Re-Imagining Social Work's Role in Suicidology: Embracing an Ecological Practice Approach

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Abstract: *Suicide continues to impact individuals and communities at alarming rates, with many vulnerable populations being at a disproportionately higher risk. As a profession, social work is well matched to address the comprehensive and intertwined risk factors that perpetuate acute and chronic risk for suicide. This conceptual article introduces a developing practice model that social workers may adopt to address suicidality for some vulnerable populations. Within this model, external processes beyond intrapsychic functioning are notable, and social workers can prioritize integrating additional systems into intervention planning. A case scenario illustrates an example of embracing an ecological systems approach that emphasizes various roles within social work practice. Introducing an applied approach to conceptualizing suicidality offers social work education and research an opportunity to advance its positionality in suicidology.*

Keywords: *Suicide, ecological systems, ecology, social work*

Suicide is an ongoing social and behavioral health issue in the United States, with approximately 49,000 individuals dying by suicide each year (Centers for Disease Control and Prevention [CDC], 2025) and more than 1.5 million individuals attempting suicide each year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Although a preventable form of mortality, between 1999 and 2018, the rate of suicide among the general population in the U.S. increased from 10.5 per 100,000 to 14.2 (Hedegaard et al., 2020), while the rate among adolescents and young adults increased from 6.8 per 100,000 to 10.6 between 2007 and 2017 (Curtin & Heron, 2019). Worldwide, the COVID-19 pandemic exacerbated many risk factors for suicide, thereby leading to noticeable increases in reports of suicide attempts (Pathirathna et al., 2022).

In Western medicine, suicidality is primarily understood and treated using a medical model. The medical model views suicide as a symptom of psychiatric illness, with implicit understanding that minimizing the presenting symptoms of such a psychiatric illness will, in turn, reduce the suicidality. This model is grossly congruent with psychological theories of suicide, such as the Interpersonal Theory of Suicide (IPTS), Hopelessness Theory, Escape Theory, Emotion Dysregulation Theory, and Psychache Theory. IPTS, for example, understands suicidal behavior to be a result of the individual's perceived burdensomeness, thwarted belongingness, and capability to engage in suicidal behaviors (Chu et al., 2017), with these concepts arguably viewed as symptoms when examined through the lens of the medical model.

These theories generate a necessary understanding of targeted aspects of psychological functioning. This offers value for specific clients or certain conversations about suicidality. For instance, these psychological theories generally draw upon the internal mechanisms of the individual, such as one's perception of self, psychological pain, or the desire to inflict

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self-injury. Therefore, the primary emphasis on intrapsychic functioning places noticeable attention on the individual. Fitzpatrick and River (2018), however, critique this approach as iterating the pathology of the individual.

Through the medical model and aligning with psychological theory, suicide is addressed by treating the underlying psychiatric illness via psychotropic medications and psychotherapy. Commonly recommended psychotherapeutic interventions to address suicidal behaviors or reduce acute risk include Collaborative Assessment and Management of Suicidality (CAMS), Safe Alternatives for Teens & Youths (SAFETY), Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), and Dialectical Behavior Therapy (DBT). With substantial literature on these treatments, they are commonly recommended and referenced in best practices, as they target symptom reduction—an intended outcome of the medical model. However, these theories and practices do not comprehensively acknowledge that external factors—the environment and societal structures—also impact suicide.

Despite a broad scope of research on these practices, there remains limited evidence that these interventions demonstrate an overall reduction in suicidal behaviors (Michel et al., 2017). Additionally, some results may not be statistically significant (Riblet et al., 2017), and some studies may not be generalizable (Tarrier et al., 2008). Since deaths by suicide remain high, current practice approaches exhibit questionable effectiveness in reducing overall numbers, especially for vulnerable populations and those with chronic histories of suicidality.

