

Accompaniment Planning: Re-sequencing Suicide-Related Care in Clinical Social Work Practice

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Abstract

Social workers frequently encounter suicidal thoughts and behaviors across practice settings. Contemporary standards of care often organize suicide prevention into a protocol-driven sequence that begins with screening and risk assessment. This sequencing rests on the assumption that risk can be identified early and reliably enough to act upon. Such an assumption is challenged by emerging empirical research, critical theorists, and people with suicide-lived experience. The confluence of these perspectives suggests that when clinical encounters are structured around risk identification before relational grounding has been sufficiently established, disclosure becomes perilous rather than relational: some individuals conceal suicidal experiences altogether. This theoretical and practice-oriented article introduces accompaniment, an ethical stance and relational practice that privileges presence over prediction, and translates it into the Accompaniment Planning Template: a structured and collaborative process organized around eight domains. The proposed re-sequencing positions accompaniment before assessment, safety planning, and follow-up, not to delay care but to establish the relational and epistemic conditions under which subsequent intervention becomes meaningful. Implications are discussed for clinical practice, education and supervision, and public health because the relational conditions that support disclosure may improve access to care and outcomes for populations historically marginalized within behavioral health and health care systems. Finally, limitations for this practice and education innovation are identified. Keywords: accompaniment, suicide prevention, therapeutic alliance, clinical social work, critical suicide studies

Introduction

Social workers routinely encounter individuals experiencing suicidal thoughts and behaviors across a wide range of practice contexts (Feldman & Freedenthal, 2006; Ruth et al., 2012; Kourgiantakis et al., 2022). As a result, suicide prevention is a central component of social work practice (Suicide Prevention Resource Center [SPRC], 2025). Such prevention practices are shaped by standards of care and are organized around a structured, protocol-driven sequence that begins with screening and culminates with various follow-up responses (National Action Alliance for Suicide Prevention [NAASP], 2018). These realities compel social workers to navigate multifaceted and often competing responsibilities (National Association of Social Workers [NASW], 2026). Such competing professional duties frequently create ethical tensions that often complicate the therapeutic alliance between social workers and clients living with suicidality (Blanchard & Farber, 2020; Kumbhare, 2022; Mooney, 2022). The therapeutic alliance is among the most consistently supported predictors of positive clinical outcome, and emerging evidence suggests it is meaningfully associated with suicide prevention (Flückiger et al., 2018; Dunster-Page et al., 2017; Huggett et al., 2024). Therefore, suicide-related care must consistently and formally center collaborative social worker-client relationships.

To better understand collaborative social worker-client relationships, this article begins with an examination of suicide-related standards of care that shape social work practice. Such a review includes critiques of the suicide risk models and descriptions of client harms that are often generated when the requisite relational grounding has not been established first. These limitations and harms are addressed with a new practice innovation—*accompaniment*. This proposed innovation is translated into a collaboratively-created plan to

better maintain the therapeutic alliance throughout a client's suicidal experiences—the *Accompaniment Planning Template*. This article then describes accompaniment planning implications for clinical practice, education and supervision, and public health. The article concludes by identifying limitations.

Current Standards of Care in Suicide Prevention

Contemporary suicide prevention in social work is shaped by professional guidelines, interdisciplinary consensus statements, and risk management frameworks (NAASP, 2018; NASW, 2026). Across settings, these standards organize care into a structured sequence: screening, suicide risk assessment (SRA), safety planning, intervention, documentation, and follow-up. National guidance presents suicide care as a systematic, protocol-driven process in which clinicians are expected to move efficiently from identifying suicidal thoughts to formal assessment and risk-reduction strategies (NAASP, 2018; NASW, 2026).

Risk assessment typically involves evaluating the presence, intensity, and duration of suicidal ideation, together with the existence of a plan, intent, access to means, and any history of prior attempts (Daray et al., 2025; Smith, 2022). These evaluations also assess a range of psychosocial risk and protective factors, which are synthesized into categorical designations—low, moderate, or high risk—intended to guide subsequent intervention. Safety planning often follows assessment and is commonly operationalized through tools such as the Safety Planning Intervention (Stanley & Brown, 2008, 2012), which focuses on coping strategies, sources of support, reasons for living, and reducing access to lethal means. Both procedures carry legal and ethical weight. Social workers are mandated to take reasonable steps to protect clients from foreseeable harm. Adherence to established assessment and documentation protocols frequently serves as evidence that the standard of care was met and provides important risk management protections for clinical social workers (Kumbhare, 2022; NASW, 2026; Stefan, 2016;).

