consequences of suicide are minimized, the deceased appears forgiven for negative behavior or if it is implied that it was reasonable for the deceased to give up and choose suicide. The suicide death of another client thus carries the risk of shifting the balance towards death, and clinicians must be aware of this.
  - Cultural norms and the stigma of suicide place pressure on the clinician to avoid discussion of suicide, to express empathy only

for emotional pain, to avoid "speaking ill of the dead," and to suggest that the deceased is "in a better place." All of these are therapeutically problematic if they convey to a suicidal client that suicide cannot be discussed, that some emotional pain is impossible to bear without resorting to suicide, that negative behavior has been forgiven, that the client is better off dead or that others are better off without the client.

- To counter these problematic perceptions and support surviving clients' struggle towards life, the clinician may use the death of a client to explore feelings about the suicide death. Clinicians can use the opportunity to express disagreement with the decision to choose suicide, emphasize alternative solutions to emotional pain and reflect collectively on how it feels to be left behind by a suicide. In work with suicidal clients, these interventions are meant to support positive coping and challenge the perceived burdensomeness and thwarted belongingness.

- Address unpaid bills
    - The outcome of mental health treatment is never certain, and fees are collected for time and knowledge rather than a defined outcome. While not an immediate responsibility, collecting unpaid bills may become relevant after short-term tasks are completed. Individual clinician preferences and circumstances will influence this decision whether to seek payment.

2. **Manage emotional responses**

- Peer support

- Case reports and surveys of clinician survivors consistently report that informal peer support from family, friends and professional colleagues is the most beneficial factor in managing emotional experiences following client suicide.
- In discussions with peers, focus on the emotional response to the suicide rather than details of the treatment to avoid legal consequences if litigation ensues.

- Supervision
  - Discussions with past and current supervisors or mentors are often helpful in managing responses to client suicide. This is especially the case if the supervisor can share personal experiences about having coped with this. As clinician survivors may be fearful or reluctant to seek assistance, supervisors should ask directly about any responses to the suicide and follow-up regularly on this topic as needed. Specific interventions by the supervisor that may be helpful include
    - Allowing the supervisee to search for the "why" of suicide in physical or psychological clues from within or outside of (in meeting with family survivors) the therapeutic relationship.
    - Addressing inevitable guilt by acknowledging the emotion and adding education about suicide (incidence, predictability, risk and protective factors) to provide perspective on the limits of clinical work with suicidal clients.
    - Advocating for the supervisee to prevent stigmatization: encouraging expressions of support for the therapist, providing accurate information about the suicide to other staff and participating in administrative proceedings.

        - Providing education about the process of grief following a suicide – i.e. likelihood of post-traumatic responses, incomplete nature of grief due to inability to participate in rituals of mourning, need for more support if a complicated grief response persists.
        - Monitoring of effects on clinical work: development of mistrust of clients or mistrust of clinical judgment.
        - Facilitating contact with other clinician survivors.
- Literature review
    - Many therapist survivors have written detailed first-hand accounts describing their experiences with client suicide (Gitlin, 1999; James, 2005; Kolodny, Binder, Bronstein & Friend, 1979; Perr, 1968; Reeves, 2003; Valente, 2003). Reviewing these reports may decrease the sense of isolation that results from this experience. Professional responses to client suicide include:
        - Shame and guilt over failing to prevent the suicide.
        - Fear of condemnation or actual stigmatization from colleagues.
        - Ruminations over missed clinical signs that may have indicated imminent suicide risk or that indicate acute suicide risk in current clients – i.e. the “search for omens.”
        - Questioning professional roles.
        - Thoughts of leaving the profession.
        - Overreactions to suicidal clients, hypervigilance regarding suicide risk, or defensive distancing from suicidal clients.
        - Fear of treating suicidal clients.

