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President Column

A. Jordan Wright, PhD, ABAP, ABPP

I want to start by wishing everyone in the Society of Clinical Psychology (SCP) the happiest of new years and a hope that you had at least some restorative time over any break you may have gotten over the holidays. It is my distinct privilege to begin my term as President of SCP, and I hope to collaborate with many of you over this year to do some good work.

About Me

For those who don't know me, let me take a moment to tell you a bit about myself. I am a Clinical Associate Professor in the Department of Applied Psychology at New York University (NYU), where I also serve as Director of the PhD program in combined Clinical/Counseling Psychology, as well as Director of the training clinic, the Center for Counseling and Community Wellbeing. Prior to my work at NYU, I served on faculty at Teachers College, Columbia University (where I earned my MA in Psychology in Education and my PhD in Clinical Psychology) and as the statewide department chair of Psychology at Empire State University, SUNY. I have worked in hospital settings, community mental health clinics, foster care, and not-for-profit organizations, as well as having my own private practice and currently serving as Chief Clinical Officer at Parallel Learning, a healthtech/edtech startup.

Beyond these roles, my passions have centered on a few primary areas within clinical psychology: social justice, psychological testing and assessment, and, above all else, training the next generation of psychologists to rise to the needs of greater society. I have authored multiple books on psychological assessment (including the Handbook of Psychological Assessment and, most recently, Essentials of Culture in Psychological Assessment) and served as President of SCP's Assessment Section (Section IX). Additionally, I have served on and

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chaired APA's Continuing Education Committee, led a task force to define education and training guidelines for psychological assessment, and served on a task force to redesign doctoral level competencies in health service psychology. Many of my most recent collaborations have been authoring articles related to better training the next generation of psychologists, from evidence-based clinical psychological assessment (EBCPA) to liberation models for redesigning curriculum.

My 2024 at SCP

I have been privileged to serve as the President Elect of SCP for this past year, and I am extremely grateful to the executive board, and especially Dr. Donna LaPaglia, who has served as SCP's President this past year with grace and dignity. Under her and others' leadership, I have seen SCP flourish. Two initiatives in particular stand out as having shaped my view of what SCP truly can be and do.

First, in February 2024, we had our inaugural, biannual SCP Conference in Atlanta. The conference was invigorating and hopeful about the future of clinical psychology. I got to sit on a panel on mentorship as well as present about models of integrating clients' culture and context with psychological science to improve our skills in case formulation, in addition to learning about and engaging with cutting-edge scholarship related to our field. More than anything, I cherished the opportunity to interact with colleagues from all different stages of their careers, witnessing firsthand how engagement between all these brilliant professionals is setting up the future of clinical psychology to thrive.

Second, this year also saw the launch of a new SCP initiative, the LEAD (Leadership Education Advancement & Development) Program, a program aimed at cultivating the next generation of leaders in clinical psychology. Through structured didactics and personalized mentoring, early career professionals have been introduced to the many opportunities for leadership within SCP, as well as upskilling themselves to capitalize on their strengths, training, and positions to deepen their leadership skills. I have been fortunate enough to serve as one of these mentors, and the experience has been both rewarding and renewing for me.

A Look Forward

My goals this year are to push forward initiatives aimed at strengthening the field of clinical psychology and, in particular, preparing the next generation of clinical psychologists to do the best work possible to contribute to society. I have a few initiatives already in the works and hope that many of you will join me in them, as learners, collaborators, teachers, and contributors. Here a few:

1. SCP is collaborating with Divisions 16 (School Psychology) and 17 (Counseling Psychology) on a webinar series looking at critical psychology models. For too long, psychology (and clinical psychology specifically) has been over-reliant on scholarship by dominant, privileged groups (e.g., cisgender, heterosexual, abled, White me using dominant, privileged models (e.g., posit quantitative models). Excellent scholarship by underrepresented groups and using underrepresented methodologies exists and can strengthen the work we do, but we need to learn how to acknowledge, honor, and integrate this work into the models we are more comfortable with. This series is meant to help us do just that.

2. SCP is collaborating with the Society for Personality Assessment (SPA) on a webinar series on understanding and integrating culture in psychological assessment. The series will focus on both how culture and systems of oppression/privilege should be considered within the content of psychological assessments, as well as how these factors can affect the process of psychological testing and assessment in ways that can alter, enhance, or obscure the data that emerge from them.

3. Planning for the 2025 APA Convention and the February 2026 SCP Conference is underway with the same general aims and goals, to improve the work we do in clinical psychology and prepare the next generation of clinical psychologists to rise to meet society's future needs. I am especially working to champion broadening and deepening our understanding of what good psychological science is, as well as engagement in discussion about what (if any) shifts in training would improve clinical psychology excellence. As with every other initiative, I hope that many of our SCP scholars and professionals will join me in these ongoing discussions!

And Finally…

I'd like to end on a note of gratitude for all the wonderful colleagues I have been lucky enough to be able to collaborate with through SCP. In addition to many of the initiatives described above, these collaborations have resulted in important scholarly work meant to push our field forward in positive directions, and for that I am extremely grateful. If my experience has taught me anything, it's that stepping up and volunteering to contribute and collaborate can have profoundly positive effects, both personally and professionally. To that end, I want to explicitly invite all of our SCP members to join us in one or more of the many ways you can get involved. There are many sections, committees, initiatives, and projects going on at any moment with SCP's vibrant community. If you are interested in leadership or contributing in any way to clinical psychology's future, please don't hesitate to reach out! Very much looking forward to a productive year at SCP!

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Acute Suicide Risk Management: Best Practices and Future Directions

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Eric S. Crosby, PhD

Introduction

Suicide rates have progressively increased in recent decades (Garnett, 2023). This is in part due to poor identification, assessment, and management of suicide risk across clinical and non-clinical settings, especially for individuals who are in acute suicidal crises in emergency department and inpatient psychiatric services. A recent review of healthcare systems-failures determined that the most proximal factors associated with suicide after an acute suicidal crisis was a missed opportunity for safety planning, which is dictated by suicide risk screening and assessments procedures (Pisani & Boudreaux, 2023; Silverman & Berman, 2014). Improved implementation of screening and assessment in healthcare settings may lead to improved implementation of suicide prevention interventions, and ultimately decrease suicide rates (Hogan et al., 2016). However, it is unclear how to improve the quality of suicide screening, assessment, and intervention for individuals who are at acute risk for suicide. Herein, we describe the gaps in the quality of care in the delivery of suicide screening, assessment, and intervention across healthcare settings, provide best practice recommendations on suicide risk management procedures for individuals at imminent risk for suicide, and discuss the future directions for increasing the evidence-base for suicide risk management practices.