These standards do not neglect the relational dimensions of practice. Professional values consistently highlight the importance of therapeutic alliance, empathy, and collaborative engagement, encouraging clinicians to approach assessment respectfully, nonjudgmentally, and in attunement with the client's lived experience (NASW, 2026). Person-in-environment perspectives and attention to social determinants of health further reflect social work's commitment to contextualizing suicide risk within broader relational and structural conditions (XXXX & XXXX). Within the prevailing suicide prevention framework, however, relational engagement frequently functions as a means to bolster assessment accuracy rather than as a precondition for it. Trust is expected to develop alongside—and often in service of—risk identification and management (Graney et al, 2020; Hawton et al., 2022).

This structure rests on three specific and consequential assumptions: that risk can be identified early, that early identification is reliable enough to act upon, and that prompt action is therefore the appropriate organizing principle of the suicide-related encounter. Those assumptions emerge from legitimate ethical and legal concerns, and shape the tempo, focus, and purpose of clinical work accordingly. They determine, in effect, the purpose of the conversation.

Social work's current standards of care thus represent a comprehensive and well-intentioned framework that integrates clinical, ethical, and legal considerations. The next section examines the empirical evidence undergirding the framework's assumptions, as well as the implications for social work practice.

Limits of Risk-Based Models

Risk-based models of suicide prevention are grounded in the assumption that suicidal behavior can be identified, stratified, and managed through systematic assessment. While this approach has become foundational to contemporary practice, a growing body of scholarship raises important questions about its predictive validity, clinical utility, and ethical implications (Belsher et al., 2019; Cockburn & Large, 2025; Smith, 2022).

One of the most significant limitations of risk-based models lies in their constrained ability to predict suicidal behavior with precision. Risk assessment tools incorporate a wide range of empirically derived factors—prior attempts, mental health diagnoses, psychosocial stressors—but these variables do not reliably distinguish between those who will and will not engage in suicidal behavior (Belsher et al., 2019; Daray et al., 2025). Suicide is a low-base-rate event, and even well-constructed models yield high rates of false positives (Belsher et al., 2019). Cockburn and Large (2025) found that the contemporary self-harm tool, OxSATS, had a positive predictive value of 2.5% at a 2% risk threshold. The finding means that approximately 97% of people flagged for risk will not die by suicide for every three that will, simultaneously missing more than half of all deaths. Such limitations likely reflect the inherently dynamic, context-dependent nature of suicidality. Finally, recent methodological innovations have shifted from categorical risk classification toward probabilistic estimation, representing genuine advances (Seyedsalehi & Fazel, 2024). However, these approaches do not resolve the underlying challenge: prediction remains contingent, uncertain, and deeply influenced by contextual variables that standardized assessment frameworks cannot fully capture (Cockburn & Large, 2025).

Beyond predictive accuracy, risk-based models reflect broader epistemological and ethical assumptions about the nature of suicide. Contemporary approaches are deeply influenced by the medicalization of suicidality—the widespread belief that it is primarily the result of individual pathology (Marsh, 2020; Smith, 2022; Stefan, 2016). This orientation has contributed to intervention strategies that prioritize detection, classification, and treatment of presumed underlying disorders. It thus risks a narrowed understanding that privileges individual-level explanations over relational, structural, and contextual factors.

Additionally, as ethical critics note, risk-based models often function within paternalistic systems in which clinicians may override client autonomy in the name of safety. Such actions raise enduring tensions around autonomy, beneficence, and justice, and frequently increases reliance on standardized procedures when clinical thresholds are ambiguous at best (Baril, 2020, 2023, 2025; Merritt, 2025; Smith, 2022). These dynamics have important implications for the therapeutic relationship. When clinical encounters center risk identification, clients may experience disclosure as perilous rather than relational. Research and lived experience accounts suggest that individuals determined to act on suicidal thoughts may become more adept at concealing them when they anticipate coercive responses (Blanchard & Farber, 2020; Merritt,

2025). Paradoxically, this relational dynamic undermines the very goals risk-based approaches seek to achieve.