Interventions grounded in the medical model often focus on symptom reduction, overlooking the importance of improving one's quality of life (Chavez et al., 2018), as the medical model lacks the capacity to be attentive to the individual's personal values and needs (Fitzpatrick & River, 2018). Additionally, Singer et al. (2017) highlights that "differences in theoretical assumptions have important implications for how and when to intervene" (p. 104). Thus, while prevalent, the medical model may not be the most value-congruent practice approach for social work.

Conceptualizing an alternative model, this paper embraces an ecological approach and offers social work educators and practitioners a framework for teaching and intervening with suicide. In training the next generation of social workers, social work must identify, define, and refine how social work understands suicide as a problem. It is just as important that social work approaches its practice in working with suicide using theories and concepts that align with its core values, ethics, and practice standards. In this paper, I argue that using an ecological lens in the assessment and intervention with clients who may be at acute or chronic risk for suicide, social workers may be better equipped to reduce the rates of suicide in the U.S. and throughout the world.

Social Work and Suicidology

According to Joe and Niedermeier (2006), between 1980 and 2006, social work contributed limited knowledge to the study of suicide. More recently, Maple et al. (2017) similarly found that social workers contribute relatively minimally to research on suicide.

Additionally, Levine and Sher (2020) stated that social work research around suicide is limited, and they iterated the importance of social work enhancing its role in suicidology and building upon pre-existing interventions.

Social work students historically receive minimal formal education in suicide prevention and treatment (Feldman & Freedenthal, 2006), and additional training focusing on the integration of knowledge and skills is warranted in social work curriculum (Osteen et al., 2014). Given that most professionals rely on the literature of their own profession as a primary reference for practice (Joe & Niedermeier, 2006), it is necessary to question the degree to which social work practitioners have access to practice models that utilize an ecological approach in working with suicidality. Singer et al. (2017) also acknowledges the importance that social workers understand how to approach working with suicidality in a manner that demonstrates consistency between the social worker's theoretical orientation and the selected interventions. Since ecology is a core principle of social work education and practice, the use of this theory in conceptualizing a client's suicidality and how to intervene accordingly is warranted as a contribution to the literature.

Social work has yet to clearly define or describe how it utilizes ecology in its conceptualization of and intervention with client suicidality. Furthermore, social work requires a practice model that comprehensively embraces its person-in-environment perspective; its ethics, values, and practice standards; and the unique functions of its various roles—specifically those that lie outside of a clinical function. Bringing forth these aspects of the social work profession, social work may be able to shine new light on understanding, preventing, and treating suicidality.

Roles of Social Work

Given its vast array of practice settings, social work identifies with a variety of practice roles. Since social work fulfils several functions across these settings, these various roles offer the social work practitioner guidance and direction on their approach to implementing a plan for intervention. These roles may include, but are not limited to case manager, advocate, clinician, facilitator, organizer, manager, administrator, and educator. Harris and White (2018) referred to this as *functional specialization*, where the role of a social worker is determined by their specific function in any given setting. However, they also warned that the functional specialization of social work may lead to fragmentation or compartmentalization of a social worker's understanding of their role in addressing the well-being of individuals, families, groups, communities, and organizations. For instance, a clinical social worker may only see their role as a therapist or counselor, thus overlooking the functions of other roles, such as advocates, educators, and case managers. Integrating the variety of social work roles with a central social work theory—ecological systems—may support practitioners in better understanding how to bring a social work perspective to its practice with suicide.

Moving Social Work Towards an Ecological Systems Approach in Suicidology

The theoretical concept of *ecology* is widely used and applied in natural and social science literature. In the height of its conceptualization in social sciences, psychologist Urie Bronfenbrenner developed the ecological systems theory. Contemporary iterations of ecology include the life model, ecosystems model, deep ecology, and social ecology. While bearing nuanced differences, each model illustrates the concept of the person-in-environment as the critical lens through which human behavior should be understood. In its application, here, the concepts of ecology are discussed, and a case scenario illustrates the potential benefit in establishing an ecological systems practice framework for suicide.

