



Mindful
Continuing Education

Ethical Decision-Making in Suicide Risk Assessment: A Trauma-Informed Framework



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Section 1: Introduction

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Suicide is a “death caused by self-directed injurious behavior with intent to die as a result of the behavior” (National Institute of Mental Health [NIMH], 2025, para. 2). Suicide is among the leading causes of death in the United States (U.S.), making it a significant public health concern (NIMH, 2025).

As stated by the American Foundation for Suicide Prevention (AFSP) (n.d.), suicide does not have one single cause. It most often happens when a person is experiencing stressors combined with health issues, which lead to feelings of hopelessness and despair. Depression is the most common mental health condition that is associated with suicide, often going undiagnosed or untreated.

Suicide as a Leading Cause of Death

In 2024*, suicide was the tenth leading cause of death for people of all ages, claiming close to 50,000 lives. In the same year, it was also:

- The second leading cause of death for people ages 10-14, 15-24, and 25-34.
- The fourth leading cause of death for people ages 35-44.
- The fifth leading cause of death for those aged 45-54.
- The eighth leading cause of death for people aged 55-64 (U.S. Centers for Disease Control and Prevention [CDC], 2024).

* Most recent data available at the time this course was written.

Suicidal Ideation and Attempts

When a person has suicidal ideation, it means that they are “thinking about, considering, or planning suicide” (NIMH, 2025, para. 4). A suicide attempt is a “self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in death or injury” (NIMH, 2025, para. 3).

In 2024*, the number of people who thought about, planned, or attempted suicide is reviewed in this section.

Adolescents (age 12 to 17)

According to the 2024 National Survey on Drug Use and Health (NSDUH)*:

- About 2.6 million people (or about 10%) had serious thoughts of suicide in the past year. This number is down from about 3.4 million people in 2021.
 - Of note, about 1.7 million people reported they were unsure or did not know whether they had serious thoughts of suicide, and another close to 1.8 million people did not want to report whether they had these thoughts. Therefore, the NSDUH has concluded that the estimate of 2.6 million people having serious thoughts of suicide is conservative.
- About 1.2 million people (or 4.6%) made a suicide plan in the past year. This number is down from about 1.6 million people in 2021.
 - Of note, about 668,000 people reported they were unsure or did not know whether they had made a suicide plan, and close to 1.5 million people did not want to report whether they had made a plan.

* Most recent data available at the time this course was written.

Therefore, the NSDUH has concluded that the estimate of 1.2 million people having made a suicide plan is conservative.

- About 700,000 people (or 2.7%) attempted suicide in the past year. This number decreased from 940,000 people in 2021.
 - Of note, about 431,000 people reported they were unsure or did not know whether they had attempted suicide, and close to 1.2 million people did not want to report whether they attempted suicide.
- Therefore, the NSDUH has concluded that the estimate of 700,000 people attempting suicide is conservative.
- About 537,000 people (or 2.1%) had serious thoughts, made a plan, and attempted suicide in the past year.

Adults (age 18 and older)

According to the 2024 National Survey on Drug Use and Health (NSDUH)*:

- 14.6 million adults (or 5.5%) seriously thought about suicide (also called suicidal ideation).
- 4.6 million (or 1.8%) planned a suicide attempt (a part of suicidal ideation).
- 2.2 million (or 0.8%) attempted suicide.
- About 1.7 million adults (or 0.6%) had serious thoughts, made a plan, and attempted suicide in the past year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2025).

When looking beyond 2024 at suicide trends for the last twenty-five years, rates have been steadily increasing since 2001. However, since 2017, suicide rates have been mostly stable, though they peaked in 2022 and decreased slightly by 2024*.

* Most recent data available at the time this course was written.

Between 45,000 and 50,000 people have died by suicide every year since 2017, with certain disparities existing in these rates (CDC, 2026c).

Some factors contributing to the small decrease in suicide rates include the establishment of the 988 Suicide and Crisis Lifeline, the expansion of state Medicaid programs (which provided insurance benefits to more people), and the distance in time from the pandemic. However, gaps in accessing mental health care and substance use treatment exist, and suicide prevention efforts remain challenged (Levine & Sher, 2019; Saunders et al., 2026).

Vulnerable Populations

Certain populations are more vulnerable to suicide compared to others. This section reviews some disparities in suicide in both adolescents and adults using U.S. data from 2023 and 2024.

Adolescents (age 14 to 17)

In 2024*, the CDC published the “Youth Risk Behavior Survey Data Summary and Trends Report: 2013 to 2023,” which examined the health behaviors and experiences of high school students in the U.S. during this time frame. Some disparities shown in the Youth Risk Behavior Survey in the areas of suicide are as follows:

- Female students, American Indian or Alaska Native students, and students who identify as lesbian, gay, bisexual, questioning, or another non-heterosexual identity (LGBTQ+) experienced serious consideration of attempting suicide, made a suicide plan, and were injured in a suicide attempt more than other groups of people.

* Most recent data available at the time this course was written.

- In the area of suicide attempts, female students, Native Hawaiian or Pacific Islander, and LGBTQ+ students had the highest rates (CDC, 2026b).

Adults (age 18 and older)

In 2024*, the following disparities in suicide existed:

- Non-Hispanic American Indian and Alaska Native people and non-Hispanic White people had the highest rates.
- Males died by suicide four times more than females (CDC, 2026c).

In 2023*,

- Adults aged 80 to 84 have the highest suicide rates.
- Suicide rates are higher for people who live in rural areas compared to those who live in big cities.
- While data is limited on the frequency of suicide among adults who identify as LGBTQ+, about 5% of individuals aged 18-25 and 1.3% of individuals aged 26 to 49 reported suicide attempts.
- For Veterans, suicide was the overall 12th leading cause of death and the second leading cause of death in those 45 and younger. The suicide rate among Veterans was about twice as high as the rate of non-Veteran adults in the U.S.
- People with disabilities were more likely to report suicidal thoughts and behaviors when compared to adults without disabilities. For example, adults with any disability were 2-3 times more likely to report having suicidal thoughts, 2-4 times more likely to report making a suicide plan, and 2-3 times more likely to report a suicide attempt.

* Most recent data available at the time this course was written.

- Certain occupations have higher rates of suicide, including:
 - Construction and extraction
 - Farming, fishing, and forestry
 - Personal care and service
 - Installation, maintenance, and repair
 - Arts, design, entertainment, sports, and media (CDC, 2026b)

Suicide Risk Assessment

As stated by Soreff (2026), “suicide risk assessment is a clinical process that integrates patient history, mental status examination, collateral information, and evaluation of acute stressors and protective factors” (para. 1). This process is multifaceted and person-centered, focused on the needs and stressors of an individual, while also helping them mobilize their strengths and supports. The purpose of suicide risk assessment is not to predict suicide, but instead to assess and reduce the risk of suicide, inform treatment planning, and promote overall wellness and recovery (Mental Health Commission of Canada, 2021).

SAMHSA (2024) recommends suicide risk assessments be conducted at the following times:

- During the first contact with a client.
- With any subsequent suicidal behavior, an increase in ideation, or a significant clinical change.
- Before any changes occur in behavioral health treatment.
- At inpatient discharge (if the client is admitted for mental health care).

Assessment Components

In 2014, a literature review was conducted to identify clinical practice guidelines for suicide risk assessment. Overall, the study found that the majority of guidelines include assessing risk factors and suicidal intent, though risk-factor assessment was the only component in all guidelines. This finding is thought to reflect a consensus in the mental health field that the beginning of a suicide risk assessment should start with identifying factors and warning signs that are associated with risk, as well as protective factors. Therefore, in general, a suicide risk assessment must include identifying and understanding the following about a client:

- Warning signs that they are presently experiencing
- Current risk factors and protective factors
- Current suicidality, including ideation, plan, behaviors, intent, and access to lethal means

A suicide risk assessment includes gathering information from the client and the client's collateral contacts (with permission), and reviewing records and results from any screening tools administered (Alonzo & Gearing, 2018; Mental Health Commission of Canada, 2021; Pal et al., 2025).

