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NASW Standards of Care for Suicide Prevention

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INTRODUCTION

Suicide is a major social, mental, and public health challenge. Suicide-related data fluctuate over time, reflecting changes in populations and in the prevalence of risk and protective factors. Risk factors are traits, circumstances, or other variables associated with an increased likelihood of suicidal behavior, while protective factors (personal, relational, community-based, or structural) strengthen resilience and buffer against risk.

Given the breadth and ubiquitous nature of suicide across all systems and settings, *all* social workers must recognize and educate themselves about their crucial role in suicide prevention, intervention, and postvention. Social workers have an ethical responsibility to stay informed about emerging trends, rely on credible and regularly updated data sources, and understand their role in prevention, intervention, and postvention. Staying current supports evidence-informed practice; effective advocacy; and culturally responsive care for individuals, families, and communities. While organizational, tribal, state, and federal regulations may shape aspects of practice, social workers must remain grounded in the core values of the profession and uphold their obligation to address suicide in any setting. As a result, all social workers, across micro, mezzo, and macro practice, are expected to possess a minimum level of competency, knowledge, and skills related to suicide. The Resources section of these standards provides recommended data sources.

Standards of care for suicide outline the minimum level of service that social workers must provide to anyone at potential suicide risk. These standards should be applied within the context of social work's foundational values of the importance of human relationships, empathy, and the person-in-environment perspective. Social workers draw on these values, as well as their

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knowledge of and skills in engaging support systems, to guide compassionate, strengths-based screening, assessment, and intervention. A strengths-based approach identifies not only suicide risk factors but also the internal and external protective factors that can provide buffers against risk. When social workers meet established standards of care, they deliver best practice services, and also reduce the likelihood of malpractice liability.

Language of Suicide

Language is important in the field of suicidology. Given that the language used to address suicide and suicidal behaviors continues to evolve, social workers must keep abreast of current, objectively focused language that avoids stigma or judgment in both practice settings and documentation. This text uses the current terminology recommended for discussion of suicide that is precise, person-centered, nonstigmatizing, and reflects respect and compassion for individuals experiencing suicidal thoughts or behaviors, as well as for those bereaved by suicide.

Relevant definitions for the language around suicide, which are also included in the glossary, include the following:

- **Suicide** is the intentional ending of one's life.
- A **suicide attempt** is any nonfatal, potentially injurious behavior with intent to die as a result of that act.
- **Suicidal ideation** refers to thoughts of ending one's life.
- N**onsuicidal self-injury (NSSI)** describes deliberate, direct tissue damage without intent to die.

When talking or writing about suicide, there are preferred and problematic phrases, as outlined in Table 1. Here is some additional information on suicide-related terminology:

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- **Suicide contagion** may occur when the exposure to suicide or suicidal behavior of one or more people influences others, directly or indirectly, to attempt suicide (see Glossary for more information).
- **Suicide clusters** occur when a group of suicides, suicide attempts, or self-harm events occur closer together in time and space than would be expected in a given community (Niedzwiedz et al., 2014); may be due to suicide contagion (Abrutyn et al., 2019).
- **Copycat suicide** is used to reflect social imitation (Gualtieri et al., 2024). However, use of this term should be limited since it can dismiss the seriousness of the suicidal behavior, especially with youth.
- **Medical assistance in dying (MAID)** replaces the terminology of "physician assisted suicide" (See National Association of Social Workers [NASW], 2026, for a more detailed explanation).

Table 1: Suicide Language

Say This	***Instead of This***	***Reasoning***
Died by suicide; took their own life	Committed/completed suicide	"Committed'' is used in the vernacular to describe crimes or sins and connotes stigma. "Completed" can confer a sense of accomplishment
Died by suicide/suicide death	Successful attempt	"Successful" implies an accomplishment
Suicide attempt	Unsuccessful attempt	"Unsuccessful" connotes failure

Person living with thoughts of suicide	Suicide ideator or attempter	Dehumanizing because it equates the problem (suicide) with the person's identity
[Describe the behavior]	Manipulative, cry for help, or suicidal gesture	These are judgmental observations
Working with someone in crisis	Dealing with suicidal crisis	"Working with" implies collaborative effort, "dealing with" sounds dismissive
Disclosed suicidal thoughts	Threatened suicide	Judgmental and can minimize personal distress

Note: Adapted from *Suicide Language* (n.d.), Suicide Prevention Alliance, https://www.suicidepreventionalliance.org/about-suicide/suicide-language/.

Principles of Standards of Care for Suicide

Social workers in all settings, whether clinical or nonclinical, and across micro, mezzo, or macro levels of practice, play essential roles in suicide prevention.

- **Micro-level practitioners** directly interact with individuals at risk for suicide and are responsible for identifying and addressing their needs through evidence-informed, compassionate, person-in-environment care.
- **Mezzo-level practitioners** support suicide-related practices through work with families, schools, organizations, and communities, shaping the environments that can reduce or exacerbate risk.

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- **Macro-level practitioners** influence population-level suicide risk by shaping policies, legislation, funding, systems design, program evaluation, and public health strategies that affect groups and communities.

These standards address prevention and intervention. Postvention refers to postsuicide responses to address grief and loss and prevent additional suicide deaths. Although postvention is temporally and conceptually related to suicide prevention, assessment, and intervention, addressing grief, loss, bereavement, traumatic stress, posttraumatic growth, suicide contagion, and other issues requires a different set of standards than those outlined in this document. These standards of care for suicide will allow social workers to establish and fortify their role in the discussion of suicide prevention and intervention through the lens and application of social work values.

Goals of the Standards of Care for Individuals at Risk of Suicide

These standards of care for suicide are intended to enhance social workers' awareness of the skills, knowledge, values, and sensitivities required to work with clients who are at risk for suicide or who are experiencing suicidal thoughts or behaviors, and to guide social work practice in prevention and intervention. They reflect social work's commitment to delivering culturally responsive care to individuals, families, couples, groups, communities, tribal communities, and social systems, while upholding client self–determination in treatment and care planning.

Depending on relevant factors like culture, resource allocation, or organizational or institutional protocols, these standards may be adapted differently. Regardless of variation in implementation, the goal is to improve social work practice and reduce suicide deaths. Adherence to these evidence-informed standards may also reduce legal liability if a death occurs.

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Specific goals of these standards are:

- Ensure that social work practice in any setting, whether micro, mezzo, or macro, is guided by the NASW (2021) *Code of Ethics*.
- Enhance the quality of social work services provided to individuals, families, and communities that are impacted by suicide.
- Review basic social work skills that are essential to evidence-informed and best practice suicide assessment.
- Establish professional expectations and guidelines to assist social workers in monitoring and evaluating their own competencies and practices related to suicide risk assessment and identifying opportunities for continuing professional development.
- Outline a framework for social workers for providing responsible and ethically sound professional behavior that incorporates standards of care for suicide that may improve client outcomes and reduce risk for malpractice liability.
- Provide a basis for social work curriculum and the development of continuing education materials and programs related to suicide prevention and intervention.
- Inform consumers, government regulatory bodies, social work licensing and accreditation systems, and others about social work professional standards and the essential role of social workers in suicide prevention and intervention.

Difference between Standards of Care and Best Practice Guidelines

While this document establishes professional standards of care for social workers across all practice settings when providing services to individuals at risk of suicide, it is important to understand what this document does not provide. Standards of care educate about evidence-

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based and evidence-informed strategies that support clinical judgment. As outlined in this document, the standards of care for suicide provide the minimum level of expected knowledge and services to be provided by all social workers, regardless of setting, level of education, or licensure. They refer to a set of requirements for social work practice that can be legally enforceable and considered in determination of malpractice liability. Adhering to these standards of care can encourage the implementation of best practice strategies that result in improved care and have the potential to reduce risk of legal liability.

