Supporting Someone Experiencing Thoughts of Suicide: **A Practical Manual**

Created for you by
Full Circle Grief Center

As a parent, caregiver, and loved one supporting someone experiencing thoughts of suicide, you deserve guidance, reassurance, and tools to navigate times of distress.

The team at Full Circle Grief Center created this manual to help you:

- Understand the differences between passive and active suicidal thoughts
- Unpack common myths and facts about suicide
- Identify key risk and protective factors
- Access resources, navigate the mental health system, and advocate for your loved one
- Create a safer living environment
- Recognize the potential signs of a mental health crisis
- Communicate with a loved one experiencing distress
- Develop a safety plan with your loved one
- Respond during a crisis
- Take care of yourself

Although this resource focuses on supporting youth, most of the information is useful for supporting loved ones of all ages.

Note: Throughout the manual, we use the terms "individual" or "person" instead of child, teen, youth, or young adult.

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full circle
remember. create. heal.

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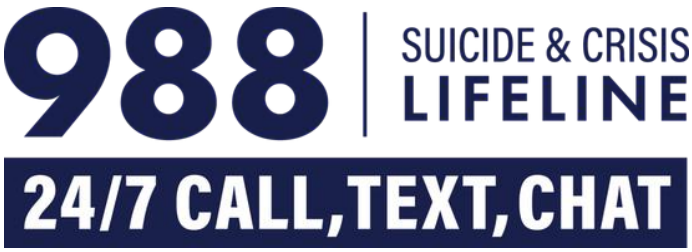

Chapter 1:
Understanding Suicidal Thoughts/Ideations

Terminology is important in making sure people are rooted in common language and understanding. Some of the sections throughout this manual will discuss terminology and help differentiate between similar words or phrases and commonly misused terms.

In this manual, you will see the terms *die by suicide* or *attempt suicide* as opposed to other commonly used phrases like *commit suicide, successful suicide*, or even *completed suicide.* Using *commit* is language that can be stigmatizing and judgmental. People can commit crimes, commit sins, or be committed to institutions; there is an element of moral judgment or a negative connotation with using the word *commit*. Moreover, *successful* or even *completed* implies that suicide is a positive outcome, so this language is not used in this manual. We invite you to join us in using these more mindful terms as well to help destigmatize conversations around suicide and mental health.

Preferred Terms:

- Died by suicide
- Attempted suicide
- Ended his/her/their life

Specific to this section, the terms suicidal thoughts and suicidal ideation are two frequently used phrases. These terms can be interchangeable and indicate an individual is having thoughts about wanting to die or kill themselves. This chapter discusses understanding suicidal thoughts or ideations and is divided into five sections: a) passive versus active suicidal thoughts/ideations, b) common factors and contributing mental health conditions, c) stigma surrounding suicide, d) myths and facts about suicide, and e) risk and protective factors.

A. Passive Versus Active Suicidal Thoughts/Ideations

Suicidal thoughts or ideations refer to thinking of or planning to end one's life intentionally. Although for some, these thoughts are foreign and possibly scary, it is relatively more common to experience thoughts of suicide than many may think. There are more individuals who think of taking their life than those who die by suicide. Suicidal ideation is often viewed on a spectrum, with passive ideation at one end and active ideation at the other. Passive ideation may include a desire to die, without a detailed plan to kill oneself. These thoughts can come and go, or they may be persistent or chronic. The key with passive ideation is that there are little-to-no specifics as to how the individual may carry out the attempt. Passive and active ideation are ways to explain an individual's emotions and behavior, but they are not independent of each other; individuals can, at any time, be passive or active in their desire to die. Therefore, an individual's ideation must always be taken seriously and considered within the context of that individual's lived experience.

On the other end of the spectrum, active ideation involves more planning or detail into how to carry out their suicide attempt. Active ideation is generally considered higher risk than passive ideation. However, passive ideation should not be ignored or minimized, and both types of ideations need to be taken seriously. See the table to the right for a summary of other common terms associated with suicidal ideation.

Suicidality:
A broad term that encompasses the entire spectrum of experiences related to suicide, including suicidal thoughts (ideation), intent, planning, and suicide attempts

Suicidal ideation:
Thoughts of wanting to die, no longer being alive, or killing oneself

Suicide plan:
A set of steps someone has identified to end their life, usually including the identification of a method or means

Suicidal intent:
Desire to act on thoughts of suicide

Suicide attempt:
A self-directed, potentially injurious behavior with the intent to die as a result of the behavior

Stigma:
Negative social attitudes towards a characteristic of an individual that may be regarded as a mental, physical, or social deficiency. A stigma implies social disapproval and can lead unfairly to discrimination against and exclusion of the individual

Non-suicidal self-injury/self-harm:
Purposefully hurting oneself without the direct intention of dying, often as a means of regulating intense or difficult emotions

Lethal means:
Any method, tool, substance, or object that a person could use to attempt to take their own life

B. Common Factors and Contributing Mental Health Conditions

Sometimes in the aftermath of a suicide, there is a tendency to try to identify a single factor or cause that led to someone taking their own life, especially as people try to make sense of their loss. However, suicide is most often a result of multiple factors that can be rooted in an individual's situation, environment, a result of navigating mental health concerns, physiology, and genetics. A combination of these factors may contribute towards feelings of hopelessness, which can create the conditions for increased thoughts of suicide and/or dying by suicide.

Listed below are some factors that have been associated with suicidal ideation, suicide attempts, and dying by suicide. It is important to know that experiencing one or more of the following factors or conditions does not mean someone ***will*** have thoughts of suicide, attempt suicide, or die by suicide. Conversely, the absence of these factors or conditions does not mean that someone ***may not*** be suicidal.

C. Stigma Surrounding Suicide

What is stigma? Stigma is a concept where negative attitudes and judgment can adversely affect someone's behavior or actions. Stigma can come from society, groups of people, or individuals. Suicide, mental health disorders or challenges, substance use, and seeking mental health support are all commonly stigmatized. Stigma can affect both the individual experiencing suicidal thoughts (i.e., self-stigma) and family members or friends who have loved ones attempt suicide and/or die by suicide (i.e., survivors of suicide loss).

Feelings of shame, embarrassment, or guilt are common for individuals with suicidal ideation. Fear of being negatively judged or discriminated against can prevent individuals and even their families from seeking help. Thus, individuals often navigate suicidal ideation alone.

We encourage parents to talk with their children about mental health and what suicidal thoughts may feel like. Talking creates opportunities for open and honest communication. Having loving and nonjudgmental conversations focusing on the person in distress as opposed to personal views of suicide can help combat stigma.

Environmental factors

- Trauma
- Child abuse and neglect
- Discrimination and oppression
- Bullying and harassment
- Domestic violence
- Substance use

Genetic or biological factors

- Serious health conditions
- Chronic pain
- Traumatic Brain Injury (TBI)
- Family member with history of suicidal thoughts or behavior

Mental health challenges or disorders

- Depression
- Bipolar disorder
- Anxiety disorder
- Substance use disorder
- Schizophrenia
- Conduct disorder

Situational stressors

- Relationship loss (e.g., death, divorce, breakup)
- Job loss
- Financial adversity
- Legal troubles
- Social media
- Difficulties with housing

D. Myths and Facts About Suicide

Conversations around suicide are often wrought with myths and misconceptions, which are often grounded in stigma, judgment, or misinformation. This section discusses some common misconceptions about suicide and corrects them with factual information.

Myth #1: Asking someone if they are thinking of suicide gives them the idea of suicide or encourages it.

Fact: This myth is grounded in stigma and fear. Asking someone directly about suicide does not plant the idea of suicide or encourage them to do it. If someone is suicidal, they have those thoughts or ideas regardless of whether you ask about it. In fact, asking directly about suicide can:

- Reduce the shame, fear, or anxiety for the individual having suicidal thoughts
- Provide some relief because they are no longer suffering in silence
- Improve the likelihood that a person will seek help
- Improve the individual's mental health outcomes

Myth #2: People who are having thoughts of suicide or who die by suicide are selfish, weak, or are taking the "easy way out."

Fact: This myth is rooted in stigma and judgment. Most people who die by suicide or attempt suicide do not want to die, nor are they "thinking only of themselves." Rather, they want to end their pain and suffering and may think that their loved ones are better without them. Those whose distress and despair are so deep often feel hopeless or helpless, and suicide seems like it is the only option to alleviate that pain. Individuals with suicidal ideation are likely experiencing significant life stressors (e.g., relationship loss, death of a loved one, trauma, substance use, financial crisis, etc.) or mental health challenges.

Myth #3: Suicide only affects those with a mental health disorder.

Fact: This myth is rooted in incomplete information. While many individuals who have suicidal thoughts or die by suicide may have a diagnosed or undiagnosed mental health disorder, others do not have a diagnosable mental health disorder. Moreover, life stressors or traumatic events can also be contributing factors to suicidal ideation.

Myth #4: People who talk about suicide are just seeking attention.

Fact: This myth is rooted in judgment and stigma. Someone who verbalizes suicidal thoughts through joking, comments, or even threats may be communicating significant pain. They need nonjudgmental listening, connection with a person(s) that they trust, and/or possibly support from a professional. Using kindness and compassion, inquiring about their thoughts from a nonjudgmental lens, and seeking mental health help are imperative.

Myth #5: Using barriers on bridges, safely storing firearms, securing medications, and other actions that reduce access to lethal methods of suicide don't work. If someone wants to take their own life, they will always find a way.

Fact: This myth is rooted in misinformation. Limiting access to lethal means is one of the best ways to prevent suicide. Impulsivity can be a factor in suicide attempts and suicide deaths. As such, preventing access to lethal methods can provide the individual with time to think through their impulses or feelings and get support.

Myth #6: Once someone is suicidal, they will always be suicidal.

Fact: This myth is rooted in misinformation and perhaps some stigma. Though suicidal ideation can be persistent or chronic for some people, most individuals who experience suicidal ideation do not stay suicidal forever. Seeking counseling for mental health challenges and/or life stressors can greatly reduce or fully eliminate thoughts of suicide. Exploring medical interventions may also be helpful. People who have had suicidal thoughts or attempts can live long, fulfilling lives.

