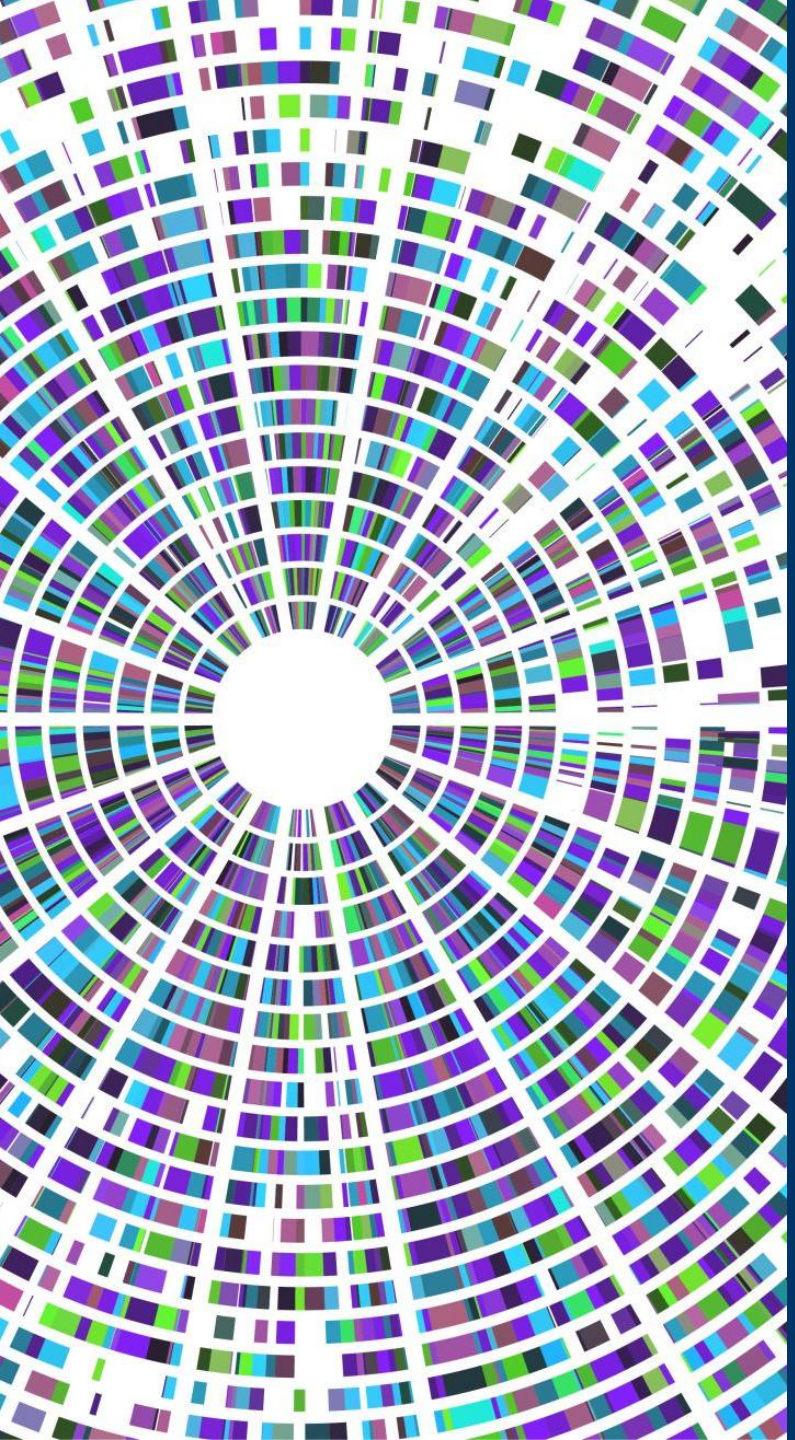


Suicide Risk Reduction 2026

3 Sections

Joseph E Thornton, M.D., DFAPA
Clinical Associate Professor of Psychiatry
University of Florida College of Medicine

Qualifications

Psychiatrist with 40 years experience,

Distinguished Fellow of the American Psychiatric Association

Administrative and management experience >30 years

Operational Suicide Safety Responsibility

Clinical Oversight

1993-1996 Correctional Institution

2003-2010 Forensic Treatment Facility

2014-2018 NF/SG VHS*

6 years Suicide Prevention Team and 3 years use of Reach Vet Machine Learning ,

UFHealth 2018-2020

UFHealth 2021- present

Scholarly Activity and Community Involvement

Teaching Medical Students and Residents

Adult Fatality Review Team in Texas

Florida Suicide Prevention Council 2023-

Psychiatry Residency and student observer of AI in Medicine 1984-1986 at Stanford University

Published on clinical computer use in 1984

In the past 3 years 2 book chapters, 5 publications, and dozens of lectures related to AI

WHY
The Clinical Mission

- S – Save lives
- A – Allevaite suffering
- V- Value Autonomy
- E- engage in therapeutic community

Section 1

Key Concepts and Skills

6 slides

Assessment

- The Joint Commission reports
  - Suicide is in top 5 sentinel events
  - Most common root cause is assessment failure by psychiatrists
  - JC has recommendations for standard of care

Complacency & Complicity

- At mortality review, the most recent note most often documents denial of SI
- Verbal denial of ideation might indicate the absence of ideation, might not
- Future commitments are no better than the demonstrated ability to fulfill commitments
- Family, Friends and Healthcare professionals at times "collude" with false reassurances
- "No Suicide Contract" by any other name, are still "no suicide contracts" and are dangerous. Caution on the limits of "contracts for safety"
- Consider this standard phrase: "Patient denies suicidal ideation, wish, plan, intent, and compulsion."

Key Concepts

Acute **(Proximal factors)**

- Imminent
- Intent
- Plan*
- Means
- Transition*
- Impulsivity***
  - Lability
  - Psychosis

