Beyond the Mandate

Simple Tools for Responding to Crisis and Suicidality in ABI Clients

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When a client says, “I can’t do this anymore,”

what happens in you first?



Freeze



Reassure too fast



Over-question



Panic inside

Your nervous system enters the room too.

Source: Hostinar, Sullivan & Gunnar, 2014, Psychol Bull (social buffering of stress)

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Asking about Suicide
Does Not "Put the Idea in Someone's Head"

Avoid

- ✕ Vagueness
- ✕ Sarcasm or jokes
- ✕ *Leading Questions: "You're not going to do anything, right?"*

Ask:

"Are you thinking about suicide?"

Be brave enough to name it.

Ask directly, stay calm, and give the person space to answer. Supportive connection can help buffer stress.

Source: *Dazzi et al., 2014; Hostinar et al., 2014.*

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Asking does not plant the idea

It may do the opposite.

Talking about it may reduce suicidal thinking

"Our findings suggest acknowledging and talking about suicide may in fact reduce, rather than increase suicidal ideation…"

Dazzi et al., 2014 · Psychological Medicine · review

High-risk youth were not harmed, and some showed less distress or suicidality.

"…depressed students and previous attempters… appeared less distressed and suicidal"

Gould et al., 2005 · JAMA · randomized trial, 2,342 students

Asking everyone is appropriate

"Our findings support the appropriateness of universal screening for suicidality"

DeCou & Schumann, 2018 · Suicide Life Threat Behav · meta-analysis

No harm found from asking

"…we found no harmful outcomes of asking"

Polihronis et al., 2022 · Archives of Suicide Research · meta-analysis

The greater risk is that nobody asks.

Source: Citations link to each study; full references in notes

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LET'S HEAR FROM AN EXPERT

A Clinician's Perspective: Recognizing and Responding to Suicide Risk in ABI

What does suicidality look and sound like in a real community ABI practice?

Shauna McManus, MSW, RSW | Eden Dales Social Work

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Suicidality after ABI

1.9×

higher suicide risk after TBI

2×

higher suicide risk after concussion/mild TBI

1 in 10

with mild TBI reported suicidal thoughts at least once during the first year

The data are clear: suicide risk is higher after TBI, and preparedness matters.

Canadian MVC data: 6.3% reported suicidal thoughts at 3 months; 8.2% at 6 months after mild TBI. Passenger status was associated with suicidal ideation at both follow ups.

Bethune et al., 2017 · Toronto tertiary-care ED

Madsen et al., 2018, JAMA (7.4M people); Fralick et al., 2019, JAMA Neurol (17 studies); Campbell-Sills et al., 2021, J Head Trauma Rehabil.

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What the ABI and suicide research tells us

3.7×

Higher suicide risk in the first 6 months after TBI

Madsen et al., 2018

2.5×

higher odds of suicidal ideation with a previous brain injury

Campbell-Sills et al., 2021

Up to 6×

higher odds of suicidal ideation with a pre-injury psychiatric history

Campbell-Sills et al., 2021

Impulsivity

Strongly associated with suicidal thoughts and attempts in veterans with TBI

Aaronson et al., 2024

Years

risk still raised 7+ years after injury

Madsen et al., 2018

Hope

a group program reduced hopelessness after TBI

Simpson et al., 2011

Risk is highest early, can remain elevated for years and hopelessness is treatable.

Source: Madsen et al., 2018; Campbell-Sills et al., 2021; Aaronson et al., 2024; Simpson et al., 2011

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Why crisis is harder after ABI

Skills required for managing a crisis:

- EMOTIONAL REGULATION
- INHIBITION
- PROBLEM-SOLVING
- INITIATION

Getting through a crisis can require:

- stopping an impulse
- imagining another future (options)
- remembering a safety plan (call for help)
- Initiating a call for help or going to the E.R.

In crisis, ABI can mean more distress with less access to the very skills needed to get through it.

Source: Tsai et al., 2021, J Neurosci Nurs; Simpson & Tate, 2007, Brain Injury

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What should raise concern after TBI?

Evidence-based risk indicators and warning signs, not proven predictors.

Hopelessness
Simpson & Tate, 2002

A past suicide attempt
Mackelprang et al., 2014

A previous brain injury
Campbell-Sills et al., 2021

Alcohol or drug use
De Luca et al., 2025; Simpson & Tate, 2005

Loss of identity, role or function
Brenner et al., 2009-qualitative themes

Worsening depression
Campbell-Sills et al., 2021

Mental-health history before the injury
Campbell-Sills et al., 2021

Heavy, ongoing post-injury symptoms
Campbell-Sills et al., 2021

Impulsivity
Aaronson et al., 2024

Fatigue, work stress, little family support
Hicks et al., 2025

A new or worsening change from baseline should get attention. Notice it then ask them directly.