A Note on Screening Tools

Clinically validated, brief, evidence-based screening tools exist to help social workers identify clients who may be at risk for suicide and need to be assessed. These tools are structured and can help ensure that many assessment components are not overlooked.

Some examples of brief, evidence-based screening tools for adults include:

- Ask Suicide-Screening Questions (ASQ)
- Columbia-Suicide Severity Rating Scale (C-SSRS) Screen Version
- Patient Health Questionnaire-9 (PHQ-9)
- Patient Safety Screening (PSS-3) (Suicide Prevention Resource Center [SPRC], 2025)

Additional examples of brief, evidence-based screening tools for adolescents include:

- Ask Suicide-Screening Questions (ASQ)
- Columbia-Suicide Severity Rating Scale (C-SSRS) Triage Version
- PHQ-9 Adolescent Version (PHQ-9A)
- Suicide Behavior Questionnaire-Revised (SBQ-R) (American Academy of Pediatrics [AAP], 2023b)

When a client is determined to be a risk for suicide based on the results of a screening tool, a suicide assessment is necessary. Also, if a suicide screening tool is not appropriate for a client, for example, based on language barriers, a suicide assessment must be conducted using appropriate approaches.

While suicide screening is a useful tool, there can still be false negatives, and social workers may still suspect suicide risk in an assessment despite a client's responses on a tool, which both support the importance of assessment (SPRC, 2025).

Warning Signs

In general, the warning signs of suicide include:

- A person talking about the following:

- Killing themselves
- Feeling hopeless
- Existing without a reason to live
- Expressing that they are a burden to others
- Feeling trapped in their life
- Unbearable pain
- A person may exhibit the following behaviors, especially if they are connected to a painful loss, change, or event:
 - Increased use of substances, including alcohol or drugs
 - Looking for a way to end their life, such as doing research online
 - Withdrawing from activities, family members, and friends
 - Sleeping too much or too little
 - Saying goodbye to people, either in person or by phone
 - Giving away meaningful possessions
 - Aggression
 - Fatigue
- A person may exhibit one or more of the following moods:
 - Depression (symptoms can include a change in normal eating habits and/or sleeping, neglecting personal hygiene, increasing physical issues, experiencing a loss of interest, withdrawing from others, and having trouble concentrating)

- Anxiety
- Loss of interest
- Irritability
- Humiliation
- Shame
- Agitation
- Anger
- Sudden improvement in mood despite ongoing concerns
- When there is concern about suicide, it is also important to be aware of a person displaying a change in behavior or new behaviors, especially after a painful loss, change, or event (American Foundation for Suicide Prevention [AFSP], n.d.).

Some additional warning signs for adolescents include:

- Lack of response to positive feedback or praise
- Acting out or running away
- Risk-taking behaviors, or in contrast, boredom
- Obsession with death and dying
- Feeling a desire to die (John Hopkins Medicine, n.d.)

Current Risk and Protective Factors

Risk factors are defined by the AFSP (n.d.) as “characteristics or conditions that increase the chance that a person may try to take their life” (para. 2). On the other hand, protective factors decrease this chance. When assessing risk and protective

factors, it is important to determine whether they are acute or chronic in a client's life.

Some risk factors for suicide include:

- Current or past mental health conditions, such as depression, anxiety, bipolar disorder, schizophrenia, conduct disorder, and/or personality traits that are difficult to manage, such as aggression, mood changes, and poor relationships.
 - It is important to understand if the client has a current or past mental health diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, their current mental status (including their cognitive and emotional functioning), and their mental health treatment history, if any.
- Other emotional and psychological concerns, such as sleep disturbances, loneliness, humiliation, shame, despair, rumination, difficulty problem-solving, and decreased psychosocial functioning.
- Substance use
- Ongoing feelings of hopelessness
- Childhood abuse, neglect, or trauma
- Generational trauma
- Serious physical illness, such as cancer, chronic pain, HIV/AIDS
- A traumatic brain injury
- Prolonged stress

- Stressful life events, such as family or marital conflict, unemployment/ financial issues, homelessness, legal problems/incarceration, losses and their impact, and exposure to trauma
- Whether a person identifies as a sexual or gender minority
- Poor coping skills
- Discrimination
- Social isolation
- Lack of access to care
- Exposure to suicide
- Family history of suicide
- Prior suicide attempts
- Access to lethal means (Alonzo & Gearing, 2018; AFSP, n.d.; SAMHSA, 2024; Sung & Focht, 2023)

As stated by Alonzo & Gearing (2018), “having one or more risk factors does not make someone suicidal, nor does the absence of risk factors negate the risk. However, the number of risk factors present often correlates with the level of suicide risk” (p. 303).

Some protective factors for suicide include:

- Access to mental health care
- Positive therapeutic relationship with a mental health professional
- Coping skills, problem-solving abilities, adaptability to change, and emotional regulation

- Self-esteem
- A support system and relationships with other people
- Responsibilities to other people, such as family, children, and/or pets
- Engaged in work or school
- Cultural and/or religious beliefs that discourage suicidal behavior and encourage connection, self-help, and a sense of purpose
- No access to lethal means (Alonzo & Gearing, 2018; AFSP, n.d.; SAMHSA, 2024; Sung & Focht, 2023)

Current Suicidality

A suicide risk assessment must include specific questions to assess ideation, plan, behaviors, intent, and access to lethal means.

Alonzo & Gearing (2018) write that the assessment should start with asking the core suicide assessment question, which is “Are you suicidal?” or “Have you ever thought of killing yourself?” They also note that the manner in which this question is asked is “fundamentally important” (Alonzo & Gearing, 2018, p. 296). For example, if the question is asked with judgment, hesitation, accusation, or anxiety on behalf of the mental health professional, a client will be less likely to disclose how they are feeling. On the other hand, if the question is asked neutrally and openly, the client is more likely to respond honestly. Three general responses are typically given to this core question:

- A clear, direct denial of suicidal ideation, behaviors, and/or plan
- A clear confirmation of suicidal ideation, behaviors, and/or plan
- A vague response that neither denies nor confirms suicidal ideation, behaviors, and/or plan

The response category can help the mental health professional determine the scope and level of detail needed during the assessment. Note that even if the denial is clear and direct, a follow-up assessment is still required. The recommendation is that every client, regardless of presentation or diagnosis, be assessed using the core question and others based on their response to it (Alonzo & Gearing, 2018).

Additional areas of suicide inquiry and assessment questions include:

- **Ideation** - understanding the frequency, intensity, and duration of the client's suicidal thoughts, including the prior 2 days before the visit, the past month, and the worst ever
 - Have you thought about death recently?
 - ◆ If so, how do you feel about these thoughts? Do they make you feel comfortable or uncomfortable?
 - ◆ How long have you been having these thoughts? How often do you have them? Do they happen around certain people, places, or times? When do they not happen?
 - ◆ Have you talked about them with anyone? What causes them?
 - Do you ever wish that you were not born, or that you would not wake up in the morning?
 - Have you ever felt trapped and unable to see a way out?
 - Do you feel hopeless?
 - ◆ If so, how long have you felt this way?
 - ◆ What people or things have led you to feel more hopeless or less hopeless about the future?