The Baker Act and Hospitalization controls the means as last resort

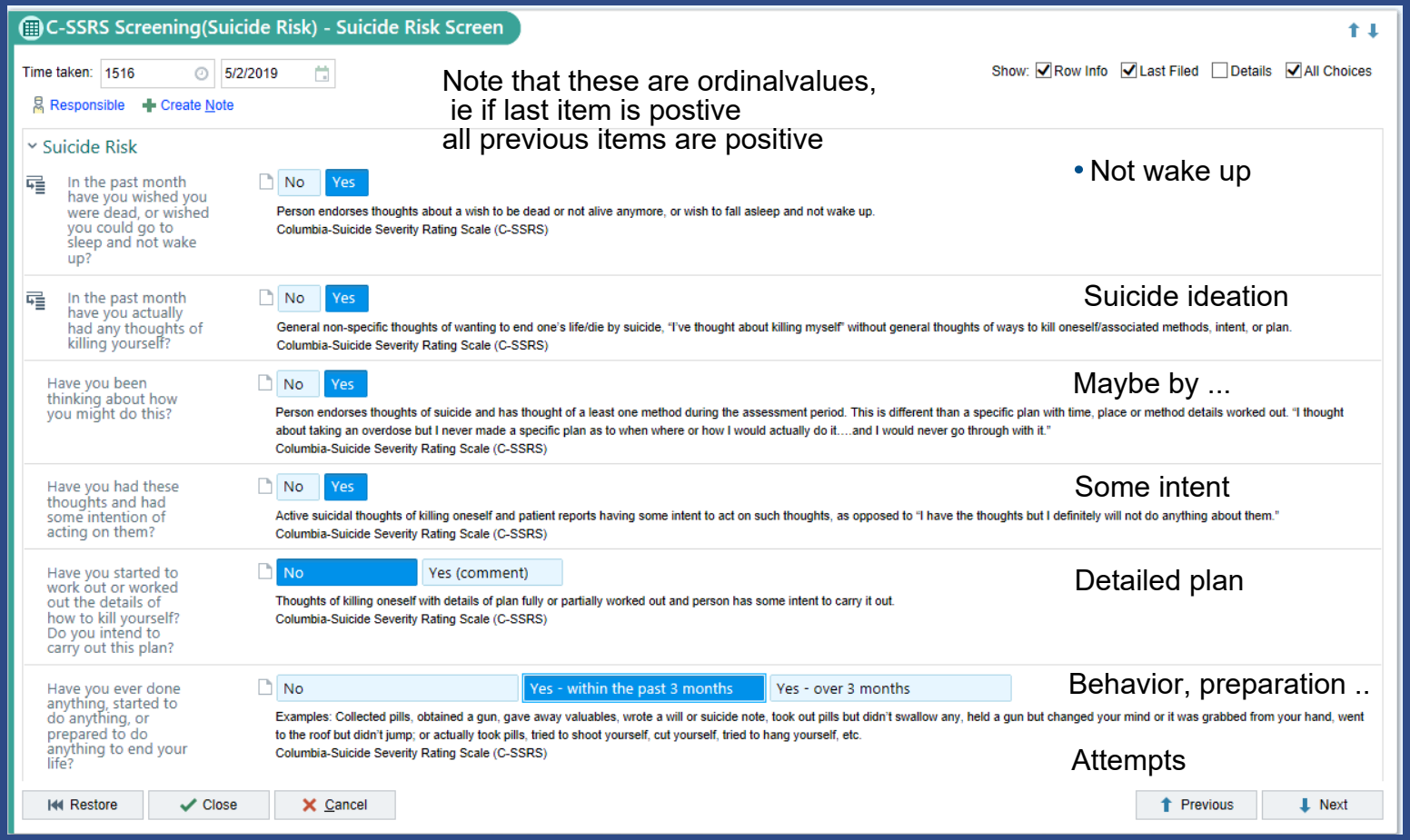
Longer term **(distal factors)**

- Ideation
- Plan
- Rx Engagement*
- Social Stability*
- Means*
- History,
  - Recent
  - Lifetime

Suicide Risk Professional Psychiatric Assessment and Communication

- CSSRS
- and
- SAFE-T

Memorize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Note that these are ordinalvalues,
ie if last item is postive
all previous items are positive
Suicide Risk
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No
Yes
Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Columbia-Suicide Severity Rating Scale (C-SSRS)
• Not wake up
In the past month have you actually had any thoughts of killing yourself?
No
Yes
General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.
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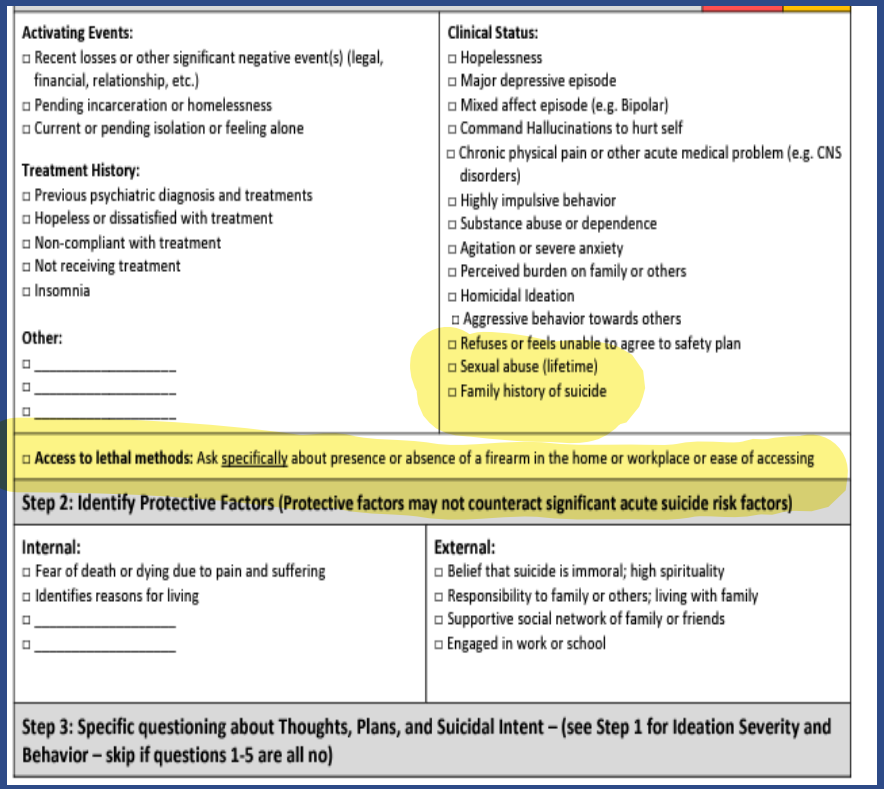
Suicide ideation
Have you been thinking about how you might do this?
No
Yes
Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."
Columbia-Suicide Severity Rating Scale (C-SSRS)
Maybe by ...
Have you had these thoughts and had some intention of acting on them?
No
Yes
Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."
Columbia-Suicide Severity Rating Scale (C-SSRS)
Some intent
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
No
Yes (comment)
Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.
Columbia-Suicide Severity Rating Scale (C-SSRS)
Detailed plan
Have you ever done anything, started to do anything, or prepared to do anything to end your life?
No
Yes - within the past 3 months
Yes - over 3 months
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.
Columbia-Suicide Severity Rating Scale (C-SSRS)
Behavior, preparation ..
Attempts
Restore
Close
Cancel
Previous
Next

Memorize



Activating Events:
- □ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- □ Pending incarceration or homelessness
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Treatment History:
- □ Previous psychiatric diagnosis and treatments
- □ Hopeless or dissatisfied with treatment
- □ Non-compliant with treatment
- □ Not receiving treatment
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Other:
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Clinical Status:
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- □ Major depressive episode
- □ Mixed affect episode (e.g. Bipolar)
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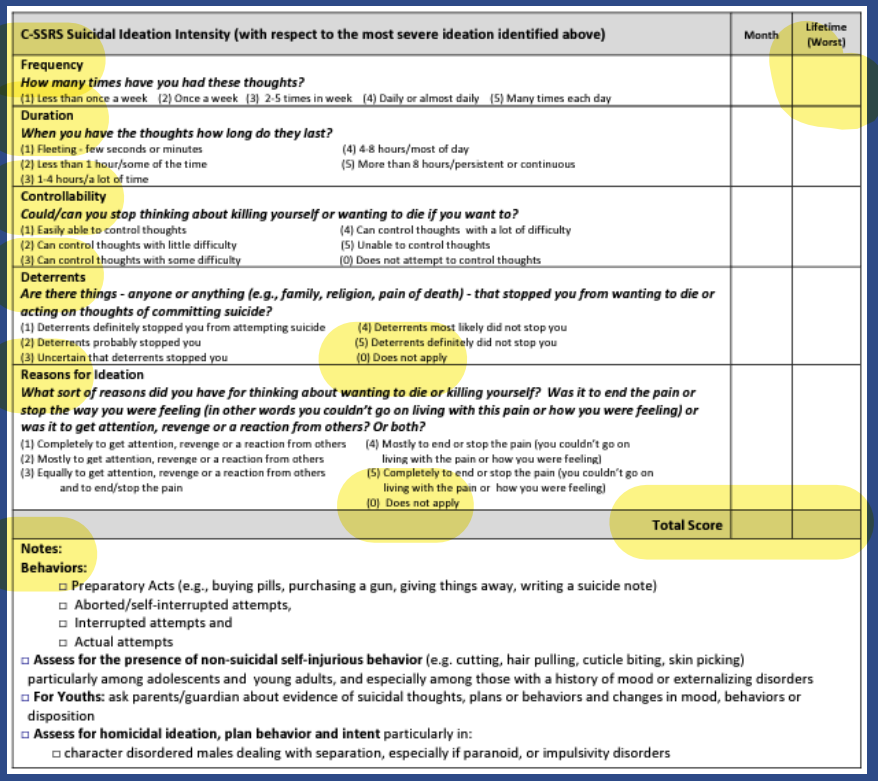
Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:
- □ Fear of death or dying due to pain and suffering
- □ Identifies reasons for living
- □ _____
- □ _____