Critical suicide studies further illuminate these limitations. Baril's (2020, 2023, 2025) concept of *suicidism* describes how risk-focused interventions can subject suicidal individuals to epistemic and institutional marginalization. Such forms of oppression contribute to experiences of coercion, silencing, and dehumanization. Tack (2026) similarly argues that dominant prevention narratives render the suicidal person an "impossible subject" whose agency is denied through practices that pathologize the desire to die and naturalize the desire to live. The confluence of these critiques suggests that the limitations of risk-based models are not only technical but also relational, ethical, and structural. The focus on prediction, classification, and liability management may constrain the conditions necessary for trust and shared understanding. These negative effects are experienced disproportionately and likely reinforce existing disparities in suicide prevention outcomes. This concern is particularly salient for populations already subject to heightened surveillance and involuntary intervention—LGBTQ+ individuals, racialized communities, and people previously harmed by institutional care—for whom the conditions of early engagement bear directly on whether care is sought at all (Holt et al., 2024; Jones et al., 2021; Shea et al., 2022). Still, for some people, the insistence that suicide ought to be prevented in every instance both invalidates and attempts to erase persistent suicide-lived experience (Dotson, 2011; Merritt, 2025). Such critiques are especially pointed for the social work profession which holds longstanding commitments to relational practice, contextual understanding, and client self-determination (NASW, 2026). The aforementioned limitations and concerns underscore the need for social workers to re-center sustained relational processes and clinical tasks that advance equity and broaden public health reach.

The Missing Phase: Toward an Ethics of Accompaniment

Across dominant models of suicide prevention, clinical social work practice is typically organized around a familiar sequence: engagement, assessment, intervention, evaluation, and termination (XXXX). Within this structure, engagement frequently functions as a prelude to assessment—a necessary step that facilitates the identification of a client's presenting concerns, as well as risk and protective factors. What lacks is not engagement per se, but a qualitatively different phase of practice—one toward sustained relationship throughout a client's suicidality (Espeland et al., 2021; Østlie et al., 2022). This absence reveals more than a procedural problem; it raises fundamental epistemological and ethical questions. When assessment subordinates the therapeutic alliance, risk logic shapes the clinical encounter from the outset. The clinician listens in order to evaluate and ask questions not to understand but to categorize. Disclosure becomes data, and the person becomes, in part, an object of assessment and intervention. As a result, the social worker–client encounter may be experienced less as a relationship of mutual recognition and more as a means of surveillance.

This dynamic does not reflect a failure of individual clinicians, but the structural conditions under which they practice. At a deeper level, this structural failure reflects the dominance of what Baril (2023, 2025) describes as the "injunction to live"—a normative imperative positioning life preservation as the overriding goal of intervention. Meeting this goal often comes at the expense of autonomy, epistemic justice, and

relational integrity. If risk prematurely structures suicide-related care, improving assessment alone cannot suffice; social workers must re-sequence practice itself. To that end, this article introduces a distinct phase that precedes assessment—a phase grounded in accompaniment.

Accompaniment, as used here, does not refer to a technique or intervention but to an ethical stance and relational practice. It involves “standing beside” rather than “acting upon”—privileging presence over prediction and evolving understanding over immediate action (Baril, 2023). In contrast to risk-based models that seek to determine what *will* happen, accompaniment attends to what *is* happening: how a person makes sense of their experience, what meanings they ascribe to their suicidality, what forms of support feel possible in the moment (Baril, 2025; Merritt, 2025; Tack, 2026). Peer-based models such as Alternatives to Suicide offer support for this orientation, with participants underscoring the value of spaces in which they can speak freely (Schlichthorst et al., 2020). Crucially, accompaniment does not require the abandonment of clinical responsibility. Rather, it reorders the conditions under which responsibility is enacted. By prioritizing the social worker-client relationship before assessment, clinicians may better understand the contextual and structural dimensions of suicidal distress. The resulting development of trust increases the likelihood of meaningful disclosure. The potential result is enhanced effectiveness of subsequent assessment and intervention. Concurrently, accompaniment challenges assumptions about what it means to help. It asks clinicians to tolerate uncertainty, resist the impulse toward immediate action, and engage with suffering that may not be easily resolved. Such experiences may include suicidal desires driven by legacies of poverty, racism, and homophobia (XXXX; Marsh, 2020). In these cases, clinical social workers need to shift from *doing* to *being*, from *managing* to *witnessing*. This change in stance holds safety, autonomy, dignity, and relational integrity in tension rather than resolving them through procedural compliance.