E. Risk and Protective Factors

Suicidality **cannot** be accurately predicted, but there are certain situations, conditions, and characteristics that may increase the likelihood of suicide; these are called *risk factors*. Conversely, *protective factors* are characteristics, situations, or conditions that can decrease the likelihood of (i.e., protect against) suicide. There are two important considerations in this section. First, risk factors are different than warning signs of suicide (see next section). Secondly, risk and protective factors do not guarantee the outcome of suicide. For example, someone can have multiple risk factors and never feel suicidal. Conversely, someone may have multiple or significant protective factors and still be suicidal.

The presence of protective factors **does not** guarantee safety.

There are certain groups, on a population level, that have experienced increased suicide risk due to the nature of their work or identity. These groups include the LGBTQIA+ community, veterans, first responders, and people living in rural communities. These populations are considered more at risk due to stressors associated with community membership like discrimination or exposure to trauma. As a reminder, membership in one or more of these communities does not guarantee that someone has, or will have, thoughts of suicide or will die by suicide.

E. Risk and Protective Factors (cont.)

The Centers for Disease Control and Prevention (CDC) identifies risk and protective factors that can occur at the individual, relationship, community, and societal levels. Look on this page for examples of risk and protective factors:

Protective Factors

Individual protective factors:

- Effective coping and problem-solving skills
- Reasons for living (e.g., family, friends, pets)
- Strong sense of cultural identity

Relationship protective factors:

- Support from family, friends, partners
- Feeling connected to others

Community protective factors:

- Feeling connected to school, community, or other social institutions
- Consistent access to quality physical and behavioral health services

Societal protective factors:

- Reduced access to lethal means of suicide among people at risk
- Cultural, religious, or moral objections to suicide

Risk Factors

Individual risk factors:

- Previous suicide attempt
- History of depression or mental health disorder
- Serious physical illness like chronic pain
- Criminal or legal difficulties
- Job loss
- Financial difficulties
- Impulsivity or aggressive tendencies
- Substance use
- Current or prior history of adverse childhood experiences (e.g., abuse, neglect)
- Feelings of hopelessness or helplessness
- Violence, victimization, and/or perpetration

Relationship risk factors:

- Bullying
- Family or loved one's history of suicide
- Loss of relationship (e.g., death, divorce, breakup)
- High conflict or violent relationships
- Social isolation
- Generational trauma

Community risk factors:

- Lack of access to healthcare (including mental health)
- Suicide cluster in the community
- Stress of assimilation
- Community violence
- Historical trauma
- Discrimination

Societal risk factors:

- Stigma associated with seeking help and mental health disorder
- Easy access to lethal means of suicide among people at risk
- Unsafe media portrayals

Chapter 2:
Recognizing When Someone May Be in Distress

Suicidality is a complex issue often caused by multiple factors, and it can manifest in a variety of ways. There may be very clear signs that someone is in distress, but often there are only subtle signs or changes. Some individuals do not display any signs of distress or that they are in crisis. This chapter looks at different indicators that signal someone may be in distress and is divided into five sections: a) signs of depression, b) signs of a mental health crisis, c) verbal cues, d) behavioral warning signs, and e) cognitive indicators.

Common Signs of Depression:

- Depressed (e.g., sad, empty, hopeless) or irritable mood most of the day
- Reduced interest or pleasure in all or almost all activities
- Weight loss when not dieting, weight gain, or increase/decrease in appetite
- Restlessness or significant slowing down in thought or activity
- Fatigue or loss of energy
- Feelings of worthlessness or excessive/inappropriate guilt
- Diminished ability to concentrate/think or increased indecisiveness
- Recurrent thoughts of death or suicidal ideation (with or without a plan)

A. Signs of Depression

Depression is a common mental health condition that affects many children and adults. It may be a chronic condition that comes and goes, or a situational issue that occurs only once. All people regardless of race, ethnicity, gender identity, socioeconomic status, or culture can experience depression. It has roots in biological, environmental, genetic, and psychological factors. Depression can be a standalone mental health condition, or it may be associated with other mental health conditions like bipolar disorder, schizophrenia, or post-traumatic stress disorder. While everyone feels sad or down at times, depression is more than that and manifests on a spectrum from mild to severe.

It is important to note that many individuals who are depressed do not experience suicidal ideation and not everyone who dies by suicide is affected by depression.

B. Signs of a Mental Health Crisis

Having a mental health disorder or challenge does not necessarily mean someone is in crisis. Millions of people in the United States that have a mental health diagnosis live healthy, adaptive lives. A mental health crisis is a much more urgent situation requiring immediate professional support. The biggest indication that someone is in crisis is when there is a noticeable and sudden change in their behavior. Keep in mind that this change in behavior may be slower and less noticeable for some individuals.

Some signs that someone is experiencing a mental health crisis can be:

- Neglect of personal hygiene
- Significant change in sleeping habits—either sleeping much more or much less than their typical sleeping patterns
- Weight gain or weight loss
- Decline in performance at work or at school
- Marked change in mood like irritability, anger, anxiety, or sadness
- Withdrawal from routine activities and relationships
- Suicidal thoughts

C. Verbal Cues

Sometimes individuals who are experiencing significant distress or thinking of suicide can convey feelings of hopelessness or worthlessness, being a burden to others, feeling trapped, having no reason to live, or feeling unbearable pain. They may express that they are struggling by using direct or indirect verbal cues. Direct verbal cues leave little room for interpretation and clearly express the desire to die. Conversely, indirect verbal cues are much more subtle and easier to miss. Both direct and indirect cues should be taken seriously, approached with compassion and care, and focused on getting the person help. See below for examples of direct and indirect verbal cues.

Direct Verbal Cues:

- *I want to die.*
- *I want to kill myself.*
- *Everyone would be better off if I was dead.*
- *I wish I was dead.*
- *My only way out is to die.*

Indirect Verbal Cues:

- *I wish I could go to sleep and not wake up.*
- *My family won't have to worry about me anymore.*
- *I can't take it anymore.*
- *I wish I was never born.*
- *Nobody cares if I live or die.*

D. Behavioral Warning Signs

In addition to verbal cues, individuals who are thinking of dying by suicide may also exhibit some behavioral warning signs. Some of the behavioral cues below are similar to the signs of depression, and others are not. Behavioral warning signs can include the following:

- Increased drug or alcohol use
- Looking for a way to end their life (e.g., searching online for methods)
- Withdrawing from typical activities
- Isolating from friends and family
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away cherished possessions
- Sudden changes in physical appearance
- Taking risks/engaging in high-risk activities
- Aggression or expressing rage
- Significant fatigue
- Recent episode of depression, emotional distress, and/or anxiety
- Becoming violent or a victim of violence
- Recent suicide attempt

E. Cognitive Indicators

While someone's behaviors or verbal cues can indicate they are thinking of suicide, cognitive indicators give insight into their thoughts or beliefs.

The last indicator of finding relief or a sudden solution to their problem is a cognitive indicator that can be misunderstood and challenging to identify. For family or friends, seeing a loved one's mood or outlook improve is often a sign that they are getting better. However, if the onset of this relief or improvement is unexpectedly quick, it can be an indication that the individual has decided to die by suicide and is at peace with that decision. The reason behind changes in mood can be very challenging to identify by friends and family.

Cognitive indicators can include the following:

- Believing they are a burden to others
- Thinking they are trapped
- Thinking death is the only solution to the problem
- Believing they are worthless
- Believing they have no purpose
- Finding relief or sudden improvement in their situation or a solution to their problem

Chapter 3:
Response to Passive Ideations and Chronic Thoughts of Suicide

It can be difficult to know how to respond to passive thoughts and ideations, and it is often distressing for the caregiver. This chapter offers strategies for responding to a loved one's passive thoughts or ideations. It is broken up into three sections: a) what passive thoughts/ideations may look like, b) contacting primary care physician or mental health professional, and c) 988 and other resources for the individual.

A. What Passive Thoughts/ Ideations May Look Like

Passive suicidal thoughts involve a desire to die without an active plan or intent to end one's life. Someone may feel hopeless and want to die, but they do not have actual intention to end their life.

It is important to note that passive suicidal thoughts/ideations can be acute or chronic. For some, these thoughts come about in a time of crisis; for others, these thoughts can always be present, with varying degrees of intensity.

Chronic suicidal ideation is the persistent, long-term preoccupation with thoughts of suicide that recur over an extended period, rather than a brief or acute crisis. This type of ideation can make daily functioning difficult and is a significant risk factor for suicide attempts, even if the person does not have a specific plan.

Some phrases individuals experiencing passive suicidal ideation may say include but are not limited to:

- *I believe everyone would be better off without me.*
- *I hope I don't wake up in the morning.*
- *If something were to happen to me, I wouldn't care.*
- *It would be easier if I just disappeared.*
- *I wouldn't care if I got sick and died.*
- *I wouldn't care if I got in an accident and died today.*

However, for some experiencing chronic suicidal ideation, the thought of suicide can become a familiar or strangely comforting source of control or escape from overwhelming emotional pain. Working with a professional may help the individual develop a long-term management plan.

Either way, it is important to find support for anyone experiencing suicidal thoughts. The type of support will differ depending on the frequency and intensity of their thoughts. Be aware that passive thoughts can quickly intensify and turn into an emergency without much warning.

B. Contacting Primary Care Physician or Mental Health Professional

Even though passive suicidal ideation may seem less urgent, it is still a sign of significant emotional pain and can escalate to more active ideation. It is important to take passive ideation seriously and seek support. If the individual is an adult, encouraging them to contact their primary care physician, or mental health professional (e.g., counselor, therapist, psychiatrist) as soon as possible to schedule an appointment is a great way to support your loved one. Due to privacy laws, you may not be able to contact your loved one's doctors but encouraging them to do so or offering to be there when they call or visit their providers can help. If they are a minor, contact their pediatrician or other providers and make an appointment for your loved one, ensuring the providers know that they are showing signs of a mental health crisis.

C. 988 and Other Resources for the Individual

People experiencing suicidal ideation may not have a primary care physician or mental health professional to contact. However, that does not mean help is unavailable. There are many hotlines and support networks that are free of charge that can be contacted for assistance. If you or someone you are concerned about is experiencing passive or chronic thoughts of suicide, support can be found at the following places.