- Personal psychotherapy
    - Individual psychotherapy may be helpful in understanding and managing emotional responses to a client's suicide.
    - The legal protection of this relationship may allow the clinician to speak more freely about treatment decisions and emotional responses, especially in circumstances where institutional regulations on confidentiality or professional stigmatization are significant.
- Individual coping strategies
    - The use of coping exercises in the form of questions can help examine the clinician’s responses to bereavement and mortality. These questions can form the basis of organizing an individual plan for managing emotional responses.
        - What types of patients distress me most when they die?
        - What are my typical patterns of expressing grief?
        - What type of support and assistance is most acceptable to me when I grieve, and how do I access this support?
        - What type of assistance do my teammates and colleagues seek and give?
        - What are my personal stressors and stress busters at this time?
        - How can others assist me with my difficulties and distress?
- Participation in the rituals of death
    - Participation in the common rituals of death (sending flowers, offering condolences, attending the funeral) can have positive effects

on clinicians and surviving family members when done in consultation and collaboration with the family.

- Following the surviving family's lead, clinicians may discuss the possibility of attending a deceased client's funeral as a way of caring for the family and participating in the grieving process.
- Prior to attending the funeral, clinicians should review guidelines regarding maintaining client confidentiality and discuss with the family how they would like the clinician to identify his or her relationship with the deceased.
- Attending the funeral can provide the clinician with a shared, rather than isolated, experience of loss. Grieving with family members also can provide a broader perspective of the client's life, given that the clinician's perspective may have been restricted to knowledge of the client's struggles discussed in treatment

3. **Suicide case review**

- Ensure proper timing – allow time for some integration of the loss before conducting an educational review. After some resolution of distressing emotions, conducting a case review allows for an opportunity for learning and professional growth. A case review examines the circumstances surrounding the client's death: details of the treatment, life circumstances preceding the suicide, suicide risk factors, protective factors, and warning signs and interventions for suicide.
- Setting of a case review: In an agency-based setting, case reviews may occur as part of a quality assurance process such as a morbidity and mortality conference where information remains privileged and confidential.

- For patients seen in a private practice setting, no analogous process exists to ensure protection from discovery should litigation ensure, and it is not possible to make a clear recommendation for conducting a suicide case review with a colleague or supervisor.
- In the absence of a protected setting for case review, clinicians may review their own work according to the guidelines below or seek advice from risk management or legal counsel on how to facilitate a review of their work.
- Components of a case review: For educational purposes, a case review should consist of the following components:
    - General circumstances of the case: treatment setting, presenting symptoms, precipitating events leading up to the suicide.
    - Risk factors: demographic, situational, symptomatic, suicide-specific.
    - Protective factors.
    - Warning signs.
    - Overall assessment of risk.
    - Treatment interventions for suicide, including safety planning.
    - Other short-term or long-term interventions that may have been implemented to modify risk or protective factors.

4. **Professional growth and responsibility**

- Review suicide risk assessment, management, and treatment practices
- Engage in altruistic activity to support others

Reviews of the process of coping with client suicide or other adverse outcomes suggest stages of response with an immediate stage of shock and disbelief, a middle stage of overwhelming emotions, and a final stage of resolution. Clinicians progress through stages of response to adverse patient outcomes in a manner comparable to the response to client suicide.

After experiencing a client's death by suicide, clinicians may find it helpful to adjust their practices and engage in altruistic activities to support others in preparing for or coping with similar crises. The goal of this process is to "thrive" by allowing clinicians to grow from a painful experience in a way that enhances their treatment for clients and provides support to fellow clinicians.

Section 11: Workplace Suicide Prevention

The National Guidelines for Workplace Suicide Prevention defines a comprehensive approach to reducing suicide. These guidelines identify that by creating a workplace culture characterized by respect, connectedness, and caring. Their guidelines, *A report of findings to direct the development of national guidelines for workplace suicide prevention*, highlight nine workplace strategies that can protect against suicide (Spencer-Thomas & Mortali, 2019):

- Gaining buy-in from leadership to implement interventions
- Reducing job strain and barriers to seeking help
- Talking about suicide to increase understanding and reduce stigma
- Prioritizing self-care and efforts to build resilience
- Training employees to address suicide risk based on their role

- Having peer support and wellness ambassadors fearing mental health and crisis resources (e.g., mental health first aid, Employee Assistance Programs)
- Mitigating suicide risk through reducing access to lethal means
- Having a crisis response plan (e.g., accommodations, postvention)
- Reducing Job Strain

If a client's work environment is creating job strain, it is encouraged to help them understand the difference between a healthy and an unhealthy work environment. Job strain refers to the combination of high job demands and low job control, and it can lead to increased stress and potential mental health issues. The goal is to identify if the job strain is causing suicidal thoughts.