- **Intent** - exploring the extent to which the client expects they will carry out the suicide plan and believes it will be lethal. This part of the assessment also includes exploring ambivalence and the reasons a person has for living rather than dying.
 - How close have you come to acting on these thoughts?
 - How likely are you to act on these thoughts now? (can use a scale from 1 to 10)
 - How likely are you to act on these thoughts in the future? (can use a scale from 1 to 10)
 - Are you tired of living, or do you ever feel like life is not worth living?
 - Do you want to die, or does it not seem that another solution is possible?
 - If there were a solution to your problem, would you take it?
 - What things in your life give you meaning and make you want to go on living?
- **Plan and behaviors** - exploring the timing and location, lethality, and what acts have taken place to prepare. Also inquiring about stopped attempts and rehearsals versus self-injurious acts (non-suicidal).
 - Have you made a plan to kill yourself? Is there more than one plan?
 - ◆ If yes, what does the plan include?
 - ◆ How detailed is it?
 - ◆ Have you thought about when you will carry out the plan?

- ◆ Have you researched methods you could use as a part of the plan?
- ◆ Are you concerned that you will be interrupted or caught while carrying out the plan?
- ◆ How lethal is the method? Is death likely?
- What preparations have you made? For example, have you purchased the items you need? Gave things away? Wrote notes?
- Have you ever started to act out the plan but stopped?
- Is there anything that is stopping you from carrying out the plan?
- Have you ever acted aggressively or impulsively towards someone or something?
- Do you feel you have control over your thoughts and behaviors?
- **Lethal means** - assessing if a person has access to the means they need to carry out the suicide plan, such as a firearm, drugs, or other methods.
 - Is the method you are planning to use readily available to you?
 - Are you able to carry out the plan (e.g., physically and cognitively)?
 - Do you have access to guns, other weapons, pills, or other drugs?

For clients who are under age 18, the mental health professional needs to ask specific questions of the parent or caregiver about the client's suicidal thoughts, plan, behaviors, and mood, behavior, and/or disposition changes (Alonzo & Gearing, 2018; SAMHSA, 2024).

Additional Assessment Components

While other areas can be explored in a suicide risk assessment in addition to assessing warning signs, risk and protective factors, and specific suicide-related information, it is important to note that “a clinician may have to begin the assessment with the most pertinent categories and continue with a more in-depth evaluation during later sessions” (Alonzo & Gearing, 2018, p. 298). Therefore, additional areas to be explored include sociodemographic data, the identified problem/symptom history, suicide history, and family/peer suicide history.

Sociodemographic Data

Sociodemographic data is essential to obtain, as risk can be attributed to specific demographic characteristics. Understanding an individual's sociodemographic data can not only help a mental health professional determine relevant risk and protective factors but also incorporate these aspects of a person's life into their treatment plan. Pertinent demographic information includes:

- Age
- Gender
- Race
- Ethnicity
- Culture
- Immigration status and their experience with immigrating
- Acculturation
- Languages spoken
- Religion

- Marital status
- If they have experienced domestic violence or intimate partner violence
- If they use or abuse substances
- Past or current abuse and/or neglect
- Sexual orientation
- Socioeconomic status
- Education level
- Academic history
- Occupation
- Employment history
- Social support
- Where they live and who they live with
- Recent changes and/or losses they have experienced in their life
- Overall health
- Current medical conditions
- If they are having issues with sleep
- Past medical history
- Developmental history
- Who referred them for an assessment and/or services

Identified Problem/Symptom History

This component of an assessment focuses on issues a person may be experiencing beyond their current suicidality. Understanding the presenting problem with a detailed symptom history allows a mental health professional to assess suicide risk further and individualize a treatment plan that is focused on addressing key issues. Pertinent information to obtain in this area includes:

- What is the main problem or concern?
- Does the client have a mental health diagnosis based on criteria in the DSM?
- When did the problem start? Is it experienced consistently, intermittently, episodically, or at another frequency?
- What makes the problem better? What makes it worse?
- How does the problem impact people in the client's life?
- How has the client coped with the problem?
- What is the problem impacting the most? What is the problem impacting the least?
- Why does the client think that they have the problem?
- Details of who first identified the problem.
- What is the treatment history?
 - If counseling or therapy was received, ask questions to understand with whom, for how long, and how helpful it was.

- If medication was prescribed, ask questions to understand the name, type, dose, regimen, whether it worked for the client, whether they were compliant, and whether they had side effects.
- Has the client ever been hospitalized because of the problem? If so, ask questions to understand the details.

Suicide History

Assessing suicide history should start with exploring if a client has a history of past suicide attempt(s). If so, it is important to understand the following:

- Total number of attempts in their lifetime, with details about whether any have occurred in the last month, year, or 5 years.
- Nature of each attempt, including:
 - When and where the attempt took place
 - Who was involved, if anyone else
 - The method that was used
 - Substance involvement
 - The purpose of the attempt, such as escape, injury, or death
 - Events/stressors that happened before the attempt
 - Fear that they would be found
- Lethality:
 - How lethal the client thought the attempt would be, if they did research on lethality, and if they thought their life could be saved with medical intervention

- Post-attempt factors:
 - What happened after the attempt, including whether someone found them, whether they sought help, whether they told, what their thoughts were, and what they would have done differently
- Consequences:
 - Whether they sought medical attention in an emergency room, and if there was a hospitalization
 - Whether they received outpatient care
 - Reactions from family and other social supports
 - If nothing happened, it is important to know that as well
- Planning:
 - The amount of time that the attempt was planned before it was acted on, and whether it was impulsive or not
 - The thoughts the client had before the attempt
 - Whether the client left a note, told others, gave personal items away, or created a will

Family/Peer Suicide History

In addition to assessing a client's suicide history, it is also important to know if they have experienced the suicide or attempted suicide of a family member or friend, as this can put them at an increased risk for suicide themselves. As part of this assessment, it is essential to understand the nature of the relationship, as risk varies by the degree of relation (Alonzo & Gearing, 2018).

Alonzo & Gearing (2018) recommend opening this part of the assessment by asking, “Have any of your relatives and/or peers completed or attempted suicide?” (p. 303). If so, the following assessment questions can be asked:

- What was your relationship to that person?
- How closely did you identify with them?
- How many attempts did that person have, and how recent were they?
 - For each attempt, ask questions to understand the circumstances, method, if the person told the client or if the client found them, any consequences, how the attempted or completed suicide impacted them, and if they feel responsible.

Recommendations for Conducting a Suicide Risk Assessment

While the above components provide a foundation for a comprehensive suicide risk assessment, there are additional recommendations that provide a framework for the mental health professional conducting the assessment itself, including:

- Individualizing the assessment based on the client and evidence-based knowledge of suicide in specific areas of practice.
- Presenting with a neutral, nonjudgmental, and transparent stance to improve the client’s engagement in the assessment process and facilitate more honest responses from the client.
- Developing and maintaining a therapeutic alliance enhances the assessment process.
- Knowing the client’s culture and cultural customs, and their impact on their life, is essential.

- Patterning the assessment questions to consider their flow and sensitivity is critical to the assessment's outcome. Avoiding an interrogational style. Being open to the client answering questions on their own or out of order, as it encourages a more natural conversation.
- Instilling hope that alternative solutions to suicide are possible.
- Helping the client understand the reasons for the assessment and that it is only the first step in an ongoing process of developing a treatment plan, which can help engage and motivate them to be involved.
- Recognizing and commending a client for being honest about their thoughts and feelings.
- Knowing the professional code of ethics and laws regarding suicide within one's jurisdiction must be considered and integrated into the assessment.
- Receiving clinical supervision and guidance when working with suicidal clients, especially when determining their disposition based on the information learned during the assessment process (Alonzo & Gearing, 2018).

