But I'm not a clinician: Role of all social workers in suicide prevention

SUICIDE PREVENTION RESEARCH & TRAINING PROJECT
MONMOUTH UNIVERSITY
SCHOOL OF SOCIAL WORK

MICHELLE SCOTT
"Time of Accelerated Change"
2026 Annual BPD Conference

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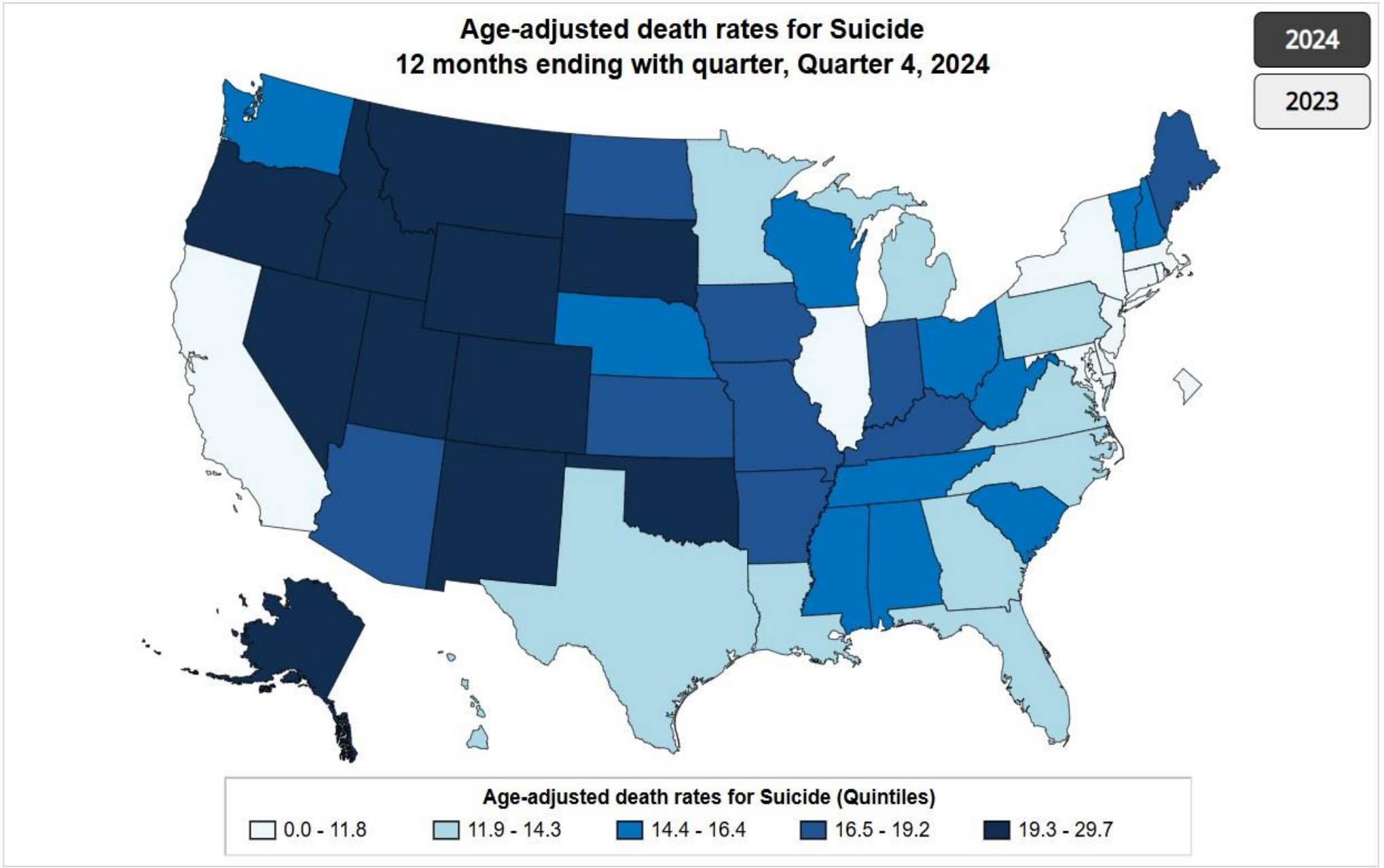
Co-chair of the NASW Standards of Care for Suicide Taskforce

What We'll Cover

1. Identifying the Problem

The scope of the problem


Age-adjusted death rates for Suicide
12 months ending with quarter, Quarter 4, 2024
2024
2023
Age-adjusted death rates for Suicide (Quintiles)
0.0 - 11.8
11.9 - 14.3
14.4 - 16.4
16.5 - 19.2
19.3 - 29.7

CDC, 2026

The Scope of the Problem-Suicide Data

- **48,800 individuals died by suicide 13.7/100,000**
  - **2024 provisional data**
  - More than1.5 million individuals made a suicide attempt.

- Effects all ages, genders and ethnicities
  - Older adults (over age of 75) highest rate
  - Second leading cause of death in individuals ages 10–34.
  - Males 50% population, 80% of deaths by suicide
  - Disproportionately effects:
    - Those identify as LGBTQIA+
    - Military/veterans
    - Involved in the criminal justice system
    - American Indians, Alaskan Natives or Black