Suicide Risk Screening, Assessment, and Intervention

There are three phases in the management of suicide risk across clinical and non-clinical settings: (1) a brief screening for suicide risk to identify recent suicidal thoughts and behaviors, (2) a brief suicide risk assessment interview to determine level of suicide risk and (3) an intervention based on current level of suicide risk in order to decrease suicide risk (Horowitz et al., 2023; Silverman & Berman, 2014). Suicide risk screening and suicide risk assessment are frequently blended, but are two distinct processes (Boudreaux et al., 2014; Horowitz et al., 2023). Suicide risk screening involves brief questionnaires, typically completed within a few minutes, administered by trained clinicians, front-line staff, and community members to evaluate past, present, and potential future suicidal thoughts and behaviors. They are highly sensitive to detecting any clinically actionable suicide risk (Boudreaux & Horowitz, 2014; Thom et al., 2020). If an individual has a positive screening for suicide risk, a suicide risk assessment should be completed to determine their current level of suicide risk. Suicide risk assessments involve an interview and collection of collateral information in less than 30 minutes by a mental health professional or trained non-mental health professional to assess for current and past suicidal thoughts and behaviors, static and time-varying risk and protective factors for suicidal behavior, and the motivations, intent, planning, and preparatory actions for suicidal behavior. This information contributes to a formulation patient's risk of suicidal behavior, typically rated from no/mild risk to high/imminent risk (Horowitz et al., 2023; Silverman et al., 2014).

Once elevated suicide risk has been identified, healthcare providers determine how best to intervene to increase immediate and future safety. These interventions typically include a brief therapeutic intervention that directly decreases suicide risk, care coordination to a higher level of care, and brief follow-up contact (Doupnik et al., 2020).

In the following sections, we provide an overview of the deficits in the implementation of suicide screening, assessment, and interventions across clinical and non-clinical settings then provide recommendations for each area to clarify best practices for clinicians and front-line staff who encounter individuals with suicidal thoughts and behaviors. Overall recommendations across each of the three phases are summarized in Figure 1.

Suicide Risk Screening

Conducting screening in diverse contexts is essential for identifying potential at-risk groups. This includes screenings in clinical settings (e.g., primary care, emergency

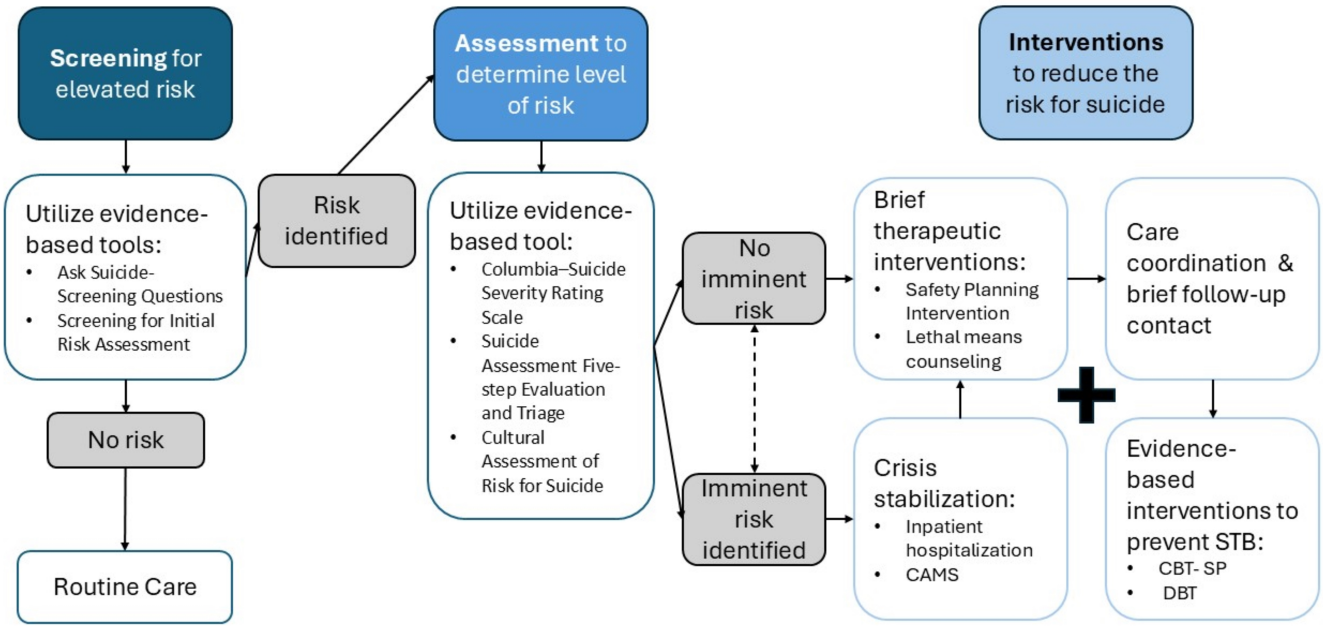

Figure 1. Steps for screening, assessing, and intervening for acute suicide risk.

department), community settings, and online settings.

Screening in the Clinical Settings

Commonly used screening tools in clinical settings include the Patient Health Questionnaire (PHQ-9) and the Ask Suicide-Screening Questions (ASQ). In primary care settings, suicide risk screening was implemented for new patients during initial visits, especially if they have not been screened in the past 12 months (Ayer et al., 2022). Those screenings might be repeated if a patient reports key risk factors (i.e., other mental health diagnoses) and a history of suicide risk within the past year (Ayer et al., 2022). Despite the availability of validated tools and the feasibility of suicide risk screening, only 14.2% of primary care providers use a standardized suicide screening tool and 27% of primary care providers rarely use any screening tools (Diamond et al., 2012). Barriers to the implementation of screenings were related to providers' levels of knowledge about suicide, their awareness of patients' previous suicide history, and whether they are working in urban or rural environments (Diamond et al., 2012). A primary reason for limited implementation of screening was providers' lack of confidence in clinical decision-making regarding the next steps if patients are screened as at risk for suicide (Horowitz et al., 2014),

Community-based Screening

Historically, marginalized and underrepresented communities in the mental health care system have reported higher suicide rates. The transition into or exposure to vulnerable environments, marked by low social support and limited access to healthcare, heightens the risk of acute and imminent suicide risks. Individuals who have experienced incarceration or are currently in prison or jail are one of the communities recognized as being at high risk for suicide. The suicide rate among incarcerated individuals was not only higher than that of the general population but also increased more rapidly between 2009 and 2020 (LeMasters et al., 2024). The imminent risk of suicide among this community is particularly elevated during transitional periods, such as the initial stages of incarceration. Current screening practices for this population often rely on clinical tools which are not fully adapted to the unique needs and strategies of correctional systems. A key challenge in this context is the shortage of trained staff and clinicians, which can result in improper administration, misinterpretation, or inaccurate use of these tools (Hausam et al., 2024). Despite the pressing need for more adaptable screening systems within communities, a significant gap remains in developing tailored tools or establishing a systematic approach to screening in correctional settings (Gould et al., 2019).

