Preventing Suicide through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force Unabridged Report Addressing Serious Gaps in U.S. Mental Health Training

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Abstract

There are twice as many suicides as homicides in the United States, and the suicide rate is rising. Suicides increased 12% between 1999 and 2009. Mental health professionals often treat suicidal patients, and suicide occurs even among patients who are seeking treatment or are currently in treatment. Despite these facts, training of mental health professionals in the assessment and management of suicidal patients is inadequate. The aims of this paper are to review the extant literature regarding the frequency with which mental health professionals encounter suicidal patients, as well as the prevalence of training in suicide risk assessment and management. Most importantly, six recommendations are made to address the longstanding insufficient training within the mental health professions regarding the assessment and management of suicidal patients.
Background

By all accounts, it took two years to convince Jonathan Schultze, a 25-year-old Marine Corps veteran of Operation Iraqi Freedom (OIF), to seek treatment; he had endured two years of depressive episodes, persistent nightmares, bouts of heavy drinking, explosive outbursts, combat-related guilt, and suicidal thoughts (Sennott, 2007). At long last, Jonathan agreed to seek help at his local Veterans Affairs (VA) Medical Center, with his father and stepmother accompanying him for emotional support. At the VA Medical Center, Jonathan informed an intake counselor that he had been having thoughts of suicide and asked to be admitted to a psychiatric inpatient unit. Jonathan was told to go home and await a phone call from a clinician who would do a screening interview.

The next day, Jonathan was called by a clinician and again reported his symptoms, including his suicidal ideation (i.e., thoughts of killing himself). Although he was found to be appropriate for admission, he was informed that he was 26th on the waiting list for the 12-bed PTSD unit. In less than 48 hours, Jonathan Schultze had contact with two mental health professionals, neither of whom inquired further into his self-reported suicidal thoughts. Four days later, he called an OIF War buddy, who attempted to convince him that suicide was not the answer. While on the phone, Jonathan hung himself with an extension cord in the basement of his home.

The apparent failure of the staff at the VA medical center to detect and respond to Jonathan’s serious level of suicide risk set off alarms throughout the VA healthcare system and helped fuel a major VA suicide prevention initiative that is ongoing. It would be a mistake, however, to think that suicide is simply a veteran or military problem, or that it is only the VA and military mental health professionals who have not been adequately trained to evaluate and manage patients who are suicidal.1

In 2009, the most recent year for which official United States suicide statistics are available, suicide was the 10th leading cause of death overall and the third leading cause of death for youth between the ages of 15 and 24 (Centers for Disease Control and Prevention [CDC], 2012). The number of suicides in the nation (36,909) was more than double the number of homicides (16,799; CDC, 2012). Most of those who died by suicide

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1 The term patient is used within this document. It is understood that some practitioners have used the word mental health consumer, client, or other term to denote a person who is being seen for mental health care. The use of patient throughout this document is solely to facilitate readability and does not imply endorsement of a traditional hierarchical doctor-patient relationship.
(reportedly between 93% and 96%) were not in a hospital or emergency room setting within the hours before their deaths (Busch, Clark, Fawcett, & Kravitz, 1993; Wolfersdorf, 2000). However, approximately one-third of people who die by suicide have had contact with mental health services within a year of their death and 20% have had mental health contact within the last month of their life (Luoma, Martin, & Pearson, 2002).

As was the case with the VA clinicians who interacted with Jonathan Schultze, when a mental health professional\(^2\) sees a patient who is at risk for suicide, he or she is faced with the need to make decisions about patient care that can have serious life-or-death consequences. If a patient dies by suicide, there is a significant emotional impact on the patient’s family, his or her social network, and the clinician or clinician-in-training treating the patient (e.g., Calhoun, Selby, & Faulstich, 1980; Cerel, Roberts, & Nilsen, 2005; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; Foley & Kelly, 2007; Fox & Cooper, 1998; Hendin, Lipschitz, Maltzberger, Haas, & Wynecoop, 2000; Kleespies, Niles, Mori, & Deleppo, 1998; Kleespies, Penk, & Forsyth, 1993; Veilleux, 2011). When a patient of a mental health professional dies by suicide, clinical, ethical, and legal questions may arise about the adequacy of the clinician’s evaluation and about the sufficiency of his or her training to perform such evaluations.

In this paper, we will establish that mental health professionals regularly encounter patients who are suicidal, that patient suicide occurs with some frequency even among patients who are seeking treatment or are currently in treatment, and that, despite the serious nature of these patient encounters, the typical training of mental health

\(^2\) Mental health professionals could be psychiatrists, psychologists, social workers, or professional counselors.
professionals in the assessment and management of suicidal patients has been, and remains, woefully inadequate. We will follow this with a review of the current state of training and competence among mental health professionals regarding suicide assessment and interventions. The paper will conclude with recommendations to address the longstanding insufficient response of the mental health disciplines to the issue of appropriate training in the assessment and management of suicidal patients.

The Incidence of Patient Suicidal Behavior in Clinical Practice

Almost all mental health professionals encounter patients who are suicidal. Psychiatrists and other clinical staff who work on inpatient psychiatry units see patients at risk for suicide daily. Suicide, particularly in hospital or inpatient settings, is a clear and obvious patient safety issue. Multiple agencies (e.g., the Joint Commission) have made it clear that suicides in inpatient settings should not happen, and yet they occur with some frequency. In 2001, Ken Kizer, former CEO of the National Quality Forum, coined the term "Never Event" for those particularly shocking medical errors, procedures, and events that should never occur (e.g., wrong-site surgery, artificial insemination with the wrong donor sperm or wrong egg; Agency for Healthcare Research and Quality, 2009). The National Quality Forum has maintained a list of 27 such "Never Events," one of which is "[p]atient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility" (National Quality Forum, 2007, p. vi). Similarly, the Joint Commission, one of the organizations responsible for accrediting and certifying healthcare organizations and facilities in the United States, closely monitors sentinel events, which are defined as "an unexpected occurrence involving death or serious physical or psychological injury" (Joint Commission, 2010a). Suicide was formerly the
most common voluntarily reported sentinel event (Daly, 2006), and has regularly been
among the five most frequently reported sentinel events in recent years (Joint
Commission, 2010b). Insufficient or absent patient assessment is reported as the root
cause in over 80% of the suicide deaths in these reported sentinel events (Joint
Commission, 2011).