Contextualizing Human Behavior

The ecological model, in general, is supported by the following assumptions: (a) an interdependence exists between all living organisms and their environment; (b) individual behavior occurs within physical, social, and cultural environments; (c) only ecological, or non-linear, thinking can help practitioners to understand more complex phenomena; and (d) successful development and adaptive functioning over the life course depend on the level of fit between the individual and their environment (Gitterman et al., 2021).

Bronfenbrenner (2005) proposed a series of defining properties that are foundational to the ecological model. Since Bronfenbrenner was primarily interested in understanding human behavior within the context of child and adolescent development, these distinctive properties reflect development across the life course and include the following propositions:

- Human development is driven by both objective and subjective elements; neither, on its own, is sufficient.
- Human development occurs through highly complex, reciprocal interactions between the individual and their environment. These enduring forms of interaction are referred to as *proximal processes*.
- Characteristics of the developing person and environment, the nature of developmental outcomes, and changes occurring over the course of time vary systematically.
- Intellectual, emotional, social, and moral development requires routine participation in progressively more complex activities over an extended period of time.

Given these assumptions and propositions, individual behavior can be understood through a thorough examination of the environment within which one's behavior is embedded. This includes individual characteristics, relationships, and larger social constructs, all of which are embedded within a temporal factor.

Ecological Systems

Applied within the context of Bronfenbrenner's original ecological systems theory, factors impacting human behavior are reflected within a series of complex systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. These systems, together, represent an ecosystem, within which transactions between the individual and their environment are continuously occurring. As such, human behavior cannot be understood, and thus treated, in an absence of understanding the environment, or ecosystem, within which the individual and the consequential behavior (e.g., suicide) is embedded.

The *microsystem* refers to the activities, roles, and interpersonal relationships within proximity of the developing individual (Bronfenbrenner, as cited in Cecconello & Koller, 2019). This may include the family, peer and social groups, neighborhood, and occupational or educational establishments. The *mesosystem* refers to the relationships that exist between microsystems (Bronfenbrenner, as cited in Xia et al., 2020). While the individual is not involved in these relationships, the relationships still impact the development of the individual. Examples may include the relationship between peer groups and work or between caregivers and school. These two systems have a direct impact on the individual.

Environments or social structures that have an indirect impact on the individual and their development are referred to as the *exosystem* (Epp, 2018). A common example within the context of social work practice is the individual's access to community-based resources, such as programs and services, or the influence of mass media. Another system with indirect impact on the individual and their development is the *macrosystem*, which refers to "overarching patterns of ideology and social institutions common to a particular culture or subculture" (Bronfenbrenner, 1979, p. 9). Examples may include social and gender norms, policy and law, or religious values.

The final, contextual element of Bronfenbrenner's ecological systems framework is the concept of time—referred to as the *chronosystem*. This system focuses on the events and expectations of the larger society (Bronfenbrenner & Morris, 2007). Within the chronosystem, three successive levels exist—micro-, meso-, and macro-time (Lerner, 2005). Micro-time refers to the continuity versus discontinuity of ongoing proximal processes; this may include pertinent lived experiences of the individual (e.g., trauma, life transitions). Meso-time refers to the periodicity of these proximal processes (e.g.., isolated expectations, chronic events). Macro-time focuses on the events within and across generations (e.g., historical trauma, socio-historical events).

This developmental theory proves useful to social work practice, as social work relies, in part, on psychological theory to inform its practice (Ungar, 2002). In considering its applicability to addressing high suicide rates, individuals presenting with suicidality ought to be understood through their own ecosystem, and treatment should be provided according to an individual's personal ecosystem. From an ecological systems perspective, factors impacting suicide are distributed across these various systems, and the following section provides a brief overview of examples.

