

NATIONAL ASSOCIATION OF SOCIAL WORKERS

Standards of Care for **Suicide Prevention**



Standards of Care for **Suicide Prevention**



Yvonne Elder Chase, PhD, LCSW, ACSW, *President*
Anthony Estreet, PhD, MBA, LCSW-C, *Chief Executive Officer*

Taskforce

Cochair: Michelle Ann-Rish Scott, PhD, MSW

Cochair: Maureen M. Underwood, LCSW

Jodi J. Frey, PhD, LCSW-C, CEAP

Stephanie Asare Nti, LCSW-C

Cortney E. Yarholar, LMSW

Jonathan B. Singer, PhD, LCSW

Sean Joe, PhD, MSW

Carolina Vélez-Grau, PhD, LCSW

Ashby Dodge, LCSW

Jessyca Vandercoy, LCSW

NASW Staff

Barbara Bedney, PhD, MSW, Chief of Programs

Mirean Coleman, MSW, LICSW, CT, Director of Clinical Practice

Copyright 2026 by the National Association of Social Workers

All rights reserved. This document is copyrighted by the National Association of Social Workers, Inc. (NASW). Readers are free to share, copy, redistribute, adapt, and build upon this material for any noncommercial purpose, provided appropriate credit is given to NASW, and any changes made are indicated. Commercial use requires prior written permission from NASW.

This document establishes professional practice standards, ethical guidelines, and competencies for social workers. While these standards may be relevant to professional licensing and liability determinations, NASW does not itself create binding legal obligations, and the legal effect of these standards in any specific proceeding will depend on applicable law and the facts of the case.

CONTENTS

Acknowledgments v

Introduction vii

Standards 1

1. Ethics and Values 1
2. Suicide-Related Knowledge 5
3. Specialized Practice Standards 6
4. Diverse Populations: Developmental, Cultural,
Historical, and Contextual Considerations 16
5. Supervision and Consultation 22
6. Advocacy and Leadership 24

Opportunities 27

Glossary 29

Resources 37

References 39

ACKNOWLEDGMENTS

This document represents a collective commitment to suicide prevention shaped by years of clinical knowledge, lived experience, research, and a shared conviction that every life lost to suicide is a loss that, in many cases, could have been prevented.

We are grateful to Dr. Yvonne Chase, NASW President, for her shared vision and deep belief in the value of social workers in the prevention of suicide. It is because of her leadership and resolute support throughout this process that the NASW is proffering the first-ever *Standards of Care for Suicide Prevention*.

We are deeply grateful for each member of the task force and their willingness to volunteer their time sharing their knowledge, experiences, and expertise to make this document possible. This document references the work of task force members when relevant to the content of the document. We also thank the many individuals who offered public comments strengthening and sharpening each page of this document, including William Benjamin Packard, LICSW; Donte T. Boyd, PhD, MSW; Don L. De Lapp, MSW, LCSW, LCADC, SAP, MAC, CCS; Laura Hernandez Gold, LCSW-S; and Heath Hightower, PhD, MSW, ACSW, LICSW-MA, LCSW-CT. We also want to give special thanks to Skip Simpson, JD, and the American Foundation for Suicide Prevention for their comments and support. Each person who shared their voice helped shape this document in meaningful ways, and their engagement reflects the urgency and importance of this work.

These standards exist for one purpose: to save lives. Suicide remains a major public health crisis, and in many cases, social workers serve as the primary link to support individuals in crisis—in hospitals, schools, community centers, and the living rooms of those most at risk. The guidance contained in this document is designed to equip social workers with evidence-informed, compassionate, and actionable standards that reflect both the complexity of suicidal experience and the best available knowledge on how to intervene effectively.

vi ACKNOWLEDGMENTS

We ask every reader to approach these pages not merely as a professional or legal obligation, but as a reflection of our core social work values. Behind every standard lies a human story—a client, a friend, a family member, a neighbor—whose life may depend on the quality of care they receive. We hope this document serves as both a resource and a reminder of the purpose behind our work.

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. While there is no one cause of suicidal thoughts or behaviors, risk factors are traits, circumstances (including exposure to death or suicide), or other aspects (community and context) 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 should 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 should 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 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.

LANGUAGE OF SUICIDE

Language is important in the field of suicidology. Given that the language used to address suicide, suicidal thoughts, and suicidal behaviors continues to evolve, social workers should keep abreast of current, objectively focused language that avoids stigma, negative attitudes, 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 the intent to die as a result of that act.
- **Suicidal ideation** refers to thoughts of ending one's life.
- **Nonsuicidal self-injury (NSSI)** describes deliberate, direct tissue damage without the 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:

- **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 minimize 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).

Thoughts of suicide occur more frequently than suicidal behaviors (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024) and do not always lead to attempts or death. These thoughts exist on a continuum from acute (single episode or time-limited) to chronic (persistent or fluctuating) that can endure for years. Individuals who live with consistent thoughts of suicide may still experience an acute suicidal crisis, though many never make a suicide attempt (Jobes et al., 2024). This document focuses on the social worker’s role in prevention and assessment of suicide across this continuum; however, a review of specific interventions and treatments are outside the scope of these standards.

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/failed 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 generalist, 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.
- **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 what social workers can do in the prevention, assessment, and initial intervention of suicidal thoughts and behaviors. As noted, it is outside the scope of this document to review the management and treatment of suicidal behaviors, nor do we outline minimum standards for addressing the aftermath of a suicide death (postvention). Postvention is intended to address grief and loss while preventing additional suicide deaths.

Because exposure to suicide, whether through personal loss, community awareness, or media coverage, can trigger suicidal thoughts, suicide loss survivors (including social workers who lose a client to suicide) are at elevated risk. Therefore, social workers should follow these standards of care with suicide loss survivors. Although postvention is temporally and conceptually related to suicide prevention, assessment, and intervention, addressing grief, loss, bereavement, traumatic stress, post-traumatic growth, suicide contagion, and other issues of postvention requires a different set of standards than those outlined in this document. These standards of care will allow social workers to establish and fortify their role in the discussion of suicide prevention, assessment, and initial intervention through the lens and application of social work values.

While the professional pathway or responsibility of macro-level practitioners may not require direct assessment of clients, all social workers should have a minimum level of knowledge about suicide risk and protective factors; how to conduct an initial suicide screen; and what

resources are available to implement a proper referral, document, and conduct appropriate follow-up. This is similar to mandated reporting for child abuse, where a minimum level of knowledge and competence is expected.