Ultimately, re-sequencing social work practice signals more than a procedural adjustment; it signals a paradigm shift. It moves suicide care away from an exclusive focus on prediction and prevention toward a model that centers relationship, meaning, and context. If risk-based models ask, “What is the likelihood that this person will die?” accompaniment begins with a different question: “What does it mean to be with this person, here, in this moment, with their suicidal desire?”

The Accompaniment Framework

The Accompaniment Framework incorporates six factors that undergird the eight domains of the *Accompaniment Planning Template*. These factors include epistemic humility, non-coercive orientation, client ambivalence tolerance, contextual awareness, clinical transparency, and clinicians’ uncertainty tolerance. In concert, these factors function to re-center and ground the social worker-client relationship. Such re-centering and grounding likely create the necessary and sufficient conditions for optimal suicide-related care (Huggett et al., 2022; Huggett et al., 2024).

Central to the accompaniment framework is a commitment to epistemic humility. Risk-based models position clinicians as knowers who must identify and act upon signs of danger. Accompaniment complicates this positioning by recognizing that the meaning of suicidal thoughts and behaviors cannot be

fully captured through standardized assessment. Clinicians and clients co-construct meaning within this relational space. This framework, thus, requires an openness to not knowing and a recognition that the person experiencing suicidality is the primary authority on their own experience (Dotson, 2011; Merritt, 2025).

A second defining feature of accompaniment is its orientation toward non-coercion. Clinical responses to suicidality are often shaped by implicit or explicit forms of control, including involuntary hospitalization and heightened surveillance (Jones et al., 2021; Shea et al., 2022). While such interventions may be ethically justified in certain circumstances, their anticipated use shapes the conditions of engagement from the outset. Accompaniment seeks to create a relational context in which coercion does not define the interaction. Rather, this new paradigm emphasizes the social worker's preference for collaboration. Such a commitment reinforces the profession's relational and dignity-promoting values.

The accompaniment framework further emphasizes holding a client's ambivalence without resolution. Suicidality is often characterized by simultaneous desires to live and to die, to endure and to escape (Baril, 2025; Merritt, 2025; Tack, 2026). Risk-based models tend to resolve this ambivalence by privileging the desire to live through strategies designed to reinforce protective factors and reduce risk (Stanley and Brown, 2008, 2012). Accompaniment, by contrast, allows ambivalence to remain present as meaningful and informative. Within this framework, social workers attend to how the desire to die emerges, what it signifies, and how it coexists with other aspects of the client's life (Merritt, 2025).

Contextual awareness also distinguishes accompaniment from individualizing approaches. Relational histories, social conditions, structural inequities, and cultural meanings all shape suicidal distress. Accompaniment therefore requires attention to experiences of marginalization, trauma, economic instability, and systemic injustice (XXXX & XXXX; Marsh, 2020). As a result, this model helps clinicians resist the tendency to locate the problem solely within the individual.

Another key principle of accompaniment is transparency. Given the power differentials inherent in clinical relationships—particularly in the context of suicide prevention—clinicians must highlight the parameters within which they operate. These parameters include the limits of confidentiality, the circumstances under which information may be shared, the responsibilities that comprise the clinical role, and the clinician's commitment to maximize a client's right to self-determination. Such transparency does not eliminate power differentials, but it can make them more visible and explicit. This candor allows clients to make more informed decisions about what and how they disclose.

In addition to promoting transparency, accompaniment likely increases safety. Rather than reducing safety, accompaniment reorders the conditions that introduce safety-oriented interventions. When individuals feel heard and not immediately subjected to control, they may be more willing to disclose the full extent of their experience. This possibility makes accompaniment a foundational phase that strengthens risk-based practice rather than replacing it.