Mental health professionals in outpatient settings also encounter suicidal patients
with great regularity. A survey of psychologists-in-training found that 97% of
respondents had provided care to at least one patient (and often several) with some form
of suicidal behavior or suicidal ideation during their training (Kleespies et al., 1993).
Moreover, in a national survey of psychologists, 97% of the sample acknowledged being
afraid of losing a patient to suicide (Pope & Tabachnick, 1993). Social workers also
encounter suicidal patients on a regular basis, with 93% of social workers in a random
nationwide sample reporting that they had worked with suicidal patients at some point.
Additionally, 87% of respondents stated that they had worked with a suicidal patient
within the past year (Feldman & Freedenthal, 2006). Other research has found that 55%
of clinical social workers reported that at least one of their patients had attempted suicide
during their professional careers (Sanders, Jacobson, & Ting, 2008).

Mental health professionals not only treat suicidal patients, but also sometimes
lose patients to suicide, leading some authors to refer to suicide as an "occupational
hazard" (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989, p. 294). Ruskin,
Sakinofsky, Bagby, Dickens, and Sousa (2004) found that 50% of psychiatrists and
psychiatry residents in their sample had experienced at least one patient suicide. This
finding was consistent with the 51% rate noted in an earlier national survey, which also
noted that a majority of psychiatrists who reported having a patient die by suicide had more than one patient die by suicide (Chemtob, Hamada, Bauer, Kinney, and Torigoe, 1988a). Research has found that psychologists, social workers, and counselors experience somewhat lower rates of patient suicide. In a national survey, Pope and Tabachnick (1993) reported that nearly 30% of psychologists had experienced a patient suicide, while Chemtob and colleagues (1988b) found that 22% of psychologists reported losing a patient to suicide. Investigations of patient suicides among social workers and counselors reveal numbers similar to those of psychologists. In a large random sample of social workers, approximately one-third of the participants reported having a patient die by suicide (Jacobson, Ting, Sanders, & Harrison, 2004), whereas 23% of professional counselors reported the same experience (McAdams & Foster, 2000).

Those still in training to become mental health professionals have not been immune to or protected from experiencing a patient suicide. Approximately one-third of the psychiatrists in the Ruskin et al. (2004) investigation experienced a patient suicide while in training. Kleespies and colleagues (1993) reported that 11% of psychology pre-doctoral trainees had a patient die by suicide, with an additional 29% reporting a patient made a suicide attempt while under their care. Further, McAdams and Foster (2000) found that 24% of their sample of counselors who experienced a patient suicide did so during their training.

**Current Status of the Field**

Maria was a 24-year-old Hispanic-American woman who had suffered from episodes of severe depression and occasional suicidal thoughts. She had been sexually abused as a teenager by an uncle who lived in the same building as her immediate family. She was being treated with psychotherapy at a university clinic by a psychology intern

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3 This case is based on actual events but changes have been made to protect the identity and confidentiality of those involved.
for her depression, sexual trauma, low self-esteem, and history of self-directed violence (i.e., inflicting superficial cuts and cigarette burns on her arms and legs). Additionally, her primary care provider had prescribed an antidepressant.

Maria had become very attached to her therapist, but the internship year was coming to an end and she was transferred to a new psychology intern for ongoing treatment. After two sessions with her new therapist, she called and said that her depression was worse than ever, that she had a gun, and that she was thinking of shooting herself. After efforts to convince her to come to the clinic for an evaluation failed, the therapist and her supervisor called the police. The police responded and took Maria to a local emergency room where she was evaluated by a psychiatrist, who recommended that she be hospitalized. Maria agreed, but said that she needed to get some things from her apartment before entering the hospital. The psychiatrist, who felt that she was now being compliant with treatment, allowed her to go home, accompanied by a nursing assistant. Maria and the nursing assistant collected some of her personal belongings and were leaving the building when Maria said that she had forgotten one thing. She ran back into her apartment and shot herself. Neither the police nor the psychiatrist had checked on the location of the gun which she had threatened to use earlier in the day.

Scenarios such as this one with Maria (whose suicide risk was underestimated and who was allowed to return to an unsafe environment) have led to numerous calls from national and international public, private, and governmental organizations to improve training in the assessment and management of suicide risk. In 1999, Dr. David Satcher, then Surgeon General of the United States, issued *The Surgeon General’s Call to Action to Prevent Suicide*. In this document, Satcher asserted that suicide is a public health problem and provided a vision that would lead to a cohesive and comprehensive national suicide prevention strategy (U.S. Public Health Service, 1999). The strategy included having mental health professionals achieve competence in suicide risk assessment and management. In addition, the Joint Commission (2010a), the Institute of Medicine (IOM; 2002), the U.S. Department of Health and Human Services (USDHHS; 2001), and the World Health Organization (UN/WHO; 1996) have all noted the critical need to improve the competence of mental health professionals in assessing and managing suicide risk.
Competence has been defined by various authors in a number of different ways. Competence within the medical community has been defined as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities being served" (Epstein & Hundert, 2002, p. 226). When discussing competence in suicide risk assessment and management, we refer to Quinnett's (2010) definition in which competence is defined as the capacity to conduct:

[A] one-to-one assessment/intervention interview between a suicidal respondent in a telephonic or face-to-face setting in which the distressed person is thoroughly interviewed regarding current suicidal desire/ideation, capability, intent, reasons for dying, reasons for living, and especially suicide attempt plans, past attempts and protective factors. The interview leads to a risk stratification decision, risk mitigation intervention and a collaborative risk management/safety plan, inclusive of documentation of the assessment and interventions made and/or recommended.

Competence is an essential component in the assessment and management of suicidality. Given the numerous studies which have clearly revealed that the prevalence of suicide is high and that suicide has a significant negative impact on individuals and society, there has been little attention directed to the systemic problem of inadequate training of mental health professionals in the assessment and management of suicidality. This critical deficiency in training has persisted for over 30 years (e.g., Light, 1976) despite the multiple calls to action (e.g., National Strategy for Suicide Prevention; USDHHS, 2001; IOM, 2002). It would appear that the colleges, universities, clinical training sites, and licensing bodies that prepare mental health professionals to serve at-risk populations have dismissed, if not ignored, these numerous requests and demands. Various organizations and numerous national leaders have articulated what is required to
serve the millions of suicidal persons who seek mental health treatment, yet little change or improvement has been initiated.