The standards differ from best practice or clinical guidelines, which allow for more flexible professional judgement and choice of intervention strategies used to meet the standard (Callahan, 1996; Knapp, 2024). Best practice guidelines provide recommendations on how to implement the standards through the provision of optimal care based on the latest research and evidence base (Callahan, 1996; Knapp, 2024). Best practice or clinical guidelines may vary by setting, geographical region, profession, and level of provider education and are less likely to be adopted consistently (Zonana, 2008).

A national standard of care for suicide risk applicable to all clinicians and professional practices was established by the National Action Alliance for Suicide Prevention (NAASP, 2018). NAASP is a public-private partnership charged with championing suicide prevention as a national priority. The six steps specified in this standard of care include

1. Initial screening
2. Formal assessment as indicated
3. Development of a collaborative safety plan
4. Counseling about access to lethal means
5. Documentation of care plan

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6. Follow-up

This text incorporates these national standards (Standard 3: Specialized Practice Standards) and provides an interpretation of each standard through the lens of social work values and ethics. There is an expectation that all social workers and social work organizations will be educated about the standards of care for suicide and seek education and training on their implementation.

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STANDARDS

1. ETHICS AND VALUES

Social workers must adhere to the values and ethics of the profession utilizing the NASW (2021) *Code of Ethics* when interacting with clients who are at risk for or currently experiencing suicidal thoughts or behaviors.

Interpretation

Service

Social workers are called on to use their training, skills, and knowledge to address social problems and provide ethically informed service to people in need. Given the extent of suicide across the lifespan and the many individual and social determinants that contribute to risk, clients in both generalist and clinical settings may experience suicidal thoughts and behaviors. Because social work prioritizes service to others and places clients' needs above self-interest, social workers must examine their personal attitudes and values about suicide (Rudd et al., 2008; Suicide Prevention Resource Center [SPRC], 2006). Being aware of one's views, biases, and values facilitates the introspection that is needed for providing responses to clients at risk of suicide that prioritize their needs and values.

Social Justice

Another requirement for social workers is to improve the lives of others by challenging social injustices. Social workers' social change efforts are focused primarily on issues of poverty, respect for social and ethnic diversity, and addressing forms of injustice—including the stigma associated with suicide. To honor the value of social justice, social workers must recognize suicide risk among populations that experience not only mental health challenges but also social determinants of health that are harmful. These include individuals who are vulnerable due to

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discrimination, oppression, housing insecurity, food insecurity, unemployment, and limited or no access to healthcare and education. Social workers must also consider populations that are at higher risk for suicide such as LGBTQIA+ individuals; military-affiliated and veteran populations, American Indian, Alaska Native, and Native Hawaiian individuals; and older adults (75 years and over) whose needs may be complicated by intergenerational trauma, social inequities, and intersecting identities. Social workers have opportunities for suicide prevention activities beyond the micro-level responses by embracing mezzo- and macro-level interventions and reforms and by advocating for improved awareness, knowledge, and approaches to suicide prevention for individuals, families, and communities.

Dignity and Worth of the Person

Social workers must also give every individual client the respect and decency they deserve as a human being. This value is reflected in respect for the client's autonomy and self-determination. When working with a person at higher risk for suicide or someone who is experiencing a suicide crisis, it is imperative that the social worker does not quickly assume the need for restrictive treatment options such as hospitalization, which may be driven by the practitioner's personal fear of providing suicide prevention interventions. When hospitalization is the optimal course of action to ensure client safety, the social worker should address possible client reluctance by carefully explaining the reasoning for this course of treatment. In some jurisdictions, clients may have legal access to MAID as part of end-of-life care. A client's interest in medical assistance in dying can present as a challenge to the values of dignity and personal worth. However, because MAID is legally and ethically distinct from suicide, MAID-related decisions fall outside the scope of these standards. Social workers should follow applicable laws and refer to NASW's

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recently updated *Practice Standards for Serious Illness Care: Hospice and Palliative Social Work* for guidance (NASW, 2026).

Importance of Human Relationships

Another focus for social workers is to build relationships with individuals and the community they are part of and to provide support and healing in the wake of societal, interpersonal, and economic hardships. Relationships are a core vehicle for change (NASW, 2021). The ability to build rapport and engage clients empathically is a fundamental social work skill that enables a trusting and meaningful connection with a client while maintaining professional boundaries. This connection creates the space for the client narrative and the assessment narrative to emerge.

Social work recognizes that interpersonal relationships and support system engagement can either exacerbate suicide risk or strengthen protective factors. For example, clients who report isolation or a lack of formal or informal supports may experience increased suicide risk and would benefit from connections to self-help groups or community resources such as faith-based organizations. Relationships are also central to collaborative safety planning and follow-up.

In tribal contexts, relationships may extend beyond the individual and family to include connections with ancestors, future generations, culture, the natural world, and the community as a whole. Among other populations, social workers should consider the importance of chosen family, especially among LGBTQIA+ clients. When combined with a standardized assessment instrument, engagement with the client's support system is essential to developing an effective suicide risk intervention strategy.

Many social workers find the professional and emotional demands of working with clients who experience suicidal thoughts or behaviors as challenging and fear inducing.

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Therefore, all social workers, regardless of education level or practice setting, need support from trusted colleagues and, when applicable, their employers. Supervision and consultation are critical components of effective practice with clients at risk for suicide and reflects social work's collaborative and interdisciplinary foundation. If a social worker does not have access to an appropriate supervisor or colleagues for consultation, it is imperative that they seek support from their organization or administration.

Integrity

An important goal for social workers is to build trust in relationships with clients by adhering to a strong set of moral and ethical principles, being honest and transparent in all interactions, and consistently acting in the best interests of the client and the profession. Social workers fulfill the core value of integrity before, during, and after their interactions with clients at risk for suicide or who experience suicidal thoughts or behaviors. Integrity begins with understanding and seeking out the skill set required to effectively intervene with a client experiencing suicidal ideation or behavior. It continues in interaction with the client through the process of informed consent regarding expectations and boundaries of interactions and interventions, including discussions of confidentiality and implementation of safety strategies. Finally, it continues in follow-up contacts related to treatment recommendations and in the process of documentation, which serves as a record describing the integrity and ethical nature of all practice decisions.

Competence

Social workers should also apply their knowledge and skills to effectively support the well-being of the community and its commitment to social justice, and to know when and how to apply ethics and advocacy for social change. Acknowledging one's personal values and attitudes about suicide is the first step toward professional competence (SPRC, 2006). Competence then requires

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training and ongoing enhancement of suicide-related knowledge and skills necessary for prevention and intervention. These standards outline the minimum level of competence that all social workers must possess regardless of degree, specialization, or setting.

Competent social workers understand the risks of overestimating or underestimating a client's suicide risk, either of which may compromise the client's rights and safety or increase provider liability. Consistent with the NASW (2021) *Code of Ethics*, which states that "social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience" (1.03a), social workers must commit to continuing professional development, especially in field suicide prevention. Social workers should utilize additional training, education, supervision, and consultation to improve their knowledge and competence in suicide prevention, intervention, and postvention, both overall and with special populations.