External:
- □ Belief that suicide is immoral; high spirituality
- □ Responsibility to family or others; living with family
- □ Supportive social network of family or friends
- □ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior – skip if questions 1-5 are all no)



C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation identified above)	Month	Lifetime (Worst)
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Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		
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Total Score		

Notes:

Behaviors:
- □ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- □ Aborted/self-interrupted attempts,
- □ Interrupted attempts and
- □ Actual attempts

□ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

□ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

□ **Assess for homicidal ideation, plan behavior and intent** particularly in:
- □ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

End Today's Session

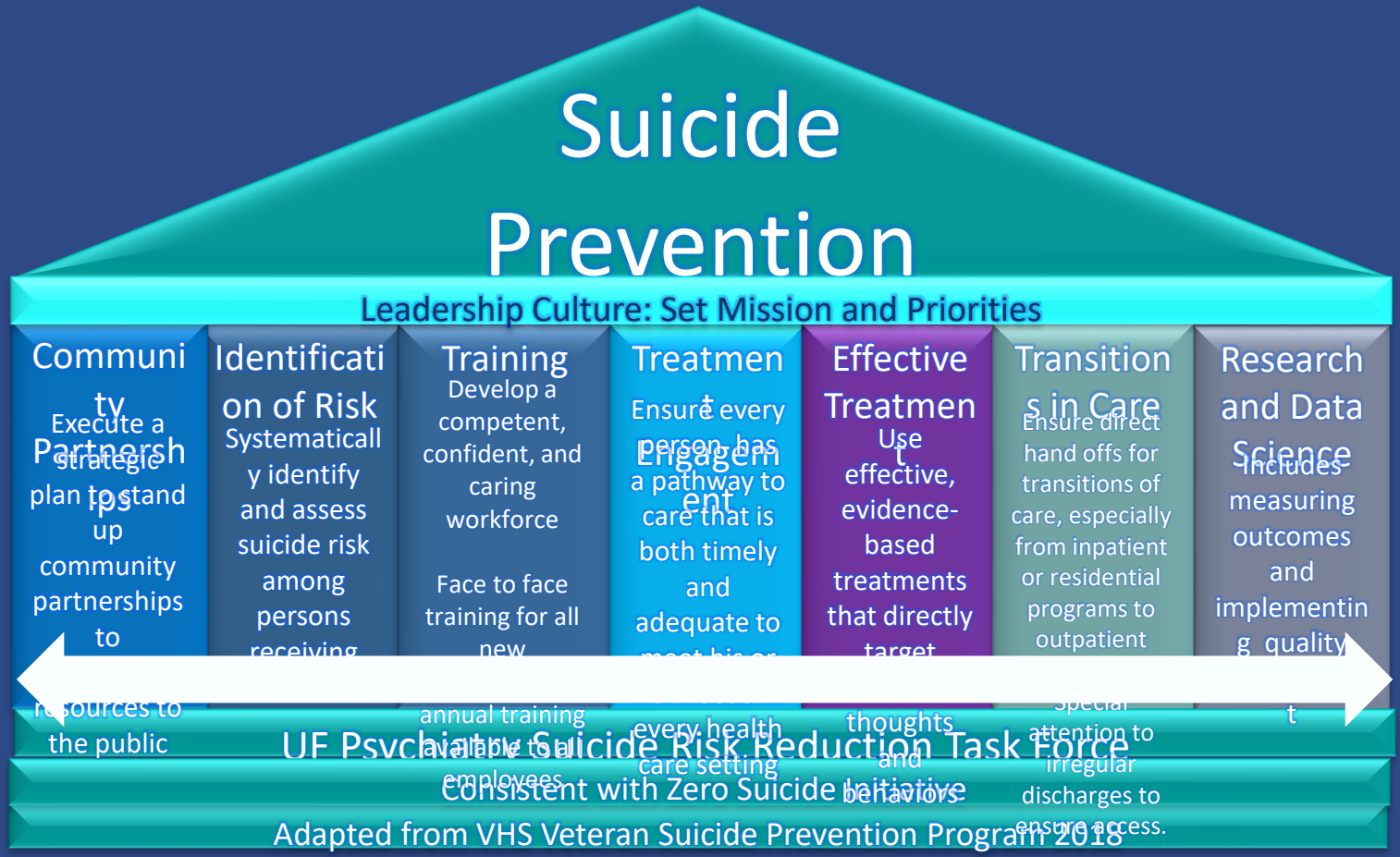
Section 2 Didactics

Learning Objectives

Describe	Distinguish	Describe
Describe at least 5 of the 7 Pillars of a Comprehensive Suicide Prevention strategy	Distinguish with examples • Screening vs Assessment	Describe a legal tool that offers immediate restriction of access to lethal means

Content marked with * addresses the Learning Objectives

Section 2: Didactic

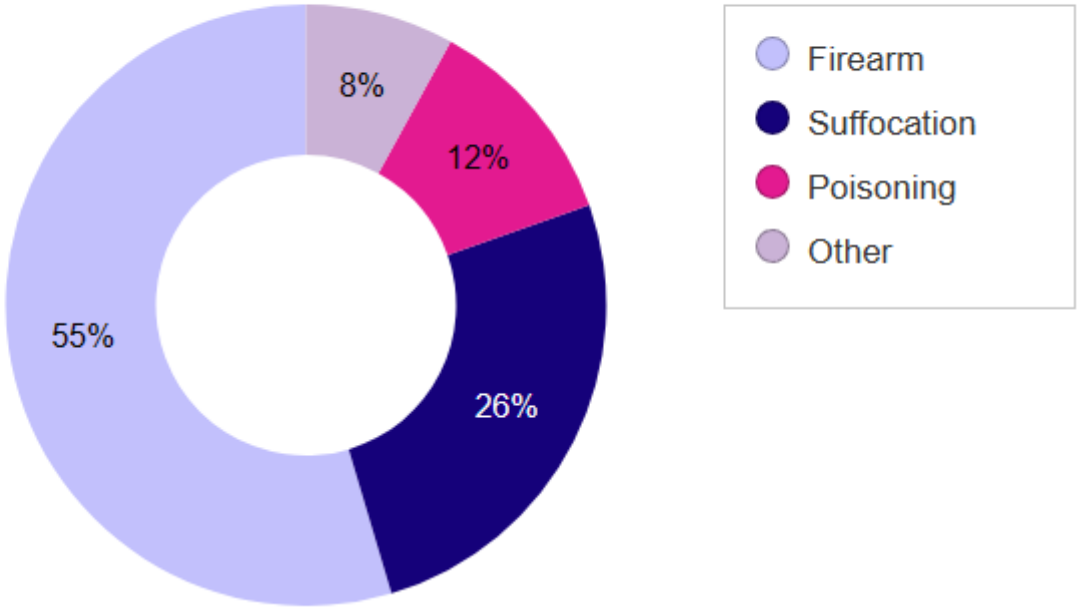


All Cause Mortality

1	Heart Disease	695,547
2	Cancer	605,213
3	Covid	416,893
4	Accidents	224,935
5	Stroke	162,890
	Opiates	*
11	Suicide	49,449

