



CREATING SAFE AND EFFECTIVE SPACES FOR SUICIDE RISK DISCLOSURE IN ROUTINE CARE



**NATIONAL LGBTQIA+ HEALTH
EDUCATION CENTER**

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KEY POINTS

- Disclosure is shaped by how clinicians ask and how they respond.
- A positive suicide screen does not automatically indicate imminent danger; it signals the need for further understanding.
- Direct, calm, and nonjudgmental language supports more accurate disclosure than vague or negatively framed questions.
- Support should match acuity - from validation and follow-up to collaborative safety planning to emergency intervention when needed.

BACKGROUND

Suicide remains a major public health concern in the United States. In 2023, 49,316 people died by suicide - about one death every 11 minutes. Centers for Disease Control and Prevention (CDC) also reports that 12.8 million adults seriously thought about suicide, 3.7 million made a suicide plan, and 1.5 million attempted suicide.¹ Rates are equally concerning among adolescents, with 10% of high school students reporting a suicide attempt in the past year.² Routine health care settings are, therefore, an important point of contact for suicide prevention. Many people who later die by suicide have seen a health professional in the year before death, and primary care contact is especially common.³ At the same time, risk is often invisible unless patients feel safe enough to talk about it. In routine care, one of the most important tasks is not simply identifying who may be at risk, but creating conditions in which disclosure becomes more likely.

IN 2023:

49,316

DEATHS BY SUICIDE

12,800,000

SERIOUS THOUGHTS OF SUICIDE

3,700,000

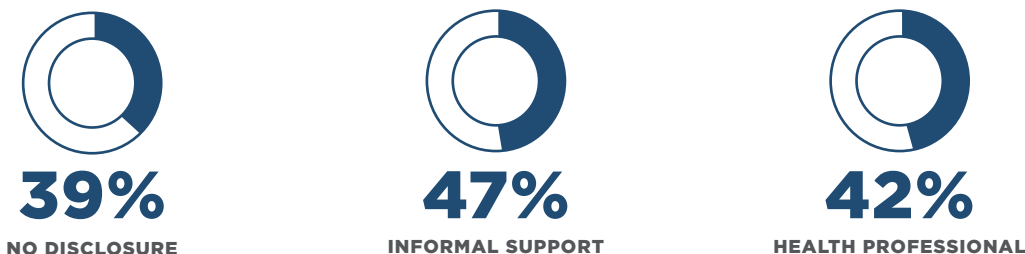
MADE A SUICIDE PLAN

1,500,000

ATTEMPTED SUICIDE



THE DISCLOSURE GAP IN HEALTH CARE



Suicidal thoughts are common, but disclosure is far from guaranteed. In a large survey of adults with past-year suicidal ideation, 39% reported that they had not disclosed their thoughts to anyone; 47% disclosed to an informal support, and 42% disclosed to a health professional.⁴ Studies of suicide decedents likewise suggest that prior disclosure of suicidal intent is often absent or limited, and patterns of disclosure vary by age and context.⁵ This gap matters because nondisclosure should not be confused with low risk. Many patients who are struggling are already in care, but they may not be saying what they are experiencing. A systematic review notes that about three in four people who died by suicide had contact with primary care in the year before death, and approximately 45% had contact within the month before death.³ The implication for routine care is clear: opportunities for prevention are frequently present, but they depend on whether communication happens.

Why patients may not disclose suicidal thoughts


People often do not disclose because disclosure can feel dangerous. Common concerns include shame, stigma, fear of hospitalization or loss of autonomy, worries about being judged, and uncertainty about whether the other person will understand or overreact.⁶ Importantly, anticipated responses shape willingness to disclose. In one study, stigma-related concerns were the most common barriers to accurate disclosure, whereas wanting emotional support and wanting the person asking to understand were key facilitators.⁶ Prior disclosure experiences matter too: disclosures of suicidal thoughts and behaviors are often perceived as helpful overall, but negative or invalidating reactions can make future disclosure less likely.⁷

IMPROVING OUR UNDERSTANDING OF SUICIDAL RISK TO ENHANCE DISCLOSURE RESPONSES

A clinically helpful starting point is to remember that suicidal thoughts are not all the same. A positive response to a suicide screen does not automatically mean imminent danger, just as denial does not guarantee safety.⁸ Suicidal thinking can range from passive wishes not to wake up, to active thoughts of suicide, to urges accompanied by intent or planning. The meaning of these experiences can differ substantially across people and across moments.^{8,9}