CDC, 2026 & 2024; Na et al., 2025; Hockhauser et al, 2020

2. Relevance to BSW Social Workers

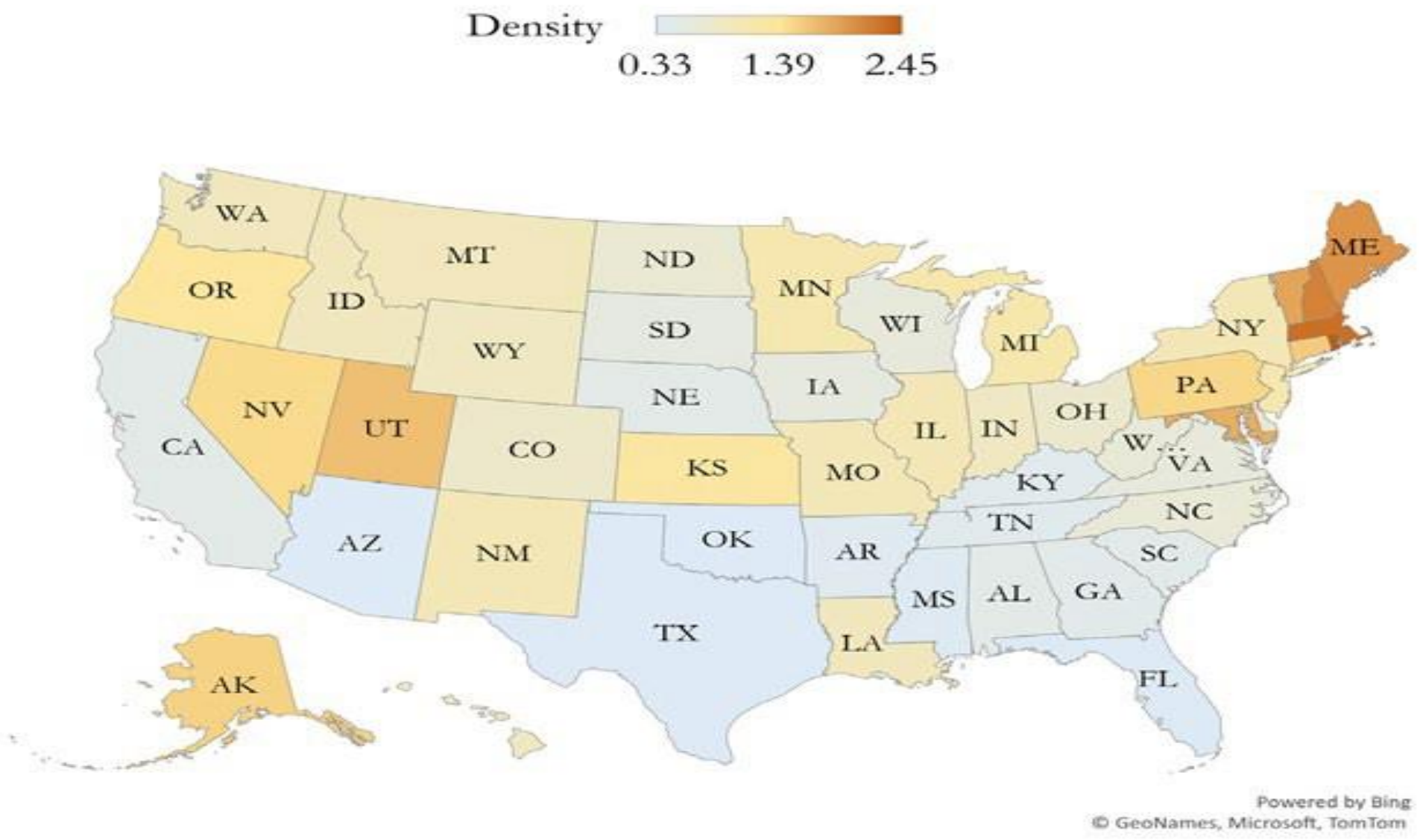
CLARIFYING	The scope of the problem
INCLUDING	**Relevance to BSW social workers**

- Social workers provide majority of mental health services
  - 50-90% had client who is suicidal or made an attempt
  - About a third had a client die by suicide
  - Social work students interacting with clients at risk for suicide or currently suicidal has increased from 40% to 70.6% in the past 10 years
    - 11.5% of MSW students lost a client to suicide while in placement