The Role and Importance of Social Work in Suicide Risk Assessment

In the U.S., social workers are the nation's largest group of mental health service providers, making them an essential profession to suicide prevention (Levine & Sher, 2019; National Association of Social Workers [NASW], n.d.). One study of about 600 social workers found that close to 93% of respondents reported working with at least one suicidal client in their career, while almost 80% worked with a suicidal client in the last year. Despite this reality, another study of about 600 social workers found that close to 80% did not receive formal training on suicide in the master's level program, and just over 40% reported that they did not

take any classes that addressed prevention or intervention (Levine & Sher, 2019; SPRC, 2025). Furthermore, a recent study by the Suicide Prevention Resource Center (SPRC) examined the topic of suicide risk assessment with 500 social workers in the U.S. The study found that 14% reported never receiving training on suicide risk assessment, and 17% reported that they never completed this type of assessment with a client. Additionally, when asked about confidence and ability in conducting a suicide risk assessment, 7% of social workers either disagreed or strongly disagreed with feeling confident in their ability, and 14% noted they felt uncertain (neither confident nor unconfident) in their ability to do this type of assessment.

Since social workers are providing a significant amount of mental health services in the U.S., these study results are concerning. In addition to being skilled in suicide risk assessment, social workers need to consider the legal, ethical, and professional liabilities associated with navigating suicide risk (SPRC, 2025). As stated by the SPRC (2025), “an inadequate response to suicide risk can lead to repercussions for the social worker, such as negligence claims, actions from licensing boards, harm to professional reputation, and damage to the social worker’s sense of professional confidence” (p. 4). All of these considerations highlight the importance of social workers receiving training to help them be prepared to address suicide risk and provide appropriate care to their clients (SPRC, 2025).

Course Summary

This course can help social workers enhance their knowledge and expand their skill set in suicide risk assessment. Participants will learn to identify ethical principles relevant to suicide risk assessment, including the dignity and worth of a person, the importance of human relationships, professional integrity,

competency, autonomy, beneficence, nonmaleficence, duty to protect, and confidentiality. Conducting trauma-informed suicide risk assessments using culturally responsive strategies without causing harm or retraumatization is outlined. Navigating complex ethical dilemmas when assessing and responding to suicide risk and managing countertransference during this process are explored. Participants will learn to apply the ethical principles, including those from the National Association of Social Workers (NASW) Code of Ethics, with evidence-based suicide prevention practices for various populations to make ethically sound, trauma-informed decisions in these high-risk situations. Documenting suicide assessments and ethical decision-making in a clear, defensible, and clinically appropriate manner is also reviewed.

Section 1 Key Terms

Suicide is a “death caused by self-directed injurious behavior with intent to die as a result of the behavior” (NIMH, 2025, para. 2).

A suicide attempt is a “self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in death or injury” (NIMH, 2025, para. 3).

Suicidal ideation means that someone is “thinking about, considering, or planning suicide” (NIMH, 2025, para. 4).

Suicide risk assessment is a “clinical process that integrates patient history, mental status examination, collateral information, and evaluation of acute stressors and protective factors” (Soreff, 2026, para. 1).

Warning signs of suicide are signs that people may show when they are thinking about or planning to attempt suicide (AFSP, n.d.).

Risk factors are “those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological, or social factors in the individual, family, and environment” (U.S. Department of Health and Human Services [HHS], 2001, p. 5). In terms of suicide, risk factors are “characteristics or conditions that increase the chance that a person may try to take their life” (AFSP, n.d., para. 2).

Protective factors are “factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological, or social factors in the individual, family, and environment” (HHS, 2001, p. 5). In terms of suicide, protective factors decrease the chance that a person may try to take their life (AFSP, n.d.).

Suicidality is “a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide” (HHS, 2001, p. 7).

Section 1 Reflection Questions

What clients in your practice are most vulnerable to suicide?

What has been your experience with suicide risk assessment? Are there certain areas of knowledge or skill that you would like to improve?

Section 2: Ethical Principles Relevant to Suicide Risk Assessment

References: 2, 3, 5, 08, 11, 13, 21, 22, 26, 31, 38, 41, 47

Ethical principles are “fundamental guidelines that govern behavior and decision-making, particularly in the fields of social and human sciences. These principles promote honesty, integrity, fairness, and respect for individuals, ensuring that

actions align with moral standards and societal expectations. They serve as a framework for evaluating ethical dilemmas” (United Nations Educational, Scientific, and Cultural Organization, n.d., para. 1).

Ethical principles as well as laws, regulations, and standards for clinical practice apply to social workers who are working with individuals at risk of suicide.

Therefore, social workers need to be aware of all these elements within the jurisdictions in which they practice. Amidst the variety that can accompany these elements, the NASW Code of Ethics provides a framework to guide social workers' clinical practice and professional conduct by establishing overarching principles and setting high standards for practice, regardless of regional differences (SPRC, 2025).

As stated by the SPRC (2025),

“The NASW Code of Ethics provides social workers with a blueprint for ethical practice. By following this blueprint, social workers can take a proactive approach to addressing potential liability risks in suicide risk assessment. Comprehensive suicide risk assessment is an ethical cornerstone of social work practice that reduces professional liability risk and safeguards the lives of individuals at risk for suicide. While all the ethical values and principles outlined in the NASW Code of Ethics have relevance in suicide risk assessment, the principles of Dignity and Worth of the Person, Importance of Human Relationships, Integrity, and Competence are especially pertinent” (p. 5).

The additional ethical principles relevant to suicide risk assessment include autonomy, confidentiality, nonmaleficence, beneficence, and the duty to protect (Alonzo & Gearing, 2018). All these principles are reviewed in this section.

Dignity and Worth of the Person

The social work value of dignity and worth of the person supports the ethical principle that social workers respect each person's inherent dignity and worth (NASW, 2021a). The NASW Code of Ethics states this ethical principle as follows:

“Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients’ socially responsible self-determination. Social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients’ interests and the broader society’s interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession” (NASW, 2021a, para. 21).

This ethical principle underscores the importance of treating each person with respect, empathy, and understanding, and of honoring their individuality. In the context of suicide risk assessment, this means recognizing the worth of every life, valuing each client, and ensuring that each assessment and intervention is person-centered and tailored to each client's unique circumstances and lived experience (SPRC, 2025).

Importance of Human Relationships

The social work value of the importance of human relationships supports the ethical principle that social workers recognize this value (NASW, 2021a). The NASW Code of Ethics states this ethical principle as follows:

“Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as

partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities” (NASW, 2021a, para. 22).

This ethical principle emphasizes the power of connection between people and its transformative potential. In the context of suicide risk assessment, this connection is essential as it can help the person who is at risk feel less alone in their experience. Additionally, when rapport and trust have been established as a part of a therapeutic relationship, a client will likely feel safer to disclose their thoughts, feelings, and concerns related to suicide, which can support a more accurate suicide risk assessment. This ethical principle also highlights the ways that the nature of relationships, not only between a social worker and their client, but between the client and the other people in their life, can either protect or worsen suicide risk (SPRC, 2025). Furthermore, “it is a reminder that addressing suicide risk is not just about understanding an individual’s personal characteristics in isolation but also appreciating the situational and relational factors influencing their well-being” (SPRC, 2025, p. 6).

Integrity

The social work value of integrity supports the ethical principle that social workers behave in a trustworthy manner (NASW, 2021a). The NASW Code of Ethics states this ethical principle as follows:

“Social workers are continually aware of the profession’s mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers should take measures to care for themselves professionally and personally. Social workers act honestly and responsibly

and promote ethical practices on the part of the organizations with which they are affiliated” (NASW, 2021a, para. 23).

At the core of this ethical principle is truthfulness in all aspects of social work practice. Regarding suicide risk, it means being clear and honest with clients about the assessment process, possible interventions, and confidentiality limitations. This honesty is part of building rapport and trust, and ensures that a client is aware of the suicide risk concern and the steps the social worker will take for their well-being.