Emerging evidence suggests that suicidal thinking may sometimes serve a short-term affect regulation function - that is, the thought of escape can temporarily reduce distress, even while the overall pattern remains dangerous over time.¹⁰ Theoretical models likewise emphasize that suicidal ideation and suicidal action are related but distinct processes, and that risk is shaped by both enduring vulnerability and rapidly shifting situational factors¹¹

Observable warning signs are also variable and may be absent. Outwardly normal, future-oriented, or calm behavior does not reliably indicate safety. In one large National Violent Death Reporting System (NVDRS) analysis, an authenticated suicide note was documented in only about 31% of suicide cases.¹² Risk can also escalate quickly: in one study of suicide attempters, nearly half reported that the period between the first current thought of suicide and the attempt was 10 minutes or less.¹³ These findings underscore why clinicians should avoid relying on a single sign, a single moment, or a single level of apparent distress.



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WHAT EFFECTIVE SUICIDE RISK INQUIRY SHOULD INCLUDE

Best practice is to use a validated screening process and, when needed, a more focused suicide risk assessment. The Joint Commission recommends that assessments following a positive screen directly ask about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.¹⁴ Common tools used across settings include the Ask Suicide-Screening Questions (ASQ) and the Columbia-Suicide Severity Rating Scale (C-SSRS), although the choice of instrument should fit the clinical setting and workflow.^{15,16} Common elements across validated risk assessments include:

- ✓ ***Asking directly about suicidal thoughts.***

- ✓ ***Clarifying whether thoughts are passive, active, intermittent, escalating, or accompanied by urges.***

- ✓ ***Assessing intent, access to means, and capability to act.***

- ✓ ***Exploring recent changes, including worsening intensity, agitation, entrapment, substance use, or disruptions in support.***

- ✓ ***Identifying protective factors and reasons for living.***

- ✓ ***Clarifying what the person needs right now and what will help them stay safe.***

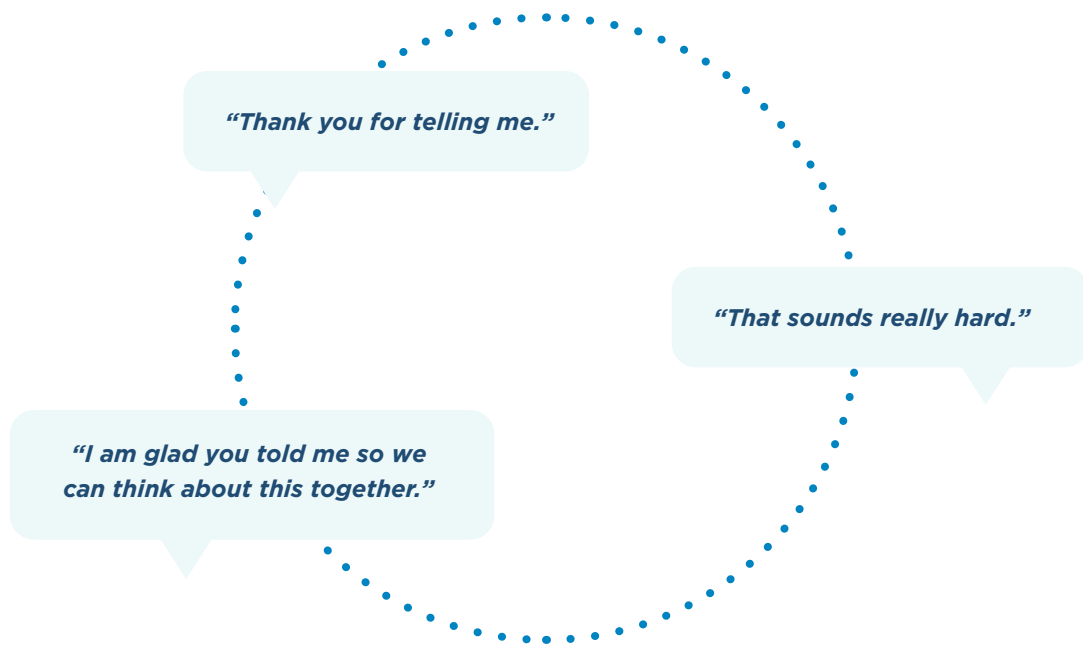
Current guidance also emphasizes that assessment should lead to action that matches acuity rather than to a one-size-fits-all response.¹⁷

HOW TO ASK IN A WAY THAT SUPPORTS DISCLOSURE

How clinicians ask is often as important as what they ask. Direct, calm, and nonjudgmental language tends to support more accurate disclosure than vague or negatively framed questions. Asking, “You are not thinking about suicide, are you?” can communicate a preferred answer and make honest disclosure harder (18). It is usually more effective to introduce the topic in a universal, matter-of-fact way and then ask clearly.