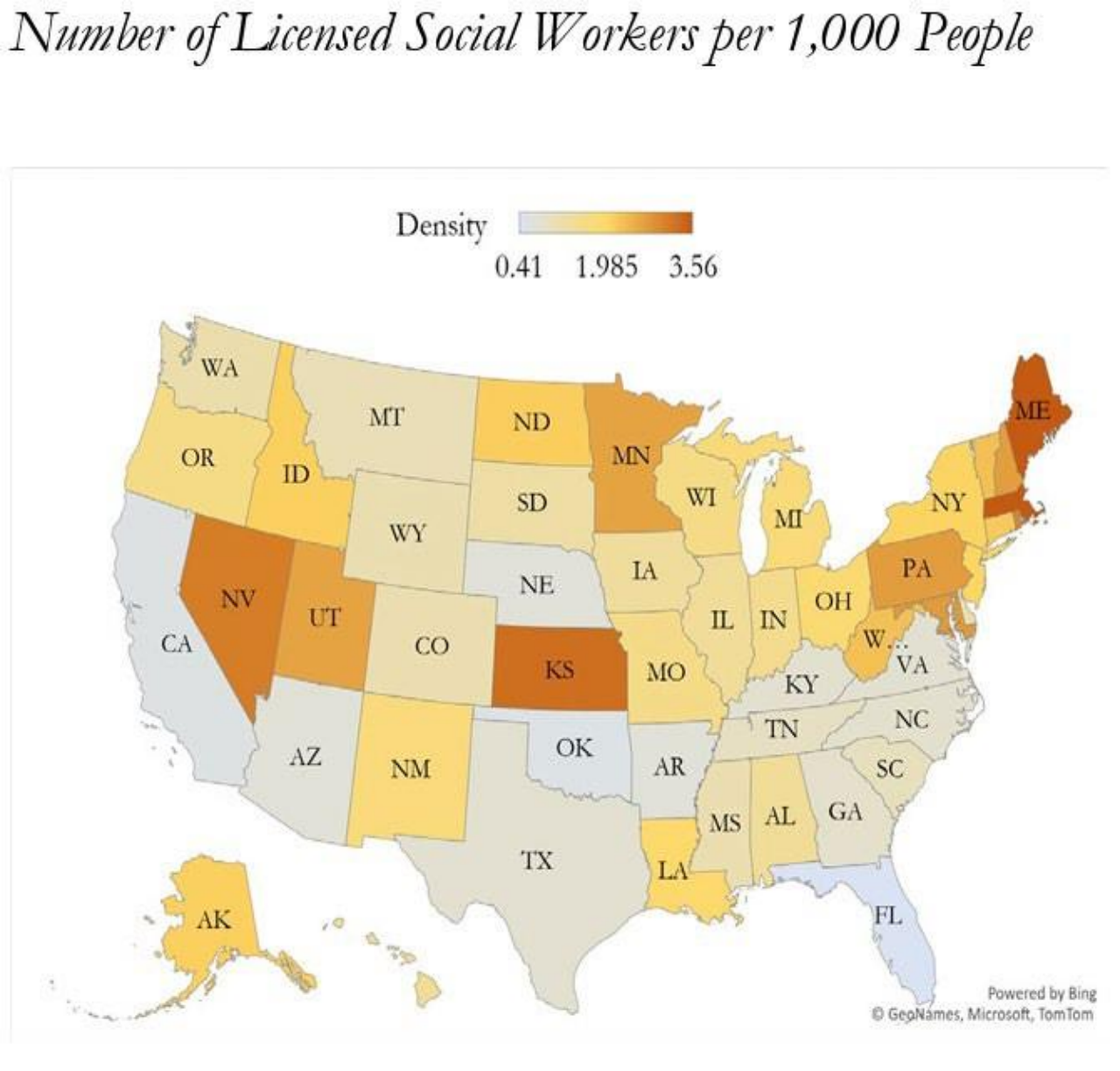
Ok but I'm not a clinician….

US Bureau of Labor Statistics, 2024; Feldman & Freedenthal, 2006; Jacobson et al., 2004; Sanders et al., 2008; Schmidt, 2016; Christensen, 2024; Peterson et al, 2002; Simpson, et al.,2016; Bonger and Stolberg, 2009; **Jobes et al., 2008;** (Groth & Boccio, 2019;). Dahl-Jacinto & Hays, 2024

Number of Licensed Clinical Social Workers per 1,000 People



ASWB Social Work Workforce Study, Kim (2024)



29.43% of BSW's providing behavioral/mental health services

ASWB Social Work Workforce Study, Kim (2024)

But I'm not a clinician…

- 70% of jobs with children, families and schools only require BSW
- 54% of suicide decedents in 27 states did not have a known mental health condition
  - Life stressors
  - Lack social support
  - Specific personality traits such as impulsivity
  - Adverse childhood events
  - Physical disorders with increased pain
  - Military personnel
  - Developmental or genetic conditions
  - Social determinants of Health:
    - employment, financial and housing loss or insecurity

Kim, 2024; US BLS, 2025; Choi et al, 2022, Mathieu et al, 2022; Stone et al, 2018; Sher, 2024; Na et al, 2025

Can we agree BSW graduates work with individuals like this?

Are they prepared to meet this challenge?

Social Workers Receive Limited Education in Suicide-Related Content

- **What is suicide-related content**
  - Prevention
  - Intervention
  - Postvention
- **Limited to None in Social Work Undergraduate (and graduate)**
  - More likely provide education now compared to 2012
  - Most (61%) education during practicum
  - If any, may be suicide risk assessment

Ruth et al, 2012; Mirick, 2020, 2024

Readiness of BSW Faculty/Instructors (n = 135)

- **Students receive 6.6 hours of suicide-related content**
- **Optimistically – 70%+**
  - **risk and protective factors**
  - Warning Signs
  - Asking about suicide
- **Places to improve:**
  - **72**% not enough taught
  - Almost 20% still teach “no harm”/“no suicide” contracts
  - 23.4% do not teach “means safety”
    - But… 62% teach safety plans (which should include means safety)

Mirick, 2020, 2024

If 61% report practicum is place of learning…

Are BSW supervisors ready?

Scott and Osteen, unpublished

Demographics of BSW Supervisors (n=228)

	BSW Supervisors (n = 228)
Female	84.1%
White	74.1%
Hispanic/Latino	10.5%
Black/African American	9.2%
Asian, Am. Ind/A. Native, N. Hawaiian/Pac. Islander	4.8%
Middle Eastern/N. African	1.4%
Mean age	41.1 (SD= 10.5)
less than 30 yo	3.1%
30 -50 yo	56.9%
51-70 yo	38.5%
over 70	1.5%

Setting of BSW Supervision (n = 228)

States Represented		37
Time as supervisor	less than 5	15.8%
	5-10	36.4%
	11-20	19.7%
	more than 20	9.3
Community Based Setting		46.1%
Urban/City		49.3%

Main service supervise:

Case management/care coord.	42.6%
Direct clinical practice/therapy	
Individuals	30.2%

Exposure to Suicide

	BSW SUPERVISORS	BSW STUDENTS
Likelihood work with:		
• At-risk for suicide	91.5%	79.5%
• Client with ideation	95.9%	83.2%
• Client who made attempt	85.8%	69.5%
• Actual Suicide death	30.1%	6.4%
• More than 1x	46.0%	33.3%
• Personal Exposure	45.2%	

What BSW Supervisors Actually Do in Practice

(adapted Roush, 2018; Mirick, 2024)