**The Prevalence of Training in Suicide Risk Assessment and Management**

Despite the prevalence of patient suicidal behavior and deaths by suicide, the mental health disciplines have been, at best, inconsistent in training mental health professionals in the evaluation and management of suicidal patients. In professional psychology, for example, there have been a number of surveys over the past 25 to 30 years documenting this inconsistency. Bongar and Harmatz (1990) found that only 40% of graduate programs in clinical psychology offered any formal training in the study of suicide. Kleespies et al. (1993) reported that approximately 55% of graduate students in clinical psychology had some form of didactic instruction on suicide during their graduate education. The instruction, when given, was quite limited (i.e., one or two lectures; Kleespies et al., 1993). Consistent with Kleespies and colleagues’ (1993) findings, Berman (1983) reported that the average amount of formal didactic training for psychologists in the assessment and treatment of suicidal patients was two hours. It is critical to note that didactic training is not necessarily synonymous with effectively building the skills needed to conduct adequate suicide risk assessments and treat suicidal patients. Providing information to trainees is necessary, but not sufficient, as trainees must also be given opportunities to translate this information into competent practice by assessing and treating suicidal patients with proper supervision. Additionally, Ellis and Dickey (1998) found that, for both psychology internship and psychiatry residency programs, "training in suicidology seems lacking in both quantity and quality in many programs" (p. 496). Dexter-Mazza and Freeman (2003) found that approximately half of
psychology interns had been in graduate programs that did not offer training in the assessment and management of suicidal patients. This trend has continued, as evidenced by a recent study that again found training to be limited among graduate programs in psychology (Jahn et al., 2012). Only 3.8% of the responding programs offered a suicide-specific course, with nearly 76% of responding directors indicating that they wanted to include more suicide-specific training, but encountered a variety of barriers to doing so. In addition, the majority of surveyed programs continued to rely on passive training that integrated this information into other courses, practicum experiences, or workshops (Jahn et al., 2012).

Training has been similarly sporadic among social work training programs. Less than 25% of a national sample of social workers reported receiving any training in suicide prevention, with a majority of the respondents reporting that their training had been inadequate (Feldman & Freedenthal, 2006). While deans, directors, and faculty of graduate social work programs view suicide as an important educational issue, the amount of suicide education in master's level programs remains insufficient, with both faculty and deans/directors reporting that most students receive four hours or fewer of suicide-related education (Ruth et al., 2009). One author summarized the state of affairs in the following way: "...clearly, social work schools need to be better about educating students about suicide" (Charter, 2009, p. 8).

The lack of training is even more pronounced among professional counseling and marriage and family therapy training programs. Wozny (2005) found that suicide assessment and intervention courses were only present in 6% of accredited marriage and
family therapy programs and in only 2% (i.e., 1 out of 50 programs) of accredited counselor educations programs.

Only the field of psychiatry seems to be attempting to ensure that their trainees are, at a minimum, exposed to the skills required to properly conduct a suicide risk assessment and address suicidality in treatment. Ellis, Dickey, and Jones (1998), for example, conducted a national survey of the directors of training listed in the directory of the American Association of Directors of Psychiatric Residency Training and found that 94% of the responding directors reported some form of training in suicide risk assessment and intervention in their residency programs. However, there was considerable variability when they were asked about the specific forms of training offered, with the majority of directors reporting that most of the training occurred in passive formats (e.g., therapy supervision, general seminar) and only 27.5% reporting training via skill development workshops. The findings left the authors of the study questioning whether the training was adequate to meet the challenges of working with suicidal patients.

Likewise, in a more recent national survey, Melton and Coverdale (2009) contacted the chief psychiatry residents at accredited psychiatry programs identified through the Accreditation Council for Graduate Medical Education (ACGME) and, similar to the survey by Ellis and colleagues (1998), found that 91% of the programs offered some teaching on the care of suicidal patients. Grand rounds and case conferences were the most frequently cited training formats. The average number of seminar sessions or lectures was only 3.6, and the specific content that was covered by the different programs was often vague and non-descript (Melton & Coverdale, 2009). Consistent with other mental health professionals, many of the chief psychiatry residents were of the
opinion that the teaching and focus on suicide intervention was insufficient (Melton & Coverdale, 2009).

The ACGME Psychiatry Residency Review Committee establishes the topics that must be covered by accredited residency programs. While they are the only accreditation body to specifically include suicide in their requisite training curriculum, even it remains somewhat minimized as part of a resident’s forensic psychiatry experience with the stipulation that the forensic psychiatry experience “must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others” (ACGME, 2007, p. 17).

The American Board of Psychiatry and Neurology (ABPN) also lists “suicide” among the necessary competencies for general psychiatric physicians (ABPN, 2011); however, within psychiatry, not all subspecialties make explicit reference to suicide as an essential competence area. For example, psychosomatic medicine does not specify this competence area, even though pain patients are at elevated risk for suicide (ABPN, 2008). Overall, as a discipline, psychiatry appears to be making a more overt effort than the other mental health disciplines to ensure that residents receive instruction on the assessment and management of suicidal patients. Nevertheless, it is clear that even within psychiatry, there is varying attention directed to this essential clinical care domain.

The lack of training requirements stands in stark contrast to the ongoing calls for improvement in this area. The original National Strategy for Suicide Prevention (NSSP; USDHHS, 2001) outlined critical objectives that would address the oft-cited and previously discussed deficiency in training regarding suicidality. Objective 6.3 of the
NSSP specifically stated that the goal was to, "by 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors" (p. 82). There was a similarly stated objective (6.2) directing that the same goals be addressed in medical residency programs and physician assistant educational programs. Furthermore, objective 6.9 called for an "increase [in the] number of recertification or licensing programs in relevant professions that require or promote competencies in depression assessment and management and suicide prevention" by 2005 (USDHHS, 2001, p. 86).