REQUIREMENTS 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.

The goal is to improve social work practice related to suicide prevention and reduce suicide deaths. Adherence to these evidence-informed standards is one factor that may be considered in evaluating the appropriateness of professional conduct, but adherence does not guarantee any particular legal outcome.

These standards establish the following requirements:

- Ensure that social work practice in any setting, whether micro, mezzo, or macro, is guided by the current NASW *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 screening and assessment.
- Establish professional requirements for social workers monitoring and evaluating their own competencies and practices related to suicide screening and risk assessment, and identifying opportunities for continuing professional development.
- Outline a framework for social workers to provide 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 curricula 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 THEIR INTERPRETATION

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-based and evidence-informed strategies that support clinical judgment. These standards describe the minimum level of professional practice expected of social workers when serving clients at risk of suicide, regardless of setting, level of education, or licensure. They are intended to guide professional conduct and may be relevant to professional licensing, disciplinary, and civil liability proceedings, though their application in any specific legal context will depend on the facts and circumstances of that case and the laws of the applicable jurisdiction.

Best practice or clinical guidelines in this document—the interpretation of the standards—allow for more flexible professional judgment and choice of intervention strategies used to meet the standard of care (Callahan, 1996; Knapp, 2024). The interpretation provides 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). While standards of care are required actions, the process of implementing the standards may vary by setting, geographical region, and level of provider education and may not be done consistently (Zonana, 2008).

The national recommended standards of care for people with suicide risk applicable to all clinicians and professional practices were 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 these standards 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
6. Follow-up

This text incorporates these six steps into 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.

STANDARDS

1. ETHICS AND VALUES

Social workers shall adhere to the values and ethics of the profession using 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 should 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 should recognize suicide risk among populations that experience not only mental health challenges but also social determinants of health

2 STANDARDS OF CARE FOR SUICIDE PREVENTION

that are harmful. These include individuals who are vulnerable due to discrimination, oppression, housing insecurity, food insecurity, unemployment, and limited or no access to healthcare and education. Social workers should also consider populations that experience higher rates of suicide, such as LGBTQIA+ individuals; military-affiliated and veteran populations; American Indian, Alaska Native, and Native Hawaiian individuals; and older adults (66 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, someone who is experiencing a suicide crisis or living with chronic thoughts of suicide, it is imperative that the social worker seeks services in the least restrictive environment. If a more restrictive environment, such as hospitalization, is the optimal course of action to ensure client safety, the social worker should proactively address client concerns by transparently explaining the reasoning for this course of treatment. Beyond these immediate safety measures, when a client's persistent pain and suffering lead to a desire to die, the social worker should work to understand the underlying reasons for their wish to die while adhering to established standards of care for suicide prevention. In some jurisdictions, this exploration may involve legal options like MAID as part of end-of-life care or Psychiatric (or Mental Health) Advanced Directives (or PAD), documenting mental health treatment preferences before a crisis. While a client's interest in MAID can challenge social work values of personal autonomy and self-determination, it is legally and ethically distinct from suicide. Although MAID-related decisions fall outside the scope of these standards, social workers are still expected to follow the standards of care for suicide to support the client through their emotional pain and suffering. Social workers must follow applicable laws and should refer to NASW's 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 systems (i.e., family, peer, tribal, or community-based) engagement can either exacerbate suicide risk or strengthen protective factors. It is important for social workers not to assume family engagement is a positive support for the client. 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 and crisis helplines (e.g., 988 Suicide and Crisis Lifeline, the Crisis Text Line, and local crisis helplines). Relationships are also central to the development of a collaborative safety plan and during 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. 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, they should seek support from their organization administrators.

4 STANDARDS OF CARE FOR SUICIDE PREVENTION

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 interactions 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 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 should 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.

2. SUICIDE-RELATED KNOWLEDGE

Social workers shall remain current in their knowledge of suicide-related statistics, epidemiology, risk factors (including social determinants and exposure to death or suicide), protective factors, screening and assessment resources, safety planning, referral resources, and, if relevant—based on their licensing—intervention and treatment strategies. Social workers should 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 practice for communication about suicide) as well as variables associated with the risk of suicide contagion and the components of postvention strategies as they work with suicide loss survivors or communities.

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 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

6 STANDARDS OF CARE FOR SUICIDE PREVENTION

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 the importance of family, relationships, spirituality, and cultural strengths of the community.

Use of Resources and Referral

Social workers should maintain continuity of care by ensuring that clients receive coordinated psychosocial services and advocacy across service delivery systems, in collaboration with caregivers, school personnel, and community providers. Knowledge of local, state, and national suicide-related resources is essential when referral to other services is necessary. 988 Suicide and Crisis Lifeline is a national resource provided in various languages (including supports for the deaf and hard-of-hearing community) that assists with crisis stabilization and connection to resources; talk, text, and chat options are available.

The social worker should 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. All social workers in a professional pathway that affords them the opportunity to work directly with clients (in clinical or generalist practice) are expected to adhere to Standard 3. 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.

It is understood that macro-level social workers who do not interact directly with clients are expected to adhere to their professional pathway and will not be required to practice outside of their competence as it relates to assessment, safety planning, and counseling on access to lethal means. However, not unlike mandated reporters for child abuse or other conditions, they are expected to know the risk and protective factors for suicide, screen for suicide risk, make a proper connection to an appropriate care provider via an immediate warm handoff and/or implementation of crisis protocol, document, and follow up.

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

3.1. INITIAL SCREENING

Social workers shall ask all clients in a clear and direct manner about thoughts of suicide (e.g., “Are you thinking about killing yourself?”; “Do you wish to be dead?”) and suicidal behavior (e.g., “Have you ever tried to hurt yourself to end your life?”).

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 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 suicidal thoughts or behaviors a safe environment 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 suicidal thoughts or behaviors 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

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 free and 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. NASW does not endorse any specific instrument and assumes no responsibility for the validity or outcomes of third-party tools. Selection of an appropriate instrument remains the professional judgment of the social worker in the context of their practice setting, the client’s background, and applicable organizational protocols.