Suicide Risk Assessment, adjust tx	76.0%
Continue to See	80.3%
Collaborative Safety Plan	77.3%
Counsel Means Safety, include family	77.3%
Provide Crisis line resources	85.1%
Permission to Talk to others	**39.2%**
Refer Immediately to Inpatient	**20.1%**
Refer to Psychiatrist for Evaluation	23.4%
Refer Immediately to Emergency Department	**14.9%**
Obtain No Harm/No Suicide Contract	**24.7%**
Refer to Non-Psych. Physician Medical Eval.	17.6%

What BSW Supervisors tell Supervisees to Actually Do in Practice

Suicide Risk Assessment, adjust tx	83.9%
Continue to See	77.5%
Collaborative Safety Plan	82.0%
Means Safety, include family	82.7%
Provide Crisis line resources	88.3%
Permission to Talk to others	**51.8%**
Refer Immediately to Inpatient	**19.3%**
Refer to Psychiatrist for Evaluation	33.6%
Refer Immediately to Emergency Department	**23.6%**
Obtain No Harm/No Suicide Contract	**40.4%**
Refer to Non-Psych. Physician Medical Eval.	27.0%

3. Drafting Standards (NASW Taskforce)

Meet NASW Task Force Members

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 Velez-Grau, PhD, LCSW
Ashby Dodge, LCSW
Jessyca Vandercoy, LCSW

Meet Task Force Consultants

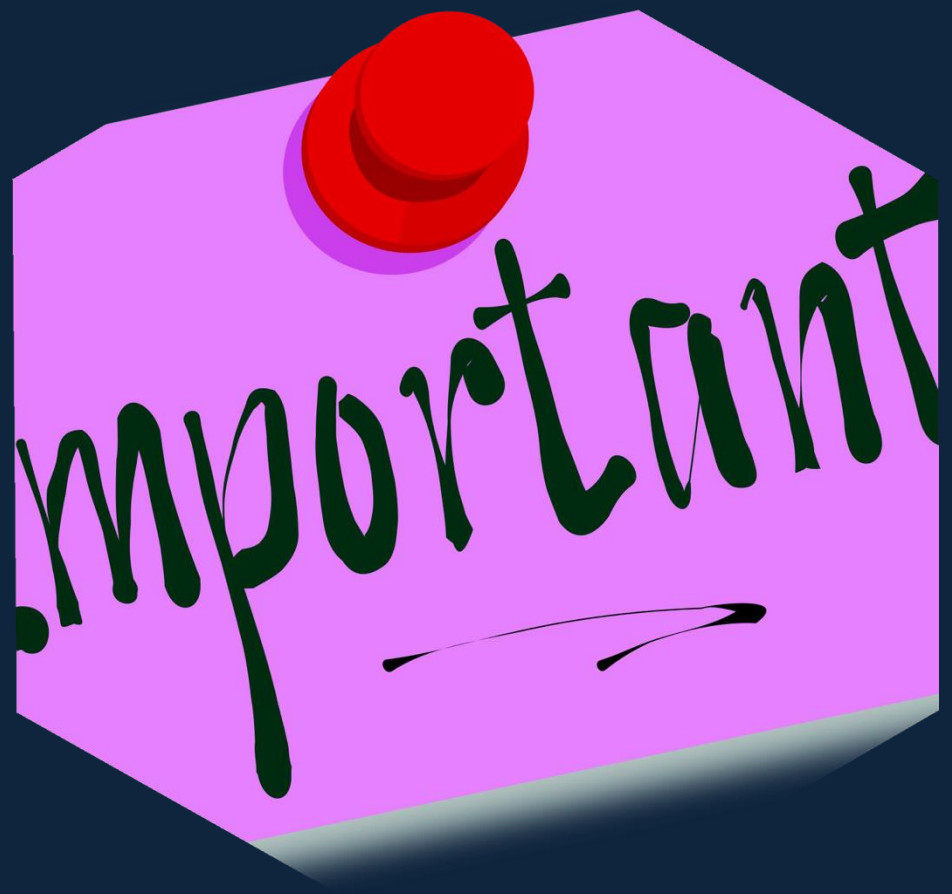
- Skip Simpson
- Richard McKeon
- Members of 988 (Gillian Murphy, Shye Lewis)

Highlights of Task Force Discussions

- Address social determinants of risk
- Stay true to Social Work Values: rapport, engagement and empathic bridge
- Important to include support system in assessment
- Incorporate cultural sensitivity to suicide rates
- Reframe barriers as opportunities
  - Understanding native sovereignty in collaborative practice
- Delineate standards in generalist v. clinical settings
  - Establish minimum standards for ALL SOCIAL WORKERS
  - Consider training standards for 988
  - Use Consultation and Supervision

CRITICAL ISSUE:

Difference Between Standards of Care & Practice Guidelines



STANDARDS OF CARE

- **MANDATORY**
- Minimal requirements of expected knowledge & service
- Legally binding
- Considered to be enforceable in malpractice liability
- Encourages the implementation of best practice strategies

BEST PRACTICE GUIDELINES

- **FLEXIBLE**
- Provide recommendations on how to implement standards through the provision of optimal care based on latest research and evidence base
- Can vary by setting, geographical region, and profession and are less likely to be adopted consistently
- Goal is encouragement of identification & utilization of evidence- informed strategies

3. Drafting Standards

Other NASW Standards of Care

WHAT WE LEARNED:

- Start with ethics and values
- Be clear, precise, practical and articulate clear goals
- Define the meanings of key words
- Provide interpretation for each standard
- List relevant references and provide additional resources to learn more!