Integrity includes not only truthfulness but also making decisions that align with ethical guidelines and keeping the client's best interests at the forefront. Additionally, it includes social workers acknowledging their limitations and seeking supervision or consultation, or referring a client to another mental health professional when it is in the client's best interest (SPRC, 2025). Furthermore, integrity “emphasizes the social worker’s commitment to ensuring that every action, decision, and intervention is rooted in honesty, ethical standards, and unwavering dedication to safeguarding the well-being of those at risk” (SPRC, 2025, p. 6).

Competence

The social work value of competence supports the ethical principle that social workers practice within their areas of competence and continue to develop and enhance their expertise throughout their career (NASW, 2021a). The NASW Code of Ethics states this ethical principle as follows:

“Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession” (NASW, 2021a, para. 24).

This ethical principle emphasizes the importance of receiving training to equip oneself with the required skills for practice and of staying informed about the latest research in the field. It encourages social workers to be self-motivated and take the initiative to find workshops, training programs, and certifications that support their competence in the field, including in suicide risk assessment. This is especially important as research has shown that suicide risk assessment is often not taught in graduate programs, and is instead learned on the job and during post-graduation education opportunities (SPRC, 2025).

Autonomy

Autonomy is a “form of personal liberty of action in which the individual determines his or her course of action in accordance with a plan of his or her own choosing” (Shannon & Kockler, 2009, p. 47). It involves making independent decisions that align with an individual’s personal values and goals, instead of being swayed by external factors. Autonomy has been considered a fundamental human need that promotes well-being, motivation, and psychological health because, when experienced, it provides an individual with a sense of psychological freedom, control, and choice (Cherry, 2026).

According to Shannon and Kocher (2009), there are two components to autonomy:

- A person must be able to think through a plan of action, examine alternatives, and distinguish among them.
- A person must also have the capacity to put their plan into action and carry out their decision (p. 47).

One idea that shapes the concept of autonomy is that “all persons have intrinsic and unconditional worth, and therefore, should have the power to make rational

decisions and moral choices, and each should be allowed to exercise his or her capacity for self-determination” (Varkey, 2021, p. 19). Therefore, autonomy honors individualism, affirms that a person is in charge of their own life and decisions, and mandates a strong sense of responsibility (Shannon & Kockler, 2009).

Within the concept of autonomy is self-determination. In the NASW (2021b) Code of Ethics, the ethical standard of self-determination states:

“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” (para. 2).

As stated by Alonzo & Gearing (2018), “autonomy is one of the foremost principles that affect a practitioner’s course of action regarding a suicidal client. The principle of self-determination involves the client’s right to take action rooted in his or her own goals, desires, and wishes” (p. 12). Since suicidality often occurs in people living with mental illness, if a social worker were to grant autonomy to a suicidal client to act on their thoughts and feelings, it is considered by some to be the same as allowing a noncompetent person to make a life-threatening decision. Regardless of whether someone has a mental illness or not, they may still be at risk for suicide based on the social worker’s assessment. According to the NASW Code of Ethics, a social worker has the right to limit their autonomy and self-determination based on the client’s suicide risk (Alonzo & Gearing, 2018).

Autonomy is directly linked to informed consent, which is “having a competent understanding of risks, benefits, and alternatives from which a client can make a decision regarding an appropriate course of action” (Alonzo & Gearing, 2018, p. 12). When walking a client through the process of informed consent, they must recognize the importance of their autonomy as well as knowing its limitations, meaning that if they become suicidal, they could be considered not competent to provide informed consent and make decisions about their own care. This is considered ethically justified to prevent suicide, especially since suicidal behavior is considered one by-product of mental illness (Alonzo & Gearing, 2018).

Beneficence

Beneficence is “the responsibility to act in a way that seeks to provide the greatest benefit” (Bernet & Roberts, 2012, p. 468). It is the ethical principle that focuses on doing the greatest good possible, requiring social workers to strive for and honor their clients' well-being and take actions that give them the greatest benefit. According to Alonzo & Gearing (2018), “beneficence should take precedence over autonomy, as the death of an individual would not generally be considered a ‘good’ act” (p. 13).

Nonmaleficence

On the other hand, nonmaleficence is the ethical principle of doing no harm. Social workers have a legal and ethical obligation to protect their clients from harm, which, in the context of suicidality, requires them to take necessary action to prevent a client from taking their own life. This requirement can lead to feelings of conflict in working with suicidal clients. Since social workers strive to honor autonomy, limiting it can feel paternalistic or intrusive. At the same time, when a

client is suicidal, the social worker is likely justified in limiting a client's autonomy for their overall safety and well-being.

One framework for navigating ethical decision-making in these situations states that paternalism on behalf of a social worker is justified when:

- The harmful consequences of supporting a client's autonomy are irreversible.
- There is an immediate need to rescue the client from harm.
- Placing temporary limitations on the client presents an opportunity for greater freedom rather than focusing solely on their safety.

Suicidal behavior could fall into any of these circumstances; therefore, understanding this framework, as well as a jurisdiction's laws and the profession's ethical responsibilities, can help guide a social worker through the actions they need to take to prevent a client from suicidal impulses, while also feeling justified in doing so.

Duty to Protect

Similar to nonmaleficence is the duty to protect. The duty to protect and the duty to warn are legal concepts that outline a clinician's responsibilities towards their clients and the public.

- "The duty to protect involves safeguarding a patient from self-harm or preventing them from harming others.
- "The duty to warn arises when a mental health professional learns that a patient poses a particular threat of harm to another person. Under this duty, the professional must alert the potential victim or law enforcement to prevent harm" (Geoffroy, 2024, para. 5).

Based on the definitions of these concepts, the duty to protect is most applicable to a social worker in terms of suicide risk assessment. When a social worker enters a therapeutic relationship with a client, they accept certain responsibilities, including protecting the client from harming themselves. However, this duty is open to interpretation, and there is variation in the field about how it is understood (Alonzo & Gearing, 2018). There is also variation in the laws that govern this duty. Some jurisdictions require mandated reporting of suicide risk to law enforcement, while others permit disclosure and leave reporting to the clinician's discretion (National Conference of State Legislatures, 2022).

Confidentiality

Confidentiality is another ethical responsibility that social workers have to their clients. Some of the ethical standards from the NASW Code of Ethics that are particularly important to client suicidality include:

- Social workers should protect confidentiality, except “when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.
- If social workers plan to disclose confidential information, they should (when feasible and to the extent possible) inform clients about the disclosure and the potential consequences prior to disclosing the information. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.
- Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients’ right to confidentiality.

Social workers should review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker–client relationship and as needed throughout the course of the relationship” (NASW, 2021b, para. 31-33).

As noted above, social workers can breach confidentiality when a client poses a danger to themselves, and an ethical conflict may arise over whether the social worker is helping or harming the client by doing so. Considering beneficence and nonmaleficence can help a social worker through this conflict (Alonzo & Gearing, 2018).

Confidentiality and Adolescents

When working with clients aged 18 and under, additional ethical challenges arise regarding confidentiality when safety concerns are present. If a client under age 18 presents with suicidal ideation, the risk assessment must include their caregiver(s).

The American Academy of Pediatrics (AAP) (2023a) recommends that the suicide safety assessment be done between the adolescent patient and the social worker. An AAP policy, “[Unique Needs of the Adolescent](#)” and “[Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents](#),” highlight the need for a confidential, one-on-one visit between an adolescent patient and a social worker as an opportunity to have an open and honest discussion about the adolescent's psychosocial situation, mental health, and suicidal thoughts and behaviors. State law considerations regarding adolescent confidentiality, consent, and documentation must be taken into account (AAP, 2023a; AAP, 2026).