Online-based Screening

Online screening offers a valuable supplement to traditional methods (Coppersmith et al., 2018; Lao et al., 2022). Online screening includes self-screening and the prediction of suicide risk in the public based on online behaviors, such as help-seeking behaviors or narratives related to suicide risk (Christensen et al., 2014). People are often more comfortable sharing their suicide risk online than in face-to-face or clinical settings, due to reduced concerns about stigma and the greater accessibility of online spaces

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(Pretorius et al., 2019). Therefore, monitoring online behaviors can help supplement early detection of at-risk individuals outside of traditional clinical settings. However, current online screening presents some challenges. A primary concern is ethical issues surrounding monitoring users' suicide risks without their consent (Lehavot et al., 2012). This concern is shared not only by researchers and mental health professionals but also by the companies operating social media platforms, as they are responsible for ensuring data security and user privacy. Another critical issue lies in the methodological limitations of online suicide screening tools. Unlike assessment and diagnosis, the goal of suicide screening is to include as many individuals at potential risk as possible, even if it means identifying some false positives, rather than focusing exclusively on those with confirmed suicide risk. Unfortunately, many online and machine learning-based screening tools tend to prioritize accuracy over the essential principle of sensitivity, potentially overlooking high-risk groups.

Clinical, Community-based, and Online Screening Recommendations

To encourage the use of screening tools by clinicians, it is essential to integrate suicide literacy education, training on use of suicide screening tools, and protocols for post-screening suicide risk assessment and intervention. For example, providers should be given clear information on the clinical actions to take in guiding patients who are screened as at risk for suicide. Detailed guidelines on how to communicate with patients are also essential. For instance, pediatricians have been tasked by the American Academy of Pediatrics with managing mild to moderate suicide risk and they may require specific guidance on how to communicate with both their patients and the patients' parents (Horowitz et al., 2021; Hua et al., 2024). Suicide literacy education is equally crucial, as it enhances providers' comfort in discussing suicide risk with patients and increases their awareness of the importance of using screening tools. These supports for providers would help increase both the frequency and quality of the implementation of existing screening tools.

In terms of community-based screening, especially for incarcerated community members, a screening tool that focuses on evaluating current suicide risk—such as the Screening for Initial Risk Assessment (SIRAS)— can identify incarcerated individuals at imminent risk for suicide (Hausam et al., 2024). Implementing SIRAS has led to increased access to professional care, higher rates of medication use, and the development of safer institutional environments. Justice-involved individuals frequently undergo environmental and geographical transitions. Many individuals transfer between correctional facilities—such as moving from jail to prison or from one prison to another. Some are also transferred across state lines based on facility availability. Establishing effective systems for transferring and managing screening information is essential to ensuring a continuum of care for this population throughout their transitions (Daniel, 2006). This requires a uniform system of documentation, efficient information transfer, and enhanced collaboration between facilities (Daniel, 2006). Such improvements would help prevent duplicated screenings and reduce gaps between screening and intervention.

To address the concerns of online screening discussed above, we propose several recommendations. Regarding the ethical issues and implementation of screening tools on social media, obtaining user consent for social media data tracking could help individuals monitor their risk naturally without compromising their privacy (Coppersmith et al., 2018; Padrex et al., 2016). Most importantly, collaborative efforts with social media companies, media and communication experts, and policymakers are crucial to navigating the systemic and ethical implementation of screening tools online. Regarding the gap between the focus of screening and the methodological approach to screening performance, we recommend prioritizing sensitivity in tool development when there is a significant trade-off between sensitivity (how accurately it detects individuals at actual risk of suicide) and specificity (how accurately it detects individuals without actual risk of suicide; Donnelly et al., 2023; Hughes et al., 2023). Allowing for more false positives (lower specificity) better supports the prevention of under-detection, which is a higher priority in the screening process compared to diagnosis and assessment.

Suicide Risk Assessments

Hayoung Donnelly, PhD

There are several gaps in the delivery of suicide risk assessments across healthcare settings, particularly for patients experiences acute suicidal crises in emergency departments or psychiatric inpatient settings. Across healthcare settings, suicide risk assessments are frequently not completed or are poor quality when they are

completed, and as a result, patients are not provided the appropriate suicide prevention care (Wyder et al., 2020). A suicide risk assessment was not completed for almost 20% of mental health service users who died by suicide and over two-thirds of mental health service users who died by suicide received an incomplete or brief suicide risk assessments that lacked relevant suicide risk factors or comprehensive documentation of other critical elements in a suicide risk assessment (Huisman et al., 2011). Fewer than 20% of patients with a positive suicide risk screening in an emergency department received a lethal means assessment and approximately half of the patients who presented due to suicidal thoughts or behaviors were not assessed for a history of self-injurious behaviors, access to various self-harm methods, and a current plan for suicide (Betz et al., 2018; de Beer et al., 2018; Mahal et al., 2009). Moreover, patients in emergency departments who presented due to suicidal thoughts or behaviors often do not have a determination about suicide risk identified or described in clinical documentation to guide suicide prevention interventions (de Beer et al., 2018).

There is a lack of psychometrically valid measures for assessing imminent risk. In youth, there is no standardized developmentally appropriate measure of immediate risk for suicide for youth (Cater et al., 2019). While standardized interviews like the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) have shown the most promise in evaluations of predictive validity for both adults and youth, further psychometric testing is needed to identify a single tool to assess acute risk for suicide, particularly in non-mental health settings (Cater et al., 2019; Liu et al., 2024). Significant limitations exist for all current youth self-report measures assessing suicidal thoughts and behaviors, indicating an urgent need for the development of new valid self-report measures for this population before one can be recommended for broad implementation across settings (Liu et al., 2024). Furthermore, cultural variations in presentations of acute suicide risk have been excluded from nearly all risk assessments (Molock et al., 2023). The Cultural Assessment of Risk for Suicide (CARS; Chu et al., 2013; Chu et al., 2018) self-report measure has shown strong psychometrics for capturing suicide risk among ethnic and sexual minority groups based on the Cultural Theory and Model of Suicide (Chu et al. 2010), but this measure focuses on assessing recent, not acute or imminent suicide risk.

Suicide Risk Assessment Recommendations

Based on the current gaps in suicide risk assessment implementation, we recommend that mental health care settings enhance policies and processes to improve the quality of suicide risk assessments and management of suicide risk. The Joint Commission on Accreditation of Healthcare Organization has established performance requirements for accredited hospitals and behavioral health care organizations treating individuals with behavioral health conditions and those at acute risk for suicide (The Joint Commission, 2019). The National Patient Safety Goal 15.01.0 requires an evidence-based process for suicide risk assessment for individuals who screened positive for suicidal ideation and documentation of patients' overall suicide risk level and the plan to reduce suicide risk.