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2. SUICIDE-RELATED KNOWLEDGE

Social workers should maintain currency in their knowledge of suicide-related statistics, epidemiology, risk factors, protective factors, screening and assessment resources, safety planning, referral resources, and, if relevant—based on their licensing—intervention and treatment strategies. All social workers shall be knowledgeable about suicide-related resources and community services and make appropriate referrals as needed. Social workers in administrative or leadership roles should be aware of safe messaging guidelines (best practices for communication about suicide) as well as variables associated with the risk of suicide contagion and the components of postvention strategies.

Interpretation

While most undergraduate and graduate social work programs and state licensing boards currently do not require education in suicide prevention, intervention, or postvention, these standards encourage social workers to receive and maintain current knowledge on all these topics by attending trainings and being aware of new developments in the field (see the Resources section for more information).

Specific Knowledge of Screening, Assessment, and Intervention Strategies

There are currently a variety of evidence-based screening, assessment, and intervention strategies for suicide prevention and many hospital and clinical settings have these tools embedded in their protocols and electronic health records. There is also a selection of brief interventions and therapeutic treatment models that have evidence of effectiveness with clients at risk for or currently experiencing suicidal thoughts or behaviors. The Suicide Prevention Resource Center (SPRC; n.d.-a) has an updated list of treatment models in their Best Practices Registry.

There are, however, some limitations in these tools that social workers should consider. First, most standardized screening tools fail to include social determinants or systemic risks. Second, the effectiveness of intervention strategies may be compromised because many of them were piloted in White, middle-class populations. Cultural, linguistic, and developmental adaptations may be necessary to fully capture risk or protective factors relevant to specialized populations such as American Indian or Alaska Native populations and children or youth. Practitioners should consider supplementing standardized measures with narrative assessment, community consultation, and culturally congruent approaches that recognize relationships, spirituality, and cultural strengths of the community.

Use of Resources and Referral

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Maintaining continuity of care requires social workers to ensure that clients receive optimal psychosocial services, advocacy, collaboration, and coordination with appropriate resources. Sometimes this may necessitate a referral to other services which is why knowledge of local, state, and national suicide-related resources is essential. The social worker must maintain collaborative contacts with other social workers or relevant professionals and know how to make appropriate referrals that include clear protocols for documentation and follow-up assessment of referral efficacy. Given that suicidal urges can fluctuate over time, clients who are currently stable but demonstrate risk factors for suicide should be provided with suicide resources as part of a safety plan, empowering them to take proactive steps if those feelings resurface.

3. SPECIALIZED PRACTICE STANDARDS

Six standards of care for suicide screening and assessment have been promulgated for use by all clinical and professional practices by NAASP (2018). These standards recognize these steps as feasible and practical actions that can be applied in both clinical and generalist social work settings, especially when they are integrated with social work values, ethics, and skills. As espoused by NASW, these steps incorporate the person-in-environment perspective, which is more comprehensive and inclusive than the more typical, individual-focused medical model interpretation of care. Standard 3 comprises successive actions that social workers engage in to identify and respond to potential suicide risk.

The following outlines the six NAASP standards of care for suicide incorporating social work values and ethics.

3.1. Initial Screening

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Social workers must ask all clients initially about thoughts of suicide (e.g., killing themselves, wish to be dead).

Interpretation

Screening for suicide is a brief, initial check to determine if a client might be at risk for suicide. It was adapted from public health approaches in physical health promotion to identify individuals who may need further assessment, support, and interventions or treatment. Initial screening is warranted in all social work settings, whether generalist or clinical, independent of whether a client is demonstrating signs of suicide risk. Broaching the topic provides clients who may be reluctant to bring up their personal concerns about discussing suicidality with permission to address the subject.

To ask *all* clients directly through a standardized screening instrument or in narrative questioning if they are experiencing thoughts of suicide or killing themselves is the fundamental approach. For example, a social worker can add the following question to their repertoire of questions: “Have things in your life ever been so bad that you thought about taking your life?” (Underwood et al., 2018). Approaching the question about suicidality from the perspective of “taking your life” can open the door to conversation with a client who is personally struggling with acknowledging that they are thinking about suicide. Starting the conversation with a question about “wishing you did not wake up” has also been suggested as a way to ease into the conversation. If this approach is used and the response is affirmative or if there is hesitation, it is imperative that the question be followed by more direct questions about specific thoughts of killing oneself.

Standardized Screening Instruments

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There are multiple standardized suicide screening instruments that are used in social work. Some of these are the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011), Ask Suicide Screening Questions (ASQ; Horowitz et al., 2012), the Patient Health Questionnaire–9 (PHQ-9; Kroenke et al., 1999; and the Patient Health Questionnaire modified for Adolescents (Johnson et al., 2002). These tools are publicly accessible, and free training in their use is available online and should be completed prior to usage (see Resources). Some of these measures have been tested with special populations and have adaptations available. A measure that incorporates the sociocultural determinants of risk is the Culturally Responsive Assessment of Suicide (CARS; Chu et al,. 2013, Molock et al., 2023) and it can be easily integrated into a suicide assessment intervention.

Dynamic Nature of Suicidality and Risk Stratification

Some screening measures introduce risk stratification (i.e., low, medium, and high), which can provide a false sense of security for the provider or organization if the client identifies as low risk (Large et al., 2016, Large et al., 2017). Insurance and organizational policy may require the use and documentation of risk stratification but given the dynamic state of suicide (Kleiman et al., 2017), a client may screen as low risk at one point in time and then escalate in risk outside of the time captured by the initial screen. What can make the screening process more effective is including additional narrative questions that provide more details and lead to more clarity. Engaging clients more fully in their own treatment by helping them identify the situations that may increase their risk for suicide in the future as well as the supports and resources to utilize if this happens (i.e., collaborative safety planning) introduces the process of clinical intervention during the assessment process.

Concern Can Remain Even if Client Denies Suicidality

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It is important to recognize that some clients may be reluctant to acknowledge suicidality during the screening process. Utilizing the social work values and skills of rapport building and human connection may create a safe environment that helps a client have an honest discussion about their suicidality. But if the client continues to deny suicidality within the context of a safe therapeutic relationship, social workers need to look beyond the screening data to identify risk and protective factors that may escalate or mitigate a suicidal crisis in the future and provide appropriate care (i.e., safety plan), referral, and/or resources.

3.2. Formal Assessment, as Indicated

All social workers are to gather information about risk and protective factors, ideation, intent, and plan of an individual who indicates thoughts of suicide or suicidal behaviors to inform service delivery. Social workers' assessment should reflect the person-in-environment perspective by including individual, interpersonal, historical, community, and societal influences on suicide risk and protection.

Interpretation

The purpose of suicide assessment is to confirm risk, determine severity, and guide the treatment plan. Its main goal is to evaluate modifiable risk factors, the client's psychosocial history, social determinants that may be associated with suicide risk, and the client's protective factors to inform clinical decisions. If a client expresses thoughts of suicide during screening, or risk is identified through the presentation of risk factors, additional questions and a detailed clinical evaluation or assessment are required to determine the severity and immediacy of the risk. If a suicide risk assessment is not within the social worker's job responsibilities, they must follow these standards within the context of their agency or organization regulations and protocols to

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ensure the client is connected to additional care and document the concerns and referral in the appropriate records.

There are a range of standardized assessment instruments available which provide lists of questions related to risk factors and protective factors. SPRC provides additional information on assessments that are widely used and/or at no cost and are applicable across a broad range of ages.

