



The Role of Clinical Social Workers and Mental Health Counselors in Preventing Suicide

Recognizing the Warning Signs

Responding to the Warning Signs

References

Resources

- **Resources for Clinical Social Workers and Mental Health Counselors**
- **General Resources on Suicide and Suicide Prevention**

Martha worked at a community mental health center. Edward had been her client for six months, ever since he'd been released from the hospital, where he'd been treated for bipolar disorder. Recently, his drinking had intensified, and today, for the first time, he had come to a session intoxicated. Edward was extremely remorseful, though, telling Martha, "You never have to worry about seeing me in this condition again. No one will ever have to see me in this condition again." Martha asked him what he meant by this. He replied, "You know. You know." Martha asked if he were planning to kill himself. He just looked at the floor despondently. Martha said that, under the circumstances, she thought it was better to bring in some help, and she asked Edward if he minded. He said he didn't think that anyone could help, but he didn't care if she called someone. Martha had the center's receptionist get in touch with both Edward's wife and the center's consulting psychologist, and Martha kept Edward in her office until they arrived. Together, they and Edward agreed that it might be best if he returned to the hospital for a while. Martha called to make the arrangements, and Edward and his wife went directly from the center to the hospital.

The Role of Clinical Social Workers and Mental Health Counselors in Preventing Suicide

Ninety percent of suicides that take place in the United States are associated with mental illness, including disorders involving the abuse of alcohol and other drugs (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Approximately 50 percent of those who die by suicide were in treatment with a mental health professional at the time of their death (Goldsmith et al., 2002). The suicide of a client has been called an "occupational hazard" for psychologists and other mental health providers (Bongar, 2002).

Two major risk factors for suicide are the presence of more than one psychiatric diagnosis (or the co-occurrence of a psychiatric diagnosis and substance abuse) and affective disorders, particularly depression. Research indicates that 50 percent of those who die by suicide were afflicted with major depression and that the suicide rate of people with major depression is eight times that of the general population. However, it's important to note that the majority of those with major depression do not, in fact, die by suicide (Jacobs, Brewer, & Klein-Benheim, 1999). One of the major challenges for

This effort has been funded in part with Federal funds from the [National Institute of Mental Health](#), [National Institutes of Health](#), under Contract No. N44MH22044.

clinical social workers and others engaged in mental health counseling is deciding who among their clients is at serious risk of suicide and requires intervention.

This publication was not designed to provide guidance for the clinical assessment or treatment of patients who are at risk of suicide. Rather, our goal is to provide some overarching considerations to help practitioners determine when further assessment or treatment might be warranted. More comprehensive information on assessment and treatment can be found in the [References](#) and [Resources](#) sections, below.

Recognizing the Warning Signs

People who are in danger of harming themselves may try to reach out to you—sometimes directly, sometimes indirectly. This can be true for someone with whom you have established a professional relationship as well as someone you are seeing for the first time. As a clinical social worker or mental health counselor, you should be alert for imminent warning signs that a patient may be at risk of suicide, for example:

- Talking about suicide or death
- Giving direct verbal cues, such as “I wish I were dead” and “I’m going to end it all”
- Giving less direct verbal cues, such as “What’s the point of living?”, “Soon you won’t have to worry about me,” and “Who cares if I’m dead, anyway?”
- Isolating him- or herself from friends and family
- Expressing the belief that life is meaningless or hopeless
- Giving away cherished possessions
- Exhibiting a sudden and unexplained improvement in mood after being depressed or withdrawn
- Neglecting his or her appearance and hygiene

These signs are especially critical if the patient has a history or current diagnosis of a psychiatric disorder, such as depression, alcohol or other drug abuse, bipolar disorder, or schizophrenia.

A client’s recent history may provide additional evidence of his or her risk of suicide. Recent life stressors, including physical illness (especially if associated with pain), emotional trauma (resulting from, for example, the loss of a job or a loved one), and whether the client has access to lethal means (especially guns), provide valuable information about a client’s risk (Jacobs et al., 1999). Clients who struggle with feelings of helplessness, hopelessness, or depression, or who have had recent experiences in which they felt humiliated or that they believe will bring shame to their families (Bongar, 2002), may also be at elevated risk.

Responding to the Warning Signs

According to the *Harvard Medical School Guide to Suicide Assessment and Intervention*, “There is no psychological test, clinical technique, or biological marker sufficiently sensitive and specific to support accurate short-term prediction of suicide in an individual person” (Jacobs et al., 1999, p. 4). However, the guide also suggests that the use of a suicide assessment can “allow for a more informed intervention” (p. 6). These interventions can include decisions about whether additional expertise, medication, or hospitalization is warranted.