Therapeutic risk management for suicidal patients is a recommended best practice for assessment and management of suicide risk after a positive screening (The Joint Commission, 2019). Therapeutic risk management involves three steps: (1) assessment of suicide risk with structured instruments, (2) stratification of suicide risk in terms of severity (i.e., low, moderate, high current risk) and stability of risk over time (i.e., acute/short-term vs. chronic/long-term duration of risk), and (3) safety planning for suicide risk (Wortzel et al., 2013).

Two examples of structured, evidenced-based suicide risk assessment interviews are the Columbia-Suicide Severity Rating Scale (C-SSRS) and Suicide Assessment Five-step Evaluation and Triage (SAFE-T). The Columbia-Suicide Severity Rating Scale (C-SSRS) full scale provides a comprehensive evaluation of past and current suicidal thoughts and behaviors, including the degree of suicidal plans, intent, controllability and preparatory acts, self-harm behaviors, and their lethality (Posner et al., 2011). The C-SSRS can be combined with a clinical evaluation of other significant suicide risk and protective factors (e.g., see Bryan & Rudd, 2006; Chu et al., 2015). Alternatively, the SAFE-T evaluates suicide risk and protective factors as well as the extent of suicidal thoughts plans, intent, and previous suicidal behaviors (Fowler et al., 2012). Each of these suicide risk assessments includes suicide risk stratification in terms of severity.

However, only stratifying suicide risk in terms of severity does not adequately capture the nuances of suicide risk. Therapeutic risk management for suicidal patients suggests that it is also important for clinicians to evaluate the stability of patient suicide risk over time, especially for those at who have a combination of risk and protective factors (Wortzel et al., 2014). As noted by Wortzel and colleagues (2014), an individual with an extended history of multiple suicide attempts who was recently discharged from psychiatric hospitalization and endorsed suicidal ideation with a specific plan may be considered at high risk for suicide in terms of severity. However, when also considering that stability of suicide risk over time, the individual states that their current degree of suicidal ideation represent their baseline level of functioning, they have been using their safety

plan effectively, and they increased their mental health treatment engagement since discharge from psychiatric hospitalization. A single severity designation of high risk is unlikely to capture the true nature of this individual's current degree of suicide risk. A two-dimensional low acute risk (severity) and high chronic risk (stability) designation better explains this and similar individual's suicide risk, and provides a more refined conceptualization to guide intervention recommendations. The details about the suicide risk assessment process and suicide risk formulation results (i.e., severity and stability of suicide risk) should be documented and the client should periodically be reassessed for suicide risk as clinically appropriate.

Brief Suicide Prevention Interventions

Brief suicide prevention interventions delivered during single in-person encounters in acute care settings have shown promise (Doupnik et al., 2020). Brief therapeutic interventions include the Safety Planning Intervention, problem-solving skill delivery, motivational interviewing techniques, or lethal means counseling. Care coordination interventions include the provision of resources and referrals, warm hand-offs to outpatient mental health, mobile crisis response team services, and the inclusion of personal supports to support care access. Brief follow-up contact typically involve phone calls, text messages, or letters to encourage or facilitate engagement with further mental health treatment. A meta-analysis found that brief suicide prevention interventions were associated with reduced subsequent suicide attempts, increased linkage to follow-up mental health care, but were not associated with reduced depression symptoms (Doupnik et al., 2020).

However, due to the limited quality and availability of culturally and developmentally appropriate suicide risk assessments, patients at-risk for suicide are often not provided the appropriate and effective suicide prevention interventions. Although safety plans are often listed in treatment plans, there is limited collaboration with patients in their development, limited discussion with patients of how and when to use the safety plan, and plans are not often regularly reviewed with patients (Gamarra et al., 2015). Similarly, there is limited collaboration during care coordination with other providers. Outpatient clinicians sometimes rely on their own "gut feeling" in order to decide to initiate hospitalization (Davis et al., 2023). In addition, less than half of individuals discharged from a psychiatric hospitalization had a discharge plan sent to a follow-up outpatient provider within 24 hours of discharge and less than half of emergency departments provided warm handoffs to outpatient mental health treatment providers (Benjenk et al., 2020; Chitavi et al., 2024). Subsequently, less than half of individuals discharged from psychiatric hospitalization and a psychiatric emergency department visit attend a mental health follow-up appointment within one to two weeks (Barker et al., 2020; National Committee for Quality Assurance, 2022).

Brief Suicide Prevention Interventions Recommendations

The Safety Planning Intervention (SPI; Stanley and Brown, 2012) has been consistently identified in meta-analyses and systematic reviews as the most promising brief suicide prevention therapeutic intervention (Doupnik et al., 2020; Nuij et al., 2021; Ferguson et al., 2022). The SPI is effective at reducing the risk for future suicidal behaviors (including suicide attempts), but may be less effective at reducing the severity of subsequent suicidal ideation (Nuij et al., 2021). While the SPI is mostly delivered in person, digitally supported versions of the intervention have also been found to be acceptable and feasible (e.g., JASPR; Dimeff et al., 2021).

The SPI can be effective when delivered as a standalone single-session intervention, with brief follow-up contact, or combined with other interventions, such as the CALM (Counseling on Access to Lethal Means) or STOP (Steps to Prevent Firearm Injury) lethal means safety counseling programs and the SAFETY-A (Safe Alternatives for Teens and Youths-Acute) program (Ferguson et al., 2022; Sale et al., 2018; Mueller al., 2020). Lethal means safety counseling has been found to be an acceptable approach for reducing future suicide risk during evaluation in acute care settings, but future research is needed to understand the clinical effectiveness of this intervention alone at reducing future suicide behaviors and if there is a need for further cultural adaptations (Spitzer et al., 2024; Siry et al. 2020). SAFETY-A, which includes safety planning and home safety education, has shown promise as a brief trauma-informed, cognitive behavioral family intervention to decrease the short-term risk of future suicidal behavior when delivered in pediatric emergency room settings (Asarnow et al., 2015; Hutcherson et al., 2021). While recent work has shown promise in reducing youth suicide risk through the collaborative development of safety plans and reduced access to lethal means, a meta-analysis has found continued limitations to the effectiveness of interventions to reduce the risk of suicide for adolescents (Itzhaky et al., 2022; Runyan et al. 2016; Leyenaar et al., 2022).

After a suicide risk assessment has been repeated, if a brief therapeutic intervention is deemed to be insufficient,

care coordination may be required to attain access to an appropriate treatment. It is important to use multi-method interventions in care coordination to decrease barriers to accessing behavioral health services. This may include facilitated appointment scheduling and reminders through phone and text formats, walk-in services, and warm handoffs (Crable et al., 2021; Young et al., 2020).