In late 2010, two organizations (i.e., the Suicide Prevention Resource Center [SPRC] and the Suicide Prevention Action Network [SPAN]) collaborated on the publication of 2010 Progress Review of the National Strategy. This document provided a detailed analysis of how, and to what degree, the original National Strategy for Suicide Prevention (USDHHS, 2001) had been implemented. The 2010 Progress Review of the National Strategy (SPRC & SPAN, 2010) included an entire section that summarized the current standards for clinical training and noted to what degree the NSSP goals and objectives were being met. Unfortunately, the findings are disheartening. After reviewing the standards for 11 different mental health professional groups (i.e., physician specialties [psychiatry, family practice, pediatrics, emergency medicine], substance abuse counselors, employee assistance professionals, and behavioral health providers [psychology, social work, psychiatric nursing, counseling, marriage and family therapy]), "only the Council for the Accreditation of Counseling and Related Educational Programs…had increased attention on suicide in its 2009 standards compared to the
previous version" (SPRC & SPAN, 2010, p. 23). The report goes on to state "two other accrediting organizations (the National Association for Alcoholism and the Drug Abuse Counselors and [the] Employee Assistance Certification Commission) have limited mention of suicide in their certification examinations, but not [in their] accreditation standards" (SPRC & SPAN, 2010, p. 23).

The 2010 Progress Review of the National Strategy (SPRC & SPAN, 2010) notes that several, albeit few, individual professional training programs have voluntarily incorporated suicide-specific training and some professional organizations have attempted to provide their members with continuing education programs or pertinent suicide prevention materials since 2001. To date, with a small minority of exceptions, no professional training programs or licensing exam boards have explicitly incorporated clinical competencies associated with the prevention of adverse outcomes for suicidal patients.

Moreover, state licensing boards for clinical social workers and psychologists, whose mission is to protect the public’s health and safety from untrained and unqualified providers, do not require exam items on the assessment and management of suicidal patients. This is another area in which psychiatry appears to be on the forefront of the mental health field. The American College of Psychiatrists Psychiatry Resident-in-Training Examination, which is completed by nearly everyone who will be board eligible during their residence, includes suicide-specific questions within the emergency psychiatry domain (American College of Psychiatrists, 2011).

In addition to the lack of items on licensure examinations, licensing boards’ mandatory continuing education requirements for license renewal are quite variable
across states and healthcare fields, with several states having no continuing education requirements for mental health professionals. Most states specify a set number of continuing education hours that must be completed annually or biannually, with numerous states requiring that a certain amount of continuing education be devoted to a specific content area. For example, topics required by some states include cultural competence, prevention of medical errors, diversity, and prevention of child abuse. Psychiatrists, and other physicians, generally have fewer specific requirements for continuing education topics; however, some states include subjects such as end of life care, risk management, and pain management as requirements for medical care providers. While states with no continuing education requirements are in the minority, their existence alone is disconcerting. Furthermore, not a single state or mental health licensing body requires continuing education addressing suicide, suicide risk, or other behavioral emergencies. However, continuing education on other topics is mandated in a majority of states for licensure renewal. In fact, 27 states require continuing education in ethics for licensure renewal for psychologists, 27 states require continuing education in ethics for licensure renewal for social workers, and 21 require continuing education in ethics for licensure renewal for addictions counselors. This mandatory education ensures that mental health professionals are informed about the current issues in ethics, yet there is no similar requirement to ensure that mental health professionals are using current information to assess and treat suicidal patients.

The evidence clearly suggests that there has been negligible progress in improving the competence of mental health professionals in evaluating, managing, and

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4 Our review of state CE requirements found eight states having no CE requirements for psychologists, three states having no requirements for social workers, and six states having no requirements for physicians, including psychiatrists.
treating suicidal patients. However, it is not a lack of effective training materials that has hampered such progress.

Training is Available and Accessible

There have been concerns raised in the past regarding the effectiveness of continuing education programs in impacting providers’ behaviors or changing patient-related outcomes (Davis et al., 1999). Recent research has suggested that interactive continuing medical education (CME) training programs, especially those that included supervised skill demonstration and rehearsal, significantly affected healthcare providers’ behavior (Bloom, 2005). In the medical setting, training has been shown to reduce medical errors and cultivate a culture of safety (Donnelly, Dickerson, Goodfriend, & Muething, 2009; Eppich, Brannen, & Hunt, 2008). Within the mental health field, a recent review has raised questions about the efficacy of training in a workshop format for improving the clinical care of the suicidal patient (Pisani, Cross, & Gould, 2011). Despite this review, studies have shown improvements in knowledge and skills due to continuing education programs.

Sockalingam, Flett, and Bergmans (2010), for example, found that training in suicide intervention for psychiatry residents increased comfort in treating suicidal patients and improved self-reported clinical practice. McNiel et al. (2008) reported that a five-hour workshop on evidence-based assessment of suicide risk and violence risk significantly improved the ability of psychiatric residents and psychology interns to identify risk factors for suicide when compared to a control group. The group members that received training were also able to be more specific about the significance of risk and protective factors when developing plans for intervention to reduce risk. Allgaier,
Kramer, Mergl, and Hegerl (2009) found that a four-hour training improved attitudes regarding the treatability of older adult suicide risk and increased knowledge about pharmacotherapy for depression and suicide risk among geriatric nursing staff. Moreover, Slovak and Brewer (2010) found that licensed social workers had more positive attitudes toward using firearm assessment and safety counseling when they had received training on the use of firearm counseling for suicide prevention. While Pisani and colleagues (2011) had some reservations about the efficacy of continuing education programs in changing clinical practices, they noted that there is strong support for the effectiveness of evidence-based training workshops in transferring knowledge and shifting attitudes. In fact, this same research group, one year later, tested a 3-hour training for mental health professionals and demonstrated that their program was able to "improve clinicians' knowledge, confidence, and skill" in assessing and responding to suicide risk (Pisani, Cross, Watts, & Conner, 2012, p. 30).