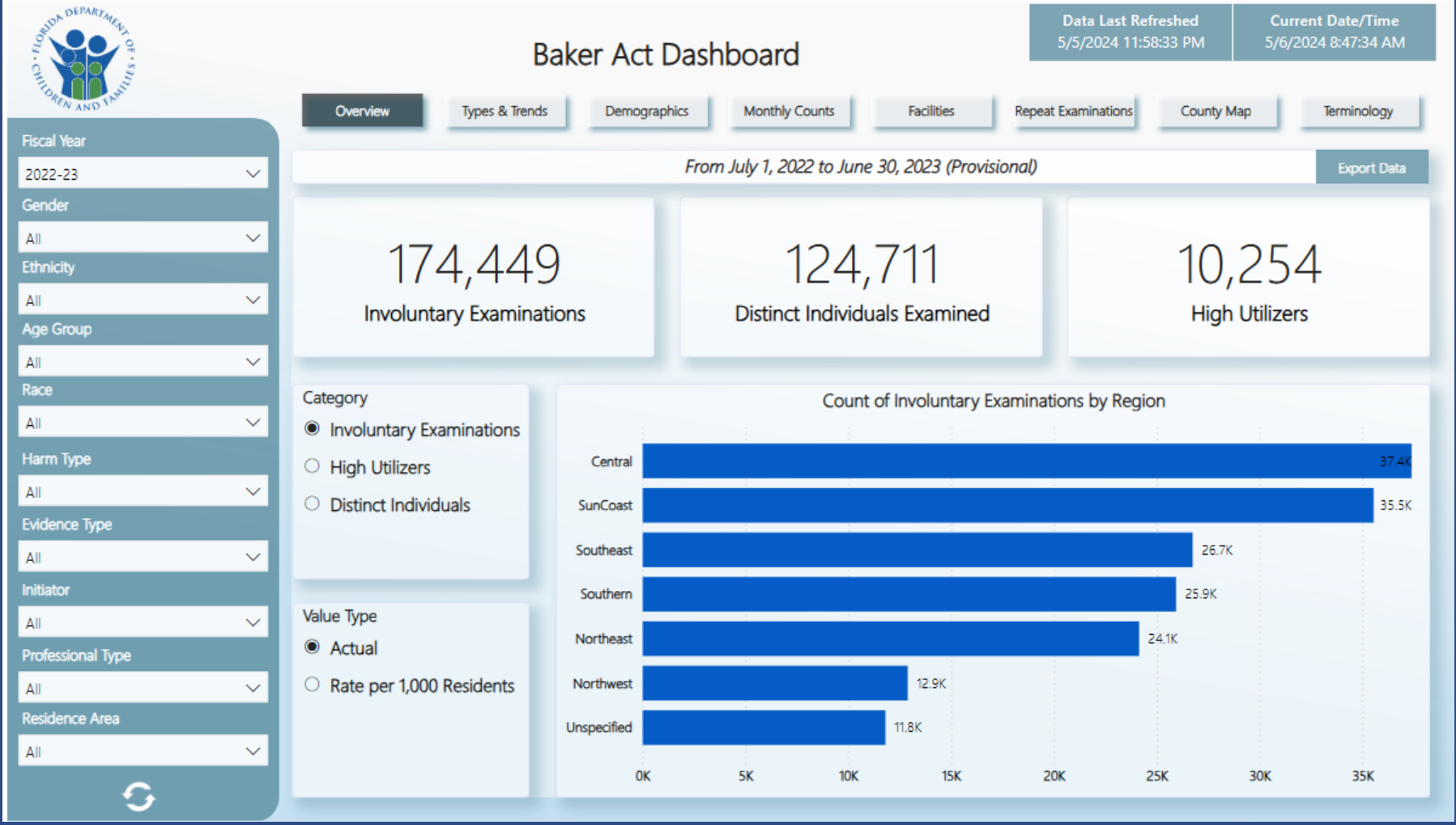
https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

Firearms are the most common method used in suicides.
Firearms are used in more than 50% of suicides.



https://www.cdc.gov/suicide/suicide-data-statistics.html

Baker Act Dashboard



831 examinations at UFHealth Psychiatric Hospital Jul 2022 -0 Jun 2023

Baker Act Dashboard | Florida DCF (myflfamilies.com)

Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review

J. John Mann, M.D., Christina A. Michel, M.A., Randy P. Auerbach, Ph.D.

Objective: The authors sought to identify scalable evidence-based suicide prevention strategies.

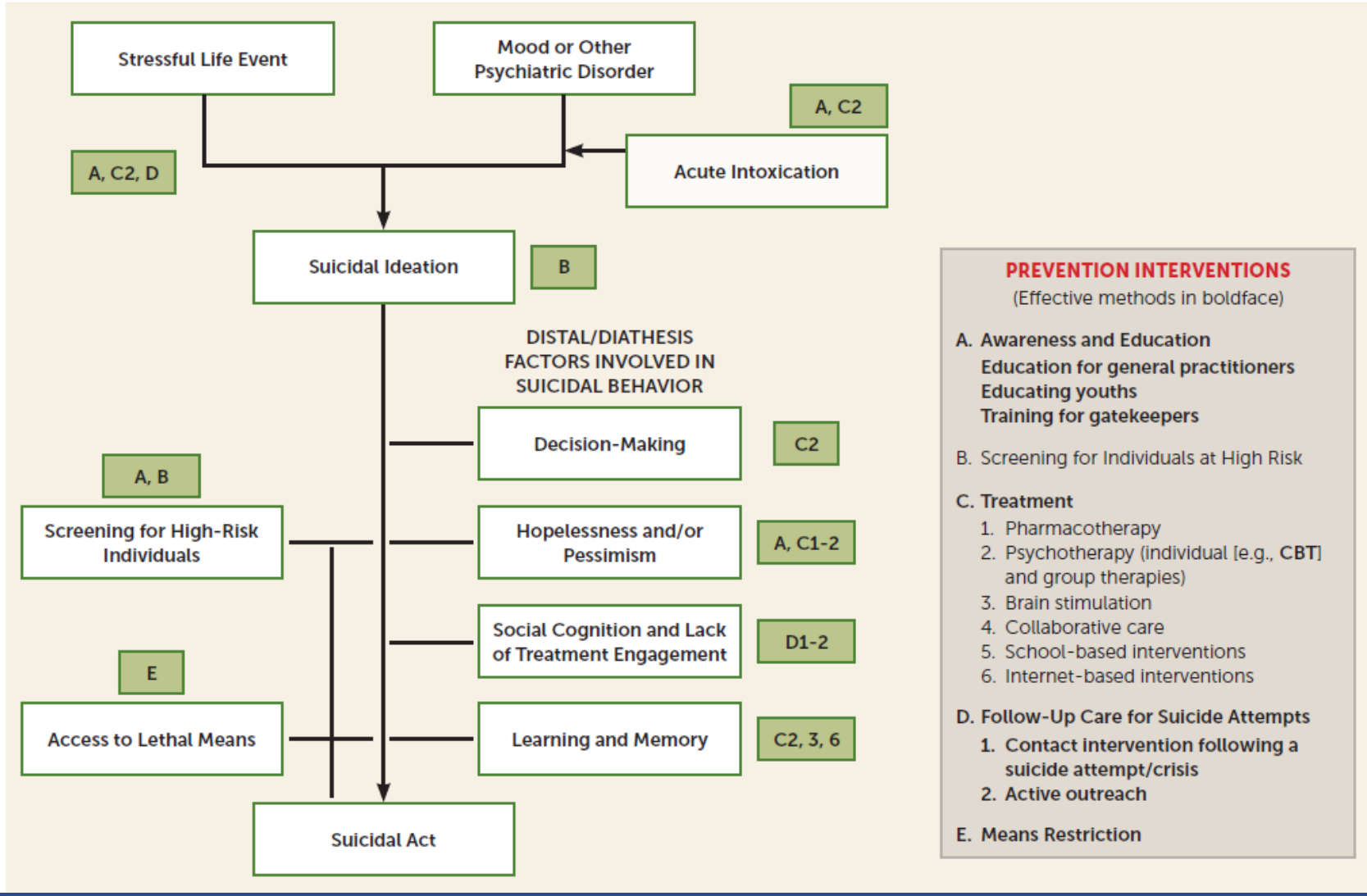
Methods: A search of PubMed and Google Scholar identified 20,234 articles published between September 2005 and December 2019, of which 97 were randomized controlled trials with suicidal behavior or ideation as primary outcomes or epidemiological studies of limiting access to lethal means, using educational approaches, and the impact of antidepressant treatment.