If a client's risk level is persistently elevated (e.g., the person continues to indicate an imminent plan and intent to harm themselves), stabilization may be needed in a secure healthcare setting like a psychiatric inpatient or crisis stabilization unit. Although cognitive-behavioral therapy (e.g., Cognitive-Behavioral Therapy for Suicide Prevention [CBT-SP]; Stanley et al., 2009) and dialectical behavior therapy (DBT; Linehan et al., 2006) have been found to prevent suicidal behavior following crisis stabilization (Mann et al., 2021), the evidence for treatments that reduce suicidal thoughts and behaviors during inpatient stabilization is very limited (Santel et al., 2023; Jobe et al., 2015; Calati and Coutet, 2016). The Collaborative Assessment and Management of Suicidality (CAMS; Ellis et al., 2012) is one of the only evidence-based suicide-focused interventions that has been shown to help patients understand and manage suicidal thoughts and behaviors across both inpatient and outpatient settings (Ellis et al., 2017; Santel et al., 2023; Tyndal et al., 2022).

Beyond psychotherapy approaches to stabilization, intravenous ketamine has been found to reduce suicidal ideation within hours, but it remains unclear how effective this psychotropic intervention is for preventing future suicidal behavior (Lengvenyte et al., 2021; Mann et al., 2021). Although alternative forms are becoming more accessible, other formulations of ketamine (such as intranasal and oral delivery forms) have not been shown to have the same effect on reducing suicidality (Dadiomov and Lee, 2019). Therefore, the need for further research to develop effective and accessible stabilization treatment options following suicidal crises is critical.

Conclusion and Call to Action

There are several gaps in quality of care in the identification, assessment, and management of suicidal thoughts and behaviors. Use of the current recommendations should result in improved implementation of suicide screening, assessment, and intervention practices. We call on clinicians to use evidence-based tools and methods for suicide risk screening, assessment, and intervention, especially with individuals at elevated and acute risk for suicide. However, we know that clinicians do not function alone and that the identification of evidence-based suicide screening, assessment, and intervention practices does not guarantee that these practices are effectively delivered across healthcare settings.

The development of strategies to improve the implementation of evidence-based suicide screening, assessment, and intervention practices has the potential to improve the adoption, fidelity, and integration of these practices into healthcare settings. Effective implementation strategies for suicide prevention practices involve analyzing the people, settings, and factors influencing implementation; co-development with all parties involved in implementation (e.g., patients, front-line staff, supervisors, and executive management); and refinement of strategies to increase their feasibility and acceptability (Wensing et al., 2020). Plan-do-study-act (PDSA) cycles are an effective way to develop and refine implementation strategies to improve the quality of care for those at risk for suicide by integrating patient feedback into adjustments of ongoing care procedures (Minian et al., 2024; Boudreaux et al., 2020). To support organizations, national and state-level policy evaluations and impact measures—such as reductions in suicide rates (Schlichthorst et al., 2022) and increased suicide literacy within communities (American Foundation for Suicide Prevention, 2023)—are essential for assessing the effectiveness and impact of current approaches in reducing the risk and harm of suicidality.

References

American Foundation for Suicide Prevention (2023). *2023 Impact Spotlight "Helping Corrections Staff Prevent Suicide - The Statewide Rollout of Talk Saves Lives: An Introduction to Suicide Prevention in the Correctional Environment in Indiana*". 1, 1-3. https://www.datocms-assets.com/12810/1721929447-impact-spotlight-1-oct-2023.pdf

Asarnow, J. R., Berk, M., Hughes, J. L., & Anderson, N. L. (2015). The SAFETY Program: a treatment-development trial of a cognitive-behavioral family treatment for adolescent suicide attempters. *J Clin Child Adolesc Psychol, 44*(1), 194-203. https://doi.org/10.1080/15374416.2014.940624

Barker, L. C., Sunderji, N., Kurdyak, P., Stergiopoulos, V., Gonzalez, A., Kopp, A., & Vigod, S. N. (2020). Urgent outpatient care following mental health ED visits: A population-based study. *Psychiatric Services, 71*(6), 616–619.

Benjenk, I., Shields, M., & Chen, J. (2020). Measures of care coordination at inpatient psychiatric facilities and the Medicare 30-day all-cause readmission rate. *Psychiatric*

Services, 71(10), 1031–1038.

Betz, M. E., Kautzman, M., Segal, D. L., Miller, I., Camargo Jr, C. A., Boudreaux, E. D., & Arias, S. A. (2018). Frequency of lethal means assessment among emergency department patients with a positive suicide risk screen. Psychiatry Research, 260, 30–35.

Boudreaux, E. D., & Horowitz, L. M. (2014). Suicide Risk Screening and Assessment: Designing Instruments with Dissemination in Mind. American Journal of Preventive Medicine, 47(3, Supplement 2), S163–S169. https://doi.org/10.1016/j.amepre.2014.06.005

Boudreaux, E. D., Haskins, B. L., Larkin, C., Pelletier, L., Johnson, S. A., Stanley, B., ... & Ma, Y. (2020). Emergency department safety assessment and follow-up evaluation 2: an implementation trial to improve suicide prevention. *Contemporary Clinical Trials, 95*, 106075.

Bryan, C. J., & Rudd, M. D. (2006). *Advances in the assessment of suicide risk*. https://doi.org/10.1002/jclp.20222

Calati, R., & Courtet, P. (2016). Is psychotherapy effective for reducing suicide attempt and non-suicidal self-injury rates? Meta-analysis and meta-regression of literature data. *J Psychiatr Res, 79*, 8-20. https://doi.org/10.1016/j.jpsychires.2016.04.003

Carter, T., Walker, G. M., Aubeeluck, A., & Manning, J. C. (2019). Assessment tools of immediate risk of self-harm and suicide in children and young people: A scoping review. *Journal of Child Health Care, 23*(2), 178-199.

Chitavi, S. O., Patrianakos, J., Williams, S. C., Schmaltz, S. P., Ahmedani, B. K., Roaten, K., Boudreaux, E. D., & Brown, G. K. (2024). Evaluating the Prevalence of Four Recommended Practices for Suicide Prevention Following Hospital Discharge. *The Joint Commission Journal on Quality and Patient Safety*. https://doi.org/10.1016/j.jcjq.2024.02.007

Christensen, H., Batterham, P. J., & O'Dea, B. (2014). E-health interventions for suicide prevention. *International Journal of Environmental Research and Public Health, 11*(8), 8193-8212.