Just as it does in the screening process, risk stratification may also appear in assessment and the same rules (discussed in "Dynamic Nature of Suicidality and Risk Stratification**"**) apply. Even if your organization requires risk stratification, the provider must recognize that risk stratification is not a determination that can predict suicidal outcome. Instead, the social worker should draw on their social work skills to complete a thorough assessment based on the person-in-environment approach and use the information collected to inform suicide prevention intervention strategies and protocols to support the client.

Social Work Values in Assessment

Like in the screening process, social workers should conduct all assessments within the context of the social work values and skill set of being nonjudgmental, collaborative, supportive, and respectful while building rapport and a strong therapeutic alliance (Praetorius, 2021). When a client is overwhelmed by isolation and hopelessness, social workers can "lend hope" (Clark & Hoffler, 2014) through the use of a possessive pronoun (e.g., "we," "us") or incorporate the suggestion of collaboration (e.g., "Let's put our heads together"). Rather than using a medical model of diagnoses and deficits, when social workers employ these joining techniques the risk factors of isolation and hopelessness can transform into feelings of connection and hope, which are protective factors for suicide (Bird et al., 2014; Heller, 2015).

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These simple techniques reinforce to the client that they are not alone, and the social worker is joining them in problem solving (Underwood et al., 2018).

Person-in-Environment Risk and Protective Factors

Competent assessment of suicide risk must be greater than the individual level of risk and protective factors and more broadly incorporate person-in-environment considerations. This approach acknowledges the relevance of a social constructionist assessment by considering the impact of the environment and other sociocultural influences (e.g., structural racism, [Alvarez et al., 2022] as well as discrimination, oppression, inequities, and intergenerational trauma [Button, 2016]) as risk and protective factors. Because of this, social workers must also embrace cultural humility by acknowledging the various individual and social determinants of risk and protective factors that are present and with which they may be unfamiliar (i.e., Structural Racism and Suicide Prevention Systems Framework [Alvarez et al., 2022] and CARS [Chu et al, 2013; Molock et al., 2023]). Regardless of cultural group, however, there are aspects of the suicide risk assessment process that remain static (Rudd, 2006). Questions related to history of suicide risk, access to lethal means, and support system availability are examples of areas that must be included regardless of issues related to cultural diversity.

Frequency of Assessment

Given the transient and, at times, reoccurring nature of suicidal thoughts and behavior, risk assessment should be ongoing throughout the course of treatment. How this is conducted may vary based on the situation and client. With clients who exhibit some degree of risk in outpatient care, it is important to ask questions about suicidal ideation at each session to check in and determine if more focus on reviewing and updating the safety plan is necessary or if

additional assessment and/or a more intensive level of intervention is needed. This is especially critical for clients who experience chronic or persistent thoughts of suicide. Social workers should explain to clients that talking with them about suicidal thoughts and changes in their intensity over time is an important focus of treatment and that safety plans need to be reviewed and adapted as stressors and challenges change in life. For individuals with suicidal thoughts, events that trigger thoughts of suicide should be explored and specific and accessible coping mechanisms identified that the client could use outside of the treatment setting.

3.3. Development of Collaborative Safety Plan

All social workers should complete a collaborative safety plan with clients who are at risk for suicide or experiencing suicidal thoughts or behaviors.

Interpretation

Safety planning reflects collaboratively identified information by the social worker and client, including distress triggers and a hierarchy of coping techniques about what to do to distract from distress triggers, where to go for help, and with whom (i.e., personal and professional networks) to talk to in order to minimize suicide risk. Developing the plan reinforces the client's agency and highlights the importance of including human relationships in their coping repertoire. A collaborative safety plan promotes client safety with respect for client dignity, worth, and self-determination, emphasizing what the client will do to stay safe rather than focusing solely on reactions to distress.

After the written safety plan is completed, two additional areas should be explored. The first is discussing reasons for living. Social workers can shift the focus from the "deficits"

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of triggering events to the "strengths" in the client's reasons for living by saying "You've told me your reasons for dying; now I'd like you to hear about your reasons for living." This reflection of self-determination and dignity focuses on positive, protective factors.

The second additional step, also grounded in self-determination and personal autonomy, is asking the client how likely they are to use the plan and identify potential barriers to implementation. The plan can then be revised to better reflect the client's perceptions of its utility. Social workers must obtain training and competence in development of collaborative safety plans (see Resources).

It is important to note that safety plans are different from "no harm" or "no suicide" contracts. Historically, "no harm" or "no suicide" contracts—an agreement in which a person promised not to engage in suicidal behavior or self-harm and to contact a designated person or service if they experienced thoughts of suicide—were regularly used in clinical settings. There is no evidence, however, that they effectively mitigated suicidal behavior, and their use may have provided clinicians with a false sense of security that the client was safer after signing the contract. In addition, they are not legally binding (Rudd et al., 2006) and do not reflect social work values (Sanders et al., 2006). Rather than being collaborative, they are directive and authority-based, and do not consider the environmental factors that could contribute to distress or support safety.

3.4. Counseling about Access to Lethal Means

All social workers should understand the role of access to lethal means in death by suicide and ask questions about access to and safe storage of such lethal means.

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Having access to lethal means can increase the possibility of a death by suicide. Social workers must recognize that the category of lethal means is broad and includes not just firearms and medications but encompasses environmental means such as access to bridges or other high places, trains, or sharp objects (Pollock, 2019). Once the range of methods of suicide is considered, the second key component of this standard is counseling regarding safe storage or access to these means. This requires discussion with the client and their support system about strategies to monitor and limit that access, especially for the period of time that the client remains at risk for suicide. Engaging the support system in this process speaks to the social work perspective of acknowledging the influence of person-in-environment and the importance of human relationships. Social workers should educate the client's support system about the critical role they can play in limiting the at-risk client's access to lethal means for as long as the risk remains (Harvard Injury Control Resource Center, n.d.). The CALM training is evidence-based and is available at no charge on the Counseling on Access to Lethal Means (https://www.calmamerica.org) website as well as on multiple other sites.

3.5. Documentation of Care Plan

All social workers should document adherence to the standards of care for suicide including care processes, decision making, consultation and supervision, and the rationale for care provided and care considered but ruled out.

Interpretation

Documentation related to the standards of care for suicide must be concise, complete, logical, and purposeful (Reamer, 2005); more information does not provide more protection against liability if the right information is not included (Reamer, 2013). According to the NASW (2021)

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Code of Ethics, "social workers' documentation should protect client's privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services" (3.04[c]). Information overload in records can lead to decreased accuracy in the quality of decision making. It has been found that weaker documentation is the result of weaker suicide assessment and intervention knowledge (O'Connor et al., 2004).

There are several important purposes for documentation:

- To provide a history of interventions
- To provide rationale for decisions made in care planning
- To demonstrate awareness of state or tribal-specific laws regarding mental health and gun possession

State/tribal-specific laws are specifically relevant in states that use what are referred to as Extreme Risk Firearm Protection Orders (ERFPO)—colloquially referred to as red flag laws. ERFPO require certain people to petition the court to potentially remove firearms from someone who is determined to be at risk to self or others; these certain people may include social work clinicians.

Relevant documentation should detail the risk factors for suicide at the time of interaction with the client and the actions taken as part of care planning to address those risks, with the rationale underlying those treatment decisions. The contemporaneous records of the suicidal impulses present at the time of initial screening and assessment are essential information, especially if a referral is made for subsequent services. Because suicidal impulses may be transient, the documented history will provide evidence of suicidal thoughts and/or behaviors that were present at the time of the initial interview but may not be present or disclosed by the client at a later point in time or after a referral (Kalafat & Underwood,

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2004). What is often missing in documentation but is required to meet this care standard is a description of the disposition options considered but not taken. For example, if a treatment decision is made to recommend hospitalization, documentation should include not only the reasons for this recommendation but the reasons why outpatient care was not considered appropriate. Timely documentation should also include names of screens and assessments administered (including dates and scores), and, when possible, the client's own words indicated by quotation marks. Written communication, including text messages, are part of the documented record.