While there are a number of formal suicide risk instruments, survey research indicates that the majority of clinical social workers prefer to rely on a clinical interview to assess suicide risk (King, Kovan, London, & Bongar, 1999). A starting place for such an interview is by explicitly asking whether the client has been thinking of suicide, and, if so, whether he or she has made a plan and/or has access to lethal means (especially a firearm). Other considerations in assessing immediate risk include the presence and intensity of hopelessness and psychological pain, whether the client has actively engaged in suicide planning, and whether the client has engaged in previous self-destructive behavior.¹

The use of medications (especially antidepressants) should always be considered when developing a comprehensive treatment plan for patients with a major depressive disorder, or patients who express suicidal ideation, intent, or plans. Antidepressants are effective in reducing the symptoms of depression, as well as other problems, including obsessive-compulsive disorders and panic disorders. The Food and Drug Administration has determined that there is some evidence for an association between the class of antidepressants known as selective serotonin reuptake inhibitors and the emergence of suicidal behaviors, particularly in children and adolescents. Although this is a relatively rare occurrence, mental health professionals should carefully monitor the signs and symptoms of depression during the first few months of treatment with any antidepressant medication. Careful monitoring might include frequently contacting the client (in person or by telephone), teaching the client’s family and support network how to monitor the emergence of suicidal ideation and behaviors, and providing emergency contact information.

You may determine that a client needs an inpatient assessment or treatment. It is always preferable for patients to be active participants in the decision to be hospitalized—to voluntarily agree to be hospitalized and to “sign in” on their own, taking full responsibility for their decision and acknowledging the purpose of the hospitalization. If a client is incapable of signing in voluntarily or refuses to do so, it will be necessary for you, ideally in collaboration with the patient’s family, to initiate an involuntary commitment process in which the client is hospitalized against his or her will. All states have policies and procedures for initiating and completing such a process. You should familiarize yourself with your state’s policies on both voluntary and involuntary admission procedures.

¹ For more information on assessing suicide risk, see Jacobs et al., 1999, and Linehan, 1999.

References

- Appleby, L., Shaw, J., Amos, T., et al. (1999). *Safer services: Report of the National Confidential Inquiry into suicide and homicide by people with mental illness*. London: Department of Health.
- Bongar, B. (2002). *The suicidal patient: Clinical and legal standards of care* (2nd ed.). Washington, DC: American Psychological Association.
- Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press. Retrieved March 14, 2005, from <http://www.nap.edu/books/0309083214/html/>
- Jacobs, D., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment: An overview and recommended protocol. In D. Jacobs (Ed.), *Harvard Medical School guide to suicide assessment and intervention* (pp. 3–39). San Francisco: Jossey-Bass.
- King, A., Kovan, R., London, R., & Bongar, B. (1999). Toward a standard of care for treating suicidal outpatients: A survey of social workers' beliefs about appropriate treatment behaviors. *Suicide and Life-Threatening Behavior*, 29(4), 347–352.
- King, E., & Barraclough, B. (1990). Violent death and mental illness: A study of a single catchment area over eight years. *British Journal of Psychiatry*, 156, 714–720.
- Linehan, M. (1999). Standard protocol for assessing and treating suicidal behaviors. In D. Jacobs (Ed.), *Harvard Medical School guide to suicide assessment and intervention* (pp. 146–187). San Francisco: Jossey-Bass.

Resources

Resources for Clinical Social Workers and Mental Health Counselors

Treatment Resources

American Academy of Child and Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(7 Suppl), 24S–51S.

(The full text of this article is available for members at the American Academy of Child and Adolescent Psychiatry website: <http://www.aacap.org/>. A summary is available at http://www.guideline.gov/summary/summary.aspx?doc_id=3019.)

American Psychiatric Association. (2003). *Practice guidelines for the assessment and treatment of patients with suicidal behaviors*. Arlington, VA: Author. Retrieved April 12, 2005, from http://www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf

Bongar, B., Berman, A., Maris, R., Silverman, M., Harris, E., & Packman, W. (Eds.). (1998). *Risk management with suicidal patients*. New York: Guilford Publications.