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; thus, the social workers should clearly document the dynamic, point-in-time nature of that risk in the event a client’s status

rapidly changes hours after an assessment. 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 Suicidal Thoughts or Behaviors

It is important to recognize that some clients may be reluctant to acknowledge suicidal thoughts or behaviors 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 suicidal thoughts or behaviors. But if, within the context of a safe therapeutic relationship, the client continues to report no suicidal thoughts or plans, 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

To inform service delivery, social workers who interact with clients in generalist or clinical direct practice shall gather information about suicide risk and protective factors, ideation, intent, and plans of an individual who indicates thoughts of suicide or suicidal behaviors. It is imperative that when social workers in generalist practice suspect or observe potential suicide risk, they refer clients to a clinician for a comprehensive assessment. 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 risk factors (especially those that may be modifiable), 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

10 STANDARDS OF CARE FOR SUICIDE PREVENTION

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 professional responsibilities, they must follow these standards within the context of their agency or organization regulations and protocols to ensure the client is connected to additional care (i.e., a warm handoff) 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 should 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 & Hoffer, 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”). When social workers employ these joining techniques rather than use outdated models of diagnoses and deficits, 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). 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 should 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, structural inequities, and intergenerational trauma [Button, 2016]) as risk and protective factors (including reasons for living, supportive relationships, access to health and mental health resources, and identity-based/culturally grounded strengths such as family, community connection, and spirituality). Because of this, social workers should 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 context, certain core components of suicide risk assessment remain constant (Rudd, 2006). These include assessing history of suicidal thoughts and behavior, access to lethal means, and support system availability.

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 should 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 A COLLABORATIVE SAFETY PLAN

Social workers shall 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 (see Stanley–Brown Safety Planning Intervention, <https://suicidesafetyplan.com>; B. Stanley & Brown, 2012). 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” 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 the 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 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; thus, “no harm” or “no suicide” contracts should not be used.

3.4. COUNSELING ABOUT ACCESS TO LETHAL MEANS

Social workers shall 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.

INTERPRETATION

Having access to lethal means can increase the possibility of a death by suicide. Social workers should 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 (i.e., family or community-based support) 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 Research Center, n.d.). The CALM training is evidence-based and available at no charge on the Counseling on Access to Lethal Means website (<https://www.calm-america.org>) as well as on multiple other sites.

3.5. DOCUMENTATION OF CARE PLAN

Social workers shall 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.

14 PRACTICE STANDARDS FOR SCHOOL SOCIAL WORKERS

INTERPRETATION

While documentation is important in the legal context, it is also an important part of reflective and ethically grounded practice serving to demonstrate best practice and the suicide care pathway in service of our clients. Documentation related to the standards of care for suicide prevention should be concise, complete, logical, and purposeful in demonstrating the guidance of care and practice provided (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) *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 a 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 relevant in states that use Extreme Risk Firearm Protection Orders (ERFPOs)—colloquially referred to as red flag laws. ERFPOs require certain people to petition the court to potentially remove firearms from someone who is determined to be at risk to their self or others; these certain people may include social work clinicians. Furthermore, since petitioning a court may involve breaking client confidentiality, social workers must adhere to the following section of the *Code of Ethics*: “Clinicians need explicit ethical backing in the text to disclose confidential information without consent for ‘compelling professional reasons’ to prevent ‘serious, foreseeable, and imminent harm’” (NASW, 2021, 1.07[c]).

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 provides 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, 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 also the reasons why outpatient care was not considered appropriate. Timely documentation should also include the 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 may be presumed 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; I. H. 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 (Hepworth et al., 2016). 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 record their actions. Further guidance for documentation can be found in NASW's (2025a) *Practice Standards for Clinical Social Workers*.

3.6. FOLLOW-UP

Social workers shall 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., 2016). Care coordination includes the use of warm handoffs, proactive outreach after acute crises, and coordination across service systems (e.g., schools, emergency departments, outpatient settings, and community-based services). Case management and care coordination not only facilitate client connections to resources but 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 (Hepworth et al., 2016). 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 an exacerbation of the client's risk factors. 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).

4. DIVERSE POPULATIONS: DEVELOPMENTAL, CULTURAL, HISTORICAL, AND CONTEXTUAL CONSIDERATIONS

Social workers shall 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 the 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., age, race, ethnicity, immigration status, disability, LGBTQIA+ identity) 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 subpopulations at risk for suicide. This section does not address all subpopulations, and those groups identified represent heterogeneous communities that can span dozens or more ethnicities, languages, religions, trauma history, socioeconomic status, immigration/generation status, and relationships to mental health services, each requiring a different approach. Social workers are encouraged to seek additional knowledge and support when working with clients so that unique characteristics and circumstances are not overlooked during assessment and care. Furthermore, social workers should continue to advocate for additional research, policy changes, and adaptations of suicide-specific interventions to address the unique needs of various populations and the structural inequities driving mental health disparities. See NASW's (2015) *Standards and Indicators for Cultural Competence in Social Work Practice*.

Developmental Considerations

Suicide impacts individuals of all ages; however, there are specific considerations needed when working with different age cohorts in the population. Social workers must be aware of the intersectionality of age with race, ethnicity, immigration status, disability, LGBTQIA+ identity, and others, as they compound risks and impact the 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 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. Social workers who work with the school-age population should be familiar with navigating confidentiality, family engagement, and procedures for reentry following hospitalization. School social workers should be familiar with the NASW (2025b) *Practice Standards for School Social Workers*.

Emerging Adulthood (Ages 25–44). Emerging adulthood is a distinct developmental period with individuals navigating critical life transitions, including entering college or the workforce; developing an identity; and gaining responsibilities and independence regarding housing, finances, careers, relationships, and families. From a clinical perspective, this age group is highly vulnerable to the emergence of co-occurring mental health and substance use disorders. During these transitions to adulthood, new risk factors for suicide may emerge, including relationship dissolution (separation/divorce), parenting stress, infertility, postpartum depression/psychosis, and housing or economic instability. Furthermore, untreated trauma or the escalation or onset of substance use or severe persistent mental illness (e.g., bipolar disorder, schizophrenia) may emerge. At the same time, this period may lead to developing strong protective factors/reasons for living such as meaningful employment, stable partnerships/marriage, child-rearing responsibilities, access to employee assistance programs or employer-sponsored healthcare, and active community or religious engagement.

Working Adults (Ages 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 (e.g., construction, farming/ranching, forestry, transportation, manufacturing, military, police, 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. Rural settings can also play a role in risk as it can be related to increased access to lethal means and lack of access to 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 (Tiesman et al., 2023).