Full Circle Grief Center's Suicide Postvention, Education, Advocacy and Care Resources (SPEAC)

Facts About 988

Accessible. It serves as a universal entry point so that no matter where you live, you can reach a trained crisis counselor who can help people in suicidal crisis or mental health-related distress 24 hours a day, 7 days a week, across the U.S.

Comprehensive. 988 is a direct connection to compassionate care and support for anyone experiencing mental health-related distress –whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress.

For Everyone. People can also dial 988 if they are worried about a loved one or someone who may need crisis support.

988 | SUICIDE & CRISIS LIFELINE

24/7 CALL, TEXT, CHAT

To learn more about 988, visit: bit.ly/988forHope

Chapter 4: Immediate Response to Active Thoughts/Ideations

When someone shares that they are experiencing suicidal thoughts, your immediate response can make a critical difference in their safety and willingness to accept help. The first moments of disclosure require compassion, patience, and presence rather than quick solutions. By listening without judgment, acknowledging the person's pain, and avoiding dismissive or minimizing statements, you can create a safe space where they feel heard and valued. Remaining calm and supportive in these moments communicates that they are not alone and that you are committed to helping them access the care they need.

This chapter provides an overview of strategies for immediately responding to someone with active suicidal ideation. It is divided up into five sections: a) recommendations for support, b) what to do if someone is in immediate danger, c) contacting emergency services, d) contacting crisis hotlines, and e) checklist for crisis situations.

Tip: It may be helpful to keep this manual and a completed safety plan in an easily accessible place for reference when needed.

A. Recommendations for Support

As a support person, allow the individual to speak openly and freely without interrupting them. To help them feel comfortable and heard, acknowledge their pain and use empathetic statements such as, "*It sounds like you're in a lot of pain right now. I want to understand and help you.*" In addition, communicate openly with them about how much you care and share your commitment to help them get the support they need.

B. What to Do if Someone Is in Immediate Danger

In some situations, suicidal thoughts escalate into immediate risk, which may include a person beginning an attempt, expressing intent to act soon, or having access to lethal means. In these moments, safety must take priority over everything else. Acting quickly, remaining calm, and ensuring the person in crisis is not left alone are essential.

Signs of immediate danger include:

- actively attempting to harm themselves
- expressing intent and having access to lethal means (e.g., firearm, large quantities of pills)
- displaying extreme agitation, confusion, or overwhelming thoughts or perceptions

These signs often warrant immediate intervention from emergency services.

C. Contacting Emergency Services

Sometimes professional or emergency intervention is necessary to protect someone's life. Knowing when and how to contact emergency services can help caregivers feel confident seeking help and reduce delays in care and ensure responders understand that the situation is a mental health emergency. It is always a possibility that interaction with one of these services could lead to a law enforcement response and/or forced hospitalization for the person in crisis. Communicating clearly, providing accurate details, and advocating for the individual's needs are essential when seeking immediate help. When you call emergency services for someone in crisis, it helps to be calm, clear, and specific so first responders know exactly what's happening. See below for information on when to call and what to say, along with a sample script.

Dos and Don'ts for Immediate Response to Active Suicidal Thoughts

DOs

- Listen actively without interrupting
- Acknowledge their pain with empathy
- Stay physically and emotionally present
- Be clear about your role and support
- Encourage professional help/seek professional help, especially if the individual is a minor
- Take every mention seriously

DON'Ts

- Don't argue, judge, or try to "fix"
- Don't dismiss feelings ("*You'll get over it*")
- Don't compare their pain to your own experience of loss or others
- Don't leave them alone if in immediate danger
- Don't promise secrecy if they are in immediate danger
- Don't minimize the risk

When to call 911

- The individual has taken steps toward self-injury/self-harm.
- The individual is in danger of immediate self-injury/self-harm.
- The individual is disoriented, severely agitated, or unable to ensure their own safety or the safety of others.

What to say when calling 911

- State the emergency right away: "*This is a mental health emergency. Someone is suicidal, and I need immediate help.*"
- Give identifying information.
  - Exact location/address
  - Your name and phone number
  - The individual's name, age, and physical description
  - Describe the immediate risk
  - Mention if they have expressed intent ("*They said they want to die*")
  - Mention if they have a plan ("*They told me they plan to [method]*")
  - Mention if they have access to means (weapons, pills, etc.)
  - Example: "*They said they want to overdose, and they have the prescription medication with them.*"
- Share their current state.
  - Are they threatening to act right now?
  - Are they injured or unconscious?
  - Are they calm, agitated, or aggressive?
- Request a mental health–trained responder if available.
  - "*If possible, please send officers or responders trained in mental health crisis intervention.*"
  - Stay on the line until the 911 operator says it's okay to hang up.

Example Script:

"*Hello, my name is [your name]. I'm at [address]. An individual I'm with [their name, age] is suicidal. They said they want to [method], and they have [the means] with them. They are [calm/agitated/unconscious]. Please send help immediately. If available, please send someone trained in mental health crisis response.*"

D. Contacting Crisis Hotlines

Crisis hotlines are lifelines for people in emotional pain or distress. They provide confidential, 24/7 access to trained counselors who can help de-escalate crises and connect individuals with ongoing support. Encouraging an individual to use a hotline can help them feel less isolated and more willing to seek professional help. Parents and caregivers are encouraged to call the hotline with their child to help them feel more comfortable while gaining support. In addition, contacting a crisis hotline can help guide you and the individual towards next steps for treatment and support. As a support person, you may need to provide gentle encouragement for the individual to contact a crisis line. Below are some hotlines that can assist someone experiencing suicidal ideation:

Hotlines:

988 Suicide & Crisis Lifeline

- Available 24/7 by **calling or texting 988**.
- Connects to trained crisis counselors.
- Can dispatch local mobile crisis units as necessary.

Crisis Text Line

- **Text HOME to 741741** to connect with a crisis counselor by text.

Examples of phrases to use include:

- Validating their feelings: "*I can hear how much you're hurting. You don't have to go through this alone. The Suicide & Crisis Lifeline is always there. If you call or text 988, someone will pick up and just listen.*"
- Offering to stay with them: "*I know reaching out can feel scary. How about we call together? I can sit with you while you talk or even be on the line at first if that helps.*"
- Normalizing the call: "*A lot of people call 988 when they feel like this. The counselors are trained to talk to people who have these feelings. It's what they're there for.*"
- Giving options: "*You don't have to figure everything out right now. You could call, text, or even chat online with the Lifeline, whichever feels easiest.*"
- If they hesitate: "*That's okay if you're not ready. Just know the number is always there. You deserve support whenever you want it.*"
- If risk is urgent or immediate: "*I'm really worried for your safety right now. I think we need to get help immediately. I'm going to call 911 so we can keep you safe.*"

E. Checklist For Crisis Situations

When a suicide crisis unfolds, it may be difficult for you to stay calm and think clearly. A structured checklist can help ensure no critical step is overlooked, from ensuring immediate safety to documenting important information for health providers or emergency personnel. The step-by-step guide to the right can help protect the person in crisis, as well as the individual doing the intervention, and support effective communication with professionals.

Checklist For Crisis Situations

Tip: It may be helpful to keep this manual and a completed safety plan in an easily accessible place for reference when needed.

Step 1 Ensure Immediate Safety

- Stay with the person and keep them in sight at all times.
- Remove or secure lethal means,
- which should be an agreed-upon act between the caregiver and person in crisis if possible.
- Stay calm, speak gently, and avoid confrontation.

Step 2 Assess the Situation

- Ask directly: "*Are you thinking about suicide?*"
- Determine if there is a plan, means, or timeline.
- Assess if they are hearing voices, severely agitated, or acting irrationally.

Step 3 Call for Help

- If imminent danger: Call 911 or take them to an emergency room.
- If not immediate danger:
  - Call 988 Suicide & Crisis Lifeline.
  - Contact a local crisis response team.
  - Reach out to a therapist, psychiatrist, or healthcare provider.
  - Refer to their safety plan if one was created.

Step 4 Document Key Information

- Full name & date of birth
- Current medications (type, dose, schedule)
- Diagnoses or mental health history
- Insurance information
- Emergency contacts

F. Mandatory Reporters

Mental health mandatory reporters are professionals who are legally required to act if they believe someone is in danger of harming themselves or someone else. This responsibility is often called the duty to warn and duty to protect, and it exists to help keep people safe. Most of the time, what a person shares with a therapist, counselor, doctor, or other mental health professional is private. However, there are a few situations where confidentiality can be broken to prevent serious harm.

Duty to Warn

If a professional learns that an individual has made a *specific and believable* threat to hurt another person, they are required to warn the person who could be harmed or notify the proper authorities. This helps prevent potential violence.

Duty to Protect

If a professional believes a person is in **serious or immediate danger** of harming themselves or someone else, they must take steps to help keep everyone safe. These steps can include:

- Contacting emergency services
- Informing parents or caregivers
- Recommending/arranging hospitalization or a safe place for the individual
- Reaching out to people who might be at risk

Mandatory reporters typically include:

- Therapists, counselors, and psychologists
- Psychiatrists and psychiatric nurses
- Doctors, nurses, and social workers
- School counselors and certain school staff

Chapter 5:
Harm Reduction Principles

Harm reduction principles refer to practical strategies and compassionate approaches that aim to reduce the immediate risk of self-harm or suicide, even if a person is not ready or able to stop having suicidal thoughts. Rather than focusing solely on eliminating these thoughts, harm reduction acknowledges the reality of a person's distress and works to make their situation safer while offering support.

Applied to suicide risk, harm reduction can include:

- Reducing access to lethal means (such as locking up medications or firearms) to lower the likelihood of a fatal attempt.
- Creating a safety plan that identifies coping strategies, warning signs, and supportive people the individual can reach out to in times of crisis.
- Encouraging open, nonjudgmental communication so the person feels understood rather than shamed.
- Helping the individual stay connected with professionals, caring adults, or peers who can offer ongoing support.
- Promoting small steps toward safety, even when the person cannot commit to long-term treatment or recovery right away.