Ecological Systems of Suicide

Individual

At the individual level, suicide is prominently understood through biological and psychological factors. Examples of biological factors include age, sex, and health conditions. For instance, Steele et al. (2018) noted that suicide is the second leading cause of death among individuals 10-24 years old in the U.S., with LGBTQ identity increasing risk among this age group. Among adult populations, individuals who identify as male, Caucasian, and are over the age of 65 are at an increased risk for death by suicide (Steele et al., 2018). Additional factors impacting suicidality include various health conditions, such as COPD, asthma, cancer, diabetes, spine disorders, and heart disease (Crump et al., 2013). Neurobiological factors, such as neurotransmitter dysfunction (Michel et al., 2017), genetic associations (Ludwig et al., 2017), and the structure of frontal neural systems (Cox Lippard et al., 2014) are also associated with increased risk for suicide.

Known psychological risk factors include mental pain, difficulties with communication, impulsivity, and aggression (Gvion & Levi-Belz, 2018). These factors likely increase one's susceptibility to developing psychological disorders. Common psychiatric problems related to increased suicidality include mood disorders, psychosis, personality disorders, anxiety, trauma-related disorders, and substance use (Bachmann, 2018). While these biological and psychological factors exist within the individual system, the emergence of suicidal behaviors occurs through a bi-directional relationship between the individual and larger systems of that person's ecosystem, which moderates the impact of various conditions and risk factors that contribute to suicidality.

Microsystem

Within the microsystem, risk factors related to suicidality pertain to the adequacy and quality of one's access to adaptive supports. This may include family, peers, work or school, and community involvement (e.g., sports, church, volunteering). For instance, gender and sexual minorities may benefit from more peer support due to the additional stigma associated with their gender and/or sexual identities (Williams et al., 2018). According to Frey et al. (2019), accessing social support can directly impact one's post-traumatic growth following a suicide attempt. Furthermore, individuals who disclose their experience with suicidality to family members exhibit an increased likelihood of improved mental health outcomes (Frey et al., 2015). As such, the impact of social support in preventing suicide may be even more critical than previously understood. Therefore, in practice, social workers need to evaluate the meaningfulness of one's support system, considering ways in which support may be reinforced and strengthened.

Mesosystem

In consideration of suicidality, the mesosystem captures the concept of social cohesion—the connectedness of social structures within one's environment. For instance, neighborhoods exhibiting a lack of social cohesion are associated with a higher probability

of suicidal ideation among older adults in Korea (Kim & Park, 2021). However, neighborhood cohesion can serve as a protective factor against stressful life events and mental or behavioral health problems among adolescents—both of which are known to impact suicidality (Kingsbury et al., 2020). Additionally, the degree to which a family system exhibits cohesion (e.g., whether a partner is integrated into the individual's family system) is another meso-system example, as family cohesion is one moderating factor for suicidality. This is especially relevant for individuals experiencing psychotic spectrum disorders or those identifying as a person of color (Lopez & Weisman de Mamani, 2022).

Exosystem

Within the exosystem, consideration must be given to one's access to healthcare and means for suicide, while also acknowledging the influence of mass media (e.g., suicide contagion). For instance, social media can impact suicidal behavior (Luxton et al., 2012), and the reporting of deaths by suicide of celebrities has had a meaningful impact on the suicide numbers among the general population (Niederkrotenthaler et al., 2020). Additionally, Paladhi et al. (2021) found that firearm-owning households had more access to healthcare, but those with risky firearm storage practices had less access to healthcare. One barrier to accessing healthcare relates to healthcare insurance policies, yet Lang (2013) noted that states enacting mental health parity experienced significant decreases in suicide rates.