Older Adults (66 and Older). Older adulthood can be a profound period of transition and identity status changes (e.g., moving from active employment into retirement, experiencing aging-related challenges). Adults ages 75 and older have the highest rate of death by suicide and the lowest ratio of suicide attempts to death (Garnett et al., 2023). Older adults face elevated suicide risk through cumulative losses due to the convergence of physical decline (chronic illness, pain, cognitive changes; Fässberg et al., 2016), financial vulnerability (Comans et al., 2013), and losses in relationships, which can lead to loneliness and isolation. Suicide risk in this group may be underassessed, particularly in regard to access to lethal means. Also relevant is the role of late-onset alcohol, substance, or prescription medication misuse to cope with grief or physical pain. Social determinants of risk include financial, housing, and food insecurity and lack of access to care. Protective factors include redefined identity and purpose, social connection, physical activities, learning new activities, increased spirituality, and connection to religion.

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 should 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.

Asian Community. The Asian American community is a diverse population within itself. Understanding cultural and identity-level factors (e.g., discrimination, acculturation, stress between generations navigating different expectations at home and in school/work environment, “saving face” by suppressing emotions to protect the family, and dealing with the “model minority” stereotype; Lee et al., 2009) are important within the Asian American community. These factors may lead to stigma regarding disclosing mental health distress and seeking services resulting in isolation, loneliness, and undertreatment of mental health conditions (Lee et al., 2009; Renahan, 2022). The stigma of disclosing mental health distress may lead to increased disclosure of physical symptoms (i.e., the somatization of emotional distress) and seeking medical help in an effort to mitigate the shame of admitting anxiety or depression (Choi et al., 2016). Protective factors include an active problem-focused coping strategy, strong ethnic identity and cultural connectedness, family cohesion, and social support from faith communities and cultural organizations. As with other populations, it is critical that social workers acknowledge their own cultural humility and limitations reading the dynamics that relate to this specific population and seek to educate themselves.

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 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/ethnic 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.

Hispanic/Latine Community. “Hispanic” is a U.S. Census term used to describe people who descend from Spain and Latin American countries, including Mexico, Central and South America, and the countries in the Caribbean where Spanish language is spoken. “Latina/Latino” (and gender-neutral “Latine”) refers to geography (people from Latin America who share similar values and may share the Spanish language, although Brazilians are considered Latines). This section focuses on the Latine population living in the United States.

Rates of death by suicide have increased among the Hispanic adolescent and adult populations, and suicide ideation and attempts continue to increase, particularly among female adolescents and nonelderly adults (Gaylor, 2023; Polanco-Roman et al., 2025; Verlenden, 2024). While clinical issues like depression and trauma are significant, risk is compounded by community-level trauma (e.g., violence, victimization) and structural inequalities, including acculturative and immigration stress, discrimination, acculturation gaps, underemployment, poverty, food insecurity, unsafe schools, and rising firearm access (Fortuna et al., 2016; Hall et al., 2021; Khubchandani & Price, 2022; Martínez et al., 2025; Silva & Van Orden, 2018). Protective factors cluster around strong, supportive relationships, school and community connectedness, and positive cultural identity and engagement. Responsive care addresses both individual and structural factors.

LGBTQIA+ Communities. LGBTQIA+ 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, which contribute to higher rates of suicide among this group. Culturally responsive care must address these layered experiences to support LGBTQIA+ individuals effectively.

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, moral injury, frequent transitions and relocations, reintegration challenges, and a culture of access to lethal means. Protective factors are also present, including purpose and a strong identity (e.g., camaraderie, mission focus, spirituality, and family). It is important to recognize and engage with the military community and potential military-specific resources, such as the Veterans Crisis Line offered by 988 Suicide and Crisis Lifeline and those offered by the U.S. Department of Veterans Affairs.

Non-Hispanic White Men. While the populations described earlier face elevated risk relative to their share of the general population and warrant the focused, culturally responsive practice this document outlines, White men consistently represent the single largest cohort of suicide deaths by total number (Centers for Disease Control and Prevention [CDC], 2025a). This pattern holds across age groups, with the highest suicide rates among middle-aged and older White men (El Ibrahimy et al., 2021). A critical prevention priority is their own barriers to help seeking, including cultural norms around self-reliance and emotional disclosure, underrepresentation among mental health providers, and disproportionately high rates of gun ownership. While it is important that research and prevention frameworks center minority and historically underrepresented populations given the documented disparities, this emphasis should not obscure the risk that suicide poses to White men. Comprehensive, population-aware practice requires holding the reality that all populations may be at risk for suicide. It is important to address the specific vulnerabilities of groups facing structural inequities.

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 (2025a) *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; Groth & Boccio, 2019; Kumbhare, 2022; 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 and support their supervisees during work with clients at risk for suicide and, if a client dies by suicide, during postvention.

Consultation can validate the social worker’s observations of suicide risk, associated risk and protective factors, and actions taken and not taken. Consultation serves to enhance professional judgment, promotes critical thinking, and improves decision making to better serve clients. Because social workers recognize the value of interprofessional 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, 2025a). 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 (Bongar & Stolberg, 2009; Scott & Underwood, 2025).

Social workers can be impacted by exposure to trauma, and may be considered suicide loss survivors following the suicide of a client. Receiving 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 SPRC 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 (2025a) *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

Social workers shall 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 should advance the profession's role in suicide prevention, intervention, and postvention through advocacy, community engagement, and leadership to 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 for national 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 lethal means; and digital media/artificial intelligence safety.
- Advocate for societal change to address social determinants of risk (e.g., broader conditions that contribute to suicide distress, such as housing instability, economic insecurity, systemic racism, and barriers to healthcare) to prevent suicide.
- Develop, adopt, and implement organizational policies and protocols related to these standards, including implementation of effective suicide prevention and suicide-specific intervention strategies and postvention protocols.
- Implement documentation standards reflecting suicide standards of care and safer care 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.
- 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 professional 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 standards of care for suicide. Not unlike being a mandated reporter for child abuse, social workers must be knowledgeable of the risk factors, warning signs, and protective factors; knowing how to screen for suicide risk, the resources to make a proper referral/warm handoff, and how to document the interaction and conduct a proper follow-up.

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 (Frey et al., 2025a, 2025b). 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.

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 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.

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 risk factors (including exposure to death), the client’s psychosocial history, social determinants that may be associated with suicide risk, current and prior history of suicidal thoughts and behaviors, and the client’s protective factors to inform clinical decisions (SPRC, 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 them—to encourage self-advocacy and self-judgment in negotiating the social services and welfare system (definitions from Barker, 2014).