In essence, harm reduction recognizes that any step that increases safety, connection, and support—no matter how small—is valuable and can save lives.

A. Access to Lethal Means

Removing or restricting access to lethal means is a crucial step to making suicide as preventable as possible. Although it is not possible to make a home perfectly safe, there are ways to put more time and space between a means of suicide and a suicidal person. See below for steps to take to reduce access to lethal means.

Weapons

- It is necessary to remove all items that can be used to harm oneself from the home.
- Remove firearms from the home entirely.
- If firearms cannot be removed from the home:
  - Store them unloaded in a gun safe or lock box with the ammunition stored separately
  - Use trigger locks or cable locks on firearms
  - Keep the key or the combination to the safe/lock box secure and inaccessible to the individual at risk
- Lock away knives, razor blades, scissors, safety pins, nails, needles, and other sharp objects.

Substances

- If substances that can be misused are kept in the home, they should be locked away and monitored by a parent, trusted adult, or other family member.
- Keep track of bottles of alcohol and secure them in a locked cabinet.
- Lock all forms of drugs or marijuana in a lock box with the key and/or combination available only to trusted adults.

Medications

- Parents/caregivers (to youth) or a trusted friend/family member (to adults) should be the only ones administering medications.
- A trusted adult should secure over-the-counter and prescription medications in a locked box or cabinet.
- Remove unused or expired medications (take them to a pharmacy or fire station for proper safe disposal).
- Keep track of all medication bottles and the number of pills in each container, including over-the-counter medications.

Resource: lockandtalk.org

LOCK & TALK VIRGINIA

Lock Meds
Lock Guns
Talk Safety

Parents and Caregivers' Considerations

- Monitor online activities and watch for researching methods of suicide, spending time in chatrooms or social media sites dedicated to self-harm or suicide, and/or the existence of bullying through means such as Snapchat, Instagram, TikTok, etc.
- Investigate if any materials or items in your child's possession could be used for self-harm.
- When the person in crisis is visiting others in their homes, ask about ownership of guns as well as the storage of weapons, medications, alcohol, or drugs. Use that information to determine if your child or teen will be safe in that environment.

Other Considerations

- If an individual is at risk for vehicle-based suicide, such as carbon monoxide poisoning or intentional crashes, hold onto their keys temporarily and offer rides or alternative transport if needed.
- Remove or limit access to belts, ropes, electrical wire, long cords, drawstrings, scarves, and shoelaces.
- Monitor individuals' living spaces where they are often alone (i.e., bedrooms and bathrooms).
- Lock all toxic household cleaners, pesticides, and chemicals away or remove them from the home entirely.
- Secure and lock high-level windows and access to rooftops.
- Consider supervision or limiting time alone.

Chapter 6: Communication Strategies

Ideal communication with someone regarding suicidal ideation or mental health concerns is about listening deeply, validating emotions, and expressing concern. This chapter describes effective communication strategies, including how to respond to suicidal disclosures, listen without judgment, validate feelings, and encourage professional help while respecting the individual's autonomy. It is divided into five sections: a) how to respond when someone expresses suicidal thoughts, b) how to talk to a person who is in crisis, c) listening skills and validating emotions, d) encouraging professional help, when necessary, without judgment or coercion, and e) calming techniques.

Phrases to express support

- *Whenever you want to talk, I'm here to listen and support you.*
- *I won't judge, and I'll never stop supporting you, no matter what challenges you face.*
- *How are you feeling? I've noticed you're (sad, angry, or acting out more).*
- *Are you thinking of hurting yourself? Should I be concerned about your safety?*
- *I love you.*
- *I'll be here for you no matter what.*
- *My love is unconditional.*
- *I had no idea you were in that much pain.*
- *I'll get you the help you need to get through this challenging time or tell me how I can help.*
- *Talk to me, I want to hear what you have to say.*

A. How to Respond When Someone Expresses Suicidal Thoughts

Hearing someone express thoughts about suicide can feel overwhelming, but your response can play a vital role in their safety. People in crisis need to feel heard, taken seriously, and supported without judgment. Responding calmly, with compassion and honesty, shows that you care and that they are not alone. This section offers practical guidance for acknowledging their disclosure, asking direct questions, and maintaining a steady, reassuring presence.

- As a family member or friend supporting a loved one, make sure you express gratitude and concern to them for sharing their thoughts of suicide.
  - An appropriate response would be, "*Thank you for telling me. I know that wasn't easy.*"

- Do not be afraid to ask directly about suicide, as it allows the person to feel understood.
  - An example of a way to ask is, "*Are you thinking about ending your life?*" or "*Are you having thoughts of suicide?*"

- To create a safe space for the individual, make every attempt to stay calm and steady. Your tone and body language can help reduce panic or fear during a very stressful time.

B. How to Talk to a Person Who Is in Crisis

The words you choose matter, but the goal is not to find the "perfect" thing to say. Instead, try to demonstrate that you care and value them. This section highlights helpful phrases that can provide comfort, as well as common missteps to avoid.

Helpful things to say:

- *I'm here with you. You're not alone.*
- *I can see this is really painful for you.*
- *Your life matters to me.*
- *I want to understand what you're going through.*

Things to avoid saying:

- *You're overreacting.*
- *Other people have it worse.*
- *Suicide is selfish.*
- *You're just seeking attention.*

C. Listening Skills and Validating Emotions

Often, the most healing gift you can offer is active listening, which helps a person in crisis feel understood and less alone. Validation that you hear them and want to help them will communicate that their feelings are real and important. Rather than rushing to "fix" the problem, focus on creating a safe space where emotions can be shared openly.

Recommendations for effective listening and validation of feelings include:

- Practice active listening by putting away all distractions.
- Maintain eye contact (unless it causes further agitation), nod, and give verbal cues like "*I hear you.*"
- Reflect back what you hear.
  - Example: "*It sounds like you feel trapped and hopeless.*"
- Validate their emotions.
  - Example: "*Many people in your situation feel really sad and fearful.*"
- Let them know their feelings are real and understandable.
  - Example: "*It makes sense you're overwhelmed, given what you've been through.*"
- Avoid rushing to fix the problem; instead, stay with their emotions before suggesting next steps.

Food for Thought:

Being a supportive person during times of crisis can help keep the individual safe in the present, especially when they are currently resistant to seeking professional help. You are encouraged to seek professional help yourself or use 988 to help guide you in supporting the individual as well as in taking care of yourself during this time of crisis.

D. Encouraging Professional Help When Necessary

While personal support is essential, professional intervention may be necessary to seek help immediately to ensure safety and healing. Encouraging someone in crisis to seek help should be done gently, respecting their autonomy and readiness. When framed without judgment, seeking support can feel like an empowering step rather than a demand.

It is important that you normalize seeking help, sharing that many individuals need extra support and someone to talk to about their challenges in life. It's helpful to compare mental health to physical health with statements such as, "*If you broke your arm, you'd see a doctor. Mental health deserves the same care.*" These comparisons may decrease the stigma of seeking professional mental health treatment.

Keep in mind that previous positive or negative experiences with mental health professionals can influence their openness to seeking professional support. These feelings are valid and should be listened to with openness and consideration. Talk to them about their concerns, what characteristics they feel are important in a mental health professional, and what has not worked in the past. These answers can help guide you as the caregiver to research and identify therapists or medical professionals who may be a positive option at this time. To help build trust, these concerns can be discussed with the therapist or medical professional during an introductory meeting or first session.

To encourage the person in distress who may be scared and confused, you can suggest calling a hotline together, helping them schedule an appointment, or providing transportation to the appointment. An individual may be hesitant when the topic is first discussed, and as a support person, we must accept their timeline. If they are hesitant, let them know you will be there to support them and can help if/when they're ready to seek professional counseling. An example of a supportive statement is, "*I understand this feels hard. I'll be here to help when you decide to get additional support.*"

When possible, parents or caregivers are encouraged to discuss support options or choices for care with their children. Ideally, this conversation can happen when there is not an active crisis. However, if there is an immediate safety concern, parents or caregivers will need to make decisions that are in the best interest of their child.

E. Calming Techniques

In moments of acute distress, emotions may feel overwhelming and unmanageable. Simple calming strategies can reduce agitation, restore a sense of safety, and create space for clearer thinking.

Grounding Techniques
When an individual is experiencing panic or trouble regulating their emotions, encourage them to try the "5-4-3-2-1" method. Ask them to name five things they see, four they feel, three they hear, two they smell, and one they taste.

Breathing Exercises
When supporting an individual who is experiencing distress or feeling overwhelmed, encourage them to take slow, deep breaths. It is often helpful to inhale for four seconds, hold for four seconds, and exhale for six to eight seconds.

De-escalation Technique
When an individual is in crisis or extremely agitated, it is wise to speak calmly and at a lower volume, use their name, avoid confrontation or arguments, and reassure them with phrases like, "*You are safe right now. I'm here with you.*"

Soothing Activities
When someone is in crisis, their stress response is often heightened, making it difficult to think clearly, breathe regularly, or make safe choices. Soothing activities are helpful because they calm the body and mind, which can reduce the intensity of overwhelming emotions and help them feel more in control and regulated. Examples include holding a warm drink, listening to calming music, taking a walk, smelling a favorite scent, or moving to a quieter environment.

Chapter 7:
Navigating the Mental Health System

Mental health networks are often complex and difficult to navigate. Understanding what mental health is and is not, along with the different types of professionals, treatment options, and rights of families and their loved ones, can feel daunting and overwhelming.

This chapter clarifies some of these concepts, terms, and services and provides strategies for helping your loved one. It is divided in twelve sections: a) understanding mental health, b) types of mental health professionals, c) treatment options defined, d) inpatient versus outpatient care, e) how to advocate for your loved one, f) questions to ask treatment providers, g) involuntary hospitalization, h) emergency substantial risk order (ESRO), i) insurance considerations, j) rights in mental health services, k) consent and confidentiality, and l) barriers to care and tips to overcome.

A. Understanding Mental Health

Mental health is about how we think, feel, and act in our daily lives, shaping the way we handle stress, connect with others, and make decisions. Just like physical health, everyone has mental health, and it can be strong and positive at times or more challenging at other times. It is influenced by many factors—our biology, life experiences, support systems, and the communities we live in—and it naturally changes over time depending on what's happening in our lives.