AVOID suicide impulse, suicide gesture, successful attempt, committed suicide, completed suicide

Say Instead:

Died by suicide

Made suicide attempt

Person who made an attempt/has thoughts of suicide

LET'S REVIEW THE CURRENT LANGUAGE OF SUICIDE

Addressing what we learned about social workers reluctance/ fear to address suicide risk

Be YOU! Be a Social Worker!

Define suicide in a way that activates already learned social work knowledge

- Initial approaches aid in rapport building; have a conversation
- Reframing the question about suicide may help bypass stigma/fear/panic
- Suicide reflects deficit in problem solving skills (Shneidman, 1960-70's)
- Crisis states predict challenges to problem solving
- Key crisis intervention strategies can provide support, control, and structure (Underwood et al, 2018)

Incorporating Social Work Principles

- 6 core values
- Empathy
- Person-in-Environment
- Follow-up

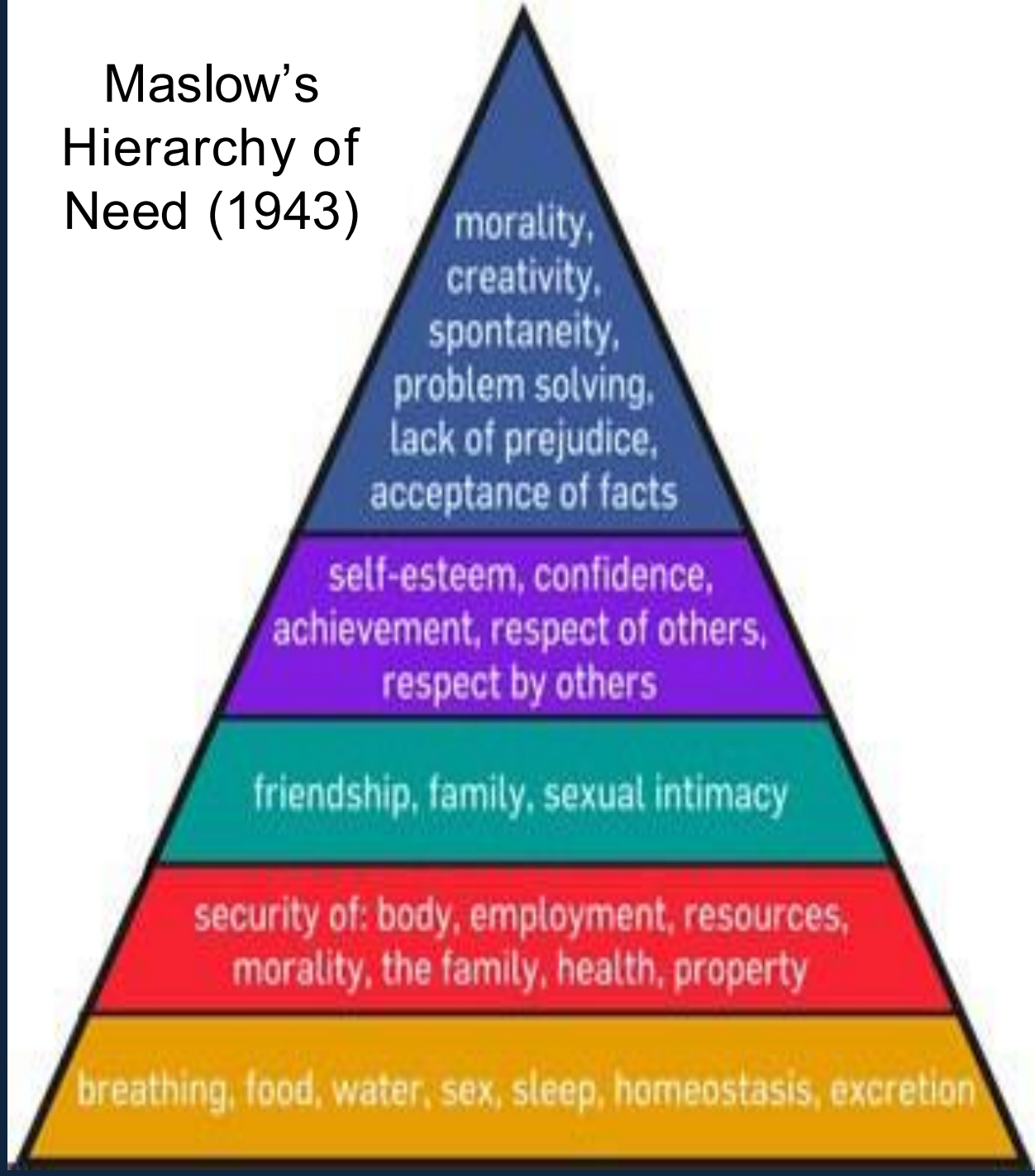
Suicide Through the Lens of the Six Core Values of Social Work

SERVICE	SOCIAL JUSTICE	DIGNITY AND WORTH OF PERSON	IMPORTANCE OF HUMAN RELATIONSHIPS	INTEGRITY	COMPETENCE
Self awareness of attitudes and values essential to objective rssponse to suicide crisis (Rudd et al, 2008)	Micro and Macro-systems reforms related to suicide prevention, intervention & postvention (Bryan, 2021)	Socially responsible self-determination balancing needs of client's and broader societal interests – Perceived Burdensomeness, (Silva et al., 2015)	Relationships as vehicle for change; risk/protective factors, support systems, safety planning, follow up & consultation/ supervision	Honest and Transparency, Developing knowledge and skill set to effectively intervene; documentation to verify action	**Enhancing skills & knowledge related to suicide (i.e., suicide prevention, screening, assessment, intervention,& postvention)**

IMPORTANCE OF PERSON-IN-ENVIRONMENT

- Recognizes social determinants of health
- Includes identification & engagement of support system
- Incorporates case management in using community resources