According to Workplace Suicide Prevention (n.d.), people are less likely to experience job strain when they have:

- Autonomy and decision-making power
- Job variety and meaningful work
- Job security
- A sense that they are rewarded for their efforts (e.g., income, recognition)
- Minimal conflict between family and work demands
- Reasonable, well-defined expectations
- Good relationships with colleagues and supervisors
- A flexible yet consistent, work schedule

A company could reduce job strain if their company prioritized (Workplace Suicide Prevention, n.d.):

SELF CARE

Companies should respect employee breaks, encourage self-care, and help employees develop work-life balance.

HEALTHY COPING

Companies should support and promote healthy ways to cope with stress. By providing resources and education on stress management and encouraging activities that do not involve drinking, such as exercise and mindfulness, companies can empower their employees to take control of their mental health.

SAFETY AND HEALTH

Companies should ensure that job responsibilities do not cause illness or physical pain in their employees. By making efforts to reduce incidents of injury, pain, or illness when job responsibilities increase the risk of danger or harm, companies can provide a secure and protected environment for their employees.

WORKPLACE PROGRAMS

These are specific programs that have been developed to help workplaces implement suicide prevention efforts. Two include the Interactive Screening Program and Mental Health First Aid at Work. These programs provide employees with the tools and knowledge to recognize and respond to signs of behavioral health issues, substance use problems, or significant distress, thereby creating a supportive and proactive work environment.

Interactive Screening Program

The American Foundation for Suicide Prevention (AFSP, n.d.) has teamed up with businesses to prevent suicide. Recognizing that many individuals do not want to disclose feelings of stress and psychological pain to their employer, AFSP offers an anonymous Interactive Screening Program.

The Interactive Screening Program allows individuals access to evidence-based, online screening tools designed to create awareness about symptoms of common mental health conditions. As a follow-up, the program offers confidential referrals for mental health providers to employees.

The Interactive Screening Program is linked to the employer's Employee Assistance Program (EAP) but operates directly with employees via email and online tools.

Mental Health First Aid at Work

Mental Health First Aid (MHFA) is a program that teaches people to recognize and respond to signs of behavioral health issues, substance use problems, or significant distress. MHFA at Work specifically trains employees to notice and address mental health challenges in the workplace.

The training is tailored to each organization and the curriculum takes about 8 hours to complete. Among other details, MHFA at Work promotes upstream efforts such as building resilience and creating a supportive and accepting culture (National Council for Mental Wellbeing, n.d.).

Summary Workplace culture can affect suicide risk by creating a culture characterized by respect, connectedness, and caring. Specific strategies to reduce job strain were discussed as an upstream intervention for suicide prevention.

Companies can also use interventions like the Interactive Screening Program and Mental Health First Aid at Work to reduce their employees' suicide risk.

Section 12: Summary

Suicide can be prevented. A proactive approach includes the development of screening, assessment, and response protocols across multiple areas of the hospital and in different clinical settings, collaboration with healthcare facilities to implement response toolkits, and advocacy for federal and state legislation mandating continuing education for health care providers.

The best way to care for both our potentially suicidal clients and ourselves is by practicing patient-centered clinical risk management that supports the treatment process and preserves the therapeutic alliance. Ultimately, providing high-quality clinical care with proper documentation leads to the most effective risk management. Social workers must understand that the law does not require adherence to best practices or the ability to predict suicide in order to avoid liability in the case of a suicide or suicide attempt.