During these conversations, a social worker needs to be mindful of language about suicide and terms that could insinuate stigma or blame. Having these conversations through a trauma-informed lens can provide a supportive environment. Using a non-judgmental tone, asking open-ended questions, actively listening, making eye contact, and using culturally responsive, family-centered language are all a part of trauma-informed patient-centered care. Furthermore, the social worker can consider sharing that the steps they are taking are standard practice, which can normalize the experience for the patient and their family (AAP, 2026).

Before beginning the assessment, the social worker can set expectations for the visit and review confidentiality with the patient and their parent(s)/caregiver(s) together. The social worker needs to share that they will keep anything discussed during the one-on-one visit confidential unless someone's safety is at risk.

Then, the social worker can meet with the patient one-on-one to assess their situation, mental health, and suicide risk. If suicide risk is detected during screening and/or within the assessment, the social worker must notify the patient's parent(s)/caregiver(s). Prior to doing so, the social worker can gently reinforce confidentiality, explain the need to speak with their family after the assessment, and outline what will happen next. The social worker can also ask the patient how they want to be involved in that conversation, including whether the social worker will disclose to the family privately or with the patient in the room, if the patient will disclose to their family privately, or if the patient would like the social worker to be in the room when they talk with their family.

No matter whether the social worker is a part of a conversation or leading it, they need to have the opportunity to speak with the parent(s)/caregiver(s) before the end of the visit. They can offer to meet with the patient and their family together or privately (AAP, 2023a; AAP, 2026).

Section 2 Key Terms

Ethical principles are “fundamental guidelines that govern behavior and decision-making, particularly in the fields of social and human sciences. These principles promote honesty, integrity, fairness, and respect for individuals, ensuring that actions align with moral standards and societal expectations. They serve as a framework for evaluating ethical dilemmas” (United Nations Educational, Scientific, and Cultural Organization, n.d., para. 1).

Autonomy is a “form of personal liberty of action in which the individual determines his or her course of action in accordance with a plan of his or her own choosing” (Shannon & Kockler, 2009, p. 47). There are two components to autonomy: a person must be able to think through a plan of action, examine alternatives, and distinguish among them, and they must also have the capacity to put their plan into action and carry out their decision (Shannon & Kockler, 2009, p. 47).

Beneficence is “the responsibility to act in a way that seeks to provide the greatest benefit” (Bernet & Roberts, 2012, p. 468).

Nonmaleficence is the ethical principle of doing no harm (Alonzo & Gearing, 2018).

Section 3: Trauma-Informed, Culturally Responsive Strategies for Suicide Risk Assessment

References: 2, 10, 17, 22, 24, 25, 34, 37, 40, 43

Trauma-Informed Care

Trauma-informed care focuses on the events clients experience to gain a comprehensive understanding of their situation, past and present. It shifts the question from “what is wrong with you” to “what happened to you and how has it affected you” (Center for Health Care Strategies, n.d.). As stated by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2026), a trauma-informed approach “realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved within the system, and responds by fully integrating knowledge about trauma into policies, procedures, and practices, while seeking to actively resist retraumatization” (para. 2).

Several principles guide trauma-informed approaches that recognize and intentionally respond to the ongoing, adverse effects of trauma, including:

- **Safety** - creating an environment where clients and staff experience feeling physically and psychologically safe.
- **Peer support** - using the lived experience of others to establish safety and hope, build trust, enhance collaboration, and promote recovery and healing.
- **Trustworthiness and transparency** - decisions made on the organizational level consider the importance of building and maintaining trust with clients and staff.

- **Collaboration and mutuality** - power differences between clients and staff are leveled.
- **Empowerment, voice, and choice** - organizations are rooted in the belief that clients can heal, and they promote recovery from trauma (Substance Abuse and Mental Health Services Administration [SAMHSA], 2026).

Trauma-informed care is especially important as it is estimated that 70% of adults in the U.S. have experienced trauma at least once in their lives. Regarding mental health, one estimate states that over 90% of clients have experienced trauma. Trauma is also a risk factor for suicide and is therefore a part of suicide risk assessment (National Council for Behavioral Health, 2022).

Culturally-Responsive Care

According to the National Center for Cultural Competence (n.d.), culture is defined as:

“The learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they “know” about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death” (para. 1).

Each individual has a unique cultural identity, or sense of who they are, shaped by physical, mental, and social traits. Therefore, culturally responsive care is the “intentional and consistent decision mental health care providers make to see, respect, and celebrate the aspects that make each person unique. It is an

acknowledgment of their intersectional existence in the world. How this shapes their experiences” (Mason, n.d., para. 11). Culturally responsive care also “guides mental health providers towards fully seeing and valuing clients for all aspects of their identity, background, and experiences. By helping people feel safe, understood, and accepted, cultural competence makes mental health care more accessible and effective” (Mason, n.d., para. 1).

Cultural competence is one of the ethical standards in the NASW Code of Ethics (NASW, 2021b). Cultural competence is more than awareness; it is having the expertise and skill to provide services that are responsive to a person’s cultural beliefs, practices, and needs (CDC, 2026a). It is putting knowledge into action, which is especially important for social work practice as social workers work with clients from many different walks of life (Mason, n.d.).

In the NASW (2021b) Code of Ethics, the ethical standard of cultural competence (standard 1.05) states the following:

- a. “Social workers should demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- b. Social workers should demonstrate knowledge that guides practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups. Social workers must take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege.
- c. Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction), recognizing clients as experts of their own

culture, committing to lifelong learning, and holding institutions accountable for advancing cultural humility.

- d. Social workers should obtain education about and demonstrate understanding of the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.
- e. Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients' use of and access to electronic technology and seek to prevent such potential barriers. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services" (para. 17-21).

Strategies for Suicide Risk Assessment

The following are some trauma-informed, culturally responsive strategies for suicide risk assessment to avoid harm and retraumatization:

- Going into the assessment with an individualized, client-focused, nonjudgmental approach, with a perspective that a person has likely experienced some type of trauma in their lifetime.
- Approaching the client in a matter-of-fact, supportive manner to build trust, respect, acceptance, and thoughtfulness.
- Presenting with a neutral and open stance to improve the client's engagement in the assessment process and facilitate more honest responses from them.

- Maintaining a calm and confident demeanor. Adjust tone and volume of speech to match the client's level of engagement and comfort.
- Preparing for any type of disclosure by trying not to appear uncomfortable, but rather gracious and understanding.
- Offering a calm, neutral space (as much as possible) that is sensitive to potential environmental triggers. Avoid culturally inappropriate or insensitive items in the space. Respect the client's personal space.
- Developing and maintaining a therapeutic alliance. Providing choice (as appropriate) to allow a person a sense of control. Practicing transparency in communication.
- Providing education and clarifying what the client can expect during the assessment.
- Using open-ended questions and eliciting only the necessary information.
- Observing non-verbal cues for signs of distress. Acknowledging when assessment questions may be difficult or uncomfortable to answer.
- Using plain, direct, compassionate language.
- Observing trauma manifestations and responses, including difficulty identifying and regulating emotions such as anger, fear, sadness, or shame; avoidance; isolation; cognitive issues such as intrusive thoughts or memories, idealization, and hallucinations or delusions; flashbacks; disassociation; self-medicating behaviors; disordered eating; compulsive and/or impulsive behaviors; sleep disturbances; seeing or talking about things in extremes; hypervigilance and heightened startle response; numbness and detachment; and physiological complaints.

- Allowing the client time after the assessment to become calm and reoriented to the present time and place, especially if they have intense emotional responses during the assessment.
- Providing feedback on the assessment, avoiding complicated language and explanations. Allowing the client time to process the feedback, ask questions, and discuss next steps.
- Knowing the client's culture and cultural customs, and their impact on their life.
- Understanding different types of trauma, what is currently prevalent in a client's life and within their community, and the historical trauma that they may have faced (e.g., racism and other forms of discrimination)
- Being informed and seeking training on trauma-informed, culturally responsive care, and implementing the skills and knowledge learned.
- Practicing self-awareness in terms of your own experiences and biases that may influence interactions with a client (Alonzo & Gearing, 2018; SAMHSA, 2014; The University of Texas at Austin, Center for Health Communication, 2025).