Bronheim, H. E., Fulop, G., Kunkel, E. J., Muskin, P. R., Schindler B. A., Yates W. R., et al. (1998). The Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting. *Psychosomatics*, 39(4), S8–S30. Retrieved March 23, 2005, from <http://www.apm.org/prac-gui/psy39-s8.shtml>

Brown, G. (2002). *A review of suicide assessment measures for intervention research with adults and older adults*. Bethesda, MD: National Institute of Mental Health. Retrieved April 12, 2005, from <http://www.nimh.nih.gov/suicideresearch/adultsuicide.pdf>

Ellis, T. (2002). Psychotherapy with suicidal patients. In D. Lester (Ed.), *Suicide prevention: Resources for the millennium* (pp. 129–152). Philadelphia: Brunner-Routledge.

Frierson, R. L., Melikian, M., & Wadman, P. C. (2002). Principles of suicide risk assessment: How to interview depressed patients and tailor treatment. *Postgraduate Medicine*, 11(3), 65–66, 69–71. Retrieved April 12, 2005, from http://www.postgradmed.com/issues/2002/09_02/frierson4.htm

- Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press. Retrieved March 14, 2005, from <http://www.nap.edu/books/0309083214/html/>
- Goldston, D. (2002). *Assessment of suicidal behaviors and risk among children and adolescents*. Bethesda, MD: National Institute for Mental Health. Retrieved April 12, 2005, from <http://www.nimh.nih.gov/suicideresearch/measures.pdf>
- Hawton, K., & Wan Heeringen, K. (Eds.). (2000). *International handbook of suicide and attempted suicide*. Chichester, UK: John Wiley and Sons.
- Jacobs, D. (Ed.). (1999). *The Harvard Medical School guide to suicide assessment and intervention*. San Francisco: Jossey-Bass.
- Maris, R., Berman, A., & Silverman, M. M. (Eds.). (2000). *Comprehensive textbook of suicidology*. New York: Guilford Press.
- Quinnett, P. G. (2000). *Counseling suicidal people: A therapy of hope*. Spokane, WA: QPR Institute. Retrieved March 18, 2005, from <http://www.qprinstitute.com/>
- Roy, A. (2001). Psychiatric treatment in suicide prevention. In D. Lester (Ed.), *Suicide prevention: Resources for the millennium* (pp. 103–128). Philadelphia: Brunner Routledge.

Videos

- American Foundation for Suicide Prevention (Writer) & Kingsley Communications (Producer). (1999). *The suicidal patient: Assessment and care* [Motion picture]. (Available from the American Foundation for Suicide Prevention at <http://www.afsp.org/survivor/doctor.htm>)

Websites

- Therapists as Survivors of Patient Suicide (http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm). This website is a project of the Clinician Survivor Task Force of the American Association of Suicidology. It contains a bibliography, personal accounts, clinician contacts, and annotated references.

General Resources on Suicide and Suicide Prevention

Suicide Prevention Resource Center (<http://www.sprc.org/>). The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and materials to strengthen suicide prevention efforts. Among the resources found on its website is the SPRC Library Catalog (<http://library.sprc.org/>), a searchable database containing a wealth of information on suicide and suicide prevention, including publications, peer-reviewed research studies, curricula, and web-based resources. Many of these items are available online. [Clinical Resources](#) can be accessed through a link on the left-hand side of the Library Catalog.

American Association of Suicidology (<http://www.suicidology.org/>). The American Association of Suicidology is a nonprofit organization dedicated to the understanding and prevention of suicide. It promotes research, public awareness programs, public education, and training for professionals and volunteers and serves as a national clearinghouse for information on suicide.

American Foundation for Suicide Prevention (<http://www.afsp.org>). The American Foundation for Suicide Prevention (AFSP) is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP's activities include supporting research projects; providing information and education about depression and suicide; promoting professional education for the recognition and treatment of depressed and suicidal individuals; publicizing the magnitude of the problems of depression and suicide and the need for research, prevention, and treatment; and supporting programs for suicide survivor treatment, research, and education.

National Center for Injury Prevention and Control (<http://www.cdc.gov/ncipc/>). The National Center for Injury Prevention and Control (NCIPC), located at the Centers for Disease Control and Prevention, is a valuable source of information and statistics about suicide, suicide risk, and suicide prevention. To locate information on suicide and suicide prevention, scroll down the left-hand navigation bar on the NCIPC website and click on "Suicide" under the "Violence" heading.

National Suicide Prevention Lifeline (<http://www.suicidepreventionlifeline.org/>). The National Suicide Prevention Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: (800) 273-TALK (8255). Technical assistance, training, and other resources are available to the crisis centers and mental health service providers that participate in the network of services linked to the National Suicide Prevention Lifeline.

Suicide Prevention Action Network USA (<http://www.spanusa.org>). Suicide Prevention Action Network USA (SPAN USA) is the nation's only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors (those who have lost a loved one to suicide) and others to advance public policies that help prevent suicide.