Macrosystem

The macrosystem addresses factors of suicide that pertain to societal views and cultural values, including social norms. Prominent examples in suicidology include stigma, societal views regarding gender and sexuality, and military culture. For instance, according to Mayer et al. (2020), anticipated stigma from disclosing one's history of suicidality increases risk for suicide, due to concern for the potential reactions of others. The role of stigma, then, is one that is inhibitory to the efforts intended to reduce suicide, and stigma may hinder or limit the access to and receptibility of prevention and treatment efforts. Furthermore, military personnel are less likely to verbally express their mental health concerns (Cox et al., 2011), and they are more likely to experience difficulties with transitioning from deployment (Lusk et al., 2015) due to the culture of the military. Among LGBTQ+ communities, youth are twice as likely to attempt suicide compared to heterosexual peers (The Trevor Project, 2021), and a hostile environment is a contributing risk factor to suicide for this community (CDC, 2016). Thus, factors outside of the individual—such as those within societal structures and cultural values—may moderate the recovery trajectory of individuals experiencing suicidal behaviors.

Chronosystem

In working with suicide, the chronosystem offers a temporal context that impacts an individual's ability to adapt within their ecosystem. Micro-time examples may include having a previous suicide attempt, exposure to isolated traumas, or various life transitions.

Identifying individuals with multiple suicide attempts could be useful in predicting one's risk for suicide, as well as in designing ad hoc prevention strategies (Berardelli et al., 2020). Major life events, such as financial problems or relationship difficulties, are other examples of micro-time factors, as they also contribute to suicidality (Gvion & Levi-Belz, 2018). Meso-time factors related to suicide include chronic events, such as the COVID-19 pandemic. Additionally, adolescents who present with a higher risk for suicide include those who have a history of exposure to trauma (e.g., domestic violence or child abuse/neglect) and have a family history of suicide or psychiatric illness (Steele et al., 2018); these events are likely to have long-lasting effects on an individual. Considering an example of macro-time, Nix (2021) iterated the importance of understanding historical trauma and its relation to Indigenous mental health and suicide, as Indigenous populations are at an increased risk for suicide (Chachamovich et al., 2015; Qiao & Bell, 2017).

Figure 1. *Case Scenario Excerpt*

Case Scenario

Jaime is a 16-year-old, gay male with a history of depression and anxiety. Jaime experiences recurrent episodes of major depression, which includes feeling hopeless, anhedonia, lethargy, isolating behaviors, and chronic thoughts of suicide, all of which are exacerbated by anxious distress. He recently discharged from a temporary hospital stay following a non-lethal suicide attempt. At discharge, he is prescribed venlafaxine, gabapentin, and alprazolam. Jaime also has a history of low Vitamin D, and his thyroid functioning is unknown. His medications will be managed by his primary care provider, as the closest psychiatric prescriber with a specialty in pediatrics is a two-hour commute from his home.

While his mother and brother are "more accepting," Jaime often feels that he cannot openly express or be himself in the presence of his family. His father often conceals Jaime's sexual orientation to extended family members and members within their community. Additionally, Jaime's family has not talked with him about his previous suicide attempt, and his parents keep firearms in the home. At school, Jaime is involved in the Gay-Straight Alliance (GSA), for which he is frequently bullied by both peers and school staff. His parents are not actively involved in his education, and Jaime is at-risk of not graduating due to poor academic performance—a result of missing school and low motivation. During COVID-19, Jaime's access to peer support significantly decreased.

Jaime's rural community is predominantly conservative with "traditional" values. Jaime is required to attend church with his family, even though the church views LGBTQ+ identities as sinful. While Jaime does not identify with his churches' values, he does identify as Christian and feels disconnected from his spirituality. Furthermore, Jaime is exposed to media depictions of suicide (e.g., popular television shows, movies, and news) at home and school.

Jaime's insurance provider network has limited adolescent therapists who are LGBTQ+ affirming, and his health coverage does not provide out-of-network benefits. Although he engaged in a brief episode of inpatient treatment, Jaime continues to experience suicidal ideations. During the prior authorization process, Jaime's insurance asks, "Why is he still suicidal? Is he not using the skills he learned during inpatient treatment?"