Concurrently, the adoption of an accompaniment framework requires clinical social workers to tolerate personal and professional uncertainty. Such uncertainties are often minimized within procedural models of

care. Without the immediate structure of assessment protocols, practitioners must navigate client ambivalence and ethical conflicts, and remain present in the absence of clear resolution. Accompaniment invites not only a shift in practice but also a shift in professional identity—one requiring support through supervision, training, and organizational change.

In multiple ways, accompaniment thus aligns clinical practice with the foundational values of social work—centering relationship, honoring lived experience, and attending to context. It also responds directly to the limitations of risk-based models by creating sufficiently safe, collaborative, and meaningful therapeutic conditions. Such engagement is more likely to emerge through an intentional and mutually created agreement.

Accompaniment Planning

Without a structured process, accompaniment risks remaining an ethical aspiration rather than a reproducible clinical approach. This article proposes Accompaniment Planning as its primary practice innovation: a structured, collaborative, pre-intervention process designed to establish the relational and epistemic conditions necessary for sustained ethical and effective suicide care.

Defining Accompaniment Planning

Accompaniment Planning can be defined as a guided, dialogical process that precedes formal suicide risk assessment and safety planning. Its purpose: to create and maintain the conditions under which such risk determinations and safety strategies can be meaningfully and mutually developed. In contrast to safety planning—which assumes a shared commitment to reducing risk—Accompaniment Planning works to establish social worker-client alignment by centering the clinical relationship, meaning-making, contextual realities, and mutual trust-building. Therefore, it may more effectively lead to meaningful safety planning.

Re-sequencing Clinical Practice

The introduction of Accompaniment Planning represents a deliberate re-sequencing of suicide-related care. Rather than beginning with assessment, the proposed sequence is:

Accompaniment → Assessment → Safety Planning → Follow-up

This reordering does not delay care but deepens it. The new sequence establishes the relational and epistemic conditions first. The subsequent assessment, intervention, and follow-up care may result in better clinical and ethical outcomes.

Structure and Domains

Accompaniment Planning comprises eight core domains that guide clinical conversations. These domains function not as a rigid checklist but as a flexible structure adaptable to context, setting, and population. Each domain of the Accompaniment Planning Template reflects a core element of the accompaniment framework and serves a distinct function within the clinical encounter. Figure 1 showcases the eight Accompaniment Planning domains, describes their purpose, and provides example prompts that can and should be adapted to specific clients and practice contexts.

[Insert Fig. 1]

Application and Use in Practice

The Accompaniment Planning Template supports flexible implementation across outpatient therapy, crisis services, hospital settings, and community-based programs. It may be used within a single extended session or across multiple encounters. In acute situations, elements of accompaniment can be integrated alongside immediate safety interventions; relational grounding, meaning of suicidality, and discussions about transparency and power remain essential even then. The template offers a scaffold for maintaining a relational orientation while navigating the complexities of suicide-related care, and its flexible design allows for cultural responsiveness across diverse contexts. Accompaniment Planning precedes, rather than replaces, discussion about safety planning. By fostering trust, supporting disclosure, and developing a shared understanding of the individual's experience, it strengthens the foundation for safety-focused work. In this way, it operationalizes this article's central argument: the beginning of suicide-related care shapes the possibilities of the therapeutic encounter.

Implications

The introduction of accompaniment and Accompaniment Planning has implications that extend beyond individual clinical encounters. The framework and template shape how suicide-related care is conceptualized, taught, implemented, and evaluated. The implications that follow are organized across clinical practice, education and supervision, and public health domains.

Implications for Clinical Practice

At the level of direct practice, accompaniment reorients the clinician's task from immediate risk determination to relational grounding, contextual understanding, and client meaning-making (Dunster-Page et al., 2017; Espeland et al., 2021; Østlie et al., 2022). First, it encourages a slower initial tempo that creates space for a client's ambivalence and meaning-making before formal assessment. This tempo preserves a clinician's responsibilities while focusing on the client's experience. Second, the plan foregrounds transparency, illuminating the power dynamics that shape disclosure. Those individuals with histories of coercive care especially benefit from such transparency. Third, the approach's focus on dialogue, meaning, context, and prior care experiences acknowledges suicidality as a complex human experience. Such focus strengthens the therapeutic alliance and increases the likelihood of meaningful disclosure. Finally, accompaniment invites greater clinician tolerance for their uncertainty—a capacity requiring institutional support, as it challenges norms that equate decisiveness with competence.