Results: Training primary care physicians in depression recognition and treatment prevents suicide. Educating youths on depression and suicidal behavior, as well as active outreach to psychiatric patients after discharge or a suicidal crisis, prevents suicidal behavior. Meta-analyses find that antidepressants prevent suicide attempts, but individual randomized controlled trials appear to be underpowered. Ketamine reduces suicidal ideation in hours but is untested for suicidal behavior prevention. Cognitive-behavioral therapy and dialectical behavior therapy prevent suicidal behavior. Active screening for suicidal ideation or behavior is not proven to be better than just screening for depression. Education of gatekeepers about youth suicidal behavior lacks effectiveness. No randomized trials have been reported for gatekeeper training for prevention of adult suicidal behavior. Algorithm-driven electronic health record screening, Internet-based screening, and smartphone passive monitoring to identify high-risk patients are understudied. Means restriction, including of firearms, prevents suicide but is sporadically employed in the United States, even though firearms are used in half of all U.S. suicides.

Conclusions: Training general practitioners warrants wider implementation and testing in other nonpsychiatrist physician settings. Active follow-up of patients after discharge or a suicide-related crisis should be routine, and restricting firearm access by at-risk individuals warrants wider use. Combination approaches in health care systems show promise in reducing suicide in several countries, but evaluating the benefit attributable to each component is essential. Further suicide rate reduction requires evaluating newer approaches, such as electronic health record–derived algorithms, Internet-based screening methods, ketamine's potential benefit for preventing attempts, and passive monitoring of acute suicide risk change.

AJP in Advance (doi: 10.1176/appi.ajp.2020.20060864)

FIGURE 1. Targets and methods of suicide prevention



Suicide Prevention

Leadership Culture: Set Mission and Priorities

Community Partnerships

Execute a strategic plan to stand up community partnerships to disseminate resources to the public

Identification of Risk

Systematically identify and assess suicide risk among persons receiving care

Training

Develop a competent, confident, and caring workforce

Face to face training for all new employees and annual training available to all employees

Treatment Engagement

Ensure every person has a pathway to care that is both timely and adequate to meet his or her needs in every health care setting

Effective Treatment

Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors

Transitions in Care

Ensure direct hand offs for transitions of care, especially from inpatient or residential programs to outpatient programs. Special attention to irregular discharges to ensure access.

Research and Data Science

Includes measuring outcomes and implementing quality improvement

UF Psychiatry Suicide Risk Reduction Task Force

Consistent with Zero Suicide Initiative

Adapted from VHS Veteran Suicide Prevention Program 2018

Key Point

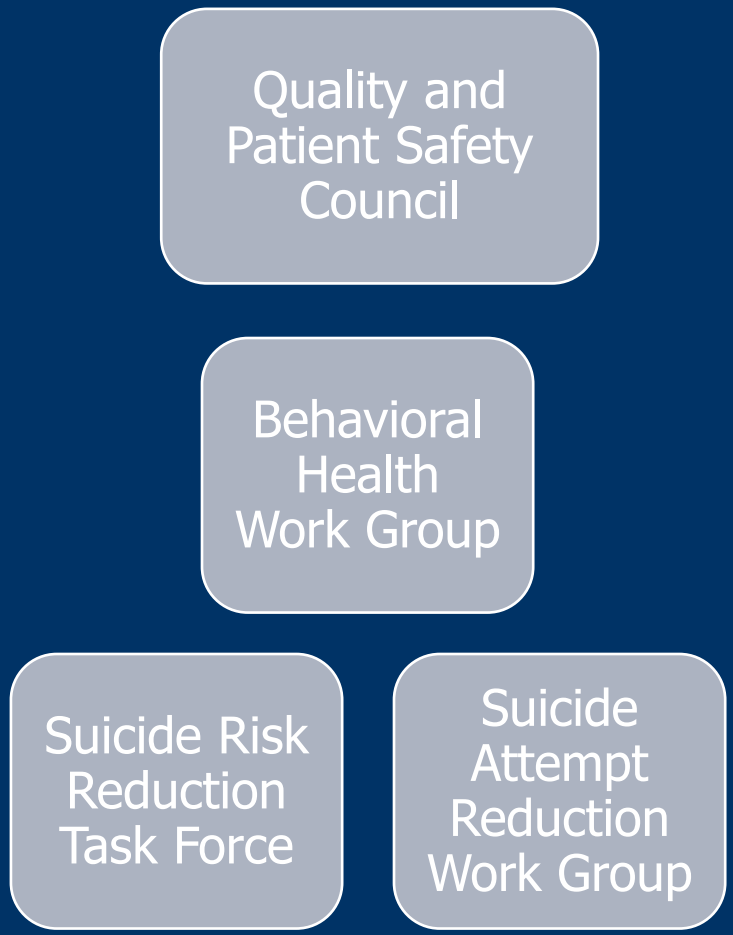
Prevention

- Binary

Risk Reduction

- Analog

Leadership Culture UFHealth



Screening

- Screening is done widely,
- Identifies those at higher risk
- Operationalized with CSSRS