Chu, C., Klein, K. M., Buchman‐Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update. *Journal of Clinical Psychology, 71*(12), 1186–1200. https://doi.org/10.1002/jclp.22210

Chu, J. P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of suicide. *Applied and Preventive Psychology, 14*(1-4), 25-40. https://doi.org/10.1016/j.appsy.2011.11.001

Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P., & Bongar, B. (2013). A tool for the culturally competent assessment of suicide: the Cultural Assessment of Risk for Suicide (CARS) measure. *Psychol Assess, 25*(2), 424-434. https://doi.org/10.1037/a0031264

Chu, J., Hoeflein, B., Goldblum, P., Espelage, D., Davis, J., & Bongar, B. (2017). A Shortened Screener Version of the Cultural Assessment of Risk for Suicide. *Arch Suicide Res, 22*(4), 679-687. https://doi.org/10.1080/13811118.2017.1413469

Coppersmith, G., Leary, R., Crutchley, P., & Fine, A. (2018). Natural language processing of social media as screening for suicide risk. *Biomedical informatics insights, 10*, 1178222618792860.

Crable, E. L., Biancarelli, D. L., Aurora, M., Drainoni, M.-L., & Walkey, A. J. (2021). Interventions to increase appointment attendance in safety net health centers: A systematic review and meta-analysis. *Journal of Evaluation in Clinical Practice, 27*(4), 965–975. https://doi.org/10.1111/jep.13496

Dadiomov, D., & Lee, K. (2019). The effects of ketamine on suicidality across various formulations and study settings. *Ment Health Clin, 9*(1), 48-60. https://doi.org/10.9740/mhc.2019.01.048

Davis, M., Siegel, J., Becker-Haimes, E. M., Jager-Hyman, S., Beidas, R. S., Young, J. F., Wislocki, K., Futterer, A., Mautone, J. A., Buttenheim, A. M., Mandell, D. S., Marx, D., & Wolk, C. B. (2023). Identifying Common and Unique Barriers and Facilitators to Implementing Evidence-Based Practices for Suicide Prevention across Primary Care and Specialty Mental Health Settings. *Archives of Suicide Research, 27*(2), 192–214. https://doi.org/10.1080/13811118.2021.1982094

de Beer, W., Witt, B. D., Schofield, J., Clark, H., & Gibbons, V. (2018). *An audit of risk assessments for suicide and attempted suicide in ED: a retrospective review of quality*. 131(1470).

Diamond, G. S., O'Malley, A., Wintersteen, M. B., Peters, S., Yunghans, S., Biddle, V., ... & Schrand, S. (2012). Attitudes, practices, and barriers to adolescent suicide and mental health screening: a survey of Pennsylvania primary care providers. *Journal of Primary Care & Community Health, 3*(1), 29-35.

Dimeff, L. A., Jobes, D. A., Koerner, K., Kako, N., Jerome, T., Kelley-Brimer, A., Boudreaux, E. D., Beadnell, B., Goering, P., Witterholt, S., Melin, G., Samike, V., & Schak, K. M. (2021). Using a Tablet-Based App to Deliver Evidence-Based Practices for Suicidal Patients in the

Emergency Department: Pilot Randomized Controlled Trial. *JMIR Mental Health, 8*(3), e23022. https://doi.org/10.2196/23022

Doupnik, S. K., Rudd, B., Schmutte, T., Worsley, D., Bowden, C. F., McCarthy, E., Eggan, E., Bridge, J. A., & Marcus, S. C. (2020). Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis. *JAMA Psychiatry, 77*(10), 1021-1030. https://doi.org/10.1001/jamapsychiatry.2020.1586

Ellis, T. E., Daza, P., & Allen, J. G. (2012). Collaborative Assessment and Management of Suicidality at Menninger (CAMS-M): An inpatient adaptation and implementation. *Bulletin of the Menninger Clinic, 76*(2), 147-171.

Ferguson, M., Rhodes, K., Loughhead, M., McIntyre, H., & Procter, N. (2021). The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review. *Arch Suicide Res, 1-24*. https://doi.org/10.1080/13811118.2021.1915217

Fowler, J. C. (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. *Psychotherapy, 49*(1), 81–90. https://doi.org/10.1037/a0026148

Gamarra, J. M., Luciano, M. T., Gradus, J. L., & Wiltsey Stirman, S. (2015). Assessing Variability and Implementation Fidelity of Suicide Prevention Safety Planning in a Regional VA Healthcare System. *Crisis, 36*(6), 433–439. https://doi.org/10.1027/0227-5910/a000345

Garnett, M. F. (2023). *Suicide Mortality in the United States*, 2001–2021. 464.

Hausam, J., Calvano, D., & Opitz-Welke, A. (2024). Comparison of two suicide screening instruments for identifying high-risk individuals in prison. *Frontiers in Psychiatry, 15*, 1362928.

Hogan, M. F. (2016). Better suicide screening and prevention are possible. *JAMA Psychiatry, 73*(11), 1111–1112.

Horowitz, L. M., Ryan, P. C., Wei, A. X., Boudreaux, E. D., Ackerman, J. P., & Bridge, J. A. (2023). Screening and Assessing Suicide Risk in Medical Settings: Feasible Strategies for Early Detection. *Focus, 21*(2), 145–151. https://doi.org/10.1176/appi.focus.20220086

Hua, L. L., Lee, J., Rahmandar, M. H., Sigel, E. J., Committee on adolescence, & council on injury, violence, and poison prevention. (2024). Suicide and suicide risk in adolescents. *Pediatrics, 153*(1), e2023064800.

Hughes, J. L., Horowitz, L. M., Ackerman, J. P., Adrian, M. C., Campo, J. V., & Bridge, J. A. (2023). Suicide in young people: screening, risk assessment, and intervention. *BMJ, 381*.

Huisman, A., Kerkhof, A. J., & Robben, P. B. (2011). Suicides in users of mental health care services: treatment characteristics and hindsight reflections. *Suicide and Life‐Threatening Behavior, 41*(1), 41-49.

Hutcherson, K., Kennard, B. D., Michaels, M., & Miles, J. (2021). Adapting the SAFETY-Acute intervention to improve quality of care for suicidal youth in emergency rooms and medical floors. *Evidence-based Practice in Child and Adolescent Mental Health, 6*(3), 369-378. https://doi.org/10.1080/23794925.2021.1975516

Itzhaky, L., Davaasambuu, S., Ellis, S. P., Cisneros-Trujillo, S., Hannett, K., Scolaro, K., ... & Sublette, M. E. (2022). Twenty-six years of psychosocial interventions to reduce suicide risk in adolescents: Systematic review and meta-analysis. *Journal of Affective Disorders, 300*, 511-531.

Jobes, D. A., Au, J. S., & Siegelman, A. (2015). Psychological approaches to suicide treatment and prevention. *Current Treatment Options in Psychiatry, 2*(4), 363-370. https://doi.org/10.1007/s40501-015-0064-3

Lao, C., Lane, J., & Suominen, H. (2022). Analyzing suicide risk from linguistic features in social media: evaluation study. *JMIR Formative Research, 6*(8), e35563.

Lehavot, K., Ben-Zeev, D., & Neville, R. E. (2012). Ethical considerations and social media: a case of suicidal postings on Facebook. *Journal of Dual Diagnosis, 8*(4), 341-346.