Translating Ecological Systems Into Direct Practice

Within suicidology, the extensive knowledge regarding factors that increase one's risk for suicide demonstrates that there is a complexity to suicide that incorporates individual characteristics, as well as environmental factors, such as social and cultural considerations. To illustrate this, the case scenario is a condensed culmination of a variety of clinical encounters (See Figure 1). It highlights the complex nature of suicide, emphasizing the importance of considering external risk factors that may hinder an individual's ability to adapt within their environment, thus increasing risk for suicide. It also exemplifies how social work can utilize its numerous roles to intervene with suicide more comprehensively.

Jamie's case offers insight in understanding how an ecological approach can support social workers with translating ecological thinking into practice when designing interventions for clients presenting with suicidality. From an ecological perspective, as Jaime's goodness of fit with his environment improves, his overall risk for suicidality should decrease. Therefore, treatment should focus on improving the fit between the person and environment by targeting key factors across the systems that compose the client's ecosystem. Table 1 provides an ecological systems breakdown of associated risk factors pertinent to Jaime's presenting suicidality; direct practice recommendations and associated social work functions are identified.

Jaime's case demonstrates the importance of acknowledging the depth of multiple systems that exacerbate both acute and chronic risk for suicide. At the individual level, Jaime presents with both physical and mental health risk factors. This includes psychiatric conditions (i.e., depression and anxiety), as well as physical health considerations (i.e., low Vitamin D and unknown thyroid functioning), which can impact the severity of depressive symptoms. The interaction between physical and mental health factors will require the social worker to be mindful of care coordination functions within practice. For instance, it will be critical to Jaime's recovery that their primary care provider, who is also serving as the prescribing provider, be frequently updated regarding Jaime's progress and response to treatment.

While Jaime presents with these individual risk factors, the transactional processes between environmental sub-elements perpetuate and sustain his suicidality. This includes Jaime residing in a rural, conservative community; experiencing invalidation at church and school—two critical microsystems within his ecosystem; and the impact of healthcare coverage limitations. Using an ecological framework requires consideration of the synergy between and within the individual and environmental elements (Xia et al., 2020). The impact of prolonged exposure to these proximal processes may exacerbate his suicidality and overall development, as he emerges into adulthood. Thus, in suicidology, social work must look beyond just the individual, which will likely require considerations of functions beyond clinical practice.

Table 1. *Case Scenario: Ecological Systems Practice Recommendations*

System	Risk Factor	Practice Recommendation	Social Work Role
Individual	Mental health	• Provide individual psychotherapy	Clinical
		• Coordinate with psychiatric prescriber	Case management
	Physical health	• Coordinate with primary care	Case management
Microsystem	Family	• Provide psychoeducation to parents regarding LGBTQ+ identities & increased risk for suicide	Clinical/Education
		• Provide family/conjoint psychotherapy	Clinical
	School	• Provide education & resources regarding bullying, LGBTQ+, & increased suicide risk	Education
	Church	• Problem-solve & process value incongruence between client & church	Clinical
Mesosystem	Parent-School	• Empower parents to be more involved in client's education to increase awareness of school-related issues	Advocacy
Exosystem	Rural community	• Provide referrals for LGBTQ+ affirming providers	Case management
		• Advocate for telehealth services where clinically appropriate	Advocacy
	Service access	• Negotiate a single-case agreement with insurance if out-of-network	Advocacy
	Media	• Process pop-culture depictions of suicide in psychotherapy	Clinical
Macrosystem	Stigma	• Decrease stigma through validation of client's lived experiences & social identifiers	Clinical
	Social & gender norms	• Provide psychoeducation regarding impact on mental health	Clinical/Education
		• Provide parents with referral to PFLAG	Case management
		• Provide client with referral to LGBTQ+ support groups	Case management
Chronosystem	Suicide-attempt history	• Develop safety plan	Clinical
		• Administer trauma screening	Clinical
	COVID-19 pandemic	• Problem-solve using coping skills & accessing social support	Clinical