COMMUNITY HELPER/TRUSTED HELPER/GATEKEEPER

Community helpers/trusted helpers, formerly known as gatekeepers in suicide prevention literature, are individuals who have face-to-face contact with many community members and may be in a position to identify people at risk of suicide and refer them to treatment or supporting services. These community helpers 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 community helper trainings.

CONTAGION

Suicide risk associated with knowledge of another person's suicidal behavior, either firsthand or through the media (CDC, 2024a). 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

How children typically grow cognitively, emotionally, and socially, developmental competence reflects the ability to assess where a child is in relation to expected developmental milestones (Henderson & Thompson, 2015). Social workers should 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. It is important to note the intersection of culture and other subgroups along with the developmental stage of the individual.

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.

LIVED EXPERIENCE

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

MALPRACTICE

When a social worker 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 client. 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.

MEANS SAFETY

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

MEDICAL ASSISTANCE IN DYING (MAID)

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*.

POSTVENTION

Activities following a death by suicide to help alleviate the suffering and emotional distress of the survivors and prevent additional trauma and contagion encompassing issues such as grief, loss, complicated bereavement, traumatic stress, posttraumatic growth, and suicide contagion.

PROTECTIVE FACTOR

A characteristic at the biological, psychological, family, or community level that is associated with a lower likelihood of problematic outcomes (i.e., a buffer) and that may reduce the impact of a risk factor on a suicide-related outcome. No protective factor is absolute and must be considered in the context of risk factors, age, and health status/severity of illness.

RISK FACTOR

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

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 replication 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 so as 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

The Stanley–Brown Safety Planning Intervention is 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 or 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 or PHQ-A (PHQ-9 adaptation for adolescents). 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 states or jurisdictions where 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, such as 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).

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 an intent to die as a result of the behavior (National Institute of Mental Health, n.d.-b). An additional list of terms related to suicide includes the following:

Suicidal or suicide 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 plan: Significant because a plan signals 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 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 Suicide Prevention (n.d.), CDC (2024b, 2025b), Center for Suicide Prevention and Recovery (n.d.), and 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 community helpers/trusted helpers (i.e., persons in a position to identify an individual at risk for suicide and make a warm handoff to an appropriate resource; formerly known as “gatekeepers”). 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 community helper 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).

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 and 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, and information on funding and training resources including the resources of the Jed Foundation)
- 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>
- Counseling on Access to Lethal Means ■ <https://www.calmamerica.org>
- Crisis Text Line ■ <https://www.crisistextline.org>
- National Guidelines for Workplace Suicide Prevention ■ <https://www.workplacesuicideprevention.com>
- National Strategy for Suicide Prevention, National Action Alliance for Suicide Prevention ■ <https://theactionalliance.org>
- SAFE-T, Suicide Assessment Five Step Evaluation and Triage ■ <https://library.samhsa.gov/product/safe-t-suicide-assessment-five-step-evaluation-and-triage/pep24-01-036>
- Stanley–Brown Safety Planning Intervention ■ <https://suicidesafetyplan.com>
- Suicide Awareness Voices of Education ■ <https://www.save.org>
- Suicide Prevention and Care Program, Indian Health Services ■ <https://www.ihs.gov/suicideprevention>

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>

Suicide Prevention Resource Center 📄 <https://sprc.org>

The Trevor Project 📄 <https://www.thetrevorproject.org> (suicide prevention for LGBTQ+ young people)

REFERENCES

- Abrutyn, S., Mueller, A. S., & Osborne, M. (2019). Rekeying cultural scripts for youth suicide: How social networks facilitate suicide diffusion and suicide clusters following exposure to suicide. *Society and Mental Health, 10*, 112–135. <https://doi.org/10.1177/2156869319834063>
- Alvarez, K., Polanco-Roman, L., Breslow, A. S., & Molock, S. (2022). Structural racism and suicide prevention for ethnoracially minoritized youth: A conceptual framework and illustration across systems. *American Journal of Psychiatry, 179*, 422–433. <https://doi.org/10.1176/appi.ajp.21101001>
- American Foundation for Suicide Prevention. (n.d.). *Brief interventions for managing suicidal crises*. <https://afsp.org/brief-interventions-for-managing-suicidal-crises>
- Apicella, M., Pontillo, M., Maglio, G., Di Vincenzo, C., Della Santa, G., Andracchio, E., & Vicari, S. (2025). Non-suicidal self-injury in adolescents: A clinician's guide to understanding the phenomenon, diagnostic challenges, and evidence-based treatments. *Frontiers in Psychiatry, 16*. <https://doi.org/10.3389/fpsyt.2025.1605508>
- Barker, R. L. (2014). *Social work dictionary* (6th ed.). NASW Press.
- Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J., & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry, 48*, 644–653.
- Bongar, B., & Stolberg, R. (2009). Risk management with the suicidal patient. *The Register Report*. <https://pages.charlotte.edu/richard-mcanulty/wp-content/uploads/sites/268/2013/09/Risk-Management-With-The-Suicidal-Patient.pdf>
- Brown, G. K., Pisani, A. R., & Harris, L. (2014, October 27). *Screening and assessment for suicide in health care settings: A patient-center approach* [PowerPoint slides]. National Action Alliance for Suicide Prevention. <https://zerosuicide.edc.org/sites/default/files/Screening%20and%20Assessment%20for%20Suicide%20in%20Health%20Care%20Settings%2010-27-14%20slides.pdf>
- Button, M. (2016). Suicide and social justice: Toward a political approach to suicide. *Political Research Quarterly, 69*, 270–280.
- Callahan, J. (1996). Social work with suicidal clients: Challenges of implementing practice guidelines and standards of care. *Health & Social Work, 21*, 277–285.