The scientific literature is beginning to demonstrate that empirically-based skills taught in a brief continuing education format can change clinic policy, confidence in risk assessment, and confidence in management of suicidal patients, with changes sustained at a six-month follow-up (McNiel et al., 2008; Oordt, Jobes, Fonseca, & Schmidt, 2009). Findings such as these, in conjunction with the known elements that facilitate the translation of continuing education training into clinical practice (Bloom, 2005), suggest that suicide-specific continuing education can “meaningfully impact professional practices, clinic policy, clinician confidence, and beliefs” (Oordt et al., 2009, p. 21). There has been strong empirical support demonstrating that physician education specifically designed to increase recognition and treatment of depression reduces suicide
rates (Beautrais et al., 2007; Mann et al., 2005). Based on such findings as this, it seems logical to concur with the assertion of Knesper, AAS, and SPRC (2010) that "there is every reason to believe that improved education and training pertaining to the management of suicide attempts and suicide ideation will have similar results" (p. 36).

At the present time, there are several training programs that have been recognized for disseminating content that is consistent with the core competencies that have been referenced earlier and are included in the Best Practices Registry. The Best Practices Registry is a collaborative project between the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention that is funded by the U.S. Substance Abuse and Mental Health Services Administration. It is designed to provide information about programs that are evidence-based and have been demonstrated to be effective in increasing suicide-specific knowledge and skills. The depth and breadth of training programs recognized on the Best Practice Registry vary in length from six hours (i.e., Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals; SPRC, 2011) to 16 hours (i.e., Recognizing and Responding to Suicide Risk; AAS, 2011). Outcome data regarding behavior change in response to these trainings is emerging, with changes documented four months after training (Jacobson & Berman, 2010).

**Systems-Level Problems Affecting Training**

Jim, a 72-year-old widower whose wife died nearly a year ago, had retired from his lifelong career within the past five years. In recent years, Jim’s health had begun declining, though he did not have any serious or terminal medical conditions. Jim's daughter, Mary, frequently checked on him and had noticed that he was growing increasingly agitated and irritable. Mary also noted that her father had been consuming alcohol more regularly and no longer "seemed like himself.” More of his conversations

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5 This case is based on actual events but changes have been made to protect the identity and confidentiality of those involved.
incorporated his feeling that he would be "better off dead" so as not to be a burden to his family. As Mary grew more worried, she tried to convince Jim to begin seeing a licensed mental health professional. When he finally, albeit reluctantly, agreed, Mary was ecstatic. She was sure that once her father began seeing a mental health professional he would “return to normal.” Even after seeing his mental health professional four times in the span of one month, Jim’s mood continued to worsen. Mary went to check on him at his home one day and found him dead of a self-inflicted gunshot wound to the head.

Mary felt sad about her father’s death and helpless about not being able to prevent it. As the next of kin, she returned to the clinician’s practice after her father’s death and learned that the mental health professional who had treated her father had never conducted a suicide risk assessment. In fact, it appeared that the provider was unaware of key warning signs of suicide that her father had been displaying (e.g., increased agitation and anger, increased alcohol use, expressing feelings of being trapped, and hopelessness; Rudd et al., 2006). Most shockingly, Mary learned that the provider she had initially been so happy and relieved to have her father see had no training in assessing or treating suicidal patients. The provider was unaware of more general important risk factors for older adults, including poor perceived health, major social changes like retirement, depression, and the recent death of a loved one (American Association of Suicidology, 2009). The provider failed to inquire about access to firearms, yet another known risk factor for suicide, as the restriction of access to lethal means has been shown to be an effective way to prevent suicide (Hawton, 2007).

Like Mary, many Americans assume that, in the same way that oncologists are trained to evaluate and treat cancer in a patient, mental health professionals are trained to recognize, assess, and treat suicidality in patients. However, unlike the depth of training required for oncologists and the mandatory licensing examinations they must pass to demonstrate that they are competent to treat patients diagnosed with cancer, there are no requirements in place to ensure that mental health professionals are competent in the area of suicide risk assessment and treatment. This is an alarming reality when one considers the fact that suicide is one of the most frequently encountered behavioral emergencies in mental health settings (Buzan & Weissberg, 1992).

The public generally assumes that seeking mental health treatment when in a suicidal crisis will result in receiving competent, professional assessment and treatment. People such as Jonathan, Maria, Jim, and their families believed that they were safely on
the path to improved well-being once they crossed the threshold of a mental health professional's office. This was not an unreasonable expectation, though it is clearly not an accurate reflection of the current state of affairs in mental health. Despite the numerous "calls to action" and sternly worded "recommendations" to increase training and ensure the competence of practitioners in the area of suicide assessment and intervention noted earlier (e.g., U.S. Public Health Service, 1999; USDHHS, 2001), virtually nothing has been done by licensing boards, training programs, and professional organizations outside of some efforts by the field of psychiatry. In fact, certain professional organizations have lobbied against efforts to include suicide assessment and intervention training as a mandatory continuing education requirement (J. Linder-Crow, President of the California Psychological Association, personal communication, December 6, 2010) with their position being that there are, in essence, "too many mandatory requirements" and "there is training at the annual state conference" (i.e., one or two annual or biannual presentations).

While the mental health field has remained stagnant regarding the dissemination of improvements in training regarding suicide assessment and treatment, there has been growing pressure from the community and grassroots organizations to ensure that suicide prevention education is provided in specific settings. For example, schools, where the issue of youth suicide has prompted action, have begun requiring mandated training in suicide prevention in many states. Recently enacted legislation in the state of Illinois (House Bill 4672) is reflective of this growing emphasis on detecting suicide risk and facilitating treatment for those at-risk for suicide. This bill stipulates two hours of mandatory "gatekeeper training" (i.e., training in suicide prevention, identification of
suicide warning signs in adolescents, and appropriate intervention and referral
techniques) for school personnel (Illinois House Bill 4672). Other states have adopted
similar legislation requiring suicide prevention training for school personnel (e.g.,
Mississippi Senate Bill 2770, California Senate Bill 1378, Louisiana House Bill 719,
Wisconsin House Bill 493, Tennessee House Bill 57, Virginia House Bill 3064, Colorado
House Bill 1098, Michigan House Bill 4375, New Jersey House Bill 3931, Vermont
House Bill 630; SPAN, 2011). Still other states, such as Florida and Kentucky, are
advancing similar legislation. Virtually all of these gatekeeper trainings that are required
for school employees recommend referral to mental health professionals for potentially
at-risk youth. Ironically, there is no such mandatory training for the mental health
professionals, who are regarded as the experts in the domain of suicide and suicide
intervention.