Implications for Education and Supervision

The adoption of accompaniment has important implications for clinical training and supervision. Traditional educational models often emphasize assessment proficiency and risk management, with comparatively less attention to the relational and ethical complexities of early engagement with suicidality. Incorporating accompaniment into curricula would require teaching relational competencies—presence, attunement, open-ended dialogue. Concurrently, social work education programs need to critically examine the limitations of prediction-oriented models and the tension between procedural expectations and relational practice. Moreover, supervision strengthens this training. Supervisors and supervisees need reflective models that prioritize curiosity, ethical discernment, and relational awareness. Such frameworks can help practitioners tolerate uncertainty, process anxiety related to liability, and develop *use of self* within therapeutic relationships that involve suicidal ideation and/or behaviors.

Implications for Public Health

From a public health perspective, accompaniment addresses a critical but underexamined dimension of suicide prevention: sustained engagement. Prevention efforts depend not only on identifying risk, but on individuals' willingness to seek help and communicate openly. When systems of care are experienced as coercive or misaligned with a person's lived experience, individuals may delay or avoid contact. This deferral forecloses opportunities for early intervention (Blanchard & Farber, 2020). By creating the relational conditions that support disclosure, accompaniment may enhance access and continuity of engagement. Such enhancements may be beneficial to LGBTQ+ individuals, racialized communities, and other people experiencing institutional harm (Holt et al., 2024; Shea et al., 2022). The accompaniment framework thus aligns with public health approaches by recognizing suicide as shaped by structural factors rather than individual pathology alone (Cramer & Kapusta, 2017; Standley, 2022).

Limitations

As a practice innovation, this framework is provisional and requires empirical examination. The arguments advanced rest on existing scholarship, clinical observation, and conceptual synthesis rather than controlled studies of effectiveness. Claims regarding improved disclosure, enhanced alliance, or increased engagement need to be systematically tested and empirically validated. The scope is also limited: the model is most applicable in settings with sufficient relational continuity, such as outpatient therapy. In high-acuity environments, the full sequence may not be feasible, though the principles of presence, transparency, and attentiveness to meaning can be integrated within time-limited encounters.

Implementation is also shaped by macro-systemic factors. Contemporary suicide care operates within environments that emphasize risk mitigation, documentation, and standardized procedures under significant time pressure. These conditions constrain relational pacing and open-ended dialogue, and liability concerns may reinforce defensive practices. Accompaniment therefore requires not only an individual-level commitment but also organizational support that recognizes the value of relational processes.

Another limitation involves cultural and contextual adaptation. The specific domains and prompts outlined in the Accompaniment Planning Template may not fully capture the diversity of cultural meanings, communication styles, and relational norms across populations. Concepts such as disclosure, autonomy,

and support are culturally mediated, and future work should adapt the model collaboratively with communities to ensure relevance across.

Finally, the framework introduces significant demands on clinicians: tolerance of uncertainty, willingness to remain present with clients' unresolved ambivalence, and the capacity to balance competing ethical commitments without immediate resolution. For practitioners trained within models that prioritize decisiveness, this shift may evoke anxiety about professional responsibility. Without adequate training, reflective supervision, and policy reforms, accompaniment risks being misunderstood as inaction.

Despite these limitations, the need for conceptual innovation in suicide care remains pressing. The persistence of high suicide rates—and ongoing suicide mortality disparities—suggests that existing models may lack sufficient efficacy. Thus, the Accompaniment Framework is offered as a hypothesis-generating contribution—one that can be refined, tested, and adapted through empirical, qualitative, and collaborative work.