- Center for Suicide Prevention and Recovery. (n.d.). *Building a suicide care pathway: Practical guidelines and clinical tools*. <https://uwcspar.org/tool/building-a-suicide-care-pathway-practical-guidelines-and-clinical-tools>
- Centers for Disease Control and Prevention. (2024a, October 3). *How to report a suicide-related cluster or get assistance*. <https://www.cdc.gov/suicide/prevention/cluster.html>
- Centers for Disease Control and Prevention. (2024b, September 10). *Preventing suicide*. <https://www.cdc.gov/suicide/prevention/index.html>
- Centers for Disease Control and Prevention. (2025a). *Fatal injury trends*. Web-Based Injury Statistics Query and Reporting System. <https://wisqars.cdc.gov/fatal-injury-trends>
- Centers for Disease Control and Prevention. (2025b, March 6). *Suicide prevention communication playbook*. <https://www.cdc.gov/suicide/playbook/index.html>
- Choi, E., Chentsova-Dutton, Y., & Parrott, W. G. (2016). The effectiveness of somatization in communicating distress in Korean and American cultural contexts. *Frontiers in Psychology*, 7, Article 383. <https://doi.org/10.3389/fpsyg.2016.00383>
- Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P., & Bongar, B. (2013). A tool for the culturally competent assessment of suicide: The Cultural Assessment of Risk for Suicide (CARS) measure. *Psychological Assessment*, 25, 424–434. <https://doi.org/10.1037/a0031264>
- Clark, E. J., & Hoffer, E. F. (Eds.). (2014). *Hope matters: The power of social work*. NASW Press.
- Comans, T. A., Scanlan, J., Lind, J., & Scuffham, P. A. (2013). Financial hardship and social determinants of suicide in older adults. *Crisis*, 34, 390–397.
- Dahl-Jacinto, H., & Hays, D. G. (2024). A phenomenological investigation of counselors' perceived preparedness with suicidal clients. *Journal of Mental Health Counseling*, 46, 213–232. <https://doi.org/10.17744/mehc.46.3.02>
- Domaradzki, J. (2021). The Werther effect, the Papageno effect or no effect? A literature review. *International Journal of Environmental Research and Public Health*, 18, Article 2396. <https://doi.org/10.3390/ijerph18052396>
- El Ibrahim, S., Smith, M. L., Chapagain, M., & Virgen, E. M. (2021). Suicide distribution and trends among male older adults in the U.S., 1999–2018. *American Journal of Preventive Medicine*, 61, 183–191. <https://doi.org/10.1016/j.amepre.2021.02.014>
- Fässberg, M. M., Cheung, G., Canetto, S. S., Erlangsen, A., Lapierre, S., Lindner, R., Draper, B., Gallo, J. J., Wong, C., Wu, J., Duberstein, P., & Wærn, M. (2016). A systematic review of physical illness, functional disability, and suicidal behaviour among older adults. *Aging & Mental Health*, 20, 166–194.

- Fortuna, L., Alvarez, K., Ortiz, Z., Wang, Y., Alegría, X., Cook, B., & Alegría, M. (2016). Mental health, migration stressors and suicidal ideation among Latino immigrants in Spain and the United States. *European Psychiatry*, 36, 15–22. <https://doi.org/10.1016/j.eurpsy.2016.03.001>
- Frey, J. J., Spencer-Thomas, S., & Mortali, M. G. (2025b). Strategies for organizational leaders and human resources professionals in workplace suicide prevention and postvention. In M.-L. Germain (Ed.), *Suicide in the workplace: Coping strategies for employees* (pp. 177–204). Palgrave Macmillan.
- Frey, J. J., Spencer-Thomas, S., & Mortali, M. (2025b). Workplace suicide postvention: Research insights and actionable frameworks. In M.-L. Germain (Ed.), *Suicide in the workplace: Coping strategies for employees* (pp. 205–216). Palgrave Macmillan.
- Garnett, M. F., Spencer, M. R., & Weeks, J. D. (2023). *Suicide among adults age 55 and older, 2021* [NCHS Data Brief No. 483]. National Center for Health Statistics. <https://doi.org/10.15620/cdc:133701>
- Gaylor, E. M. (2023). Suicidal thoughts and behaviors among high school students—Youth Risk Behavior Survey, United States, 2021. *MMWR Supplements*, 72.
- Groth, T., & Boccio, D. E. (2019). Psychologists' willingness to provide services to individuals at risk of suicide. *Suicide and Life-Threatening Behavior*, 49, 1241–1254. <https://doi.org/10.1111/sltb.12501>
- Gualtieri, S., Verrina, M. C., Sacco, M. A., Tarda, L., Calanna, L., Calafiore, J., Lombardo, S., Gratteri, S., & Aquila, I. (2024). Copycat in suicide: A systematic review of the literature. *Journal of Clinical Medicine*, 13, Article 7118. <https://doi.org/10.3390/jcm13237118>
- Hall, M., Fullerton, L., Green, D., & Fitzgerald, C. (2021). Positive relationships with adults and resilience to suicide attempt among New Mexico Hispanic adolescents. *International Journal of Environmental Research and Public Health*, 18. <https://doi.org/10.3390/ijerph181910430>
- Harvard Injury Control Research Center. (n.d.). *Means matter*. Harvard School of Public Health. <https://hsph.harvard.edu/research/means-matter>
- Heller, N. R. (2015). Risk, hope and recovery: Converging paradigms for mental health approaches with suicidal clients. *British Journal of Social Work*, 45, 1788–1803.
- Henderson, D. A., & Thompson, C. L. (2015). *Counseling children* (9th ed.). Cengage Learning.
- Hepworth, D. H., Rooney, R. H., Rooney, G. D., & Strom-Gottfried, K. (2016). *Direct social work practice: Theory and skills* (10th ed.). Cengage Learning.
- Horowitz, L. M., Bridge, J. A., Teach, S. J., Ballard, E., Klima, J., Rosenstein, D. L., Wharff, E. A., Ginnis, K., Cannon, E., Joshi, P., & Pao, M. (2012).