Maslow's Hierarchy of Need (1943)



Waiting for Release for Public Comment

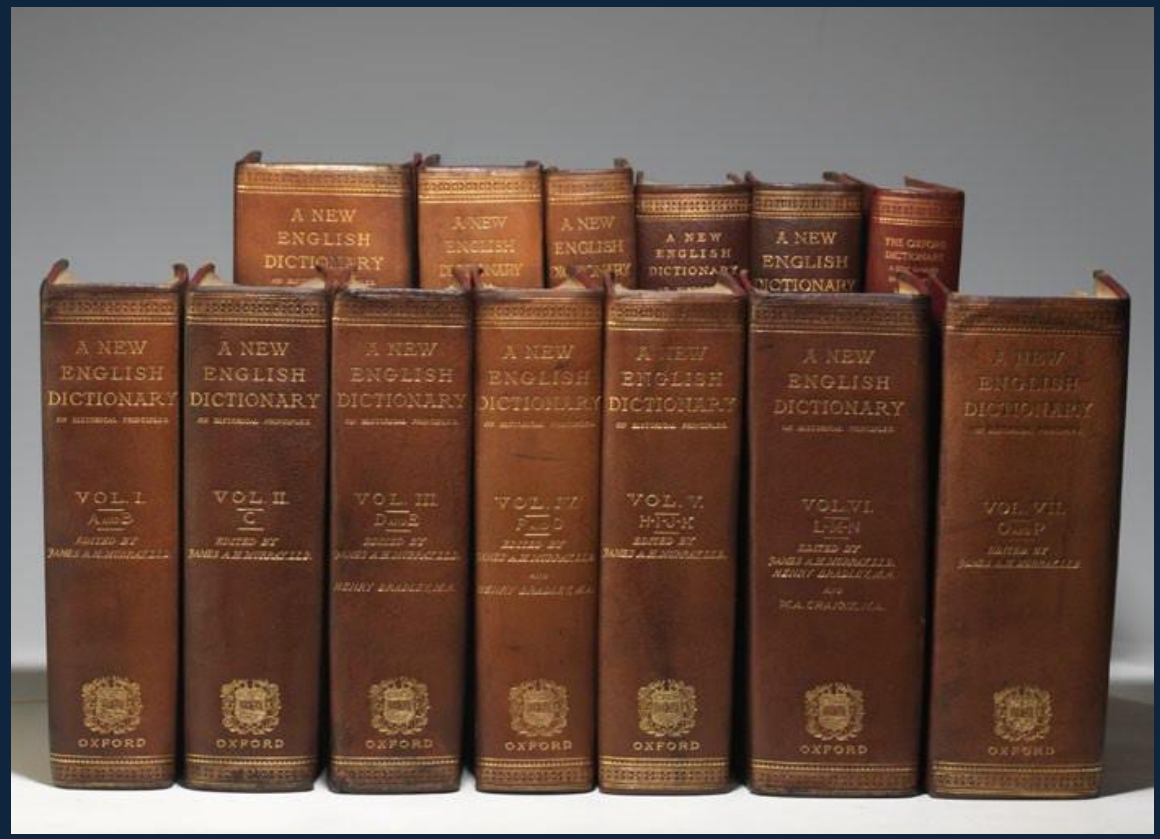
National Action Alliance for Suicide Prevention Recommended Standards of Care (2018)

- INITIAL SCREENING
- FORMAL ASSESSMENT, AS INDICATED
- DEVELOPMENT OF COLLABORATIVE SAFETY PLAN
- COUNSELING ABOUT ACCESS TO LETHAL MEANS
- DOCUMENTATION
- FOLLOW-UP

Screening v. Assessment: What's the Difference?

- **Screening:** Used to identify someone at risk for or who is currently suicidal. May be done orally or by pencil and paper. May include an evaluated/standardized instrument. Is completed within minutes to determine if there is a risk for suicide.

- **Assessment:** A more comprehensive evaluation done by a clinician to confirm suspected suicide risk, examines risk and protective factors, may estimate the immediate danger to the patient. Should be used to decide on a course of treatment.



Sample Screening Instruments Supports Documentation!

- Asking Suicide Questions (ASQ) with Brief Suicide Safety Assessment
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
- Columbia Suicide Severity Rating Scale (CSSRS) with SafeT
  - https://cssrs.columbia.edu/documents/safe-t-c-ssrs/

Training opportunities: www.preventsuicidenj.org

Missing Risk and Protective Factors

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity (If question 2 is "no" you may skip 3, 4 and 5)	Month
1) **Wish to be dead** *Have you wished you were dead or wished you could go to sleep and not wake up?*	
2) **Current suicidal thoughts** *Have you actually had any thoughts of killing yourself?*	
3) **Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) **Suicidal Intent without Specific Plan** *Have you had these thoughts and had some intention of acting on them?*	
5) **Intent with Plan** *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*	
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If "YES" Was it within the past 3 months?	Lifetime Past 3 Months

Activating Events:
- ☐ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- ☐ Pending incarceration or homelessness
- ☐ Current or pending isolation or feeling alone

Treatment History:
- ☐ Previous psychiatric diagnosis and treatments
- ☐ Hopeless or dissatisfied with treatment
- ☐ Non-compliant with treatment
- ☐ Not receiving treatment
- ☐ Insomnia

Other:
- ☐ _____
- ☐ _____
- ☐ _____

Clinical Status:
- ☐ Hopelessness
- ☐ Major depressive episode
- ☐ Mixed affect episode (e.g. Bipolar)
- ☐ Command Hallucinations to hurt self
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Highly impulsive behavior
- ☐ Substance abuse or dependence
- ☐ Agitation or severe anxiety
- ☐ Perceived burden on family or others
- ☐ Homicidal Ideation
- ☐ Aggressive behavior towards others
- ☐ Refuses or feels unable to agree to safety plan
- ☐ Sexual abuse (lifetime)
- ☐ Family history of suicide