Conclusion

This article argues that what clinicians do matters, and when and how they sustain suicide-related care matters equally. To bolster these claims, the Accompaniment Framework was introduced, and the Accompaniment Planning Template was proposed. The plan template provides a practice-oriented process through which the framework can be enacted. It promotes a re-sequencing that prioritizes relationship, meaning, and context as the starting point for clinical work with suicide-vulnerable clients.

By centering sustained relational engagement, the accompaniment framework aligns with core social work values of dignity, self-determination, and contextual understanding while addressing persistent challenges in suicide prevention. Such challenges include barriers to disclosure, disengagement from services, and inequities in access to care. For individuals who have experienced prior coercion or mistrust of formal systems, the conditions under which care begins may determine whether they seek help at all. This possibility makes accompaniment a matter of public health reach as much as clinical practice.

Accompaniment Planning translates these commitments into practice. By providing a structured yet flexible approach to the therapeutic relationship, it creates space for individuals to articulate the meaning of their experience and engage collaboratively in determining next steps. This space, in turn, strengthens the foundation upon which subsequent assessment and safety-oriented interventions may occur. Rather than replacing existing practices, accompaniment reframes them, positioning relationship as the condition that makes intervention possible.

The persistence of high suicide rates and mortality disparities underscore the need for continued innovation. Risk-based models will remain important, but on their own do not sufficiently address the relational and contextual complexities of suicidal ideations and behaviors. The framework advanced here represents one effort to expand the field's repertoire by foregrounding accompaniment as an essential phase of practice.

Ultimately, effective suicide-related care requires attention to the content of intervention and relational pre-conditions that make intervention possible and meaningful. By beginning with accompaniment, clinicians may create conditions in which individuals feel seen, heard, and able to speak more fully about their experiences. This clinical social work practice shift is both modest and profound: a reorientation from acting upon risk to being with people in moments of profound ambivalence and vulnerability.

Declarations

Author Contribution

The author wrote the title page, abstract, main manuscript, and prepared Table 1. No other authors contributed to this manuscript.

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Figures

Figure 1
Domains of the Accompaniment Planning Template

Domain	Description	Contribution to the Encounter	Example Prompts
Relational Grounding	Establishes how the conversation will proceed according to the client's stated preferences.	Supports agency and begins to counteract the asymmetry of the clinical encounter.	"What would make this conversation feel like you and I are working together?"
Meaning of Suicidality	Invites exploration of what suicidal thoughts and behaviors signify within the person's life.	Shifts the encounter from categorization toward understanding.	"What do you want me to understand about your desire to die by suicide?"
Contextual Mapping	Situates suicidality within relational, material, and structural conditions.	Enacts an Individual-in-Contexts perspective and resists reducing distress to individual pathology.	"As you're moving through your daily life, what people, places, events, and/or experiences are shaping your suicidal thoughts and/or behaviors?"
Multiplicity Exploration	Makes room for coexisting and conflicting wishes about living and dying.	Supports a nuanced account of experience rather than a unidimensional one.	"Are there parts of you that want different things right now?"
Experience of Care	Explores prior encounters with helping systems and their effect on present engagement.	Surfaces histories of coercion or invalidation that shape willingness to disclose.	"How have other people responded to your thoughts of suicide?" Your suicide-related behaviors?
Transparency and Power	Makes roles, obligations, and limits explicit, including how disagreement about risk will be handled.	Reduces uncertainty and supports more informed participation.	"Here is what I am required to do, and here is what I am not. If you and I come to see your level of risk differently, how should we handle that?"
Supports and Relationships	Identifies relational networks beyond the clinical dyad, including relationships not experienced as supportive.	Extends care beyond the social worker–client alliance and attends to broader social connection.	"Who else knows what you are carrying right now? And how would you like them to be involved?"
Readiness for Safety Planning	Collaboratively considers whether the conditions for safety-oriented work have been established.	Provides a non-coercive transition point; where readiness is absent, the conversation shifts to alternatives.	"Does it make sense to talk about a plan for the hardest moments, or is that not where we're yet? If not now, what would need to be in place first?"

Note. The eight domains function as a flexible structure rather than a fixed sequence or checklist and may be addressed in one extended session or across encounters. Accompaniment Planning precedes rather than replaces safety planning. Prompts are illustrative and should be adapted to context.

Figure 1

See image above for figure legend.