Jaime resides in an environment that is incongruent and not a "good fit" with his own personal identity and values. Environments that do not match an individual's needs are more likely to lead to dysfunction (Bronfenbrenner & Morris, 2007). Focusing solely on changing Jaime's individual thoughts and behaviors through psychotherapy and psychotropic medications may decrease acute suicidality, but it is unlikely to produce the necessary change to reduce his overall or chronic suicide risk. Using an ecological framework to assess the contributing factors to Jaime's suicidality will increase the likelihood of a more accurate intervention plan. It will also allow the social worker to consider the role and necessity to integrate additional systems beyond the individual in their intervention. One approach to integrate additional systems is for the social worker to consider other roles and functions of direct practice, such as case management, advocacy, and education.

Figure 2. *CACE Social Work Practice Model for Suicide Assessment and Intervention*

Clinical, Advocacy, Case Management, and Education (CACE) Social Work Practice Model for Suicide Assessment and Intervention

Developing a practice framework that emphasizes the importance of non-clinical functions in social work allows providers to distinctly target treatment needs throughout an individual's ecosystem. Following a comprehensive assessment emphasizing a thorough understanding of the multiple ecological layers impacting one's presenting suicidality, only then can the most effective treatment plan be developed in collaboration with the client. Figure 2 demonstrates a practice model for suicide assessment and intervention that outlines the integration of social work roles that embrace clinical, advocacy, case management, and education functions.

The *clinical* function highlights the role of providers in addressing individual and relational issues, commonly through the provision of psychotherapeutic interventions. This might include any combination of individual therapy (using processing and skill building techniques), family therapy, and/or group therapy. For licensed social workers, the clinical function is often perceived as a specialty, and it can come at the expense of more generalized social work practices. Thus, integrating additional social work roles may offer a more holistic approach to supporting suicidal individuals.

The *advocacy* function acknowledges the role of systemic issues within a client's ecosystem, and it can intervene with service system access and empowerment. Through advocacy, social workers may act on behalf of, in support of, and/or alongside the client in mitigating larger systemic issues affecting suicidality. Efforts of advocacy may include addressing healthcare access, navigating barriers related to service delivery, or empowering clients with the knowledge and skills necessary to self-advocate.

The function of *case management* allows the social worker to address communication needs between systems. With this function, the social worker provides referrals or coordinates care with providers. This role increases in importance for more complex cases. For instance, individuals with several service providers or those experiencing numerous acute stressors (e.g., housing, financial problems, unemployment) will benefit from supplemental case management that accompanies the clinical function of the practitioner.

Finally, the social work function of *education* allows for increasing insight and awareness by offering the individual and their microsystems with information about suicide. This might include providing education to important microsystems, such as parents, a partner, or other family members. This function additionally allows for increasing the client's understanding of the intersectionality between specific vulnerable identities and suicide, as well as the potential and very real consequences of not addressing these issues. Thus, the CACE Practice Model offers a defined framework by which social workers can support clients in both establishing and sustaining stabilization by targeting specific risk factors throughout the client's respective ecosystem.

Discussion

While suicide is commonly viewed as a sole symptom of intrapsychic functioning, ecology informs us that suicide may be better understood as a symptom of the context within which an individual is developing. According to Lerner (2005), a piecemeal analysis of isolated aspects and attributes is insufficient, and perhaps misleading, in understanding human behavior. For instance, the concept of social cohesion is acknowledged in other theories of suicide, such as IPTS and Durkheim's theory of suicide, but understanding the co-existence and complexity of this concept as it is embedded in other levels of the ecosystem warrants a more comprehensive model from which to base social work practice. While existing models of intervention maintain relevance and usefulness, considerations for alternative approaches more distinctly grounded in social work values offer additional opportunity to support clients who may not benefit from current assessment and intervention practices. Since social workers are the highest percentage of mental health providers in the U.S. (American Board of Clinical Social Work, 2022), it is urgent to plainly recognize the complexity of factors impacting assessment and intervention.