With timely, evidence-based, and often low-cost interventions, suicides can be prevented. For national responses to be effective, a comprehensive suicide prevention strategy is needed and spread throughout the country. Further initiatives can include the creation of a train-the-trainer program to strengthen evidence-based education, knowledge sharing with a national healthcare organization to produce toolkits on trauma-informed care, and the development of simulation-based learning in higher education. These efforts highlight how social workers can drive systemic change, empowering healthcare systems to counter suicide risk more effectively while encouraging prevention through education and advocacy.

Terms commonly used in suicide prevention (https://sprc.org/topics-and-terms/)

- **At risk:** Characterized by a high level of risk for suicide and/or a low level of protection against suicide risk factors. An individual displaying warning signs of suicide would also be considered at risk. Note that most members of any at-risk group will not display warning signs, attempt suicide, or die by suicide.
- **Cluster:** A group of suicides or suicide attempts, or both, that occurs closer together in time and space than would normally be expected in a given community. Some researchers divide clusters into
    - "**mass clusters**," in which suicides occur closer in time than would be expected by chance following media coverage," and
    - "**point clusters**," which involve suicides or episodes of suicidal behavior localized in both time and geographic space, often occurring within a small community or institutional setting.
- **Contagion:** Suicide risk associated with the knowledge of another person's suicidal behavior, either firsthand or through the media. Suicides that may be at least partially caused by contagion are sometimes called "copycat suicides." Contagion can contribute to a suicide cluster.
- **Intervention:** An activity or set of activities designed to decrease risk factors or increase protective factors.
    - **Indicated intervention:** An activity that targets individuals who exhibit symptoms or have been identified by screening or assessment as being at risk for suicidal behavior. For example, safety planning for people who have reported thinking about suicide is an indicated intervention.

    - **Selective intervention:** Activities targeting a group whose members are generally at higher than average risk for an adverse health condition (e.g., suicidal behaviors) regardless of whether individual members of the group display symptoms or have been screened for the condition. For example, suicide prevention interventions targeted at victims of intimate partner violence are selective interventions because intimate partner violence is associated with an increased risk of suicidal behaviors.
    - **Universal intervention:** An activity designed to prevent negative health outcomes (e.g., suicide attempts and suicides) in an entire population regardless of the risk status of members of that population. For example, a middle school life skills curriculum that includes coping and help-seeking skills is a universal intervention since it would be directed at all the students in that middle school regardless of their level of risk for suicide.

- **Lethal means:** Objects, substances, or places someone may use to take their life.
- **Lethal means reduction:** Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.
- **Non-suicidal self-injury (NSSI):** Injury inflicted by a person on themselves deliberately but without intent to die.
- **Postvention:** Activities following a suicide to help alleviate the suffering and emotional distress of the survivors and prevent additional trauma and contagion.

- **Prevention:** Activities implemented prior to the onset of an adverse health outcome (e.g., death by suicide) and designed to reduce the potential that the adverse health outcome will take place.
- **Protective factor:** A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.
- **Risk factor:** A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes, like suicide.
- **Suicidal behaviors:** Suicide, suicide attempts, suicidal ideation, and planning/preparation done with the intent of attempting or death by suicide.
- **Suicidal crisis, acute phase:** The acute phase is the period in which an individual experiencing a suicidal crisis is at imminent risk for acting on thoughts of suicide. The acute phase starts when the individual shifts from thinking about taking their life to preparing to take their life.
- **Suicidal ideation:** A broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.
- **Suicide:** A death resulting from an action taken by a person with the intent or reasonable expectation that the action will result in their death.
- **Suicide attempt:** When someone harms themselves with an intent to end their life, but they do not die as a result of their actions.
- **Suicide attempt survivor:** A person who has attempted suicide, but did not die.

- **Suicide loss survivor:** A person who has lost a family member, friend, classmate, or colleague to suicide. Sometimes called “suicide survivor,” although the term “suicide loss survivor” is often favored to avoid confusion with “suicide attempt survivor.”
- **Suicide plan:** An individual’s thinking about a suicide attempt that includes elements such as a timeframe, method, and place.
- **Warning signs:** Behaviors and symptoms that may indicate that a person is at immediate or serious risk for suicide or a suicide attempt.

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