Additionally, documentation is important from a legal perspective. It should demonstrate that the actions taken by the social worker are aligned with what a "reasonable person of ordinary prudence" (Reamer, 2003) would have done in a comparable situation and, as such, it can offer protection from malpractice liability. If clinical decisions and their rationale are not documented, it will be assumed that standards of care were not met and the provider may be found liable if a death by suicide occurs (Bongar & Stolberg, 2009; Knapp, 2024; Simpson et al., 2016; Stanley et al., 2019).

There are multiple documentation models in social work, each with the purpose of providing accountability, corroborating the delivery of appropriate services, and supporting clinical decisions (Evans, 2017). Some organizations will have electronic health/medical records (EHR/EMR) that provide fields to include this information. If the EHR/EMR does not include specific fields for relevant content related to the standard of care for suicide, efforts should be made to include it as attachments, open text fields, or professional documentation notes. If an organization does not have a required mental health documentation protocol, social workers should use the mechanisms available (i.e., incident reports, personal files) to

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record their actions. Further guidance for documentation can be found in NASW's (2025) *Practice Standards for Clinical Social Workers*.

3.6. Follow-Up

All social workers should conduct follow-up with clients who are at risk for or experiencing suicidal thoughts or behaviors.

Interpretation

Follow-up reflects social work values as well as NAASP (2018) standards of care by mitigating client isolation through case management and care coordination (Hepworth et al., 2017). While these strategies facilitate client connections to resources, they also provide human connection and embody the social work values of human relationships and social support, which can provide stability for the client and protection against suicide risk (Evans, 2017). Scheduled follow-up visits should be supplemented with brief, intermittent, and repeated check-ins at shorter intervals like the first 24 hours or daily when the social worker is concerned about a client's potential risk for suicide. Follow-up check-ins or contacts may include phone contacts, voicemails, text messages, postcards, or letters, and should be included in documentation. This is a simple and low-cost strategy, often referred to as caring contact, which has been shown to be especially effective in preventing repeat suicide attempts during the six months following discharge of the client from the emergency department. In addition, these contacts can serve to decrease loneliness, which is a risk factor for suicide (Inagaki et al., 2019).

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4. SPECIAL CONSIDERATIONS WITH DIVERSE POPULATIONS AND DEVELOPMENTAL COMPETENCE

Social workers must understand the cultural, historical, developmental, and contextual factors, and their intersections, that shape the experiences of diverse communities across the United States as they relate to provision of effective and equitable suicide-related care.

Interpretation

Standard 4 acknowledges that diversity in its broadest sense, incorporating people of different gender identities, social classes, cultures, occupations, religious and spiritual beliefs, ages, and physical and cognitive abilities, requires additional interventions that are both culturally sensitive and culturally competent. Social workers must recognize how intersecting identities (e.g., race, ethnicity, immigration status, disability, LGBTQ+, age) compound risk through systematic barriers that can create limited access to both care and relevant resources for suicide prevention. It is also important to recognize that certain medical and physical limitations or disabilities, including those that may be invisible (e.g., chronic pain), can lead to increased risk for suicide due to minimization of symptoms, heightened social stigma, loss of status, and exclusion or isolation.

While the steps in Standard 3 are required to be completed with all community members, Standard 4 provides information on unique risk and protective factors to be considered when implementing the Standards with special populations at risk for suicide. This section does not address all special populations; thus, social workers are encouraged to seek additional knowledge and support when working with special populations so that unique characteristics and circumstances are not overlooked during assessment and care. Furthermore, social workers must continue to advocate for additional research and adaptations of suicide-specific interventions for

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special populations and to address structural inequities driving mental health disparities. See NASW's (2015) *Standards and Indicators for Cultural Competence in Social Work Practice*.

Diverse Population Considerations

American Indian and Alaska Native Populations. American Indian and Alaska Native communities represent more than 574 federally recognized tribes, each with its distinct culture, language, governance structure, and spiritual traditions. Tribes are sovereign nations and maintain government-to-government relationships with the U.S. government; therefore, social workers must avoid generalizations and ensure their practice aligns with each tribe's laws, local customs, and culturally grounded approaches to intervention and healing.

American Indian and Alaska Native people have resiliently navigated historical and intergenerational trauma. Colonization, forced relocation, boarding schools, termination and relocation policies, and the suppression of language and culture have created cumulative trauma and unresolved grief carried across generations. Today, over half of Native people live in urban areas due to the federal relocation programs of the 1950s, while many others live in reservation, rural, or frontier communities. Each context shapes access to resources, cultural connection, and community support in different ways. Native people are diverse in their levels of assimilation, cultural expression, community involvement, and lived experience, and this diversity must be honored in practice. Profound strengths and protective factors come from relational respect; cultural identity; spiritual practices; and healing through connection with family, elders, community, and cultural lifeways.

Black Community. Black youth and adults are at increased risk for suicide due to multiple environmental factors. Social determinants of risk for suicide include racism; discrimination; exposure to violence; lack of access to health and mental health services; and

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cultural stigma regarding mental health and mental health services, partly rooted in historical practices of medical and psychological abuse toward Black individuals. Protective factors include having healthy relationships and connections with family and community, strong sense of racial/ethical identity and spiritual beliefs, sense of control, and willingness to seek physical and mental health treatment.

Immigrants, Refugees, Asylum Seekers, and International Communities. This population may present with significant historical or current trauma and displacement. Systemic inequities that lead to marginalization and increased suicide risk include racism, poverty, language inequity, and legal precarity. The current sociopolitical context, cultural norms or stigma around mental health and help-seeking, and mistrust of culturally insensitive services further increase risk. Risk may be compounded by lack of familiarity with systems, insurance limitations, and limited or nonexistent interpretation services. Family dynamics of acculturation stress, role shifts, intergenerational conflicts, and survivor's guilt should be considered as potential contributors to risk. Protective factors include strong cultural or ethnic identity and spiritual values, family and community support (i.e., elders, faith leaders, mentors), stable living conditions, meaningful social engagement, and cultural and community beliefs that support life and facilitate coping with adversity.

LGBTQIA+ Communities. LBTQIA+ individuals are not inherently at higher risk for suicide due to their sexual orientation or gender identity. Rather, their risk increases due to disparities associated with racism, oppression, and other structural inequities. Culturally responsive care must address these layered experiences to support LGBTQIA+ individuals effectively.

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Suicide risk is often highest just before and just after the coming-out process for LGBTQIA+ individuals. Relevant risk factors include ongoing discrimination, bullying, harassment, hate-based violence creating chronic stress, family rejection, limited access to affirming mental health services or gender-affirming care, and identity-specific stressors. Protective factors include access to gender-affirming resources and services, pronoun respect, and supportive adults and allies.

Military and Veteran Communities. This population's risk comes from the military's unique cultural, occupational, and psychological factors (i.e., stoicism, resilience, and fear of career impact) and its associated risks of elevated exposure to trauma, frequent transitions and relocations and reintegration challenges, and a culture of access to lethal means. Protective factors are also present, including purpose, strong identity (i.e., camaraderie, mission focus, spirituality, and family).