☐ **Access to lethal methods:** Ask <u>specifically</u> about presence or absence of a firearm in the home or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:
- ☐ Fear of death or dying due to pain and suffering
- ☐ Identifies reasons for living
- ☐ _____
- ☐ _____

External:
- ☐ Belief that suicide is immoral; high spirituality
- ☐ Responsibility to family or others; living with family
- ☐ Supportive social network of family or friends
- ☐ Engaged in work or school

Add The SafeT for Comprehensive Assessment

Activating Events:
- ☐ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- ☐ Pending incarceration or homelessness
- ☐ Current or pending isolation or feeling alone

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- ☐ Previous psychiatric diagnosis and treatments
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External:
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- ☐ Supportive social network of family or friends
- ☐ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior – skip if questions 1-5 are all no)	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	**Month**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	
Total Score	

NIMH TOOLKIT: SCREENING TOOL FOR YOUTH AND ADULTS

asQ: Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the patient:

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

   If yes, when was the most recent attempt? _____ O Within last 12 months O Over 1 year ago

If patient answers Yes to any of Questions #1 through #4, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? O Yes O No

   If yes, describe briefly: _____

No to all Questions #1–#4	**Yes** to any of Questions #1–#4 and...	
	Yes to Question #5	**No** to Question #5
Negative screen	**Acute positive screen** (imminent/acute risk identified)	**Non-acute positive screen** (potential risk identified)
No intervention is necessary at this time. **NOTE:** Clinical judgment can always override a negative screen.	• **Patient requires a STAT/urgent safety/full mental health evaluation. Patient cannot leave until evaluated for safety.** • Keep patient in sight. Remove dangerous objects from room (if possible). • Alert clinician responsible for patient's care.	• **Patient needs a brief suicide safety assessment to determine if a full mental health evaluation is needed (and when).** **EXCEPTIONS:** When positive screen is solely due to Yes on Question #4 (i.e., lifetime suicide attempt), then a brief suicide safety assessment may not be necessary if: **For adults:** most recent attempt is >1 year ago **For youth/young adults** (e.g. under age 25): most recent attempt is >1 year ago AND a documented brief suicide safety assessment has been conducted since that attempt • Non-acute positive status does NOT require 1-to-1 observation while patient is awaiting further assessment (unless there are other safety concerns). • **If adult patient, or parent/guardian of youth patient, refuses the brief suicide safety assessment, document the refusal. Patient can be permitted to leave, unless there are other safety concerns.** Follow-up call is recommended. • Alert clinician responsible for patient's care.

If the patient refuses to answer the screening questions:

- **For youth**, refusal is considered a **non-acute positive screen**.
- **For adults**, refusal is NOT considered a positive screen. No intervention is necessary at this time unless there are other safety concerns. Document the refusal.

What is the difference between a “no harm/suicide” contract and Safety Planning?

Patient Safety Plan Template

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 4: People whom I can ask for help:

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

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

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

Step 6: Making the environment safe:

1. _____
2. _____

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

_____

Safety Plan Template: Barbara Stanley and Gregory K. Brown

https://sprc.org/resources-programs/patient-safety-plan-template

Should include:

- Actions & decisions
- Measures/Scores
- Client's word
- Support and crisis support planning
- Options considered and rejected
- Actions and referrals for unmet needs
- Consultation/Collaterals (i.e. parents)

Documentation Domains

What Supervisors teach and what wish students knew before coming to placement

What core standards are taught in BSW practicum

	Never	Ask	ALL	Client
Statistics/epidemiology	5.8	12.9	52.5	23.0
MH as Risk Factors	3.6	5.8	67.9	18.2
SDH as Risk Factors	4.4	5.8	59.1	27.0
Protective Factor	5.8	4.4	65.0	20.4
Asking about Thoughts/Beh.*	4.3	5.1	67.4	18.8
Standardized Screen/Risk Assess.*	10.9	7.2	60.1	17.4
Safety Planning*	6.5	4.3	62.3	22.5
Access to Lethal Means*	9.5	6.6	50.4	29.2
No Harm Contracts	26.1	6.5	33.3	31.2
Documentation*	9.4	4.3	56.5	26.8
Malpractice/Liability	20.4	10.9	38.7	23.4
Follow-up*	8.1	4.4	57.0	25.2
Resources	2.2	5.1	76.6	12.4
Standards of Care*	10.9	5.8	54.0	25.5

8 Things BSW Supervisors Wish Students Knew

Theme	Representative Quote
Lack of foundational suicide-related knowledge/training	"None of my BSW students have had training related to suicide."
Need for early integration of suicide content before practicum	"All of the information discussed in this survey SHOULD be taught prior to field placement."
Comfort & confidence when discussing suicide	"Many students are afraid to ask clients about suicidality."
Lack of applied skills (i.e., assessment & safety planning	"They often don't know what specific warning signs to look for beyond the obvious ones."

8 Things BSW Supervisors Wish Students Knew

Theme	Representative Quote
Emotional preparedness, managing reactions, and using supervision	“Managing their initial panic when a client discloses suicidal thoughts.”
Cultural competence: awareness of cultural & contextual factors	“Familiarity with cultural considerations and stigma surrounding suicide.”
Experiential learning (i.e., need role play & simulation)	“More role playing scenarios to support students.”

Call for Curriculum Reform & Systemic Integration

95.1% of BSW Supervisors and 95% of MSW Supervisors

"Agree" or "Strongly agree" that suicide prevention, intervention and postvention education should be required by CSWE

"This needs to be talked about earlier and more training given in schools."