Source: See speaker notes for full citations

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Which brain state are we in?

Informed by Siegel's window of tolerance and Perry's state-dependent functioning.



Me
What state am I in?



Client
What state are they in?

CALM
In the window of tolerance: thinking and problem solving are accessible

ACTIVATED
At the edge of the window-stress is rising

OVERWHELMED
Outside the window of tolerance, thinking has become less accessible

1 **Regulate myself** → 2 **Co-regulate** → 3 **Co-Create a Plan**

My state first. Then theirs. Then the plan.

Source: Siegel, 1999 & 2010 (window of tolerance, hand model); Perry, 2006 (state-dependent functioning)

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Regulate → Relate → Reason

Adapted from Dr. Bruce Perry's Neurosequential Model

REGULATE
Calm the body first

- Slow your breath
- Lower your voice
- Slow your pace
- Pause

RELATE
Person before problem

- *"Thank you for telling me."*
- *"I'm here. You're not alone with this."*
- *"Let's take one part at a time."*

REASON
Then ask

- Thinking about suicide?
- Right now?
- Thought about how?
- Access to means?
- Tried before?
- Who can we bring in?

Source: Perry, 2009, J Loss Trauma; Perry & Winfrey, 2021

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Say it so it can be heard

Clear steps for a stressed or injured brain.

1. **Most important thing first** *Kessels, 2003*
2. **Be specific, not general** *Kessels, 2003*
3. **One step at a time** *INCOG 2.0, 2023*
4. **Write it down for them** *Kessels, 2003; INCOG 2.0*
5. **Ask them to say it back** *Talevski et al., 2020*
6. **Put it in their phone; give family a copy** *INCOG 2.0, 2023*

Vague

"Reach out if things get worse."

Clear

"If you are in danger of hurting yourself, you have agreed to call or text 9-8-8"

"I will see you next week, Wednesday at 10 am."

Short. Specific. Written. Said back.

Source: Kessels, 2003, J R Soc Med; Velikonja et al., 2023, INCOG 2.0 (JHTR); Talevski et al., 2020, PLoS ONE

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When you need to escalate

Instead of…	Say…
"I'm sorry, but I have to…"	***"This is to keep you safe."***
"Please don't make me call…"	***"I'm going to call for help now."***
"If you don't calm down…"	***"I hear your pain. Let's focus on safety."***

"This is not a punishment. It is care. I will be with you through this."

911 may not always act.
That doesn't mean you were wrong to call. Document it and debrief.

Be the steady one: calm, confident, clear. Your steadiness can help reduce distress.

Source: EDSW Suicidal Ideation & Self-Harm Protocol, 2026; Hostinar et al., 2014

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Why we don’t use no-suicide contracts

There is no evidence that no-suicide contracts prevent suicide.
Safety plans should be adapted to cognitive, developmental and communication needs.

A signed contract does not guarantee disclosure.

“…may be signed to avoid the detection of suicidal intent”

CAMH, 2011, Suicide Prevention and Assessment Handbook

Don’t ask for a Promise. Build a plan.
Ask: “What would make tonight safer?”

Source: American Academy of Pediatrics, (2024), American Psychiatric Association (2003), CAMH, 2011; Kroll, 2000; Rudd et al., 2006; Stanley et al., 2018

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Supporting Emergency Assessment with a Clear Referral Letter

Acute distress + ABI can make self-advocacy harder-especially in a busy emergency

"in the middle of a busy emergency, having the letter meant I didn't have to find all the words myself."

Anonymized composite based on clinical experience

A useful emergency department referral letter says:

- Who you are + role
- What client said/what you observed
- Why you're concerned
- What you're asking for: Urgent assessment
- How the emergency can reach you
- Share minimum necessary information; obtain consent where appropriate or rely on applicable safety exceptions.

Give the client a copy + send to emergency room when appropriate + confirm receipt if possible

Why it helps: Acute stress can impair working memory and flexible thinking; shame and stigma can also make disclosure harder.

When shame and overwhelm take away the words, the letter can speak for them.

Source: Clement et al., 2015; Blanchard & Farber, 2020; Shields et al., 2016; Melzer et al., 2024

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Safety planning after ABI

1. **Warning signs**
   How will I know I'm getting worse?
2. **Internal coping strategies**
   What can I do by myself first?
3. **People/places for distraction**
   Where can I go or who can I be around?
4. **People I can ask for help**
   Who can I tell directly?
5. **Professionals/crisis lines**
   Who do I call?
6. **Making the environment safer**
   What needs to be removed, locked up or handed over and who can help?