Sometimes, challenges in our mental health take the form of mental health conditions, which involve changes in thoughts, feelings, behaviors, or moods.

These conditions can impact how we cope with stress or life transitions and may affect daily life, including work, school, relationships, physical health, and sleep. Mental health conditions are just as real and persistent as physical ailments, though they can look different for each person based on genetics, environment, history of trauma, and other personal factors. Common examples include anxiety, depression, eating disorders, and post-traumatic stress disorder (PTSD).

Having good mental health doesn't mean you'll never struggle, and having a mental health challenge doesn't mean you can't live a meaningful, fulfilling life. Mental health struggles are not signs of weakness or personal flaws—they are real health issues, the same way a broken bone or high blood pressure is. Mental health isn't something only "some people" have; we all have it, and it can shift throughout our lives. Finally, mental health challenges aren't always visible. Someone may look fine on the outside while struggling on the inside, which is why compassion, listening, and understanding matter so much.

B. Types of Mental Health Professionals

There are various types of mental health professionals who can assist individuals, couples, and families in a variety of settings. These professionals can provide support to individuals experiencing suicidal ideation as well as anyone dealing with life stressors. On the next page are examples of different mental health professionals and the type of services they can provide.

Prescribe and monitor medications

- ***Psychiatrists*** are licensed medical doctors who hold a Doctor of Medicine (MD). Psychiatrists can diagnose mental health conditions, prescribe and monitor psychiatric medications, and provide therapy.
- ***Mental health nurse practitioners*** can provide assessments, diagnoses, and therapy for mental health conditions and substance use disorders.

Other Professionals

- ***Certified peer specialists*** have their own lived experience of mental health conditions and/or substance misuse disorders. They then undergo training to provide others guidance, support, and mentoring.
- ***Social workers*** who practice in the general field of social work provide case management, intake and discharge planning services, placement resources, and other resources to support the empowerment and well-being of individuals in the community.

Assessment and Therapy

- ***Psychologists*** hold a Doctor of Philosophy (Ph.D.) in the field of psychology, and they are licensed by their state's licensure board. They conduct mental health evaluations via clinical interviews and psychological evaluations and testing. Psychologists are able to make official diagnoses in accordance with the Diagnostic and Statistical Manual of Mental Illnesses (DSM). Psychologists can also provide individual and group counseling utilizing a variety of clinical approaches, including cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT).
- ***Counselors***, ***clinicians***, and ***therapists*** are masters-level mental health professionals who operate under different titles depending on their education and treatment setting. They often hold a degree in a mental health-related field, such as psychology, counseling, or marriage and family therapy. Generally, counselors, clinicians, and therapists are trained to work with individuals, groups, and/or couples who are experiencing mental health conditions. These professionals may be licensed, for example, Licensed Professional Counselors (LPC) and Licensed Marriage and Family Therapists (LMFT). They may also be under the supervision of a licensed professional.
- ***Clinical social workers*** hold a master's degree in social work. Clinical social work is a specialty practice area of social work that focuses on the assessment, diagnosis, and treatment of mental health issues. These professionals are often trained in case management and client advocacy as well as may be licensed as Licensed Clinical Social Workers (LCSW).

C. Treatment Options Defined

Many different types of treatment options for mental health conditions exist. Psychotherapy is a common form of treatment that explores our thoughts, feelings, and behaviors. Psychotherapy can look different depending on the setting, the professional, and the implemented approaches. Many treatment options are used in conjunction with one another to provide the best support. On the next page are a variety of treatment options available to your loved one.

Therapy and Counseling

- For some individuals, therapeutic treatments such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) can reduce suicidal thoughts and behaviors. Not all therapists receive the same training or have expertise in all areas. Seek a practitioner who specializes in suicide-specific treatment.
- Therapy helps individuals learn coping skills, manage overwhelming emotions, and address underlying issues such as depression, trauma, or anxiety.

Medication

- Psychiatric medications, such as antidepressants, mood stabilizers, or antipsychotics, may be prescribed when mental health conditions like depression, bipolar disorder, or psychosis contribute to suicidal ideation.
- Medication is often combined with therapy for the most effective treatment.

Hospitalization or Intensive Treatment

- In cases of high risk, inpatient care in a hospital or residential treatment center may be necessary to ensure safety and provide intensive support.
- Partial hospitalization or intensive outpatient programs can also provide structured care without full admission.

Social and Community Support

- Support from family, friends, and peer groups can play an important role in recovery.
- Community resources such as support groups, crisis centers, and faith-based organizations can also provide connection and hope.

D. Inpatient Versus Outpatient Care

Depending on the frequency, intensity, and severity of your loved one's suicidal ideation, the physician, psychologist, or therapist may make a recommendation for inpatient care or outpatient care. As a patient or a caregiver, you are encouraged to ask questions about such care and the reasoning behind the recommendations. Keep in mind, this process is not linear, and changes are made based on the individual's current situation and changing needs.

Partial Hospitalization Program (PHP)

- Partial hospitalization is an outpatient program where patients spend 6 or more hours per day, usually every weekday, receiving structured treatment while still sleeping at home. Programs may be offered at hospitals, mental health clinics, or behavioral health centers.
- Treatment typically includes individual therapy, psychiatric care, group therapy, psychoeducational sessions, and creative or recreational therapies to support emotional expression and coping skills.

Intensive Outpatient Program (IOP)

- Intensive outpatient programs provide care for approximately 3–4 hours per session, typically scheduled in the afternoons or evenings, 3–4 days per week. Like partial hospitalization, patients return home after each session.
- IOP is designed for individuals who need more support than standard weekly therapy but are not currently in need of IP or IP is not available for them currently. It can often be coordinated alongside school or work responsibilities.

Outpatient Treatment

- Outpatient care is a broad term that can refer to many types of treatment, including but not limited to therapy offices, community health centers, and intensive outpatient programs. Unlike inpatient, outpatient care does not require overnight stays or 24/7 supervision. Outpatient care allows individuals to receive treatment while living on their own.
- Standard outpatient care usually involves weekly therapy sessions, psychiatric visits, or group meetings. For someone experiencing suicidal thoughts who does not require intensive care, outpatient treatment may include multiple therapy sessions per week or a combination of individual therapy and a weekly group session to provide consistent support and monitoring.
- Availability for outpatient treatment may be limited in areas throughout the state; therefore, individuals may need be transported to resources outside of their immediate area.

Inpatient Hospitalization (IP)

- An individual may need inpatient treatment for more intensive care, including crisis intervention, medication stabilization, and supervision. Inpatient care offers a structured environment for individuals to stabilize.
- Inpatient hospitalization provides around-the-clock, intensive care and support, meaning patients stay at the facility both day and night. Depending on location, this care may take place on a dedicated psychiatric floor within a general hospital or at a standalone psychiatric facility, including behavioral health hospitals or specialized clinics.
- Inpatient care is typically used when someone is at significant risk of harming themselves or others.

E. How to Advocate for Your Loved One

When someone you care about is struggling with suicidal thoughts, it can feel overwhelming to know how to help. Advocacy means standing by their side, making sure their needs are heard, and helping them access the right care and resources. Ways you can help include:

- Stay involved by attending appointments if your loved one agrees, taking notes, and helping ask questions.
- Speak up respectfully, especially if you notice concerning behaviors or worsening symptoms. You are encouraged to share these observations with treatment providers.
- Know your rights, as you have the right to ask about treatment options, safety planning, and follow-up care.
- Encourage your loved one's voice, which does not mean speaking over them. Advocacy means ensuring their needs and wishes are heard and taken seriously.

F. Questions to Ask Treatment Providers

Meeting with doctors, therapists, or hospital staff during a crisis can feel confusing and stressful. Having a few key questions prepared helps you understand the treatment plan and ensures your loved one gets the care they deserve. These questions are designed for families or support people to ask therapists, ER staff, psychiatrists, or inpatient providers when a loved one is experiencing suicidal ideation.

Immediate Safety

- What steps are being taken right now to keep my loved one safe?
- How do you assess their level of risk for suicide?
- Is hospitalization necessary at this point, and if so, what does that process look like?

Treatment Plan

- What is the recommended treatment plan (therapy, medication, hospitalization, safety planning)?
- What short-term and long-term goals should we expect?
- How will you involve my loved one in decision-making about their treatment?

Family Involvement

- How can I best support my loved one during treatment?
- Are there ways I can be involved in safety planning or follow-up care?
- What signs should I look for at home that mean I should call for help immediately?

Resources and Support

- What community resources, crisis lines, or support groups are available for my loved one?
- Are there resources or support groups for families and caregivers?
- Who do I contact if I have urgent concerns between appointments?

Practical Considerations

- What are the expected costs of treatment, and is it covered by insurance?
- What should I know about confidentiality and consent if I want to stay informed?
- What happens if my loved one refuses treatment?

F. Questions to Ask Treatment Providers (cont.)

Hospitalization for Active Suicidal Ideation

- What treatment centers/hospitals are available? Do we have the option of choosing which one is best for my loved one? Do they specialize in teens/young adults?
- What specific steps are being taken to keep my loved one safe?
- How often will they be monitored, and what does supervision involve?
- What therapies, counseling, or psychiatric care will they receive during their stay?
- What medications are prescribed, and how will side effects be monitored?
- How can my loved one be involved in decisions about their treatment?
- How can family members stay informed while respecting privacy laws?
- Are there family meetings or therapy sessions included as part of care?
- What criteria will determine when they are ready for discharge?
- What follow-up care or outpatient programs are recommended after leaving the hospital?
- Who can we contact if we have urgent concerns or questions outside of visiting hours?

G. Involuntary Hospitalization

Sometimes, a person in crisis may refuse help even though they are at serious risk of harming themselves. In these cases, involuntary hospitalization may be used as a last resort to keep them safe. You are encouraged to always check state laws for specifics surrounding your state's policies and procedures.