Legislation has been enacted to prevent deaths by suicide. Acts such as the Garrett
Lee Smith Memorial Act (P.L. 108-355, 2004) have been implemented to assist in suicide
prevention. This act designates federal funds for suicide prevention efforts at the state,
tribe, and college/university level to address the problem of youth suicide. Despite the
fact that this type of political attention has been directed toward the issue of suicide
prevention, a critical element is missing. All of the gatekeeper trainings that have been
studied and shown to be effective are delivered to non-mental health professionals who
are trained to refer potentially suicidal individuals to mental health professionals for
comprehensive assessment and treatment. It is incomprehensible that, in many states, a
teacher is now required to have more training on suicide warning signs and risk factors
than the mental health professionals to whom he or she is directing potentially suicidal
students. In addition, there is an inherent danger in referring suicidal people to mental health professionals who are not adequately trained; if these suicidal people do not feel that treatment has been effective (which is likely the case with mental health professionals who have not received proper training in treating suicidal patients), they may drop out of treatment, become discouraged about treatment with mental health professionals, and never return to treatment, leaving them at higher risk for suicide.

Because suicidal behavior is clearly a prevalent occurrence in virtually all clinical settings and because other professionals are now mandated to refer suicidal individuals to mental health professionals, mental health professionals must be prepared to effectively assess and treat suicidal patients. The lack of training required of mental health professionals regarding suicide has been an egregious, enduring oversight by the mental health disciplines. Mental health professionals must be appropriately trained and demonstrate competence in the recognition, assessment, management, and treatment of suicidal patients to reduce the rate of suicide. The deficiency in training regarding sui
cidality has been widely cited for over thirty years (e.g., Bongar & Harmatz, 1991; Charter, 2009; Dexter-Mazza & Freeman, 2003; Feldman & Freedenthal, 2006; Jacobson et al., 2004; Kleespies et al., 1998; Kleespies & Hill, 2011; Light, 1976). A panel of top suicidologists and military mental health professionals recently reiterated this deficiency in the report of the Department of Defense (DoD) Task Force on the Prevention of Suicide by Members of the Armed Forces (2010). The Task Force noted that “(a)lthough it might be assumed that all mental health professionals [associated with the DoD] are routinely trained in suicide prevention skills as part of their education and training, research has shown this is not the case” (2010, p. 93). Based on this fact, this panel of
experts made the explicit recommendation to “ensure all ‘helping professionals’ are trained in the competencies to deliver evidence-based care for the assessment, management, and treatment of suicide-related behaviors” (DoD Task Force, 2010, p. ES-16). This must be the standard for all mental health professionals, not simply those serving the Armed Forces.

On an individual level, one could argue that mental health professionals have an ethical obligation to provide only those services that fall within their area of competence. Few, however, have attained specific competence in the assessment, management, and treatment of individuals who are suicidal. In fact, numerous authors over many years have specifically called into question the ethics of mental health professionals who, without sufficient or adequate training, provide service to suicidal patients (e.g., Bongar & Harmatz, 1991; Feldman & Freedenthal, 2006; Jacobson et al., 2004; Rudd, Cukrowicz, & Bryan, 2008; Sommers-Flanagan, Rothman, & Schwenkler, 2000). Each of the mental health disciplines has ethical codes, which stipulate, in slightly different verbiage, that mental health professionals should not provide services that are beyond their area of competence (American Counseling Association, 2005; American Psychiatric Association, 2010; American Psychological Association, 2002; National Association of Social Workers, 2008). Yet, a majority of mental health professionals will provide services to potentially suicidal patients for whom they are ill-equipped, undertrained, and, most importantly, potentially incompetent to treat.

This issue, however, goes beyond the individual level and is perhaps more appropriately addressed as an issue in systemic ethics. As the term suggests, systemic ethics addresses the underlying systems and processes that give rise to uncertainty or
conflicts about values for the individuals who function within the system. In healthcare, systemic ethics calls for critical reflection on institutional or systems factors that may undermine the ethical values important to good quality care. In the matter under discussion, it is clear that mental health professionals hold it as a central value to work for the benefit of their patients (i.e., the ethical principle of beneficence – doing or producing good – is an organizing principle in all of healthcare). The system of training mental health professionals, however, has generally not prepared them to function in the best interests of their patients in regard to the crucial issue of assessing and managing patient suicidality. Yet, providers encounter suicidal patients regularly and cannot simply ignore or abandon these patients because of lack of tracking. Thus, the glaring deficiency in the mental health educational and training system creates an ethical values conflict for practitioners that needs to be addressed.

Summary

Now is the time to make changes to policy and practice to improve the competence of mental health professionals and the quality of care provided to suicidal patients. There are a number of ways to enhance and develop the overall competence of mental health professionals regarding suicide risk. This Task Force of the American Association of Suicidology strongly endorses the following recommendations to ensure that mental health professionals are properly trained and competent in evaluating and managing suicidal patients, the most common behavioral emergency situation encountered in clinical practice. This task force makes these recommendations based on the empirical findings regarding suicide and based on the task force members’ collective clinical and forensic experience. It is this task force’s belief that the implementation of the
following general and specific recommendations will be a first step toward ensuring that mental health professionals are competent to recognize, assess, manage, and treat suicidal patients.

**Recommendations to Improve Training**

**General Recommendation:** A summit comprised of national leaders in mental health should be convened to formulate plans for implementing the following recommendations.

The mental health disciplines have, to date, failed to meet the National Strategy for Suicide Prevention (USDHHS, 2001) goals of increasing the availability of suicide-specific training. However, collaborative work by the various mental health professions (i.e., American Psychiatric Association, American Psychological Association, and National Association of Social Workers) can facilitate efforts to address this failure. Given the longstanding reluctance of these groups to implement meaningful change, the additional presence of vested parties and patient safety organizations, such as the National Action Alliance for Suicide Prevention, the National Alliance on Mental Illness, the Leapfrog Group for Patient Safety, and suicide survivors, would also be encouraged to actively participate in this dialog. The American Association of Suicidology is a willing and capable host to such a summit that will aide in ensuring that the longstanding gap in the training of mental health professionals is finally closed.