Developmental Considerations

Suicide impacts individuals of all ages; however, there are specific considerations needed when working with different subgroups of the population (i.e., children, adolescents and young adults, working adults, and older adults). Social workers must be aware of the intersectionality of age with race, ethnicity, immigration status, disability, LGBTQ+ identity, age, and others as they compound risks and impact implementation of Standard 3. Social workers should ensure that the standardized screening and assessment instruments used are validated with the age group of interest.

Youth (24 and Under). Youth have unique developmental, social (including social media), and environmental vulnerabilities that shape suicide risk. Their emotional regulation, identity formation, and reliance on family and peer systems make them particularly sensitive to

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relational stressors, school dynamics, and feelings of isolation or burdensomeness. As youth age, life changes (e.g., grades, schools, friends) in the transition to independence can become risk factors for suicide. Contact with caring adults, peer support, and social connections are strong protective factors for youth.

Working Adults (45–65). Working adults, and men in particular in this age group, have the highest relative risk for suicide, which is often related to occupation (i.e., construction, farming/ranching, forestry, transportation, manufacturing, military and police or first responders), as well as access to lethal means. Additional risk factors for this population can include increased isolation; physical health challenges, especially pain; alcohol or drug use; financial challenges; barriers to help seeking due to a stigma that it is a sign of weakness; and living in areas with a shortage in healthcare professionals. Protective factors may include close connection to friends and family, including peers at the workplace; religion and spirituality; and positive environmental factors, such as safe and stable housing and financial and employment security.

Older Adults (75 and Older). Older adults have the highest rate of death by suicide and lowest ratio of attempt to death ratio (Garnett et al., 2023). This population can experience cumulative losses, such as loss of identity through retirement, loss of friends and family, loss of mobility and health through physical pain or challenges, loss of goals, loss of independence, and questioning life's meaning or purpose. These, in addition to increased isolation and access to lethal means, increase their risk for suicide. Social determinants of risk include housing and financial insecurity and lack of access to care. Protective factors include social connection, physical activities, learning activities, and redefined identity and purpose.

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5. SUPERVISION AND CONSULTATION

Social workers shall maintain access to professional supervision and/or seek consultation when working with clients who are at risk for or currently thinking about suicide or have suicidal behavior.

Interpretation

Supervision and consultation augment the core social work values of integrity and competence of the social worker. They also provide the social worker with human connection and serve as a reminder that this is beneficial not only to clients but also to social workers themselves and is especially important when working with challenging cases involving suicide.

As per the NASW (2025) *Practice Standards for Clinical Social Workers*, "the purpose of supervision is to provide education, accountability, and direction to supervisees" (Standard 6, p. 5). This is particularly critical as many social workers report feeling anxious and fearful when providing services to clients who are suicidal (Dahl-Jacinto & Hays, 2024). Due to this fear, social workers may be more likely to refer a client to another professional or recommend hospitalization, both of which could violate the client's rights to dignity and personal autonomy (NASW, 2021), access to care and the least restrictive treatment (Dahl-Jacinto & Hays, 2024; Kumbhare, 2022; Groth & Boccio, 2019; Scott & Underwood, 2025). It is the responsibility of social work supervisors to be knowledgeable in suicide prevention, intervention, and postvention as well as in how to guide their supervisees during work with clients at risk for suicide and during postvention, if a client dies by suicide.

Consultation can validate the social worker's observations of suicide risk and associated risk and protective factors as well as actions taken and not taken. It serves to

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enhance professional judgement, promotes critical thinking, and improves decision making to better serve clients. Because social workers recognize the value of intercollegiate and interdisciplinary work, case consultation may be obtained from qualified professionals in other related disciplines if a social work supervisor is not accessible or is not knowledgeable in the field of suicidology (NASW, 2025). This holds true in all practice settings and for all social workers, regardless of education and licensure. Even if a supervisor is available, collegial support through consultation can help mitigate fear and protect against malpractice (Knapp, 2024), since consultation can be a validity check for actions taken or not taken (Bonger & Stolberg, 2009; Scott & Underwood, 2025).

Social workers can be considered suicide survivors following the loss of a client to suicide, and supervision, consultation, and peer support can be critical self-care strategies to promote healing (Sanders et al., 2008; Ting et al., 2006; Ting et al., 2008). The Suicide Prevention Resource Center offers postvention resources for professionals who have lost a client by suicide.

NASW and the Association of Social Work Boards (2013) offer *Best Practice Standards in Social Work Supervision* that social workers should use for guidance on supervision. NASW's (2025) *Practice Standards for Clinical Social Workers* includes a standard on supervision and consultations that should be used to inform clinical social work practices. In addition, all social workers should abide by the statutes and regulations regarding supervision and consultation in their states of practice.

6. ADVOCACY AND LEADERSHIP

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Social workers must advocate for policy and take an active role in suicide prevention leadership on the micro, mezzo, and macro levels through the adoption of these standards.

Interpretation

Social workers must advance the profession's role in suicide prevention, intervention, and postvention through advocacy and leadership that improve suicidal outcomes and organizational or social worker liability through the adoption of best practices and evidence-based strategies. A sample of suggestions for advocacy and leadership are provided here; however, this list is not fully inclusive, as other opportunities for advocacy and leadership should be sought as new challenges and opportunities emerge.

- Advocate public policy challenging myths and stigma associated with mental health, suicide, and help-seeking; access to mental health services/mental health equity; safe storage of firearms and medications; digital media/artificial intelligence safety.
- Advocate for societal change to address social determinants of risk to prevent suicide.
- Develop, adopt, and implement organizational policies and protocols related to these standards, including suicide prevention, implementation of effective suicide-specific intervention strategies, and postvention protocols.
- Implement documentation standards reflecting suicide standards of care and suicide safer practices, especially in electronic health and medical records.
- Support supervision informed by standards of care for suicide.
- Implement organization-based self-care and postvention services, especially in managing grief and loss following the suicide of a client through debriefing and support.

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- Promote culturally relevant suicide prevention awareness campaign messages and resources, using safe messaging that promotes hope, resilience, and help-seeking, and incorporates the voices of families and those with lived experience.
- Provide appropriate level of suicide prevention, intervention, and postvention training and education to social workers in agencies and organizations, including the minimum standards of care for all social workers, and advanced suicide-specific interventions and work with special populations for clinical social workers.
- Advocate for required suicide prevention, intervention, and postvention training in undergraduate (BSW) and graduate (MSW) education and in social work licensing requirements.

Finally, if social workers are employed in multistakeholder systems where assessing suicide risk is outside their current responsibilities or organizational function, they must be able to ensure the minimum standard of care is met if they interact with someone at risk for suicide. While it may not be a specific job responsibility, it is part of the expectation of the profession that all social workers know how to address the standard of care for suicide. In workplaces and professional organizations, social workers can champion upstream, midstream, and downstream approaches to suicide prevention that focus on the health and safety of an organization. One example available to social work leaders is the National Guidelines for Workplace Suicide Prevention which help organizations prevent suicide crises and provide a pathway for supporting loss with evidence-informed postvention support (see www.workplacesuicideprevention.com). This can serve as an example that suicide prevention is everyone's responsibility.

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OPPORTUNITIES

These standards are grounded in research, policy, lived experience, and best practice. Social workers have the unique opportunity to be leaders in suicide prevention, intervention, and postvention with a unique skill set embedded within the framework of social work values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Social workers will inevitably encounter people at risk for suicide in the diverse settings in which they work due to individual, social, or societal risk factors. Each encounter is an opportunity for social workers to prevent death by suicide. These standards complement the strengths of social work and its emphasis on empathic relationship building. We must be ready to have the conversations that can keep people safe and save lives.