Emergency Custody Order (ECO):

- Is used when someone is acting in a way that shows they might hurt themselves, hurt someone else, or be unable to take care of themselves due to a serious mental health issue.
- Allows police to take a person into custody for up to 8 hours, often at a hospital or crisis center, for a mental health evaluation (conducted by a mental health professional).
- Is not an arrest and not a criminal charge, just meant to keep the person safe and help them get help quickly.

Temporary Detention Order (TDO):

- Is issued when a judge or magistrate decides the person has a mental illness, is still a danger to themselves or others, or is unable to care for themselves; needs treatment but won't accept it voluntarily.
- Holds a person in a hospital or mental health facility to receive treatment and further evaluation, lasts up to 72 hours (not counting weekends or holidays) until a court hearing is held.
- Gives the person the right to a lawyer and a hearing.

H. Emergency Substantial Risk Order (ESRO)

- Is a temporary court order meant to prevent harm when someone is believed to be in immediate danger of hurting themselves or others with a firearm.
- Involves a review of evidence by a judge; if approved, police can remove firearms right away; person cannot buy or possess firearms while order is active.
- Used in urgent situations, such as when someone is making threats, acting violently, or showing signs of severe crisis and has access to guns; meant to be a short pause during crisis.
- Can last up to 14 days; the court holds a hearing to decide whether to issue a longer-term SRO, which can last up to 180 days.
- Firearms are usually returned if the court decides the person is no longer a risk.

I. Insurance Considerations

Navigating insurance coverage during a mental health crisis can be confusing and frustrating, leaving you feeling like you have no answers. Knowing your rights and options helps ensure your loved one gets the care they need without unnecessary financial barriers. Important considerations include:

- Under mental health parity laws, most insurance plans (including Medicaid and Medicare) must cover mental health services at the same level as physical health services.
- Always ask your loved one's providers questions about coverage. For example: Is this service in-network? What out-of-pocket costs will there be?
- For crisis care, insurance generally covers emergency stabilization, but ongoing care may require pre-authorization.
- You can receive guidance by reviewing your insurance's explanation of benefits or calling them for more information. If the patient is denied coverage, they have the right to appeal coverage decisions.

J. Confidentiality and Consent

Mental health care comes with important rules about privacy and consent. These laws protect sensitive information while also allowing providers to act in emergencies. Understanding how confidentiality works, when information can be shared, and how to give consent for communication can help reduce confusion and build trust in the treatment process.

- Individuals must consent by giving written permission before providers share information with family, unless there's an immediate safety risk.
- Mental health providers must protect private information under HIPAA (Health Insurance Portability and Accountability Act), which guarantees confidentiality for individuals receiving services.
- Families can ask their loved one to sign a release form called a consent to exchange information so providers can share updates with them.
- Complaint processes: Individuals have a right to submit complaints or concerns about violations of rights or poor care to a patient advocate at the hospital, their state health department, or the professional's licensing board.
- In mental health care, minors have certain rights to consent and confidentiality, but these rights vary by age and situation, and parents or guardians may be involved when safety concerns or legal requirements arise.

K. Rights in Mental Health Services

Everyone receiving mental health services has certain rights that protect their dignity, safety, and choice. Knowing these rights helps you and your loved one feel empowered, ask informed questions, and recognize when something isn't right.

Everyone is entitled to the following:

- Safe and respectful treatment without discrimination
- Detailed information about their diagnosis and treatment options
- Participation in decisions about their care whenever possible
- Access to emergency services when in crisis
- The right to refuse certain treatments, unless legally overridden for safety reasons
- Federal law prohibits discrimination in mental health care based on race, gender, sexual orientation, disability, age, or insurance type.

L. Barriers to Care and Tips to Overcome Them

Many people face obstacles when trying to access mental health care, including transportation challenges, stigma, long waitlists, and more. Navigating our mental health systems takes time in any situation; therefore, it is ideal to start looking for additional resources or ways to address barriers to care before a crisis occurs. These barriers can feel discouraging, but there are practical ways to work around them. By learning common challenges and strategies to overcome them, you can help ensure that your loved one still receives timely and effective support.

Tips for Overcoming Barriers

- When an individual does not have access to transportation, you can explore telehealth, crisis hotlines, or community ride programs.
- If you are constrained by financial limitations or do not have insurance, you can ask about sliding-scale fees, community mental health centers, or financial assistance programs.
- When language is a barrier, you can request interpreters, as providers are legally required to offer translation services.
- Sometimes the stigma of reaching out for mental health services can be worrisome, but remind yourself and the person in distress that seeking help is a sign of strength, not weakness.
- If there is a long waitlist for care, ask about cancellation lists, short-term crisis programs, or bridge appointments while waiting for long-term care. It never hurts to explore your alternative options.
- Some individuals have past experiences that cause them to have mistrust of the system. Encourage your loved one to have open conversations with providers about fears and past negative experiences.
- If a provider is not a good fit for your loved one, don't be afraid to request a new provider or ask for a second opinion.

Chapter 8:
Creating a Safety Plan

When someone is experiencing suicidal thoughts, it can be frightening and stressful as you try to support them in their distress. Offering them both emotional support and practical tools is crucial in helping to keep them safe. One of the most effective tools is a safety plan, a practical, personalized document that provides structure and hope during a suicidal crisis. A safety plan helps individuals regain a sense of control and direction in difficult moments. It is most effective when developed collaboratively, written clearly, and kept accessible for use whenever suicidal thoughts arise. This chapter includes the following sections: a) recognizing warning signs, b) internal coping strategies, c) people or places for distraction, d) people to ask for help, e) professional support, f) making the environment safer, and g) reasons to stay alive.

Keep in Mind:

By taking the time to create a thoughtful safety plan, you're not just helping someone prepare for a crisis; you're showing them that their life matters and they are not alone. Key aspects of a safety plan are explained below, and a template example of a safety plan can be found at the following link.

Safety Plan Template (Download)

A. Recognize Warning Signs

Start by helping the individual recognize what thoughts, feelings, or situations can signal a downward spiral. It can be helpful to have them recall previous times of distress and what they experienced leading up to that distress. This may include isolation, changes in their sleep, feeling like a burden, or hopeless thoughts. Naming these early cues increases the chance of acting before things worsen. Assist the individual in identifying at least **three warning signs** that suggest a crisis may be starting. These might include things like feeling unusually overwhelmed, withdrawing from loved ones, and having thoughts that "*things will never get better*."

B. Internal Coping Strategies

Encourage them to brainstorm healthy ways to cope on their own. This could include listening to music, journaling, taking a walk, deep breathing, drawing, or distracting activities like watching a favorite show. These tools can provide a moment of calm when emotions run high. Ask them to come up with **three things** they can do alone to take their mind off suicidal thoughts. These should be safe, soothing activities that may help to reduce the emotional intensity without needing to reach out to others immediately.

C. People or Places for Distraction

Next, identify **three people or places** they can visit or call for a healthy distraction. These are not necessarily people they will talk to about their suicidal thoughts, just sources of comfort or positive energy. Examples: a trusted friend who makes them laugh, a local coffee shop or library, or a sibling they can play a game with. Include names and phone numbers for easy access. Pets can also be a good source of comfort.

D. People to Ask for Help

Have the person list trusted friends, family, or community members they can contact in distress. These should be people who are compassionate, nonjudgmental, and willing to offer support without needing to "fix" anything. List **three people** they can talk to openly when they're in distress. These should be individuals who have agreed to be listed on the plan and understand their role in a time of crisis. Include names and phone numbers here as well.

E. Professional Support

Include contact information for mental health professionals, crisis lines, and emergency services. List their therapist's name and contact information, primary care physician's name and number, the nearest emergency department/urgent care location and phone number, 988 Suicide & Crisis Lifeline (call or text 988, or chat at 988lifeline.org). This ensures they have immediate access to professional support when needed.

F. Make the Environment Safer

Reduce access to anything that could be used for self-harm. This could mean locking up medications, removing weapons, or asking someone else to hold onto potentially dangerous items temporarily. Write down at least two specific steps to reduce access to potentially harmful means. These may include giving medications to a trusted friend or locking them away, removing firearms or storing them securely outside the home. (State laws may differ regarding removal of firearms or weapons; therefore, you are encouraged to check state, county, and city laws and regulations.) Remember: small steps can make a huge difference in moments of impulsiveness.

G. Reasons to Stay Alive

Help the person list meaningful reasons to stay alive—family, pets, goals, faith, or anything else that matters to them. In a moment of darkness, even a small reminder of hope can make a big difference. These do not have to be huge, long-term things. Help them identify things they are looking forward to (e.g., like an upcoming movie release, or plans with friends) or that give them hope. This step does not have to identify reasons to stay alive forever; this can seem overwhelming and unattainable for someone in distress. Focus on short-term reasons if that is what the individual can manage. Finding a reason to stay alive for now is a significant step in keeping them safe.

Remember:

A safety plan isn't a cure, but it is a powerful tool for navigating moments of crisis. Sometimes these plans are written to keep the person safe for a very short period because the individual may not be able to look far into the future. It should be written in the individual's own words, easy to access, and reviewed regularly. Consider saving the plan on a phone, printing it and keeping it in a wallet, or giving it to someone they trust. The plan should also be reviewed and updated regularly as situations, support, or needs change. Most importantly, it should be created with compassion and collaboration, not forced or rushed.

Chapter 9:
Caring for Yourself as a Support Person

Supporting someone who has thoughts of suicide can be one of the most intense and emotionally demanding experiences you will ever face. You may feel a mix of fear, responsibility, frustration, sadness, and exhaustion—sometimes all at once. It's natural to want to be there for your loved one every moment, to do everything in your power to keep them safe. But here's the truth: you cannot pour from an empty cup. If you burn out, you'll struggle to give the care and stability the person in distress needs. Your well-being matters, not only for you, but for the person you are supporting.

This chapter offers practical strategies to help you stay grounded, healthy, and emotionally resilient while caring for someone experiencing suicidal thoughts or behaviors. It is divided into seven sections: a) recognize the warning signs of caregiver burnout, b) make your health a priority, c) set healthy boundaries, d) share the responsibility, e) manage stress and practice grounding, f) talk about what you are feeling, and g) practice self-compassion.