While this document delineates clear recommendations to address the longstanding gaps in training, there are aspects of these recommendations which will require further refinement. Collaboration among these stakeholders will be critical in addressing specifics about the implementation of training consistent with these
recommendations (e.g., designated courses addressing suicide and behavioral emergencies, multi-session workshops with skill demonstration). Additionally, this collaboration will aid in the development of an effective national certification program, ensuring recognition for those providers who have acquired the requisite knowledge and demonstrated the necessary skills to conduct appropriate suicide risk assessments and implement appropriate treatment plans to address suicidality. There are additional areas of concern, such as ensuring that supervision for practitioners-in-training is done by competent professionals and determining how best to implement the national certification program that will be advocated for below and has been recommended elsewhere (Knesper et al., 2010). The proposed summit is the ideal platform for the leaders from each of the mental health disciplines to initiate the change process that is necessary to address issues such as how to implement certification or programmatic recognition for those mental health professionals who have completed requisite training in the core competencies of suicide assessment and management.

The recommended forum would be a starting point for a change process that will continue to evolve; specific collaborative plans for improvement would be developed by the vested parties there. Given the political and bureaucratic nature of such a summit, the changes that emerge from such a session will require time to be implemented. Nevertheless, a multidisciplinary forum in which each of the mental health disciplines can share their successes and challenges is viewed as a critical step to ensure that all mental health professionals, as well as professionals-in-training, are taught the essential skills necessary for competent assessment and treatment of suicidal individuals.
Recommendation #1: Accrediting organizations must include suicide-specific education and skill acquisition as part of their requirements for post-baccalaureate degree program accreditation.

Organizations such as the American Psychological Association, the Council on Social Work Education, and the Liaison Committee on Medical Education, among others, have stringent accreditation requirements to ensure the competence and professional readiness of trainees that graduate from their programs. These accrediting bodies for each mental health discipline have similar explicit goals to “protect the interests of students, benefit the public, and improve the quality of teaching, research, and professional practice” (American Psychological Association, 2007, p. 2) by “establishing thresholds for professional competence” (Council on Social Work Education, 2008, p. 1). To meet these goals, it is essential that training programs specifically address the most acute and deadly condition for which people seek mental health treatment, suicidality. Presently, only the ACGME Psychiatry Residency Review Committee has explicitly integrated the topic of suicide risk assessment and intervention into its training program accreditation requirements (ACGME, 2007). Meanwhile, none of the accrediting organizations of other mental health disciplines (e.g., doctoral psychology programs, masters or doctoral social work programs) reference suicide in their accreditation standards. Accredited programs that aspire to train the mental health professionals of tomorrow must ensure that specific training in the detection, assessment, treatment, and management of suicidal patients is included in the formal education of these future mental health professionals.

Specifically, these programs should incorporate the core competencies that have been identified in the existing scientific literature and are considered essential for
assessing and managing suicide risk (SPRC, 2006). Falling under seven major domains, there are a number of specifically delineated competencies listed within each domain that need to be provided to all mental health professionals (e.g., recognizing risk and protective factors, designating level of risk, developing policies and procedure for following patients closely; SPRC, 2006). In addition to elucidating these competencies, recent efforts have also provided detailed guidelines for facilitating the adequate education of mental health trainees regarding these competencies (Rudd et al., 2008). These guidelines offer information for supervisors and instructors to ensure that trainees master the content and acquire the skills related to each domain.

The core competencies have been determined and operationalized. It is now necessary to require training programs to utilize these core competencies in their training of future mental health professionals. The National Strategy for Suicide Prevention (USDHHS, 2001) has already failed to achieve its goals of increasing suicide-specific training in both mental health and medical graduate programs by 2005. However, we can address this failure now. We believe that it is incumbent on every training program that aspires to produce licensed mental health professionals to require each of their students to complete specific training in the assessment and management of potentially suicidal individuals. Presently, the most empirically sound training programs in this area require a minimum of six hours (i.e., Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals; SPRC, 2011), with other empirically based programs requiring more intensive training (i.e., Recognizing and Responding to Suicide Risk; 16 hours of training; AAS, 2011). A recently created training program entails 40 hours of
coursework, didactics, and skill demonstration (i.e., QPR Online Counseling and Suicide Intervention Specialist training; QPR, 2011).

The manner in which training programs integrate these essential skills and training experiences will vary from program to program. However, at a minimum, each training program must ensure that all future mental health professionals learn the core competencies and demonstrate their ability to apply these skills. Ideally, these abilities would be demonstrated through supervised training with a competent supervisor and suicidal patients, but at a minimum, would require some measure of skills-based demonstration (e.g., supervised role plays). It is unacceptable that programs which provide nearly all of the training for future mental health professionals are not requiring their graduates to learn how to assess and manage the most common, severe behavioral emergency that will be encountered in mental health practice, suicidality.

**Recommendation #2: State licensing boards must require suicide-specific continuing education as a requirement for the renewal of every mental health professional’s license.**

Mental health professionals currently providing care have generally not received the necessary training in suicide assessment and treatment. Practicing mental health professionals must improve or maintain their knowledge of suicide risk and develop their skills in assessing and treating suicidal patients. Continuing education is essential to ensure that providers remain current in their understanding of emerging issues while also maintaining, developing, and increasing their overall competencies, thereby improving services to the public (American Psychological Association, 2009). As noted above, however, no states currently require suicide-specific continuing education for any mental
health professionals. Yet, a majority of states require ethics training, which mental health professionals are compliant and from which they presumable benefit. Thus, it has been demonstrated that a required continuing education area is feasible to implement without being overly burdensome to mental health professionals.

It is our belief that mandatory completion of two suicide-specific continuing education credit hours is logical, realistic, and essential as part of licensure renewal for all psychologists, social workers, and psychiatrists. This is a step toward ensuring that all providers are at least as knowledgeable about suicide warning signs, risk factors, and appropriate management of suicidal patients as the numerous other individuals, such as teachers, who have already been mandated to have training in this area. The irony of those with no mental health affiliation being mandated to learn about suicide while the mental health profession, which is best positioned to be competent in this area, has no such stipulation is glaring. The inclusion of two credit hours of continuing education can easily be integrated into the regular licensure-review procedures of state licensing bodies. In addition, there are ample opportunities for licensed practitioners to obtain this training. A cursory review conducted by this task force has found that, despite the availability of suicide-specific trainings, such training is not sought out by licensed practitioners who tend to restrict their continuing education to only those areas that are mandated.