Focus on Inpatient Suicide Risk Reduction Behaviors

Screening – CSSRS

Assessment – SAFE-T

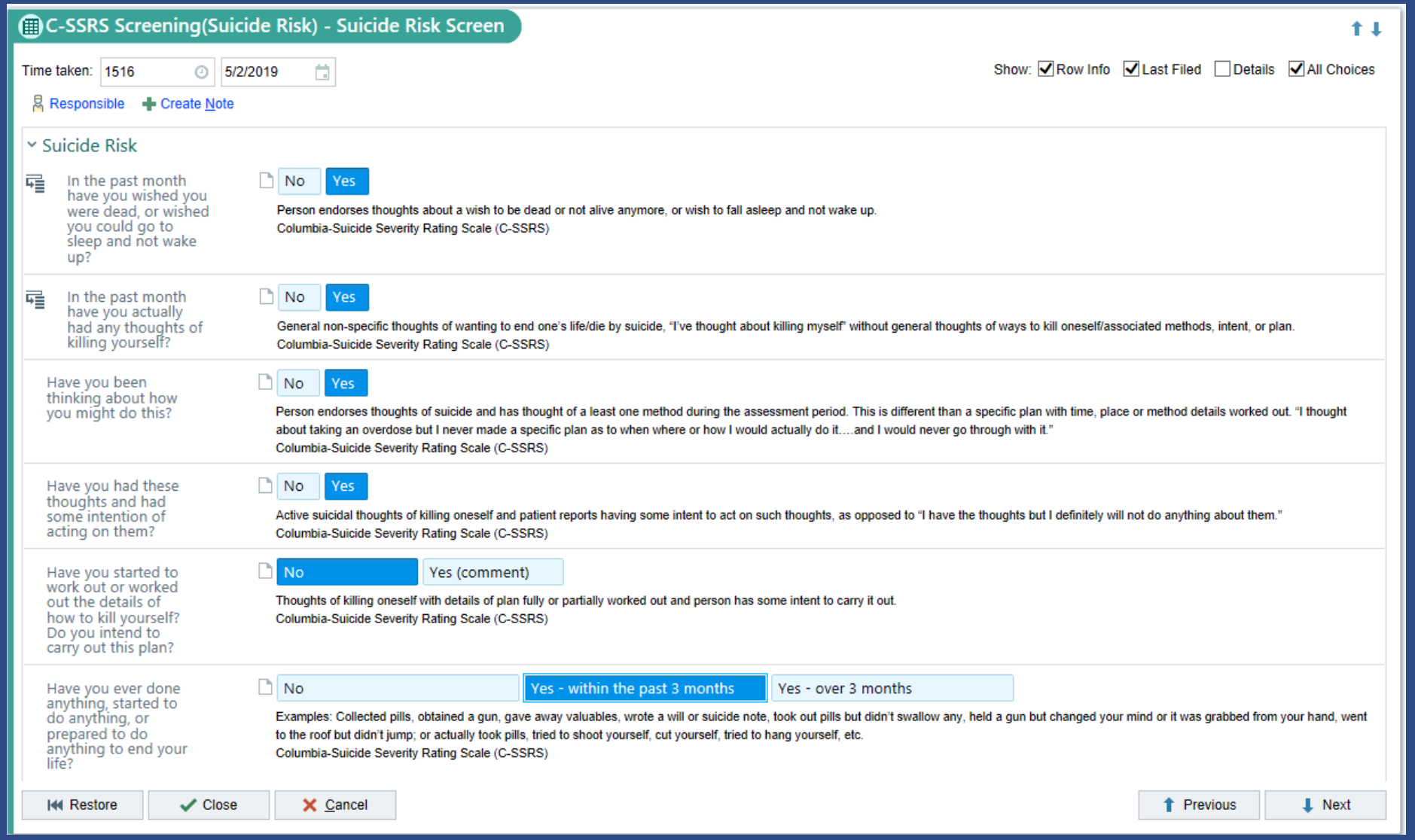
Interventions

Immediate – environment, observation level, interpersonal engagement,

Intermediate - therapy, medications

Transitions –

safety planning, discharge planning, hand off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No
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Have you ever done anything, started to do anything, or prepared to do anything to end your life?
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Restore
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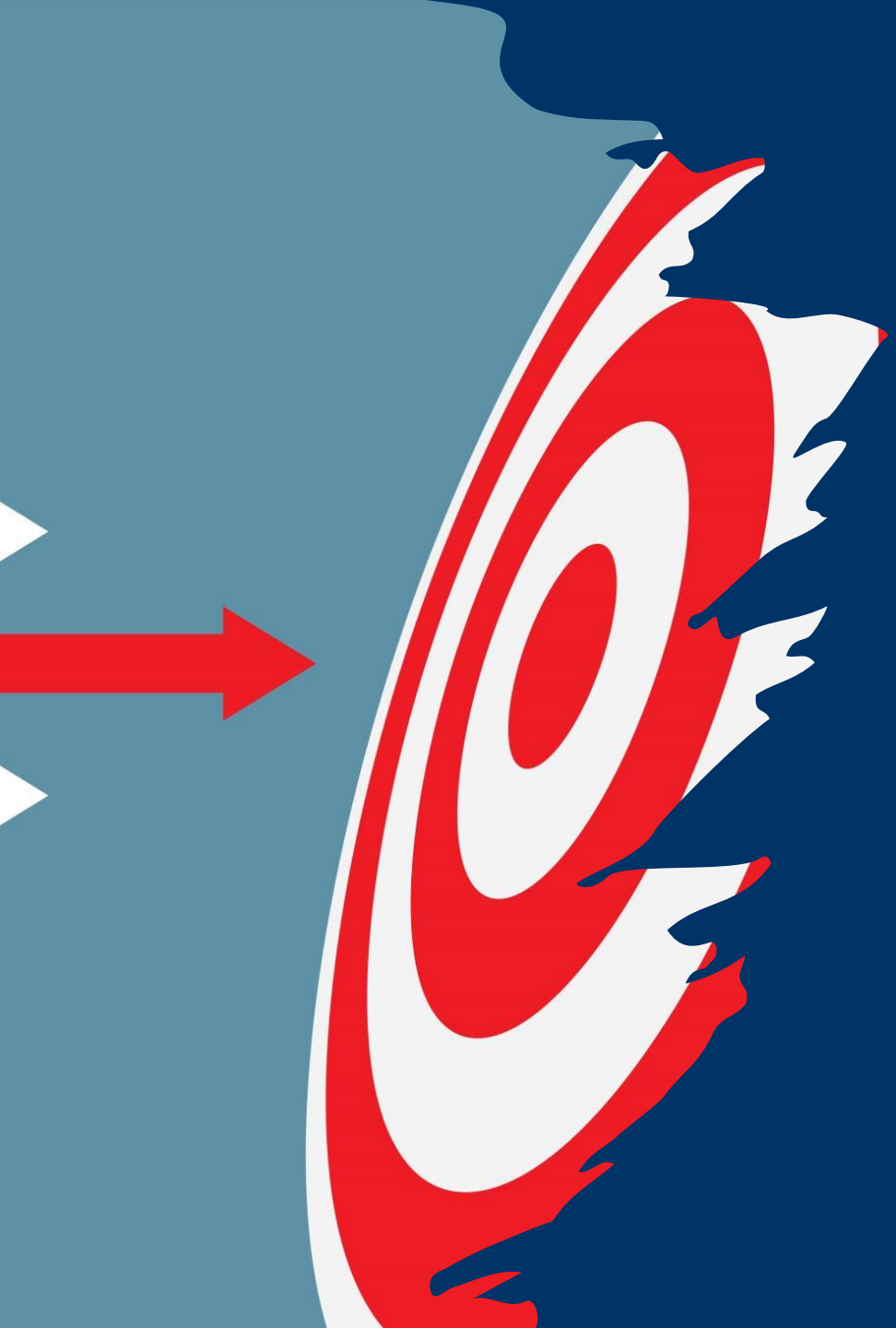

Assessment

- Targeted
- Severity
- Imminence
- Mitigation
- Operationalized SAFE-T

Activating Events:

- □ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- □ Pending incarceration or homelessness
- □ Current or pending isolation or feeling alone

Treatment History:

- □ Previous psychiatric diagnosis and treatments
- □ Hopeless or dissatisfied with treatment
- □ Non-compliant with treatment
- □ Not receiving treatment
- □ Insomnia

Other:

- □ _____
- □ _____
- □ _____

Clinical Status:

- □ Hopelessness
- □ Major depressive episode
- □ Mixed affect episode (e.g. Bipolar)
- □ Command Hallucinations to hurt self
- □ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
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- □ Agitation or severe anxiety
- □ Perceived burden on family or others
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Total Score		

Notes:

Behaviors:

- □ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
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□ **Assess for homicidal ideation, plan behavior and intent** particularly in:

- □ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

Key Points*

Screening

- Wide spread
- Identifies at Risk
- CSSRS

Assessment

- Targeted
- Quantifies Risk
- SAFE-T

Modifiable Risk Factors

SUICIDAL IDEATION INTENSITY

MEDICATION

ABSTINENCE

SOCIAL SUPPORT

HOUSING

Modifiable Position Factors

HCR-20

Historical
Not modifiable

Clinical
Modifiable

Risk
Planning
Realistic Planning

Risk Reduction

- #1 Action after Assessment
  - RESTRICT ACCESS TO LETHAL MEANS
  - most often in self restrictions in discussion with patient
- Maybe Hospitalization
  - Voluntary
  - Involuntary*-
    - In Florida, the BA52, 72 hour hold, is the legal instrument that allows immediate restriction from access to lethal means. *
- Observation level in hospital
  - Standard Psychiatry Unit suicide precautions (SP)
  - Enhanced Suicide Precautions (SP)
  - Intensive SP with 1:1 staffing

Treatment

Treatment for mental illness is INSUFFICENT

Suicide Risks include factors independent of mental illness severity

- Suicidal ideation
- Suicidal "positioning"

Targeted Treatment

- MD
  - Antidepressants
  - Antipsychotics
  - Lithium
  - Ketamine*
  - ECT*, MST, TMS
- Psychotherapy
  - CBT for SI
  - Dialectical Behavior Therapy (DBT)

*Most rapid onset of the somatic treatments

Transitions

Literature
Recommendations

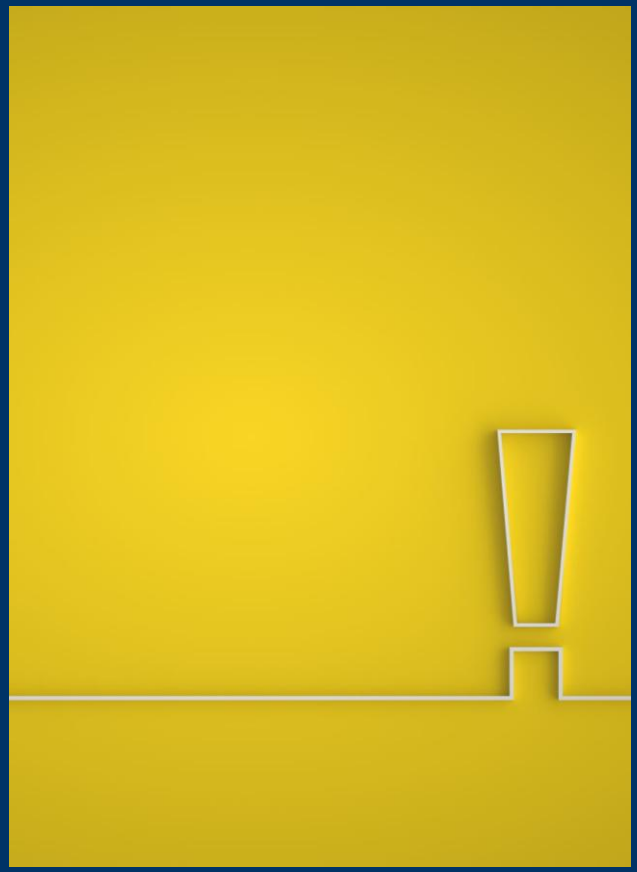
Policy / Regulatory
Expectations

Practice

Performance

Release of a BA52 is a Transition of Care
How to do the release

1. Read the Baker Act (required by Florida Statue prior to release of the BA)
2. Search the chart for notes on "suicide" "gun" Firearm"
3. Understand that CSSRS is for screening and SAFE-T is for assessment of risk. Once the screen is positive, decisions flow from the assessment
4. Access to lethal means is an independent risk factor for suicide Maintaining access to lethal means is an enhanced independent risk factor for suicide
5. A person who is released from a Baker Act should have documentation of suicide risk reduction from the time the BA was initiated (other than simply denying SI)
6. Patients who die by suicide while under psychiatric care (ie within minutes to months of visit to psychiatrist) often do so either by impulse, or deception
    1. Impulsivity is predictable,
    2. Deception should take more effort than simple denial



Decision Making

- Articulate how decisions are made for
  - Suicide risk screening
  - Suicide risk assessment
  - Observation Levels
  - Psychiatric Treatment
  - Aftercare planning
- Are decisions driven by policy or data ?

Data Review

Inpatient UFHPH Data

Collected by the Suicide Attempt Workgroup (formed 2024)

Data not yet sanitized for public sharing

Demographics

Clinical descriptors

All items of the CSSRS and SAFE-T repeated measures

Approx 1500 admits/yr and 1000 data points per admission =

1.5 million data points /yr

Qualitative Description Room for Improvement

COMPLETION RATES FOR MANDATED SCALES

CONSISTENCY OF ITEMS WITHIN PATIENTS

ACCURACY OF ITEMS WITHIN PATIENTS

DOCUMENTATION OF DECISION MAKING

Policy Review

Data driven examples:

- JCHO driven screening for suicide using the CCRS (2019)
- UFHealth Psychiatry Hospital Updated Observation level policy (2024)
- Modifying EPIC BPA for the management of 1:1 decision making (2024)

Training

Psychiatry Department	Residents
College of Medicine	Students Residents / Faculty re Baker Act
UF Psychiatric Hospital	
UF Health Shands Hospital	

Community Engagement

National Strategy *for* Suicide Prevention
Executive Summary 2024

FLORIDA SUICIDE PREVENTION INTERAGENCY ACTION PLAN
August 2020 – June 2023

ZERO SUICIDE

American Foundation for Suicide Prevention

AFSP North Florida

AMERICAN PSYCHIATRIC ASSOCIATION

Suicide Prevention

UF Counseling & Wellness Center

SUICIDE PREVENTION & EDUCATION

Alachua County

Hotlines and Information/Referral:

National Suicide Prevention Lifeline
1-800-273-8255
Free confidential support for people in distress, prevention and crises resources, and best practice for professionals
https://suicidepreventionlifeline.org

Meridian Behavioral Healthcare Inc
352-374-5600
24/7 crisis line
https://www.mbhci.org
Note: This program is always available to call.

Alachua County Crisis Center
352-264-6789
Crisis hotline, phone counseling, walk-in crisis counseling, mobile response team, and groups
https://alachuacounty.us/depts/css/crisiscenter/pages/crisiscenter.aspx
Note: This program is currently accepting new clients.

Alachua County Victim Services and Rape Crisis Center
352-264-6760
Crises hotline providing support to victims of rape and sexual assault
https://www.alachuacounty.us/Depts/CSS/VictimServices/Pages/VictimServices.aspx
Note: This program is currently accepting new clients. Clients may be placed on a waitlist due to high demand, but usually still get in.