- Ask Suicide-Screening Questions (ASQ): A brief instrument for the pediatric emergency department. *Archives of Pediatric Adolescent Medicine*, 166, 1170–1176. <https://doi.org/10.1001/archpediatrics.2012.1276>
- Inagaki, M., Kawashima, Y., Yonemoto, N., & Yamada, M. (2019). Active contact and follow-up interventions to prevent repeat suicide attempts during high-risk periods among patients admitted to emergency departments for suicidal behavior: A systematic review and meta-analysis. *BMC Psychiatry*, 19, Article 44. <https://doi.org/10.1186/s12888-019-2017-7>
- Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide & Life-Threatening Behavior*, 42, 640–653. <https://doi.org/10.1111/j.1943-278X.2012.00119.x>
- Jobes, D. A., Mandel, A. A., Kleiman, E. M., Bryan, C. J., Johnson, S. L., & Joiner, T. E. (2024). Facets of suicidal ideation. *Archives of Suicide Research*, 28, 1263–1278. <https://doi.org/10.1080/13811118.2023.2299259>
- Johnson, J. G., Harris, E. S., Spitzer, R. L., & Williams, J. B. (2002). The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. *Journal of Adolescent Health*, 30, 196–204. [https://doi.org/10.1016/S1054-139X\(01\)00333-0](https://doi.org/10.1016/S1054-139X(01)00333-0)
- Kalafat, J., & Underwood, M. (2004). Crisis intervention in the context of outpatient treatment of suicidal clients. In R. I. Yufit & D. Lester (Eds.), *Assessment, treatment, and prevention of suicidal behavior* (pp. 163–180). Wiley.
- Khubchandani, J., & Price, J. (2022). Suicides among non-elderly adult Hispanics, 2010–2020. *Journal of Community Health*, 47, 966–973. <https://doi.org/10.1007/s10900-022-01123-2>
- Kleiman, E. M., Turner, B. J., Fedor, S., Beale, E. E., Huffman, J. C., & Nock, M. K. (2017). Examination of real-time fluctuations in suicidal ideation and its risk factors: Results from two ecological momentary assessment studies. *Journal of Abnormal Psychology*, 126, 726–738. <https://doi.org/10.1037/abn0000273>
- Knapp, S. (2024). Laws, risk management, and ethical principles when working with suicidal patients. *Professional Psychology: Research & Practice*, 55, 1–10. <https://doi.org/10.1037/pro0000554>
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (1999). *Patient Health Questionnaire-9 (PHQ-9)* [Database record]. APA PsycTests. <https://doi.org/10.1037/t06165-000>
- Kumbhare, S. (2022). A reconceptualization of suicide and social workers' duty to report. *Omega: Journal of Death & Dying*, 86, 157–173. <https://doi.org/10.1177/0030222820963773>

- Large, M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLOS One*, 359, Article e0156322. <https://doi.org/10.1371/journal.pone.0156322>
- Large, M. M., Ryan, C. R., Carter, G., & Kapur, N. (2017). Can we usefully stratify patients according to suicide risk? *BMJ*, 359, Article j4627. <https://doi.org/10.1136/bmj.j4627>
- Lee, S., Juon, H. S., Martinez, G., Hsu, C. E., Robinson, E. S., Bawa, J., & Ma, G. X. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal Community Health*, 34, 144–152. <https://doi.org/10.1007/s10900-008-9137-1>
- Magnan, S. (2017). *Social determinants of health 101 for health care: Five plus five* [Discussion paper]. National Academy of Medicine. <https://doi.org/10.31478/201710c>
- Martínez, A., Kloft, S., Fernández, P., Dezyani, P., Ricci, A., Hernández, D., & Cunningham, K. (2025). A scoping review of suicide prevention interventions for Latinx adults: Strategies, gaps, and future directions. *Frontiers in Public Health*, 13. <https://doi.org/10.3389/fpubh.2025.1481904>
- Molock, S. D., Boyd, R. C., Alvarez, K., Cha, C., Denton, E. G., Glenn, C. R., Katz, C. C., Mueller, A. S., Meca, A., Meza, J. I., Miranda, R., Ortin-Peralta, A., Polanco-Roman, L., Singer, J. B., Zullo, L., & Miller, A. B. (2023). Culturally responsive assessment of suicidal thoughts and behaviors in youth of color. *American Psychologist*, 78, 842–855. <https://doi.org/10.1037/amp0001140>
- National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). *Recommended standard care for people with suicide risk: Making health care suicide safe*. Educational Development Center. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
- National Association of Social Workers. (2003). *Standards for the practice of social work with adolescents*. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-the-Practice-of-Social-Work-with-Adolescents>
- National Association of Social Workers. (2013). *Standards for social work case management*. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Social-Work-Case-Management>
- National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice*. <https://www.socialworkers.org/Practice/NASW-Standards-Guidelines/NASW-Standards-for-Cultural-Competence-in-Social-Work-Practice>

- .org/Practice/NASW-Practice-Standards-Guidelines/Standards-and-Indicators-for-Cultural-Competence-in-Social-Work-Practice
- National Association of Social Workers. (2021). *Code of ethics of the National Association of Social Workers*. <https://www.socialworkers.org/about/ethics/code-of-ethics>
- National Association of Social Workers. (2025a). *Practice standards for clinical social workers*. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Clinical-Social-Work-in-Social-Work-Practice>
- National Association of Social Workers. (2025b). *Practice standards for school social workers*. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Practice-Standards-for-School-Social-Workers>
- National Association of Social Workers. (2026). *Practice standards for serious illness care: Hospice and palliative social work*. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Practice-Standards-for-Serious-Illness-Care-Hospice-and-Palliative-Social-Work>
- National Association of Social Workers & Association of Social Work Boards. (2013). *Best practice standards in social work supervision*. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Best-Practice-Standards-in-Social-Work-Supervision>
- National Institute of Mental Health. (n.d.-a). *Adult outpatient brief suicide safety assessment guide*. Retrieved February 20, 2026, from <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/adult-outpatient/adult-outpatient-brief-suicide-safety-assessment-guide>
- National Institute of Mental Health. (n.d.-b). *Suicide*. Retrieved February 20, 2026, from <https://www.nimh.nih.gov/health/statistics/suicide>
- National Institute on Minority Health and Health Disparities. (2025). *What are health disparities?* <https://www.nimhd.nih.gov/about/what-are-health-disparities>
- Niederkrötenhaler, T., Voracek, M., Herberth, A., Till, B., Strauss, M., Etzersdorfer, E., Eisenwort, B., & Sonneck, G. (2010). Role of media reports in completed and prevented suicide—Werther versus Papageno effects. *British Journal of Psychiatry*, 197, 234–243. <https://doi.org/10.1192/bjp.bp.109.074633>
- Niedzwiedz, C., Haw, C., Hawton, K., & Platt, S. (2014). The definition and epidemiology of clusters of suicidal behavior: A systematic review. *Suicide and Life-Threatening Behavior*, 44, 569–581. <https://doi.org/10.1111/sltb.12091>