Make it ABI usable

- Keep it short (fewer words, choices)
- Write it down (don't rely on memory)
- Put numbers directly in phone
- Rehearse plan while calm
- Give a copy to a trusted support person
- Use a warm handoff-don't just give out a number

Don't just build a safety plan. Build it for the brain that will use it under stress.

Source: Stanley & Brown, 2012, Cogn Behav Pract; Stanley et al., 2018, JAMA Psychiatry

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Why family matters

Connection and the science of stress

01 Belonging

“You matter. You are not alone.”

Supportive relationships can help reduce isolation and strengthen connection.

02 Stress buffering

A trusted, caring person may help make distress feel more manageable.

Supportive relationships may help the body manage stress.

After ABI, support may do more than comfort. It may also help when thinking and self-control are harder.

Evidence: Hostinar et al., 2014; O’Connor et al. 2024

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Family as a Cognitive Scaffold

Helping bridge the gap between knowing and doing

What may be harder after ABI

- Remember the safety plan
- Pause before acting
- Get started or ask for help

How trusted support can help

- Keep the plan easy to find
- Remind the person of the next agreed step
- Help contact a clinician or crisis service

Support can help with the next step — it does not replace the person or their care team.

Sources: Jeffay et al., 2023; Velikonja et al., 2023 (INCOG 2.0).

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Family support: an emotional safety net

A.R.E. answers the question: “Are you there for me?”



Accessible

Stay present.
“I’m here with you.”



Responsive

Listen before fixing.
“I hear how much pain you’re in.”



Engaged

Show you care.
“You matter. I want you here.”

Safety planning is more than a checklist — it is an act of connection.

Source: Johnson, 2008; Carmel-Kraiem, 2012

Equipping the family

Concrete steps for clinicians



Bring them in

Invite a trusted person (with the client's agreement).



Validate

Name fear, stress, and fatigue.



Agree on roles

Set clear, realistic tasks together.



Follow up

Check in with caregivers, too.

What Can We Do?

Your role: notice, ask, respond, make it safer, connect. Not diagnose or predict.

1 Stay calm

"I'm really glad you told me." Don't rush.

2 Ask directly

Thoughts, plan, intent, means, when.

3 Know where they are

Virtual or community: address and who is nearby.

4 Assess Risk

Current thoughts + plan/intent/means or immediate danger: stay with them and escalate.

5 Consult same day

Emergency Services

6 Follow up

Confirm the handoff. Check in within 24–48 hrs.

Do not manage suicide risk alone.

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Questions

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In crisis in Canada: call or text 9-8-8

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4 questions, 20 seconds

ASQ: Ask Suicide-Screening Questions (NIMH) · free · validated with adult medical patients

1. *"In the past few weeks, have you wished you were dead?"*
2. *"In the past few weeks, have you felt that you or your family would be better off if you were dead?"*
3. *"In the past week, have you been having thoughts about killing yourself?"*
4. *"Have you ever tried to kill yourself?"*

If YES to any, ask:

5. ***"Are you having thoughts of killing yourself right now?"***

Yes to any of 1–4, no to 5

- Don't manage it alone
- Consult supervisor same day
- Connect to mental-health care

Yes to 5: urgent

- Don't leave them alone
- Get help now: 988, crisis line or ED
- 911 if danger is imminent
- Tell your supervisor

Source: NIMH Ask Suicide-Screening Questions (ASQ) Toolkit; Horowitz et al., 2012, Arch Pediatr Adolesc Med

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ED Collateral Letter Template

A concise handoff can reduce the burden on a distressed client who is struggling to explain what is happening.

Privacy note: Use consent whenever possible. If disclosing without consent, ensure the legal threshold is met for your role/setting, share only what is necessary, and document your rationale.

YOUR ROLE	I am a _____ providing community-based rehabilitation services.
CURRENT CONCERN	During contact on _____ at _____, the client reported / I observed:
SUICIDE / SAFETY INFO	Relevant statements, observed changes, or responses to direct questions:
REQUEST	I am requesting urgent assessment of the client's current mental-health and safety needs.
ABI / COGNITIVE FACTORS	Relevant memory, processing, executive-function, communication, or self-advocacy challenges:
SUPPORT / HANDOFF	Attending with: _____ Best collateral contact:

When shame and overwhelm take away the words, the letter can speak for them.

Sources: Practice template. Ontario privacy framework: PHIPA ss. 29-30, 40(1). Acute stress can impair working memory and cognitive flexibility (Shields et al., 2016).

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