Social workers have the opportunity to not only work on their competency to provide the standards of care of suicide in direct practice (i.e., micro) settings, but to also lead take the lead in addressing stigma and encouraging preparedness through education, organization, and advocacy (i.e., mezzo and macro) efforts.

The road will not be easy as there are gaps and barriers in the current system. However, these standards can provide the blueprint for future direction.

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GLOSSARY

Definitions of terms in this glossary are applicable to this document. Where available, sources are provided for each definition, and a more comprehensive list is provided in the Resources section.

ASSESSMENT

The purpose of suicide assessment is to confirm risk, determine severity, and guide the treatment plan. Suicide assessment typically follows a positive screening or clinical concern about suicide risk. Assessment is comprehensive and detailed, whereas screening is brief and surface level (see screening definition). The main goal of a suicide assessment is to evaluate modifiable risk factors, the client's psychosocial history, social determinants that may be associated with suicide risk, and the client's protective factors to inform clinical decisions (Suicide Prevention Resource Center, 2026). During a suicide assessment, social workers may use an in-depth clinical evaluation that includes structured tools, open-ended interviews, and collateral information from clinical records or family members (Brown et al., 2014). Assessments also require the social worker's knowledge regarding suicide risk and protective factors.

CLIENT/PATIENT/CONSUMER

Social workers generally use the term "client" to refer to the individual, group, family, or community that seeks or receives professional services. The term "patient" is more commonly used by social workers employed in healthcare settings. The term "consumer" is also used in settings that view the client as the end user—that is, the one capable of deciding what is best for

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them—and encourages self-advocacy and self-judgment in negotiating the social services and welfare system (definitions from Barker, 2014).

CONTAGION

Suicide risk associated with knowledge of another person's suicidal behavior, either firsthand or through the media (CDC, 2024b). Suicide contagion occurs when the exposure to suicide or suicidal behavior of one or more people influences others to attempt suicide. Exposure can be direct by having a personal connection to the person who died by suicide, or indirect through media reporting or social media posts about a person who was not a personal connection.

CULTURAL COMPETENCE

The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, genders, sexual orientations, religions, immigration statuses, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

When working with tribal nations, this includes respecting tribal sovereignty, historical context, and tribal self-determination through engaging in culturally grounded community-defined practices.

DEVELOPMENTAL COMPETENCE

This term refers to how children typically grow cognitively, emotionally, and socially, and reflects the ability to assess where a child is in relation to expected developmental milestones

(Henderson & Thompson, 2015). Social workers must tailor assessments to the child's developmental stage and integrate developmental theory with practical assessment techniques. In the NASW (2003) *Standards for the Practice of Social Work with Adolescents*, adolescent developmental competence is defined as "the ability to understand and appropriately respond to the developmental needs and tasks of adolescents, recognizing normal variations and the influence of social, cultural, and environmental factors" (Introduction, para. 6). This definition highlights the importance of tailoring interventions to an adolescent's developmental stage and context.

GATEKEEPER

Gatekeepers are individuals who have face-to-face contact with many community members and who may be in a position to identify people at risk of suicide and refer them to treatment or supporting services. Gatekeepers are not necessarily mental health professionals—they can be teachers, coaches, clergy, first responders, supervisors, peers, or others who interact regularly with people in their communities or organizations. See SPRC's (n.d.-a) Best Practices Registry for more information on the various gatekeeper trainings.

HEALTH DISPARITIES

"Systematic, avoidable health differences that adversely affect marginalized or disadvantaged populations, often due to inequities in social determinants such as housing, education, income, and access to health care" (National Institute on Minority Health and Health Disparities, 2025, para. 1).They are largely preventable and linked to intergenerational, social, economic, and environmental disadvantages.

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LIVED EXPERIENCE

A broad term encompassing a range of experiences with suicidal intensity. This range includes direct and personal experience of suicide as well as experience of the personal impact or trauma related to a suicidal crisis within one's social circle (Zero Suicide Institute, 2018).

MALPRACTICE

When a healthcare professional deviates from standards or duty to care in their profession (i.e., by a negligent act or omission), thereby causing injury or death to a patient. Individuals can file a civil action against the provider in such cases. The provider's liability is determined by foreseeability and reasonable care. Foreseeability refers to whether the clinician could have anticipated the potential or actual results of what they did or what they failed to do based on the reasonable care standard. This standard reflects what a person with similar training and education would have done in that same circumstance.

MEANS REDUCTION

Strategies to reduce the availability or ease of access to lethal means for suicidal self-directed injurious behavior.

MEDICAL ASSISTANCE IN DYING (MAID)

MAID is medical assistance that individuals may receive regarding the timing and manner of their death. For a detailed description of NASW policy on this matter, please refer to NASW (2026) *Practice Standards for Serious Illness Care: Hospice and Palliative Social Work.*

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POSTVENTION

This term refers to activities following a death by suicide to help alleviate the suffering and emotional distress of the survivors and prevent additional trauma and contagion.

PRACTICE GUIDELINES

Flexible, evidence-informed recommendations developed by professional organizations such as NASW. Unlike mandatory standards of care, these guidelines are advisory and serve to support clinical decision making by integrating research, ethical principles, and professional experience. Their primary goal is to promote consistency and quality in service delivery, enhance professional development, and facilitate the transition of research into practical applications. In the context of suicide risk assessment, the standard of care requires a social worker to evaluate risk when a client expresses suicidal thoughts. A practice guideline might recommend using a specific written assessment tool to structure and document that evaluation.

In this document, practice guidelines are found in the Interpretation of each standard of care.

PROTECTIVE FACTOR

A characteristic at the biological, psychological, family, or community level that is associated with a lower likelihood of problem outcomes (i.e., a buffer) and that reduces the impact of a risk factor on a suicide-related outcome.

RISK FACTOR

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Situation or problem that can increase the possibility that a person will attempt suicide. Risk factors can be found at the individual, relationship, community, and societal levels.

RISK STRATIFICATION

Assessment of the client's suicidal status, including both the level of severity (low, medium, or high) and temporality (acute and chronic). This method allows for the client's level of risk to be conceptualized in a nuanced way and for the identification of appropriate risk mitigation strategies.

Low risk: The individual is experiencing fleeting thoughts of self-harm or death, but no identifiable current means or plan. Thoughts are infrequent, mild in intensity, and short in duration. There is the presence of multiple protective factors, including social support, reasons for living, access to care, and coping skills.

Medium risk: The individual is experiencing suicide ideation and intent, but no current plan or immediate means. Thoughts are present, but with limited intensity and duration. There are some protective factors present (e.g., social support, reasons for living).

High risk: The individual is expressing continual, specific suicidal thoughts, plans (when and where), intent, and means (specific method). Protective factors are not relevant (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024).

SAFE MESSAGING

Communication strategies that reduce risk and promote help seeking (CDC, 2025b; SPRC, n.d.-c). Safe messages are tailored to the audience and context and are designed to promote behavior change. Studies show that certain types of media reporting about suicide deaths may spur

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imitation of suicidal behavior among vulnerable individuals (people in despair or already thinking about suicide). Thus, it is important to report on suicide accurately, avoiding graphic descriptions of suicide methods to not negatively impact people at risk.

Werther effect: In 1974, the sociologist David P. Phillips coined the term "Werther effect" to describe the mimicry of suicide after a highly publicized suicide in the media (Walling, 2021).