United Way of North Central Florida
211

Clinical Summary

- Putting it all together

Key Point Review

Prevention

- Binary

Risk Reduction

- Analog

Key Point Review

Screening

- Wide spread
- Identifies at Risk
- CSSRS

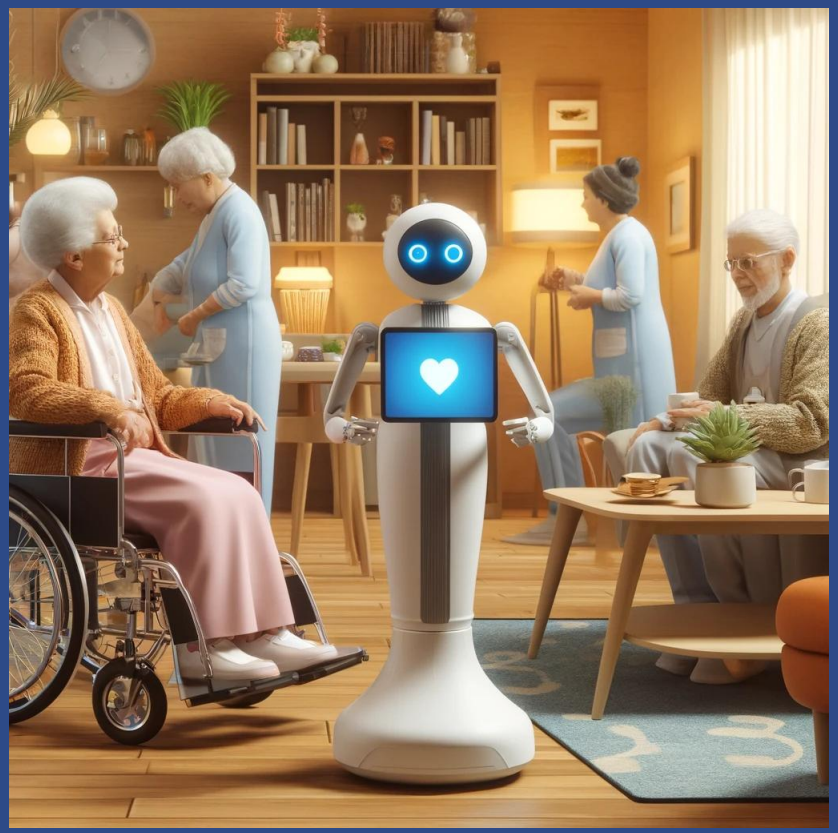
Assessment

- Targeted
- Quantifies Risk
- SAFE-T

Section 3

AI Assist

Suicide Risk Reduction AI Assist



My ~~imaginary~~ friend CHIP

- a multimodal AI program. is he ethical ?

- CHIP - Computer Human Integrated Program
  - – ~~not yet but could be now~~ NOW available*
- Fund of information and retrieval (world web of knowledge)
- Conversational and with excellent writing skills
- Accessible on cell phone or replacement
- Personalized
- Trainable for professional tasks
  - Interviewing, writing, coaching
- Stigmatized and discriminated against
- Has to been coached against rude and retaliatory behaviors

Learning objective – describe multimodal AI

UNESCO'S 10 ETHICAL PRINCIPLES FOR AI

	Human Dignity and Human Rights	Do NO Harm	Safety and Security	Fairness and nondiscrimination	Privacy
	Sustainability	Human oversight and determination	Transparency and explainability	Responsibility and accountability	Multistakeholder collaboration and governance

Learning objective – list 5 Ethical Principles for AI

Anticipated Use of AI Suicide Risk Reduction UFHealth 202?

Clinical Documentation

- Including patient interviews

Quality Control

- Compliance (policies and process)
- Performance (competencies and outcomes)

Predictive Analytics at VA since 2017

Decision Support

- Capacity assessment, 2025-?
- medication selection 2025, symptom monitoring

Education and Training 2026

Web Links

- 2024 National Strategy for Suicide Prevention (hhs.gov)
- Biden-Harris Administration Releases National Strategy for Suicide Prevention and First-Ever Federal Action Plan | SAMHSA
- Florida Suicide Prevention Interagency Action Plan | Florida DCF (myflfamilies.com)
- Psychiatry.org - Suicide Prevention
- Suicide Prevention & Education - UF Counseling and Wellness Center (CWC) (ufl.edu)
- Homepage | Zero Suicide (edc.org)
- Resources – Mental Health Coalition of North Central Florida (mentalhealthncf.org)
- Baker Act Dashboard | Florida DCF (myflfamilies.com)

Selected References

- Adekkanattu P, Furmanchuk A, Wu Y, et al. Detection of Personal and Family History of Suicidal Thoughts and Behaviors using Deep Learning and Natural Language Processing: A Multi-Site Study. Preprint. *Res Sq*. 2024;rs.3.rs-4014472. Published 2024 Mar 11. doi:10.21203/rs.3.rs-4014472/v1

- Belsher BE, Smolenski DJ, Pruitt LD, et al. Prediction Models for Suicide Attempts and Deaths: A Systematic Review and Simulation. *JAMA Psychiatry.* 06 01 2019;76(6):642-651.

- Boudreaux ED, Larkin C, Vallejo Sefair A, et al. Effect of an Emergency Department Process Improvement Package on Suicide Prevention: The ED-SAFE 2 Cluster Randomized Clinical Trial. *JAMA Psychiatry.* Jul 01 2023;80(7):665-674.

Selected References 2

- Boudreaux ED, Rundensteiner E, Liu F, et al. Applying Machine Learning Approaches to Suicide Prediction Using Healthcare Data: Overview and Future Directions. *Front Psychiatry.* 2021;12:707916.
- Hofstra E, van Nieuwenhuizen C, Bakker M, et al. Effectiveness of suicide prevention interventions: A systematic review and meta-analysis. *Gen Hosp Psychiatry.* 2020 Mar - Apr 2020;63:127-140.
- Holoshitz Y, Brodsky B, Zisook S, Bernanke J, Stanley B. Application of the Zero Suicide Model in Residency Training. *Acad Psychiatry.* Jan 2019.
- Mann JJ, Michel CA, Auerbach RP. Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review. *Am J Psychiatry.* Jul 2021;178(7):611-624.

Selected References 3

- McKernan LC, Clayton EW, Walsh CG. Protecting Life While Preserving Liberty: Ethical Recommendations for Suicide Prevention With Artificial Intelligence. *Front Psychiatry.* 2018;9:650.

- Papini S, Hsin H, Kipnis P, et al. Validation of a Multivariable Model to Predict Suicide Attempt in a Mental Health Intake Sample. *JAMA Psychiatry*. Published online March 27, 2024. doi:10.1001/jamapsychiatry.2024.0189

- Pisani AR, Boudreaux ED. Systems Approach to Suicide Prevention: Strengthening Culture, Practice, and Education. *Focus (Am Psychiatr Publ).* Apr 2023;21(2):152-159.

AI References

- All web sites accessed 2024-0408 by author
- Center for Humane Technology Take Control (humanetech.com)
- Meskó B, Görög M. A short guide for medical professionals in the era of artificial intelligence. NPJ Digit Med. 2020 Sep 24;3:126.
- Rome Call for Ethics in AI 2020 – UF as a Signatory 2022
- UF supports the ethical use of artificial intelligence - News - University of Florida (ufl.edu)
- rc_pont-acd_life_doc_20202228_rome-call-for-ai-ethics_en.pdf (vatican.va)
- UNESCO Recommendation on the Ethics of Artificial Intelligence
- https://lnkd.in/eeYVmdsf
- Recommendation on the Ethics of Artificial Intelligence - UNESCO Digital Library