HELPFUL WAYS TO ASK	RESPONSES TO AVOID
<i>“I ask everyone these questions because many people have thoughts like this when they are overwhelmed.”</i>	<i>“You are not thinking about suicide, are you?”</i>
<i>“Have you had thoughts about wanting to die or wishing you were not alive?”</i>	<i>“You are not going to do anything, right?”</i>
<i>“Can you help me understand what the thoughts have been like for you lately?”</i>	<i>Promises in place of assessment or planning</i>
<i>“How strong have the urges been?”</i>	<i>Minimizing, dismissing, or alarmed reactions</i>
<i>“What has helped you get through moments like this?”</i>	
<i>“What would help you feel safer right now?”</i>	

A substantial evidence base indicates that asking about suicide does not increase suicidal ideation or self-harm risk (19,20). In practice, asking directly can reduce shame, communicate willingness to stay engaged, and create permission for a conversation that patients may have been trying to hold alone.



HOW TO RESPOND WHEN A PATIENT SAYS YES

The initial response to disclosure should prioritize steadiness, validation, and partnership. Supportive responses do not require immediate problem-solving; they require presence. Helpful first responses include statements such as, "Thank you for telling me," "That sounds really hard," and "I am glad you told me so we can think about this together."

Research on disclosure responses consistently shows that listening without judgment, expressing care, and communicating understanding are perceived as helpful, whereas minimizing, dismissing, or reacting with alarm are commonly experienced as unhelpful.^{21,22} Asking for reassurance - for example, "You are not going to do anything, right?" - can inadvertently shift responsibility back onto the patient and may increase shame. Similarly, asking someone to sign or agree to a no-harm contract is not an evidence-based substitute for assessment, collaborative safety planning or support, as non-suicide contracts lack empirical support for their effectiveness in clinical practice.²³

A "yes" should therefore be treated as an invitation to understand the person's experience more fully, not as a cue to jump immediately to conclusions. The next step is to explore what the thoughts mean for that person, how intense and changeable they are, what increases risk, and what helps the person stay safe.⁸

Hearing a disclosure of suicidal thoughts can also be emotionally taxing for clinicians. Although the literature has more often examined suicide assessment broadly or the aftermath of a patient suicide, existing work suggests these encounters can evoke fear, anxiety, overwhelm, self-doubt, and professional distress,²⁴ underscoring the importance of supervision, consultation, and supportive organizational responses. Creating suicide-safe care, therefore, includes not only supporting the person who discloses but also ensuring that clinicians have access to clear protocols, debriefing opportunities, and team-based support.²⁵

MATCHING SUPPORT TO LEVEL OF DISTRESS

Support should scale with acuity. For patients with lower-intensity or passive suicidal thoughts and no current intent, effective care may center on validation, follow-up, strengthening supports, and monitoring change over time. For patients with ambivalence, rising distress, or limited coping capacity, clinicians may need to increase contact, collaboratively develop a safety plan, involve supportive others when appropriate, and reduce access to lethal means. For patients with strong intent, impaired ability to maintain safety, or rapidly escalating risk, the priority becomes staying present, limiting isolation, mobilizing team-based or crisis resources, and following emergency procedures appropriate to the setting.¹⁷

Across all levels of distress, one principle is consistent: the relationship remains central. Patients are more likely to disclose accurately when clinicians respond with compassion, clarity, and calm rather than fear or interrogation.

SUMMARY

Creating safer conditions for suicide risk disclosure is a core part of routine care. Patients often do not disclose suicidal thoughts because they fear consequences, stigma, misunderstanding, or loss of control. Suicidal thoughts themselves vary in form, function, and intensity, and risk can change quickly with limited outward warning. For these reasons, routine care works best when clinicians ask directly, respond without judgment, and match the next steps to the patient's current level of distress.

Disclosure is not the end of assessment; it is the beginning of a more accurate conversation. When clinicians make room for that conversation - calmly, clearly, and collaboratively - they increase the likelihood that patients will tell the truth not only once, but again when it matters most.

Resources for Clinicians

Zero Suicide - Supporting Clinicians/Toolkit

<https://zerosuicide.edc.org/supporting-clinicians>

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