Given the high rates of suicide among adolescents and young adults, and since developmental theory and ecology offer a context for human behavior, developmental science may be key in addressing client suicidality. In clinical practice, the limitations of the medical model leave social workers to navigate, without certainty, how to best address factors external to the individual in a clinical setting. Although clinicians may primarily work with individuals, families, and groups, value remains in the ability of a social worker

to identify, assess, and integrate broader systems impacting an identified client. Even if a clinical social worker may not be able to immediately or directly change societal stigma, for instance, the social worker can acknowledge the role that stigma plays in perpetuating behavioral health symptoms and overall suicidality. In doing so, the social worker may be able to mitigate the impact of larger systems through problem-solving, processing, and providing education and resources to the individual and their microsystem.

In preparing social workers for direct practice, social work education may find benefit in offering a unique perspective to understanding and working with suicide. Instead of deferring to the medical model and hyper-focusing on sole changes at the individual level, emerging social workers may be better equipped to assess the complex ecosystem of individual clients and tailor treatment planning accordingly. Since populations often deemed more vulnerable are only partially supported by predictions of current theories of suicide, such as IPTS (e.g., Barzilay et al., 2015; Khazem et al., 2015; Pisetsky et al., 2017), preparing social workers for the field requires the use of theories that can be generally applied to various populations and identities. In turn, embracing ecology and publishing specifically in social work journals may also increase the available research and scholarship of social workers in suicidology, paving the way for social work to develop its own framework through which it best understands and works with suicide.

The introduction of the CACE Practice Model offers social workers a concrete framework from which to guide their direct practice, including interventions beyond the clinical function of social work. It is worth iterating that the application of ecology within this model is not indicating that the social worker is to directly intervene with each system. Rather, the social worker continues to intervene directly with the individual, microsystem, and mesosystem, while simultaneously addressing the impact of the exosystem, macrosystem, and chronosystem on the individual. Thus, while the social worker is intervening with micro- and meso-interventions, these are tailored to uniquely reflect the risk factors throughout the individual's ecosystem.

The application of the ecological systems theory to treatment planning in direct practice highlights the importance of utilizing ecology to conceptualize a client's suicidality. In its practice with other public health and social problems—such as child welfare and substance use—social work contributed to advancing direct practice by utilizing ecology to enhance its knowledge, treatment planning, and subsequent service interventions. Since social work embodies multiple practice roles, embracing an ecological approach allows the clinician to tap into additional practice functions and interventions that may prove beneficial to suicidology.

Standardized assessments, such as the Columbia-Suicide Severity Rating Scale (C-SSRS), and treatments, such as CBTs, tend to iterate psychological risk factors, along with some temporal factors (e.g., suicide attempt history). While the standard methods may be helpful in assessing and treating some factors of suicidality, the effectiveness of these approaches may overlook immediate risk factors relevant to marginalized populations, such as systemic discrimination, lack of resources, and community values. Thus, in deferring to theories and practice approaches aligned, at least in part, with the medical

model, social workers may unintentionally overlook critical factors impacting a client's presenting suicidality.

Given that social work emphasizes the importance of integrating more just practices into the profession, ecology is more congruent with social work values, as "[Bronfenbrenner's model] may be the frame within which human decency and social justice may prosper" (Lerner, 2005, p. xxiv). Ungar (2002) additionally iterates that ecology reminds social work to celebrate diversity, deconstruct the power of traditional discourse, and to emphasize the needs of special groups—critical components lacking in other frameworks. Transitioning to a practice model that embraces ecological thinking, such as the CACE Practice Model, may offer social work an opportunity to forge its own position within suicidology.

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