Lengvenyte, A., Olie, E., Strumila, R., Navickas, A., Gonzalez Pinto, A., & Courtet, P. (2021). Immediate and short-term efficacy of suicide-targeted interventions in suicidal individuals: A systematic review. *World J Biol Psychiatry, 22*(9), 670-685. https://doi.org/10.1080/15622975.2021.1907712

Leyenaar, J. K., Tolpadi, A., Parast, L., Esporas, M., Britto, M. T., Gidengil, C., Wilson, K. M., Bardach, N. S., Basco, W. T., Brittan, M. S., Williams, D. J., Wood, K. E., Yung, S., Dawley, E., Elliott, A., Manges, K. A., Plemmons, G., Rice, T., Wiener, B., & Mangione-Smith, R. (2022). Collaborative to increase lethal means counseling for caregivers of youth with suicidality. *Pediatrics, 150*(6). https://doi.org/10.1542/peds.2021-055271

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal

behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*, 757-766. https://doi.org/10.3410/f.14771.472298

Liu, R. T., Bettis, A. H., Lawrence, H. R., Walsh, R. F., Sheehan, A. E., Pollak, O. H., ... & Marlowe, R. M. (2024). Measures of suicidal thoughts and behaviors in children and adolescents: a systematic review and recommendations for use in clinical and research settings. *Assessment*, 10731911241249438.

Mahal, S. K., Chee, C. B., Lee, J. C., Nguyen, T., & Woo, B. K. (2009). Improving the quality of suicide risk assessments in the psychiatric emergency setting: Physician documentation of process indicators. *Journal of Osteopathic Medicine, 109*(7), 354–358.

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving suicide prevention through evidence-based strategies: A systematic review. *Am J Psychiatry, 178*(7), 611-624. https://doi.org/10.1176/appi.ajp.2020.20060864

Minian, N., Gayapersad, A., Coroiu, A., Dragonetti, R., Zawertailo, L., Zaheer, J., O'Neill, B., Lange, S., Thomson, N., Crawford, A., Kennedy, S. H., & Selby, P. (2024). Prototyping the implementation of a suicide prevention protocol in primary care settings using PDSA cycles: a mixed method study. *Front Psychiatry, 15*, 1286078. https://doi.org/10.3389/fpsyt.2024.1286078

Molock, S. D., Boyd, R. C., Alvarez, K., Cha, C., Denton, E. G., Glenn, C. R., & Miller, A. B. (2023). Culturally responsive assessment of suicidal thoughts and behaviors in youth of color. *American Psychologist.* https://doi.org/10.1037/amp0001140

Mueller, K. L., Naganathan, S., & Griffey, R. T. (2020). Counseling on access to Lethal Means-Emergency Department (CALM-ED): A quality improvement program for firearm injury prevention. *West J Emerg Med, 21*(5), 1123-1130. https://doi.org/10.5811/westjem.2020.5.46952

National Committee for Quality Assurance. (2022). *Follow-Up After Hospitalization for Mental Illness.* NCQA. https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Nuij, C., van Ballegooijen, W., de Beurs, D., Juniar, D., Erlangsen, A., Portzky, G., O'Connor, R. C., Smit, J. H., Kerkhof, A., & Riper, H. (2021). Safety planning-type interventions for suicide prevention: meta-analysis. *Br J Psychiatry, 219*(2), 419-426. https://doi.org/10.1192/bjp.2021.50

Padrez, K. A., Ungar, L., Schwartz, H. A., Smith, R. J., Hill, S., Antanavicius, T., ... & Merchant, R. M. (2016). Linking social media and medical record data: a study of adults presenting to an academic, urban emergency department. *BMJ Quality & Safety, 25*(6), 414-423.

Pisani, A. R., & Boudreaux, E. D. (2023). Systems approach to suicide prevention: Strengthening culture, practice, and education. *Focus, 21*(2), 152–159. https://doi.org/10.1176/appi.focus.20220081

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry, 168*(12), 1266-1277.

Runyan, C. W., Becker, A., Brandspigel, S., Barber, C., Trudeau, A., & Novins, D. (2016). Lethal means counseling for parents of youth seeking emergency care for suicidality. *The Western Journal of Emergency Medicine, 17*(1), 8-14. https://doi.org/10.5811/westjem.2015.11.28590

Sale, E., Hendricks, M., Weil, V., Miller, C., Perkins, S., & McCudden, S. (2018). Counseling on Access to Lethal Means (CALM): An evaluation of a suicide prevention means restriction training program for mental health providers. *Community Ment Health J, 54*(3), 293-301. https://doi.org/10.1007/s10597-017-0190-z

Santel, M., Neuner, F., Berg, M., Steuwe, C., Jobes, D. A., Driessen, M., & Beblo, T. (2023). The Collaborative Assessment and Management of Suicidality compared to enhanced treatment as usual for inpatients who are suicidal: A randomized controlled trial. *Front Psychiatry, 14*, 1038302. https://doi.org/10.3389/fpsyt.2023.1038302

Schlichthorst, M., Reifels, L., Spittal, M., Clapperton, A., Scurrah, K., Kolves, K., ... & Krysinska, K. (2022). Evaluating the effectiveness of components of national suicide prevention strategies. Crisis: *The Journal of Crisis Intervention and Suicide Prevention, 44*(4), 318–328.

Silverman, M. M. (2014). Suicide risk assessment and suicide risk formulation: essential components of the therapeutic risk management model. *Journal of Psychiatric Practice®, 20*(5), 373. https://doi.org/10.1097/01.pra.0000454784.90353.bf

Silverman, M. M., & Berman, A. L. (2014). Suicide risk assessment and risk formulation part I: a focus on suicide ideation in assessing suicide risk. *Suicide and Life-Threatening Behavior, 44*(4), 420–431. https://doi.org/10.1111/sltb.12065

Siry, B. J., Knoepke, C. E., Ernestus, S. M., Matlock, D. D., &

Betz, M. E. (2021). Lethal means counseling for suicidal adults in the emergency department: A qualitative study. *West J Emerg Med, 22*(3), 471-477. https://doi.org/10.5811/westjem.2021.8.49485

Spitzer, E. G., Stearns-Yoder, K. A., Hoffberg, A. S., Bailey, H. M., Miller, C. J., & Simonetti, J. A. (2024). A systematic review of lethal means safety counseling interventions: impacts on safety behaviors and self-directed violence. *Epidemiologic Reviews*, mxae001.

Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., & Goldstein, T. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*, 1005-1013. https://doi.org/10.1097/CHI

The Joint Commission. (2019). *R3 Report—Requirement, Rationale, Reference.*

Thom, R., Hogan, C., & Hazen, E. (2020). Suicide risk screening in the hospital setting: A review of brief validated tools. *Psychosomatics, 61*(1), 1–7. https://doi.org/10.1016/j.psym.2019.08.009

Tyndal, T., Zhang, I., & Jobes, D. A. (2022). The Collaborative Assessment and Management of Suicidality (CAMS) stabilization plan for working with patients with suicide risk. *Psychotherapy (Chic), 59*(2), 143-149. https://doi.org/10.1037/pst0000378

Wensing, M., Grol, R., & Grimshaw, J. (2020). *Improving patient care.* Wiley-Blackwell.

Wortzel, H. S. (2013). The DSM-5 and forensic psychiatry. *Journal of Psychiatric Practice®, 19(*3), 238–241.

Wortzel, H. S., Homaifar, B., Matarazzo, B., & Brenner, L. A. (2014). Therapeutic risk management of the suicidal patient: stratifying risk in terms of severity and temporality. *Journal of Psychiatric Practice®, 20*(1), 63-67.

Wortzel, H. S., Matarazzo, B., & Homaifar, B. (2013). A model for therapeutic risk management of the suicidal patient. *Journal of Psychiatric Practice®, 19*(4), 323-326.

Wyder, M., Ray, M. K., Roennfeldt, H., Daly, M., & Crompton, D. (2020). How health care systems let our patients down: a systematic review into suicide deaths. *International Journal for Quality in Health Care, 32*(5), 285-291.

Young, N. D., Mathews, B. L., Pan, A. Y., Herndon, J. L., Bleck, A. A., & Takala, C. R. (2020). Warm handoff, or cold shoulder? An analysis of handoffs for primary care behavioral health consultation on patient engagement and systems utilization. *Clinical Practice in Pediatric Psychology, 8*(3), 241–246. https://doi.org/10.1037/cpp0000360

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The Committee on Science and Practice developed a manual with standardized guidance on how to use the Tolin criteria to evaluate a psychological treatment. The manual (available here https://osf.io/preprints/osf/8hcsz) includes a checklist and details the process for teams to follow. Here is an example of a recent evaluation that was submitted to and approved by the Committee on Science and Practice (CBT for Gambling Disorder: https://div12.org/wp-content/uploads/2024/07/CBT-gambling-Tolin-Criteria-Evaluation-Report.pdf) as well as one that was published (CBT for Insomnia: https://pmc.ncbi.nlm.nih.gov/articles/PMC7939024/).

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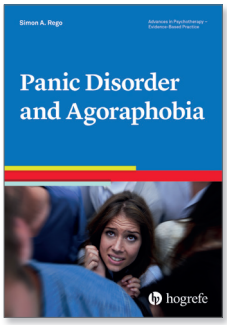

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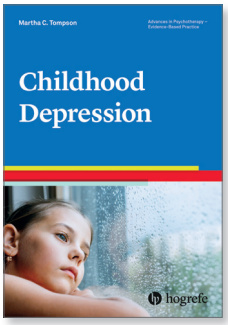

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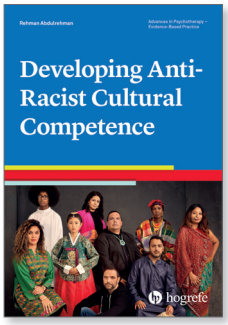

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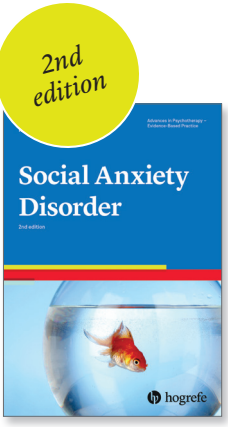
"I am proud to endorse Dr. Abdulrehman's book. It not only provides essential knowledge but also serves as a testament to his own commitment to advancing our collective understanding and promoting equity."

Monnica Williams, PhD, ABPP, Canada Research Chair for Mental Health Disparities, University of Ottawa, ON, Canada



Martin M. Antony / Karen Rowa

Social Anxiety Disorder

Vol. 12 , 2nd ed. coming May 2025, approx. viii + 100 pp.
ISBN 978-0-88937-602-1

This 2nd edition exploring social anxiety disorder (SAD) incorporates the latest theory and research on its presentation, prevalence, assessment, and treatment. The authors expertly guide mental health or healthcare professionals at any level of experience through the models for understanding this common psychological disorder, how to select the best assessment measures, and why and how cognitive-behavioral therapy (CBT) has the strongest evidence base. Downloadable handouts for clinical use are available in the appendix.

Forthcoming volumes

Disorders strand
- Adolescent Dating Violence
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- Gambling Disorder 2nd ed.
- Posttraumatic Stress Disorder
- Acute Pain
- Vaping and E-Cigarette Use and Misuse in Teens
- Childhood Irritability
- Interventions for Domestic Violence
- Supporting Children After Mass Violence
- Opiate Use Problems
- Borderline Personality Disorder

Methods and approaches strand
- Palliative and End-of-Life Care
- Pediatric Psychopharmacology
- Integrated Primary Care

See all available volumes here

Content and Structure

1. Volumes on a Disorder or Group of Disorders
The contents of each volume are structured as follows:

Description:
- Terminology
- Definition
- Epidemiology
- Course and Prognosis
- Differential Diagnosis
- Comorbidities
- Diagnostic Procedures and Documentation

Theories and Models of the Disorder

Diagnosis and Treatment Indications

Treatment:
- Methods of Treatment
- Mechanisms of Action
- Efficacy and Prognosis
- Variations and Combinations of Methods
- Problems in Carrying out the Treatment
- Multicultural Issues

Case Vignette
Further Reading
References
Appendix: Tools and Resources

2. Volumes on Methods and Approaches
The contents of each volume are structured as follows:

Description:
- Terminology
- Overview

Theories and Models

Assessment and Treatment Indications Treatment:
- Method of Treatment
- Efficacy and Prognosis
- Variations of the Method and Combinations with Other Approaches
- Problems in Carrying out the Treatments
- Multicultural Issues

Case Vignette
Further Reading
References
Appendix: Tools and Resources

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Assessing Emotion Regulation Strategies with the FEEL-KJ-2

Wednesday, March 19, 2025
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Join Hogrefe for an introductory free, one-hour webinar featuring the new Emotion Regulation Strategies Questionnaire (FEEL-KJ-2). This self-reporting tool can be used with children, adolescents, and young adults ages 9–20 years and takes about 20 minutes to complete online. The assessment can be used in school settings, private therapy practices, outpatient and inpatient facilities, clinics, special education schools, and residential facilities.

The FEEL-KJ-2 can be used to map adaptive, maladaptive, and additional regulation strategies for anger, anxiety, and sadness. The assessment is especially helpful in identifying an individual's strengths and weaknesses across these three emotions, providing valuable psychological insights beyond just identifying problems. Functionally, this information can be used to set measurable goals and objectives that support increasing the use of positive emotion regulation strategies.

Scan the QR Code to Register

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