"Social work is focusing on so much of redundancy on other things and forgetting about suicide."

"Suicide education should be improved, increased, and constantly updated."

"We should NOT be shying away from this issue—it is something we should be comfortable addressing."

"Curriculum/standard addition to BSW/MSW curriculum."

4. BSW Curriculum Ideas

- Risk and Protective Factors (including social determinants of health)
- Reframe suicide as a crisis (What's going on in your life right now that is making you think you want to die?)
- How to ask about suicide
  - Screening tools (free training: CSSRS/ASQ)
  - Use rapport and interviewing skills and empathetic bridge
- Assessment for planning and referral process – not prediction
- Safety planning (Stanley-Brown tool)
- Counseling on Access to Lethal Means (free training)
- DOCUMENTATION! DOCUMENTATION! DOCUMENTATION!
- Follow-up (Caring Contacts)

Resources for Additional Information/Training

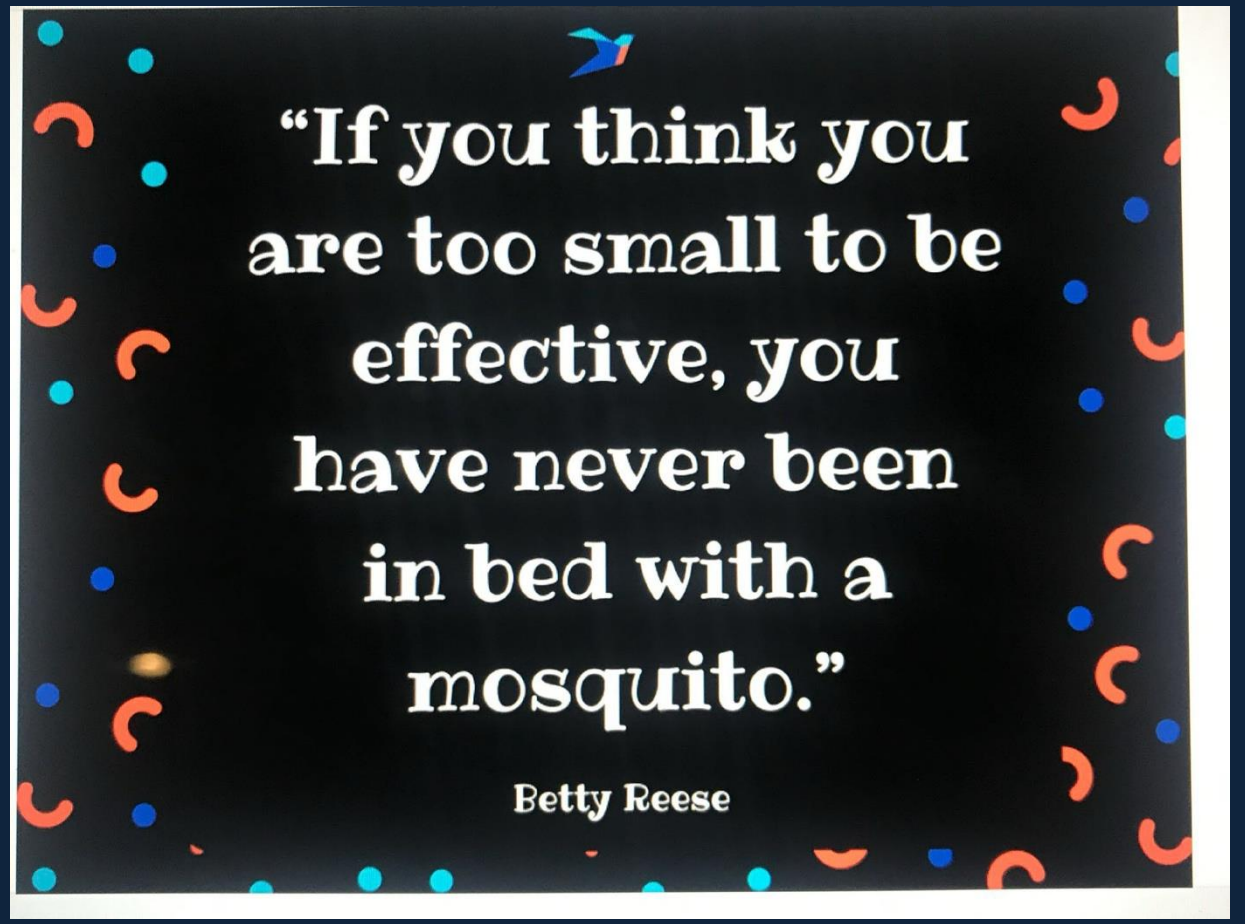
- American Association of Suicidology
- American Foundation for Suicide Prevention.
- National Institute of Mental Health. Ask Suicide-Screening Questions (ASQ) Toolkit.
- Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Suicide Prevention.
- Columbia Lighthouse Project.
- National Action Alliance for Suicide Prevention. National Strategy for Suicide Prevention.
- National Institute of Mental Health. Suicide Prevention.
- Workplace Suicide Prevention. National Guidelines for Workplace Suicide Prevention.
- 988 Suicide & Crisis Lifeline.
- Stanley-Brown Safety Plan https://suicidesafetyplan.com/
- Suicide Awareness Voices of Education.
- Suicide Prevention Resource Center.
- The Trevor Project—Suicide Prevention for LGBTQ+ Young People.
- U.S. Department of Health and Human Services. 2024 National Strategy for Suicide Prevention

5. Soliciting Input

You Tell Us

- Your questions. comments
- What you see as strengths & limitations
- Suggestions on how to improve

YOU ARE ALL IMPORTANT!!



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FEEDBACK SURVEY

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