Papageno effect: Under certain conditions, exposure to accounts of suicidal behavior in the media is associated with a lower risk of suicide attempts and can have a more positive, i.e., educative or preventive, effect, especially when the media present constructive strategies to cope with suicidal ideations or emphasize other solutions to adverse life circumstances (Domaradzki, 2021; Niederkrotenthaler et al., 2010).

SAFETY PLANNING INTERVENTION

A prioritized written list of six steps: (1) identify warning signs, (2) list individual coping strategies, (3) name people and social settings that are distracting, (4) name people to go to for help, (5) list professionals to go to for help, and (6) plan how to make the environment safe (i.e., cleansing the environment of access to lethal means). The plan is brief, in the client's own words, easy to read, and accessible in times of crisis. The most important part of the safety plan is its collaborative development. (See https://suicidesafetyplan.com/)

SCREENING

Brief and standardized process to identify individuals who may be at risk for suicide. It is designed to identify individuals who need further evaluation or support. Screening can be

conducted universally with full populations regardless of risk status, selectively with individuals from at-risk populations, or indicated with individuals who express risk factors for suicidal behavior. Screening is typically the first step, and its purpose is to detect suicide risk early. If someone screens positive for suicide, an assessment follows (please refer to the Assessment definition for differentiation). The most common suicide screening tools are ASQ, C-SSRS, and PHQ-9. A social worker can also screen with just one or two questions.

SOCIAL DETERMINANTS OF HEALTH

Physical, social, economic, and environmental conditions that influence individual and community health. These include access to nutritious food, safe housing, education, income, employment, transportation, social support, and access to quality healthcare (Magnan, 2017).

SOCIAL WORKER

In the United States, a social worker is an individual who possesses a baccalaureate or advanced degree in social work from a school or program accredited by the Council on Social Work Education. The social worker must comply with the licensing and certification requirements of the state(s) or jurisdiction(s) in which they practice, and must possess the skills and professional experience necessary to practice social work. While the roles and responsibilities of social workers at different degree levels may vary considerably, some core functions are common to all social work, for example, engagement with clients; assessment of client priorities, strengths, and challenges; development and implementation of a care plan; monitoring of service delivery, and evaluation of outcomes (NASW, 2013).

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STANDARDS OF CARE

The minimum level of acceptable practice expected of a professional in a given situation. It is often defined by what a reasonably competent professional would do under similar circumstances and is generally not flexible or adaptable. Standards of care are legally enforceable and can be used in court to evaluate negligence or malpractice. The purpose of a standard of care is to protect the public from substandard or harmful practices, define professional accountability, and serve as a legal benchmark in malpractice cases.

SUICIDE

Death by self-directed injurious behavior with a result to die as a result of the behavior (National Institute of Mental Health, n.d.-b). Additional list of terms related to suicide includes the following:

Suicidal ideation: Much more common than suicidal behavior. Suicidal ideation or thoughts exist on a continuum of severity from fleeting, vague thoughts of death to persistent and highly specific considerations of suicide. Thoughts may only occur periodically or may be unrelenting.

Suicide plans: Significant because they signal a more serious risk of carrying out suicidal behavior than does suicidal ideation without planning. Suicide planning exists on a continuum from vague and unrealistic plans to highly specific and feasible plans. Serious suicide planning may also involve rehearsal or preparation for a suicide attempt.

Suicide attempt: A deliberate act of self-harm, undertaken by an individual who has at least some intent to die, that does not result in death. Attempts have two major elements: the subjective level of intent to die (from the client's perspective, how intensely did they want to

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die, and to what extent did they expect to die?) and the objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?). Although all suicide attempts are serious, those with high intent (the client clearly wanted and expected to die) and high lethality (the behavior could have easily led to death) are the most serious.

Nonsuicidal morbid ideation: Thoughts about death (e.g., "wish to be dead") without suicidal or self-injurious content.

Nonsuicidal self-injury (NSSI): Intentional, self-inflicted damage to one's body without the intent to die. It is a behavior often used as a way to cope with emotional distress. While NSSI is not a suicide attempt, it can be a risk factor for suicide (see Apicella et al., 2025; Nock & Favazza, 2009).

SUICIDE ASSESSMENT INSTRUMENTS

Standardized, evidence-based tools (i.e., the measure has been tested for validity and reliability with certain populations), instruments or protocols that are incorporated into an interview and used to identify individuals who may be at risk for suicide. Some commonly used standardized suicide risk assessments include the Brief Suicide Safety Assessment (National Institute of Mental Health, n.d.-a), Suicide Status Form (Jobes, 2012; also see https://cams-care.com/the-cams-framework/the-suicide-status-form/), and SPRC's (2026) Suicide Screening and Assessment.

SUICIDE INTERVENTION STRATEGIES

Targeted actions designed to reduce imminent risk, stabilize clients in crisis, and connect them with appropriate care. For suggested suicide-specific interventions, see American Foundation for

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Suicide Prevention, n.d.; CDC, 2025b; Center for Suicide Prevention and Recovery, n.d.; SPRC, 2025.

SUICIDE PREVENTION RESOURCE CENTER (SPRC)

The only federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention, funded by SAMHSA.

SUICIDE PREVENTION STRATEGIES

Multilevel, evidence-based approaches designed to reduce suicide risk and promote mental health and resilience, often including training of a gatekeeper (i.e., a person in a position to identify an individual at risk for suicide and make a warm handoff to an appropriate resource). Trainings include awareness of suicide risk and protective factors, how to talk to someone at risk for suicide, and resources (CDC, 2025a; SPRC, n.d.-b). See SPRC's (n.d.-a) Best Practices Registry for more information on the various gatekeeper trainings.

WARM HANDOFF

In a warm handoff, a direct active referral is made to personally connect an individual to a service provider rather than just telling the person to contact a resource (Underwood et al., 2018).

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RESOURCES

The universe of suicide-specific resources is broad and changes frequently. The following list (presented in alphabetical order) includes potential resources to help social workers stay current and find additional information about suicide prevention, intervention, and postvention. This list is not exhaustive, nor does it imply NASW's endorsement.

2024 National Strategy for Suicide Prevention https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-use-disorder/national-strategy-suicide-prevention/index.html

988 Suicide & Crisis Lifeline https://988lifeline.org

American Association of Suicidology https://suicidology.org

American Foundation for Suicide Prevention https://afsp.org (provides updated national and state-level annual statistical summaries useful for education and community engagement, as well as information on funding and training resources)

Ask Suicide-Screening Questions (ASQ) Toolkit https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Coalition of Clinician-Survivors https://www.cliniciansurvivor.org

Columbia Lighthouse Project https://cssrs.columbia.edu

National Guidelines for Workplace Suicide Prevention https://www.workplacesuicideprevention.com

National Strategy for Suicide Prevention, National Action Alliance for Suicide Prevention https://theactionalliance.org

Suicide Awareness Voices of Education https://www.save.org

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Suicide Prevention and Care Program, Indian Health Services https://www.ihs.gov/suicideprevention

Suicide Prevention for LGBTQ+ Young People, The Trevor Project https://www.thetrevorproject.org/

Suicide Prevention Resource Center https://sprc.org/

Suicide Prevention, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services https://www.cdc.gov/suicide/index.html (offers a comprehensive suicide data and statistics portal with interactive tools to examine suicide trends, methods, and demographic variations—including among populations disproportionately affected by suicide)

Suicide Prevention, Mental Health America https://mhanational.org/resources/suicide-prevention

Suicide Prevention, National Institute of Mental Health https://www.nimh.nih.gov/health/topics/suicide-prevention

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