Section 3 Key Terms

Trauma-informed care focuses on the events clients experience to gain a comprehensive understanding of their situation, past and present. It shifts the question from “what is wrong with you” to “what happened to you and how has it affected you” (Center for Health Care Strategies, n.d.).

A trauma-informed approach “realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of

trauma in clients, families, staff, and others involved within the system, and responds by fully integrating knowledge about trauma into policies, procedures, and practices, while seeking to actively resist retraumatization” (SAMHSA, 2026, para. 2).

Culturally responsive care is the “intentional and consistent decision mental health care providers make to see, respect, and celebrate the aspects that make each person unique. It is an acknowledgment of their intersectional existence in the world. How this shapes their experiences” (Mason, n.d., para. 11). Culturally responsive care also “guides mental health providers towards fully seeing and valuing clients for all aspects of their identity, background, and experiences. By helping people feel safe, understood, and accepted, cultural competence makes mental health care more accessible and effective” (Mason, n.d., para. 1).

Section 3 Reflection Questions

Are there certain trauma-informed, culturally responsive approaches that you have found to be most beneficial when conducting a suicide risk assessment? Which ones do you find challenging to implement (if any)?

Section 4: Navigating Ethical Dilemmas in Suicide Risk Assessment

References: 1, 2, 7, 9, 15, 19, 20, 22, 29, 30, 35

Formulating risk and determining the appropriate interventions for a client based on a suicide assessment requires considering many different pieces of information at once and being able to critically think about them, including the client’s responses to a screening tool and verbal information shared during the assessment. It also includes navigating jurisdictional laws and professional ethics.

A social worker must use their clinical judgment alongside the information that they have learned during the assessment to determine a client's suicide risk. It is also beneficial if they are informed about recent evidence-based practices in their clinical area to complement their risk assessment and decision-making (Alonzo & Gearing, 2018).

Two common responses exist when clinicians are assessing for suicide and determining the client's risk level. First, suicide risk can be overestimated due to the fear of losing a client to suicide and worry about malpractice claims. Second, suicide risk may be inadequately assessed and underestimated due to a lack of training (Aspen Grove Behavioral Hospital, 2024).

Various frameworks have been proposed to help clinicians determine risk level and appropriate interventions. Two frameworks are reviewed in this section. In addition, screening tools such as the C-SSRS and the ASQ can help social workers formulate suicide risk, with clinical judgment superseding assessments made with these tools (Pal & Ramanathan, 2023).

As stated by Pal & Ramanathan (2023),

“The complexity with diagnoses spills into management of the suicidal patient, which is further complicated by the many ethical issues that need to be balanced to provide appropriate care in the least restrictive manner. In some situations, appropriate management is very clear when individuals have clear suicidal intent and behaviors. However, in other instances, the decision may not be well defined...One challenge of managing patients with suicidality arises from conflicts between the best interests of the patients (beneficence and nonmaleficence) and the rights of patients to make decisions about their own bodies (autonomy), their rights to make choices about the care that they receive, matters of confidentiality, and involving other clinicians and agents in their care. Clinicians often struggle with

determining when the risk of suicide is imminent enough to override the principles of autonomy, privacy, justice, and confidentiality in favor of beneficence and nonmaleficence” (p. 173).

SAMHSA developed the following framework to help mental health professionals, including social workers, determine a client’s risk level and appropriate interventions.

Risk Level	Risk/Protective Factor	Suicidality	Possible Interventions
Low	Modifiable/ manageable risk factors and strong protective factors	Thoughts of death, but no plan, intent, or behavior	Outpatient referral with a warm handoff for symptom reduction. Provide a crisis phone number.
Moderate	Multiple risk factors and a few protective factors Displays some elevated behavioral health symptoms	Suicidal ideation with a plan, but no intent or behavior	May need to be admitted based on risk factors. If not admitted, develop a crisis plan. Provide a crisis phone number.

High	Psychiatric diagnosis with severe symptoms or an acute precipitating event. Protective factors are not relevant in this situation.	Suicidal ideation with a plan, method, and intent to carry out the plan	Admission is generally indicated unless there is a significant change that reduces risk. Implement suicide precautions.
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(SAMHSA, 2024)

Another framework for formulating suicide risk is the Therapeutic Risk Management - Risk Stratification Table developed by the Rocky Mountain Mental Illness Research, Education, and Clinical Center for Suicide Prevention. This framework can help mental health professionals, including social workers, determine a client's level of risk (low, intermediate, and high), both acutely and chronically.

Acute and Chronic Therapeutic Risk Management

High Acute Risk - Core features include: • Suicidal ideation with intent to die by suicide AND • Inability to maintain safety independently without help or support from others A client in this category has a suicide plan and can access lethal means. Any mental health conditions and/or psychosocial stressors may also be exacerbated. The client may have also engaged in self-directed violent behavior, such as a suicide attempt and preparation (e.g., rehearsing the plan).	High Acute Risk - Actions include: • Psychiatric hospitalization is likely (whether voluntary or involuntary) to maintain safety and address modifiable risk factors • Direct observation on a secure unit with limited access to lethal means to support safety. • Co-occurring mental health symptoms should also be addressed.
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Intermediate Acute Risk - Core features include:

- Suicidal ideation AND
- Ability to maintain safety independent of outside support or help

A client in this category may present similarly to someone at high acute risk. The only difference could be the lack of intent, given that the client is unable to identify a reason for living, comply with a safety plan, or ensure their own safety. Preparatory behaviors are likely to be absent.

Intermediate Acute Risk - Actions include:

- Considering psychiatric hospitalization if risk factors are responsive to inpatient treatment (e.g., acute psychosis)
- Outpatient management that includes frequent contact with the client, re-assessment of risk, developing or updating a safety plan, and lethal means counseling.
- Outpatient care should also address risk factors that elevate risk (e.g., mental health symptoms, financial stress).

Low Acute Risk - Core features include:

- Possible suicidal ideation, but no current intent AND
- No specific and current plan AND
- No recent preparatory behaviors AND
- Collective confidence from the client, family member, and social worker) in the client's ability to maintain safety independently.

A client in this category may have suicidal ideation, but there is minimal or no intent or a specific plan. If there is a plan, it is general and/or vague, and no preparatory behaviors have occurred. A client in this situation can likely engage in appropriate coping strategies and is willing to use their safety plan during a crisis.

Low Acute Risk - Actions include:

- Mitigating chronic risk by enhancing protective factors and reducing modifiable risk factors.
- Proactively working on suicide prevention, health promotion interventions, and putting resources in place (e.g., housing, financial).
- Considering outpatient mental health treatment, especially if suicidal ideation is present and it is occurring with psychiatric symptoms.
- Risk should be reassessed based on a social worker's clinical judgment.

High Chronic Risk - Risk factors include:

- Chronic mental health conditions
- Chronic pain or other medical condition
- Chronic suicidal ideation
- History of prior suicide attempt(s)
- History of substance use disorder
- Limited ability to identify their purpose and reasons for living
- Limited coping skills
- Unstable psychosocial status (e.g., financial issues, unstable housing, intermittent employment, erratic relationships)

A client in this category is at chronic risk for becoming actively suicidal, often when psychosocial stressors occur.