- Nock, M. K., & Favazza, A. R. (2009). Nonsuicidal self-injury: Definition and classification. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 9–18). American Psychological Association.
- O'Connor, N., Warby, M., Raphael, B., & Vassallo, T. (2004). Changeability, confidence, common sense and corroboration: Comprehensive suicide risk assessment. *Australian Psychiatry*, 12, 352–360.
- Polanco-Roman, L., Oh, S., Vélez-Grau, C., Keum, B., & Miranda, R. (2025). Suicide trends from 2001 to 2022 among Latine populations in the U.S. [Preprint]. *The Lancet*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5350568
- Pollock, N. J. (2019). Place, the built environment, and means restriction in suicide prevention. *International Journal of Environmental Research and Public Health*, 16, Article 4389. <https://doi.org/10.3390/ijerph16224389>
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, 168, 1266–1277. <https://doi.org/10.1176/appi.ajp.2011.10111704>
- Praetorius, R. T. (2021). Assessment for suicide risk. In C. Jordan & C. Franklin (Eds.), *Clinical assessment in social work: Quantitative and qualitative methods* (5th ed., pp. 1–18). Oxford University Press.
- Reamer, F. (2003). *Social work malpractice and liability: Strategies for prevention* (2nd ed.). Columbia University Press.
- Reamer, F. G. (2005). Documentation in social work: Evolving ethical and risk-management standards. *Social Work*, 50, 325–334. <https://doi.org/10.1093/sw/50.4.325>
- Reamer, F. (2013). *Social work values and ethics* (4th ed.). Columbia University Press.
- Renahan, C. (2022) “Model minority” mental health: An examination of the barriers to effective care among young AAPIs. *Undergraduate Journal of Public Health*, 6. <https://doi.org/10.3998/ujph.2317>
- Rudd, M. D. (2006). Fluid vulnerability theory: A cognitive approach to understanding the process of acute and chronic suicide risk. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 355–368). American Psychological Association. <https://doi.org/10.1037/11377-016>
- Rudd, M. D., Cukrowicz, K. C., & Bryan, C. J. (2008). Core competencies in suicide risk assessment and management: Implications for supervision. *Training and Education in Professional Psychology*, 2, 219–228. <https://doi.org/10.1037/1931-3918.2.4.219>

- Rudd, M. D., Mandrusiak, M., & Joiner, T. E., Jr. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*, 62, 243–251.
- Sanders, S., Jacobson, J. M., & Ting, L. (2008). Preparing for the inevitable: Training social workers to cope with client suicide. *Journal of Teaching in Social Work*, 28, 1–18. <https://doi.org/10.1080/08841230802178821>
- Sanders, S., Ting, L., Power, J., & Jacobson, J. M. (2006). Social workers' views of no suicide contracts. *Social Work in Mental Health*, 4, 51–66. https://doi.org/10.1300/J200v04n04_04
- Scott, M., & Underwood, M. (2025). Evaluating standards of care training for social workers completing suicide risk assessment. *Research on Social Work Practice*. Advance online publication. <https://doi.org/10.1177/10497315251346037>
- Silva, C., & Van Orden, K. (2018). Suicide among Hispanics in the United States. *Current Opinion in Psychology*, 22, 44–49. <https://doi.org/10.1016/j.copsyc.2017.07.013>
- Simpson, S., Berman, L., & Stefan, S. (2016, May 27). *Legal and liability issues in suicide care* [Webinar]. Zero Suicide in Health and Behavioral Care. <https://zerosuicide.edc.org/sites/default/files/Legal%20and%20Liability%20Issues%20in%20Suicide%20Care%205.27.16%20PPT%20Transcript.pdf>
- Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19, 256–264. <https://doi.org/10.1016/j.cbpra.2011.01.001>
- Stanley, I. H., Simpson, S., Wortzel, H. S., & Joiner, T. E. (2019). Documenting suicide risk assessments and proportionate clinical actions to improve patient safety and mitigate legal risk. *Behavioral Sciences & the Law*, 37, 304–312. <https://doi.org/10.1002/bsl.2409>
- Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health* (HHS Publication No. PEP25-07-007, NSDUH Series H-60). <https://www.samhsa.gov/data/report/2024-nsduh-annual-national-report>
- Suicide Prevention Resource Center. (n.d.-a). *Best Practices Registry*. <https://bpr.sprc.org>
- Suicide Prevention Resource Center. (n.d.-b). *A comprehensive approach to suicide prevention*. <https://sprc.org/effective-prevention/comprehensive-approach>
- Suicide Prevention Resource Center. (n.d.-c). *Safe and effective messaging and reporting*. <https://sprc.org/keys-to-success/safe-and-effective-messaging-and-reporting>

- Suicide Prevention Resource Center. (2006). *Core competencies in the assessment and management of suicide risk*.
- Suicide Prevention Resource Center. (2025). *Suicide risk assessment resource guide*. <https://sprc.org/wp-content/uploads/suicide-risk-assessment-resource-guide.pdf>
- Suicide Prevention Resource Center. (2026). *Suicide screening and assessment*. <https://sprc.org/wp-content/uploads/Suicide-Screening-and-Assessment.pdf>
- Tiesman, H. M., Frey, J. J., & Spencer-Thomas, S. (2023, March 15). *Critical steps your workplace can take today to prevent suicide*. NIOSH Science Blog, Centers for Disease Control and Prevention. <https://blogs.cdc.gov/niosh-science-blog/2023/03/15/preventing-workplace-suicide>
- Ting, L., Jacobson, J. M., & Sanders, S. (2008). Available supports and coping behaviors of mental health social workers following fatal and nonfatal client suicide behavior. *Social Work, 53*, 211–221. <https://doi.org/10.1093/sw/53.3.211>
- Ting, L., Sanders, S., Jacobson, J. M., & Power, J. (2006). Dealing with the aftermath: A qualitative analysis of reactions of mental health social workers after a client suicide. *Social Work, 51*, 329–342. <https://doi.org/10.1093/sw/51.4.329>
- Underwood, M., Springer, J., Scott, M., & Fritz, S. (2018). *Lifelines intervention: Helping students at risk for suicide*. Hazelden Publishing.
- Verlenden, J. V. (2024). Mental health and suicide risk among high school students and protective factors—Youth Risk Behavior Survey, United States, 2023. *MMWR Supplements, 73*.
- Walling, M. A. (2021). Suicide contagion. *Current Trauma Reports, 7*, 103–114. <https://doi.org/10.1007/s40719-021-00219-9>
- Zero Suicide Institute. (2018). *Lived experience*. Education Resource Center. <https://zerosuicide.edc.org/toolkit/lead/lived-experience>
- Zonana, H. (2008). Commentary: When is a practice guideline only a guideline? *Journal of the American Academy of Psychiatry and the Law, 36*, 302–305. <https://jaapl.org/content/jaapl/36/3/302.full.pdf>



National Association of Social Workers
750 First Street NE, Suite 800
Washington, DC 20002-4241
202.408.8600

www.socialworkers.org