Warning Signs of Burnout:

- Persistent fatigue, even after sleeping
- Feeling numb, detached, or emotionally exhausted
- Irritability, guilt, or hopelessness
- Withdrawal from friends or activities
- Trouble sleeping or sleeping too much
- Physical symptoms like headaches, stomach issues, or muscle pain

A. Recognize the Warning Signs of Caregiver Burnout

Burnout doesn't happen overnight; symptoms build slowly and often are easy to dismiss. The earlier you notice the signs, the easier it is to address them before they become overwhelming.

Noticing these signs isn't a sign of weakness, but it is a signal that you need support, too. We all need help and support at different times in our lives. However, people may not realize you're close to burnout, so it is important to articulate when you're in need of support. Often, others will welcome the opportunity to support you in a crisis, but they need to know. In fact, the sooner you can express that you're struggling or need help, the sooner you can get support and find some relief.

B. Make Your Health a Priority

Caring for yourself is not selfish, and it is important so you can keep taking care of others. Meeting your own basic needs helps you stay emotionally present and physically strong. Suggestions include maintaining good sleep habits, eating nutritious foods, getting exercise, and taking care of your physical and mental health.

Keep in mind that setting aside even a few minutes a day for yourself can help you stay healthy and strong enough to face any challenges ahead.

- **Sleep:** Aim for 7–9 hours per night; exhaustion magnifies stress.
- **Nutrition:** Eat balanced meals and stay hydrated to stabilize energy and mood.
- **Movement:** Even a short walk or a few minutes of stretching can lift your mood.
- **Medical care:** Keep up with checkups, medications, and any ongoing health needs.

C. Set Healthy Boundaries

Being available 24/7 may feel necessary, but it is unsustainable. Setting limits helps you continue showing up in a consistent, grounded way. Boundaries aren't about abandoning someone, quite the opposite. They are about keeping yourself well enough to keep showing up. Examples of setting boundaries include saying "no" to requests that you don't have time for or cannot commit to at this time, delegating tasks to trusted friends or family members, scheduling quiet time, rest time, or technology-free time for yourself each day, and protecting time in your week for hobbies and interests.

D. Share the Responsibility

You don't have to do this alone. The responsibility of keeping someone safe is too heavy for one person to carry by themselves. Allowing others to step in helps you rest and gives the individual a stronger safety net. There are many ways to share the responsibility with others, such as asking family, friends, neighbors, or colleagues to help with meals, rides, or visiting with the person in distress. Expanding your support system can help share the emotional and logistical load. In addition, building a network of mental health professionals to partner with and help guide you in making decisions and developing a plan for treatment.

E. Manage Stress and Practice Grounding

Ongoing stress takes a toll on your mind and body. Build small daily habits that calm your nervous system. The goal is not to eliminate stress completely, but to keep it from overwhelming you. Suggestions for stress management include breathing exercises, practicing yoga or meditation, exploring nature, journaling to process emotions, listening to calming or soothing music, and taking small breaks to grab a few minutes to yourself.

F. Talk About What You're Feeling

Holding everything inside will only intensify the pressure you're under. Find safe ways to talk about your emotions and experiences. Talking openly can help you process difficult feelings like fear, anger, guilt, and grief. Carrying these heavy emotions can impact you physically, emotionally, and mentally. Sharing feelings with a trusted friend or family member, joining a caregiver support group, and seeking counseling are all helpful ways to process all you are feeling and experiencing.

G. Practice Self-Compassion

Caregiving can bring moments of frustration, resentment, or self-criticism. Being gentle with yourself helps you stay emotionally resilient. Remember that there is no perfect caregiver. You are doing the best you can in these circumstances; therefore, small victories each day deserve to be acknowledged. Caring for someone with suicidal thoughts is a marathon, not a sprint. Your care and presence matter deeply, but so does your own health. Making space for rest, boundaries, and support allows you to show up more fully and sustainably.

REMEMBER: you are not alone. Help is available for the person in distress and for you. You are part of their safety net, but you deserve a safety net of your own.

Chapter 10:
Involving Other Family Members and Children

When someone is experiencing suicidal thoughts, it can affect the entire family system. Providing safety and support for all members of the family is paramount. This chapter addresses strategies for involving other family members, including children, and consists of four subsections: a) age-appropriate ways to explain the situation, b) keeping the household stable, c) addressing guilt, fear, and confusion in family members, and d) sharing with friends and family.

A. Age-Appropriate Ways to Explain the Situation

It can be difficult and anxiety-inducing for parents or caregivers to openly discuss topics like mental health challenges or suicide, especially with their children. In some instances, parents or caregivers may lie about someone's struggles to protect them from stigma or shame. This approach is discouraged for many reasons. First, children and teens are intuitive and may sense when something is amiss. Moreover, if they are not told the truth, they may "fill-in-the-blank" with a story that could be worse than what actually occurred. They may also overhear adult conversations, hear rumors from others, or find out information on social media, which can be harmful instead of the information coming from a loving and informed adult.

Resource: AFSP booklet *Children, Teens and Suicide Loss*

Having open, direct, and truthful conversations using developmentally appropriate language is the best course of action because it can:

- Destigmatize mental health challenges and suicide
- Validate that everyone goes through challenging times
- Model open communication and talking about adversity
- Allow for questions
- Encourage help-seeking behaviors

Below are different age-appropriate ways to talk about suicide with children and teens.

Preschool-aged children

Young children most often operate in concrete thinking and need clear, direct language. They may not understand abstract language or euphemisms, so explaining what suicide means (i.e., "*to kill yourself on purpose*") or similar language can be helpful. It may be beneficial to explain that suicidal thoughts or attempts are because an individual is in unbearable pain, not because they do not love you.

Children may also engage in magical thinking and may end up feeling some responsibility for someone's suicidal thoughts or attempts (e.g., "*I got mad at my dad and now he wants to die*"). It is important to share that they are not responsible or at fault. The child may ask questions, and adults are encouraged to remain open to that. Adults may, however, want to refrain from using graphic details.

School-aged children

Like preschool-aged children, using direct language and explaining what suicide means is beneficial for these youth. School-aged children can understand more abstract concepts and handle more information, yet adults still may want to use discretion with too many graphic details. Because of the nuance and complexity that come with suicidal ideation, school-aged children may be capable of connecting to feelings like hopelessness or loneliness. In this regard, adults can help them develop empathy and understanding for a person in distress. They also have more developed language skills and may be able to articulate their feelings better than younger children. Though school-aged children may not engage in magical thinking like their younger counterparts, they are susceptible to blaming themselves. Explaining that suicide is a complex phenomenon with many causes may be beneficial while emphasizing that they are not responsible. Adults should offer reassurance, a listening ear, and a safe space to explore the child's thoughts and feelings.

Teenagers

Teenagers have more developed language skills and abstract thinking than younger children. They may also be able to communicate their needs better. Like all youth, teens may blame themselves or feel a sense of responsibility for the other person's distress. It is imperative that adults continue emphasizing the complexity of suicidal ideation and deemphasize the teens' blame or responsibility. A distinguishing developmental feature of teenagers is that they tend to turn to their friends for support or information more than family members or caregivers. As such, adults should not pressure their teens to talk. Rather, they should continue offering a safe space to explore their thoughts and feelings, even if the communication does not feel like a "two-way street." Adults may also want to be intentional by making time to check-in instead of waiting for their teens to approach them with thoughts or worries.

B. Keeping the Household Stable

Keeping the household stable when someone is struggling with a mental health disorder or suicidal thoughts is paramount for adaptive functioning for the entire family. In addition to limiting access to lethal means (see chapter 5), one of the best ways to accomplish this is to keep a routine or establish a new routine while keeping some flexibility. Children of all ages benefit from structure and routine. However, there may be times when it is best to deviate from the routine to meet the needs of your child. Consider your current routine and determine what is working for you and your family. If aspects of your routine no longer serve you and your family, adjust as needed. Depending on the age of your child, it may be helpful to include them or seek feedback in this process. Communication is a critical aspect of keeping the household stable as well. Making time to check-in with family members about how they are doing, what they are feeling, and how the routine is or is not working can be beneficial. See chapter 8 on creating a safety plan for further information for the family member experiencing suicidal ideations.

C. Addressing Guilt, Fear, and Confusion in Family Members

If an individual has had suicidal thoughts or attempted suicide, it is common to experience a multitude of emotions. Feelings like shame, guilt, fear, or anger can be common. When experiencing some of these challenging emotions, it can be helpful to ask yourself, "*where is this feeling coming from?*"

Not only is identifying the emotion important, but also determining what is driving the emotion can be helpful in reducing the intensity of that emotion, as well as communicating with your loved ones. If you think about an iceberg, the top part of it is visible, but below the surface of the water, it is much bigger and deeper than what is seen. Anger can be like an iceberg in that anger is what is visibly seen or heard, but it covers (or masks) a variety of emotions underneath. For example, if you're feeling anger towards the individual or about the situation, consider if that anger is really fear, shame, embarrassment, anxiety, or something else. If you're experiencing embarrassment or shame, reflect on the root of those feelings. Could those feelings be rooted in stigma, or do they come from a different place? Determining if the anger is truly anger or another emotion can be beneficial in communicating how you are feeling to your loved ones. It is important to note that no matter where they are rooted, all the emotions you and your loved one's experience are valid and deserve compassion.

After identifying and exploring your emotions, it is important to remember that suicide is highly stigmatized, and parental attitudes towards stigma impact their children getting the mental health support they may need. Seeking guidance from mental health professionals is a great way to engage in self-care and care for family members. Mental health professionals can also validate feelings, provide psychoeducation on suicide prevention and intervention, help identify self-care strategies, and foster healthy coping skills.

D. Sharing With Friends and Family

Leaning on family members and friends during challenging times is a great way to feel supported and take care of oneself. However, there is certainly some risk when determining whether to share that a loved one is thinking of suicide or experiencing a mental health crisis. Once information is shared, there is no longer the ability to control the narrative or gatekeep who knows.

Moreover, no matter how the information is delivered, there is no control over how the information will be perceived. As such, this decision may be wrought with anxiety for some. There is a fine line between destigmatizing conversations around suicide and weighing the risk of sharing information that may be painful.