High Chronic Risk - Actions include:

- Providing ongoing, routine mental health follow-up
- Developing a thorough safety plan and providing lethal means counseling
- Completing routine suicide risk assessments
- Building coping skills
- Managing co-occurring psychiatric symptoms

Intermediate Chronic Risk - Core features include: • Having similar risk factors to people at high chronic risk, except there is a balance with protective factors, positive coping skills, reasons for living/purpose, and psychosocial stability, which enhances a client's ability to deal with future crises without self-directed violence.	Intermediate Chronic Risk - Actions include: • Providing routine mental health care to optimize any psychiatric conditions while maintaining/enhancing coping skills and protective factors. • Developing a thorough safety plan and providing lethal means counseling. • Managing co-occurring psychiatric symptoms
Low Chronic Risk - Core features include: • A range of people with limited or no mental health or substance use issues to people with significant mental illness, but who have many strengths and resources. • Psychosocial stressors have been managed without suicidal ideation emerging. • Does not typically have a history of self-directed violence, chronic suicidal ideation, a tendency to be highly impulsive or engage in risky behaviors, and can function from a psychosocial perspective.	Low Chronic Risk - Actions include: • Appropriate mental health care as needed, with some clients being managed in a primary care setting • Others may require ongoing mental health follow-up to continue treatment.

(Rocky Mountain Mental Illness Research, Education, and Clinical Center for Suicide Prevention, 2024)

Ethical Dilemmas

An ethical dilemma can occur when two or more professional ethics conflict. One of the greatest challenges in managing clients with suicidality happens when there is conflict between the best interests of the client (beneficence and nonmaleficence) and the rights that clients have to make their own decisions about their body (autonomy), make choices about their care, matters of confidentiality, and involving other people in their care, such as support people and other clinicians (Pal & Ramanathan, 2023). As stated by Pal & Ramanathan (2023), “clinicians often struggle with determining when the risk of suicide is imminent enough to override the principles of autonomy, privacy, and confidentiality in favor of beneficence and nonmaleficence” (p. 173). However, one can consider that the ethical principles of Dignity and Worth of the Person, Importance of Human Relationships, Integrity, and Competence are more straightforward and consistent across situations.

Beneficence & Nonmaleficence

As noted above, beneficence is the ethical principle that focuses on doing the greatest good possible, requiring social workers to strive for and honor their clients' well-being and take actions that give them the greatest benefit. In terms of a client's suicide risk, it is important to consider beneficence as a priority over autonomy. In certain situations, such as a person being at high acute risk of suicide and refusing hospitalization, prioritizing their autonomy over beneficence can be considered as not acting in the client's best interest.

Similarly, with nonmaleficence, social workers have a legal and ethical obligation to protect their clients from harm, which, in the context of suicidality, requires them to take necessary action to prevent a client from taking their own life (an irreversible act). This can also mean that a social worker prioritizes doing no harm over a client's autonomy, promoting the client's overall safety and well-being.

Autonomy

According to the NASW (2021b) Code of Ethics, a social worker has the right to limit their client's autonomy and self-determination when, in the social worker's professional judgment, the client's actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others. Suicide is considered a risk that falls within this category, meaning that a social worker can take actions that do not honor a client's autonomy when they are at moderate (in some cases) or high risk of suicide and are making decisions not to receive the care that they need.

Privacy and Confidentiality

As with autonomy, confidentiality can be limited in certain situations. The NASW (2021b) Code of Ethics states social workers should protect confidentiality, except "when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others" (para. 31). The NASW (2021b) Code of Ethics also states "in all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed" (para. 31).

After a suicide risk assessment, if a social worker determines that a client requires urgent intervention (e.g, they fall into the high-risk categories or, in some instances, the moderate categories outlined above), immediate action must be

taken. This action could include encouraging the client to voluntarily agree to a psychological evaluation or admission to a treatment facility. If the client does not voluntarily collaborate, the social worker must consider breaching confidentiality and contacting 911 to arrange for the client's safe transport to a facility. Some instances may require filing a petition to conduct a psychiatric evaluation or initiating a petition for involuntary hospitalization (Monahan, 2026).

Confidentiality and the Duty to Protect

As stated by Boyles (2026), “many duty-to-protect statutes focus on threats to others. For self-directed violence, your authority to involve family or authorities typically comes from HIPAA’s ‘serious and imminent threat’ provision and your general standard of care (e.g., arranging hospitalization). Under HIPAA, you may disclose protected health information (PHI) in good faith to people who can lessen the threat (including family or police), sharing only the minimum necessary. State law still governs what is required vs. permitted” (para. 25).

Therefore, when considering the duty to protect and when to break confidentiality, social workers must be informed about the laws in their state, including those set by their professional licensing board, as they navigate the ethical responsibilities and laws related to the duty to protect (Boyles, 2026).

Managing Countertransference

According to Keenan (2024), “countertransference refers to the emotional reactions that a mental health therapist experiences in response to their patients. These emotions can vary widely, encompassing both positive feelings, such as affection or protectiveness, and negative feelings, like anger or dislike. Although all therapists experience countertransference, acting on these feelings is considered unethical and can interfere with effective treatment” (para. 1).

A systematic review of literature on countertransference towards suicidal patients in the healthcare setting found that they often elicit a variety of emotions for clinicians, from disinterest, anger, anxiety, confusion, overwhelm, helplessness, or distress, to engagement and fulfillment. These findings suggest mostly adverse suicide-related countertransference. Research also found that current suicidality, rather than past suicidality, influenced countertransference and strengthened it (Michaud et al., 2023).

Therefore, when working with suicidal patients, it is important to consider ways to manage it, including:

- Having an awareness of countertransference by engaging in self-reflection about the different feelings that clients elicit during sessions. These feelings can be explored in supervision or by a social worker seeking therapy. When engaging in self-reflection, the social worker will have the opportunity to understand themselves and their reactions better.
- Fostering emotional regulation skills, such as mindfulness meditation, can also help reduce countertransference reactions.
- Using grounding techniques and cognitive strategies to help manage these reactions and create space from them, so that they do not translate into behaviors towards a client.
- Understanding appropriate boundaries and self-disclosure. These topics can also be explored in supervision (Abrams, 2025).

Section 4 Key Terms

Countertransference “refers to the emotional reactions that a mental health therapist experiences in response to their patients. These emotions can vary widely, encompassing both positive feelings, such as affection or protectiveness,

and negative feelings, like anger or dislike. Although all therapists experience countertransference, acting on these feelings is considered unethical and can interfere with effective treatment” (Keenan, 2024, para. 1).

Section 4 Reflection Question

Think of a time when you navigated an ethical dilemma related to suicide risk. What was your decision-making process, and how did you resolve it?

Section 5: Documentation

References: 9, 12, 35, 38

According to the SPRC (2025), “good clinical documentation following a suicide risk assessment is a critical part of providing high-quality care and mitigating liability risks” (p. 14). After the assessment and interventions are complete, documentation follows and should include the following components:

- Type of contact (in-person, phone, or telehealth)
- Screening tools that were used and the results
- Explanation of informed consent and confidentiality
- Formulation of risk level (as outlined in the tables above) and rationale (why the risk level is low/moderate/high today)
 - For example, if a client denied suicidal ideation and their risk is low, the documentation should include that the social worker assessed the client’s suicide risk, the client’s response should be noted, and the rationale for the social worker determining the client’s risk should be explained.

- ◆ It is important to include patient statements and direct quotes when they are relevant.
- Treatment plan (including past and current) to address and reduce the current risk, which can include:
 - Safety planning
 - Lethal means counseling and reducing access
 - Medication
 - Psychotherapy
 - Contacting law enforcement and arranging an ED evaluation
 - Contact with supportive people in the client's life
 - Consultation
- Follow-up plan
- Collaboration, such as care coordination, and any details of disclosures that were made in good faith, to whom (Boyles, 2026; Crowe, 2016; SAMHSA, 2024).

Note: At the time this course was written, the NASW published the first draft of the [Standards of Care for Suicide Prevention](#) and made them open for public comment in [March 2026](#). Stay connected with NASW for future updated information.

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