

## **ETHICS AND SUICIDE PREVENTION: By Kenneth Norton ACSW/LICSW**

Suicide is an issue that has long raised ethical, moral, religious and cultural discussions and debate. From biblical references to Greek philosophers, to Shakespeare, and to modern day philosophers, humanity has struggled with both the concept of suicide as well as trying to make rational sense of suicidal behavior. In dealing with such a complex individual and societal issue, Social Workers may face numerous ethical challenges which we must resolve to be effective practitioners.

The historical, cultural and religious perspectives regarding suicide shape the way we think and respond regarding suicidal behavior. As individuals, each of us brings our own personal, cultural and religious views and beliefs to our work with the clients, families and communities we serve. As Social Workers, we must blend our own personal beliefs and values with those of our profession and our Code of Ethics. Of course, it is imperative that we also take into account the personal, cultural and religious beliefs of the people we are working with – that's in the Code too!

At the recent NH NASW ethics and suicide prevention workshop, most participants indicated they had received little if any training in suicide risk assessment or suicide prevention as part of their academic studies. Yet most reported they routinely deal with suicidal behavior in their work. This is consistent with the results of a survey which found over 90% of Social Workers dealt with suicidal clients yet only 20% had formal training as part of their MSW program and 64% of those surveyed felt the training was inadequate (Feldman and Freedenthal 2006). Section 1.04 of the Code indicates Social Workers should only practice within the boundaries of their education and training. Most participants at the training indicated they have received on the job training and/or sought out their own workshops in suicide prevention/risk assessment. This training issue does raise an interesting systems level ethical question regarding whether the Council On Social Work Education (accrediting body for Bachelors and Masters degree programs) have an ethical obligation to do more to insure Social Workers receive academic training in suicide prevention as a key area of practice.

An added ethical dimension related to the issue of training involves how a Social Worker responds to a client who is suicidal if that Social Worker does not have adequate skills in treating suicidal individuals. Section 2.06 of our Code indicates that Social Workers should refer clients if the Social Worker lacks the expertise needed to fully serve the client. However the Code also specifically prohibits abandoning clients and calls for an orderly transfer of responsibility – a challenge in the best of circumstances, but especially so with a client who is suicidal. Obviously, the best solution for this dilemma is to make sure you have the expertise and training needed to work with a suicidal individual so you do not have to transfer them.

Informed consent is an important part of social work practice (Section 1.03 of the code) and if it is done correctly, it can diminish or eliminate potential ethical dilemmas involving suicidal

clients. For instance, informing clients that there is an exception to confidentiality in the event they are suicidal is a critical aspect of informed consent (limitations to confidentiality are covered in section 1.07). Informed consent might also set out limitations to treatment – such as identifying the level of suicidality a Social Worker feels they can manage without referring out, or laying a foundation/expectation for involving family and or other supports if an individual’s suicidality moves beyond a certain threshold. When possible, and with the clients permission, involving family in the informed consent process or in a discussion of risks and benefits of treatment offers multiple potential benefits including educating them about warning signs and emergency resources, engaging family to support the therapeutic goals and process, thus strengthening the safety net available for this individual and minimizing the potential for lawsuits in the event of a suicide attempt or death.

Historically, the issue of self determination and suicide has been an area of great debate. In modern times the polarity of views are best represented by psychiatrist Thomas Szasz who reflecting the era of the 1960’s focus on civil rights believed suicide to be an individual right which society had no right to intervene in, while noted psychologist and suicidologist Edwin Schneidman felt that everyone is responsible for preventing suicide and society has an obligation to intervene to help save someone who is suicidal. While the Social Work Code of Ethics has a very strong foundation regarding the self determination of the client (section 1.02) the Code makes a clear exception for limiting the client’s right to self determination if in the professional judgment of the social worker the “clients actions/potential actions presents a serious, foreseeable and imminent danger to themselves or others.”

Different cultures and religions and hence individuals and families who are parts of these groups have different attitudes, values and beliefs regarding suicide. These values may pose challenges for Social Workers working with these groups. Negative attitudes may promote isolation and shame for families who have experienced suicide death. In some cultures, suicide is regarded as an honorable choice in certain circumstances. Our Code of Ethics mandates that Social Workers have an appreciation and understanding of the impact of culture on human behavior. The knowledge and understanding of specific cultural beliefs may assist in identifying and determining risk for suicide. It is important to note that the Code does not mean Social Workers must accept the practices and beliefs of all cultures, and should not in any way discourage a Social Worker from intervening with someone in imminent danger.

Many Social Workers will experience the suicide death of a client during the course of their careers. During this time of grief and emotional duress, Social Workers may find themselves faced with difficult ethical dilemmas. For instance family members have an intense need to understand *why* the death occurred and will seek out as much information as they can. Yet confidentiality does not end at death. Although most attorneys would discourage disclosing any information to family (even acknowledging they were in treatment may violate confidentiality unless family has been involved in the treatment process) studies show that clinicians are much less likely to be sued if they have contact with the family. Other ethical challenges include deciding whether to attend the memorial service. What is the motivation/benefit *to the client* in attending? Is it to deal with your own grief? Will your

presence breach confidentiality (particularly an issue in rural areas). Other ethical considerations may involve your practice with other clients. Does your grief and shock about the death of this client impact your ability to be present with other clients? Does it impact your competence and confidence in assessing risk for other clients? If you feel you are not able to see other clients for a period of time what is your obligation to those individuals on your caseload and how do you arrange coverage?

How should we respond when faced with ethical dilemmas? In addressing these complex issues it is important to apply ethical models to assist in decision making. Historical models such as “first do no harm” may need to be appended to include “do not be silent” and/or “do good.” A more comprehensive model for social workers is: **Who** will be helpful? **What** are my Choices? **When** have I faced a similar dilemma? **Where** do ethical and clinical guidelines lead me? **Why** am I selecting a particular course of action? **How** should I enact my decision (Strom-Gottfried 2007). Reviewing ethical dilemmas with a supervisor or for private practitioners, participating in an ongoing peer supervision group is an important part of the decision making process and strategies for dealing with ethical concerns. Whatever course of action you take be sure to document your thinking, who and what (eg. the Code) you consulted and how you arrived at your decision.

***It is everyone’s responsibility to prevent suicide.*** Warning signs include: talking about death or dying, isolation, anger/rage, hopelessness, increased use of alcohol or other drugs and mood changes. If you are worried about someone you think is at risk of suicide call the National Suicide Prevention Lifeline 1-800-273-TALK (8255).

This is the twelfth in a series of articles for the NH NASW newsletter on suicide prevention. Previous articles include: Suicide as a Public Health Issue, Suicide Prevention In NH, Survivors of Suicide, No Harm Contracts, Military/Veterans and Suicide, Restricting Access to Lethal Means, Suicide and Older Adults, Suicide Risk and LGBT Youth, Clinicians as Survivors, Suicide and the Economy and Media, New Media, Safe Messaging and Suicide Prevention and can be viewed in the suicide prevention/resource and support section of the NAMI NH website [www.theconnectproject.org](http://www.theconnectproject.org) Ken Norton is the Director of NAMI NH’s Connect Suicide Prevention Project and he can be reached at 225-5359 or [knorton@naminh.org](mailto:knorton@naminh.org)