When determining whether to share with family and friends, consider the following:

- No one has the right or is entitled to any information about the person experiencing suicidality.
- Before sharing, get permission from the person in distress. Failure to do so can erode trust and may rupture the relationship.
- Identify only the few or most trusted people with whom to share the information. This may also be agreed upon with the person in distress.
- Practice or rehearse what information is shared. This may be done in conjunction with the person in distress.
- Identify your needs ahead of time and share them (e.g., listening ear, no judgment, information, recommendations, etc.)
- Be prepared for a variety of reactions from supportive to judgmental.
- Anticipate your response or prepare a mental script if met with judgment.

Advantages to sharing information with family and friends can include:

- You don't have to carry fear, stress, or grief alone.
- Trusted people can provide comfort, validation, and a place to talk through emotions.
- Others can help watch for warning signs, encourage treatment, or simply be present.
- More people being aware means others can be involved in keeping your loved one safe during a vulnerable period.
- Sharing can challenge shame and silence, which are often heavy burdens.
- It opens the door for more honest conversations about mental health.
- Loved ones may be able to assist with tasks, childcare, appointments, or daily responsibilities while you or the person who attempted are coping.
- Others may have personal or professional experience they can share suggestions with you or help you navigate next steps.
- It can remind you that you're not alone in this.

Chapter 11: Ongoing Support

After the immediate crisis, an individual must lay the groundwork for a long-term plan. This support includes maintaining treatment, finding the right professional resources, connecting with peer support, and helping individuals and families cope with fears of recurrence. As a support person, you can play a vital role by encouraging treatment, celebrating progress, and helping with logistics for appointments and other support resources.

This chapter is divided into five sections: a) supporting treatment adherence, b) how to find a therapist, c) how to find a support group, d) maintaining hope while managing fear of recurrence, and e) when to change providers.

A. Supporting Treatment Adherence

Adherence to a plan for treatment is one of the strongest protective factors against relapses or recurrence of suicidal crises. With the goal of maintaining recovery and stability, treatment can include regular therapy sessions, consistent use of prescribed medications, and keeping follow-up appointments. Family members and friends can play an active role by offering reminders, practical help, and encouragement while respecting the individual's autonomy. Ongoing mental health treatment should be seen as a key aspect of maintaining overall health, much like managing a chronic medical condition.

B. How to Find a Therapist

Finding the right therapist is a critical step in building long-term stability after a suicidal crisis. A therapist provides a safe space for processing emotions, developing coping strategies, and addressing underlying mental health conditions. However, the process of locating a provider can feel overwhelming, especially when navigating insurance, availability, or specialty areas. It is important to recognize that therapy is not "one-size-fits-all." Individuals and families should be encouraged to ask questions, explore multiple options, and be open and honest about their needs. To find a therapist, consider the strategies below:

- Use directories such as Psychology Today (www.psychologytoday.com).
- Call your insurance provider and ask for a list of providers in your area.
- Ask your primary care provider for recommendations.
- Request an introductory call and ask about their experience working with individuals who have thoughts of suicide.
- For those who do not have insurance, search for free clinics and Community Service Boards in your area that provide services for individuals who are uninsured.
- Search Psychology Today for therapists who offer a sliding scale to clients who do not have, or do not want to use, insurance.

C. How to Find a Support Group

Professionally led or peer support groups can play an invaluable role in ongoing recovery. Professionally led groups are facilitated by a mental health professional, which allows for deeper clinical support, referrals to resources, and crisis planning if needed. Peer support groups are led by someone with lived experience as opposed to professional training in mental health and may offer a unique kind of empathy and understanding that professionals alone may not provide. There are multiple benefits of support groups, including reducing isolation, providing hope through shared stories, and fostering accountability and encouragement. For families, groups focused on caregiver support can also offer education, coping strategies, and connection with others who understand the challenges of supporting a person in crisis.

Support groups can be found via:

- National organizations such as National Alliance of Mental Illness (NAMI) or American Foundation for Suicide Prevention (AFSP)
- Local hospitals and community centers
- Online forums or virtual peer groups
- Including link to resources on webpage

D. Maintaining Hope While Managing Fear of Recurrence

For both survivors of suicidal crises and their loved ones, the possibility of having suicidal ideation can bring both anxiety and fear. These feelings are natural, as the experience of a crisis can leave you with ongoing concerns and emotions. At the same time, it is important to nurture a sense of hope, growth, and resilience as part of the healing process. Maintaining one's mental health is not linear, and periods of ups and downs do occur. Setbacks in our health can become opportunities to strengthen coping skills and reinforce support systems.

Loved ones play a key role in balancing worry with encouragement by remaining attentive to warning signs without creating an atmosphere of constant monitoring or mistrust. By recognizing strengths, celebrating milestones, and reinforcing the idea that growth and recovery are possible, families and friends can help individuals rebuild a life of meaning and stability.

Strategies to balance fear and hope:

- Acknowledging fears without letting them dominate conversations
- Emphasizing progress, strengths, and coping skills
- Balancing vigilance with trust and autonomy, avoiding over-monitoring the individual

E. When to Change Providers

A strong, respectful relationship with a care provider is critical to effective treatment, but not every provider/patient match will feel supportive or productive. Mental health care is highly personal, and progress depends not only on professional skill but also on trust, communication style, and the ability of the provider to listen and adapt to the individual's needs. While it is always the hope to have a good therapeutic relationship, it is also okay to not "click" with a therapist and want to find another practitioner who is a better fit. Recognizing when it may be appropriate to consider a change can help ensure that care remains effective and empowering rather than discouraging. Just like physical healthcare providers, individuals have a right to request a change or a second opinion.

Signs it may be time to switch:

- Experiencing a lack of communication or dismissive responses
- Persistent lack of improvement despite effort
- Absence of collaboration or mutual trust

Chapter 12:
Legal and Ethical Issues

Supporting someone at risk of suicide is not only emotionally challenging but also involves navigating a range of legal and ethical responsibilities. Families, caregivers, and professionals must balance the need for safety with respect for the individual's rights and privacy. Confidentiality laws protect sensitive health information, but exceptions exist when safety is at risk. Specifically, families often face uncertainty about what information they can access and what decisions they are legally allowed to make. Understanding these frameworks helps families and caregivers act responsibly and ethically while advocating for the individual's well-being. This chapter is divided into three sections: a) confidentiality laws (HIPAA and related protections), b) what family members are entitled to know, and c) legal mechanisms.

A. Confidentiality Laws (HIPAA and Related Protections)

Confidentiality is a foundational principle of mental health care, which protects patients from unauthorized disclosure of private information. In the United States, HIPAA establishes strict rules for how providers manage health information, creating a framework for trust between patients and professionals. Understanding these rules is essential for families, as they clarify when information can be shared and when it must remain private. Exceptions do exist, particularly when there is imminent risk of harm to the patient or others, but even then, disclosures are limited to what is necessary to ensure safety.

Being informed about these protections helps families know their rights and responsibilities while supporting their loved one. Below is a summary of pertinent information related to confidentiality:

- Providers cannot disclose detailed treatment information without written consent from the patient.
- Exceptions exist where confidentiality can be broken, such as imminent risk of harm, court orders, or certain public health concerns. In this situation, only necessary information is shared to lower the risk of harm and keep the individual safe.
- It is important for loved ones to remember that confidentiality is intended to protect autonomy and maintain trust between the patient and provider.

B. What Family Members Are Entitled to Know

Families naturally want to stay informed and involved when supporting someone at risk of suicide, but confidentiality laws often limit the information they can access. Understanding what can and cannot be shared helps families navigate their role effectively without overstepping legal boundaries. These rules differ depending on whether the individual is an adult or minor, as well as state-specific regulations that govern adolescent privacy. Clear knowledge of these boundaries reduces frustration, encourages collaboration, and supports care that is both ethical and in the best interest of the individual.

B. What Family Members Are Entitled to Know (cont.)

Adults

- Mental Health providers are generally legally prohibited from sharing detailed treatment information without the patient's written consent. This includes session content, diagnoses, medications, and treatment plans.
- In situations where an adult is at imminent risk of harm to themselves or others, providers may disclose limited information to appropriate parties (e.g. family member or friend) to ensure safety.
- Adults maintain the right to make their own treatment decisions unless they are legally incapacitated.

Minors

- For children under the age of 18, parents or legal guardians usually have access to mental health records, including diagnoses, treatment plans, and session summaries.
- Some states grant limited confidentiality rights to minors, which means a provider may withhold certain details from parents unless there is a safety concern or the minor consents to share the information.
- Providers often work to balance parental involvement and the child's trust in therapy. Open discussion with the minor about what will and will not be shared is highly encouraged.

C. Legal Mechanisms

Various legal mechanisms, provide a structured way for a trusted individual to step in and make decisions, while also ensuring safety and continuity of care. These tools should be considered carefully, as they limit personal autonomy and carry ethical implications. Understanding these options allows families to make informed, compassionate, and ethically responsible decisions during times of crisis.

Healthcare Power of Attorney (POA):
This legal document allows an individual to designate a trusted person to make medical decisions if they become temporarily or permanently incapacitated. A healthcare POA can be designated for a limited time for individuals to retain their decision-making abilities when they are stable.

Advance Directives:
These legal documents in which an individual specifies their preferences for mental health treatment ahead of time. An advance directive allows individuals to actively participate in their care planning while still healthy and oriented, giving families and providers clear guidance during crises. This may include preferred therapies, hospitalization preferences, medications, and crisis interventions. An advanced directive ensures that an individual's values and wishes are followed, even when they are unable to communicate effectively. Creation of this document can reduce conflict, uneasiness, and stress for families because they know the individual's preferences in advance.

Guardianship:
This is a legal arrangement in which a court appoints a trusted individual, called a guardian, to make healthcare and personal decisions on behalf of someone deemed unable to make safe decisions independently. Guardianship should be considered as a last resort, as it limits a person's autonomy and freedom to make decisions for themselves.

Regarding situations where an individual is experiencing suicidal ideation, guardianship may be considered in extreme cases where a person's suicidal thoughts are persistent, severe, and accompanied by an inability to maintain safety, even with family or professional support. A guardian would then make decisions regarding treatment, hospitalization, or safety planning to reduce risk.

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