**Recommendation #3:** State and federal legislation should be enacted requiring healthcare systems and facilities receiving state or federal funds to show evidence that mental health professionals in their systems have had explicit training in suicide risk detection, assessment, management, treatment, and prevention.
Because of the noted failure of the mental health field to implement changes that have been recommended and necessary for over 10 years in response to the NSSP (USDHHS, 2001), the assistance of the state and federal government is now needed to protect the American public and save the lives of suicidal patients. The first three recommendations of this task force are specifically directed to the same mental health leaders who have continually avoided, overlooked, dismissed, or minimized the perpetual, sometimes fatal, gap in the training of their mental health professionals. Therefore, it appears that political and financial oversight through thoughtfully considered legislation would greatly motivate institutions and individual providers to facilitate change that will address the longstanding neglect of this issue by the mental health field. Healthcare facilities that receive state and federal funds are relied on by the general public for care and treatment. It is incumbent upon these institutions to ensure that they have appropriately trained mental health professionals who can conduct thorough suicide risk assessments and provide appropriate, competent care to those in suicidal crises. If the government and Department of Defense, as noted earlier, can explicitly attempt to “ensure all ‘helping professionals’ are trained in the competencies to deliver evidence-based care for the assessment, management, and treatment of suicide-related behaviors” (DoD Task Force, 2010, p. ES-16), our federal and state funded healthcare facilities should be held to this same standard.

Medical centers, hospitals, and healthcare institutions that receive federal or state funding should be required to hire only mental health professionals who have evidence of training specifically addressing suicide risk assessment and suicidal patient care. Documentation of such training can be met through a variety of paths: through a mental
health professional’s graduate training, through continuing education programs, or through a standardized certification program.

The development of a national certification program for mental health professionals, possibly discipline specific, that is skills-based and empirically driven would greatly increase the overall competence of mental health professionals in the assessment and care of suicidal patients. This is not a novel recommendation, as Knesper et al. (2010) have proposed such a program. A mandate for such certification was drafted in a bill submitted by a previous U.S. Representative, Patrick Kennedy (D-RI; i.e., in the Health Information Technology Extension for Behavioral Health Services Act, H.R. 5040, 2010) but the bill did not become enacted prior to the conclusion of the legislative session. Under this bill, agencies that provide healthcare would have been required to show evidence that their staff members had been properly trained in suicide prevention strategies in a manner consistent with the Institute of Medicine report (2002) and National Strategy for Suicide Prevention (USDHHS, 2001). This training could have occurred in a variety of settings: the professional’s university-based curriculum; internship, clerkship, or residency training; or in post-graduate continuing education programs. Regardless of the setting in which the specific suicide-related training occurred, documentation of this mandatory training would have required specific reference to the core competencies referenced earlier in this paper.

A similar requirement was stated in the form of the Council on Integration of Health Care Education Act (H.R. 5392, 2010) which would have established a Council on Integration of Health Care Educators that would make recommendations regarding the core competencies to be required of each type of healthcare professional and behavioral
health provider if it had been passed. This task force contends that the core competencies for the assessment and management of suicidality, which have been reiterated throughout this document, have already been clearly established but have not been implemented or disseminated throughout the mental healthcare training or practice systems. Thus, requiring agencies that receive federal or state funding to ensure that their mental health professionals are competent in the assessment and management of suicidal patients appears to be necessary at this time.

**Recommendation #4: Accreditation and certification bodies for hospital and emergency department settings must verify that staff members have the requisite training in assessment and management of suicidal patients.**

As noted earlier in this paper, hospitals and emergency departments cannot be considered safe havens from suicide. Daly (2006) reported that suicide in these settings was the sentinel event most commonly reported to the Joint Commission; this underscores the critical need to address suicidality in these settings. As mentioned earlier, more recent data indicate that, while no longer the most frequent sentinel event, suicide in healthcare and medical settings remains among the top three types of sentinel events reported over the past decade (Joint Commission, 2010b). The Joint Commission has noted the presence of systemic shortcomings that contribute to suicide in the hospital and emergency department setting, specifically noting problem areas including: "inadequate screening and assessment, care planning and observation; insufficient staff orientation and training; poor staff communication; inadequate staffing; and lack of information about suicide prevention and referral resources" (The Joint Commission, 2010a, p. 2).
To protect the health and safety of suicidal patients who are in hospital, medical center, and emergency department settings, healthcare facilities must be responsible for ensuring that their clinical staff members have been specifically trained in the assessment and intervention skills necessary to work effectively with suicidal patients. While the specific mental health disciplines have been reluctant to address this essential competence area, providers in hospital and emergency department settings must comply with medical center policies and standards. Given that hospitals and emergency departments provide a large amount of mental healthcare, the institution itself is responsible for ensuring that staff members are competent to assess and manage all conditions which may be treated. Unfortunately, many hospitals have not specifically addressed this essential training, missing a critical opportunity to ensure that staff members are properly trained.

Rules or standards implemented by any, or all, of the institutional accreditation organizations (e.g., the Centers for Medicare and Medicaid Services, the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, Det Norske Veritas' National Integrated Accreditation for Healthcare Organizations) and state regulatory bodies will motivate facilities to address this problem area. Thus, requiring approved facilities to have documented evidence that their staff has been adequately trained can address the longstanding patient safety issue of improper assessment and management of suicidal patients. Such documentation could easily be reviewed as part of regularly conducted accreditation inspections. This minor addition to the accreditation process would allow each hospital and emergency department to demonstrate that all of its clinical staff members have been trained in the core competencies noted previously.
Recommendation #5: Individuals without appropriate graduate or professional training and supervised experience should not be entrusted with the assessment and management of suicidal patients.

This task force is aware of instances in which organizations regularly place individuals with only bachelor level preparation or less in situations where they are expected to conduct suicide risk assessments without appropriate supervision and to make management recommendations without prior supervisory review or, in some instances, no supervisory review. Given their lack of professional-level education and training, we find this practice irresponsible and egregious, particularly when one considers the gravity of the decisions that must be made and the potential for serious error in judgment. As this document has clearly demonstrated, even the most educated of mental health professionals have generally been exposed to minimal formal training in this critical, specialized skill. Even those trainings specified earlier as meeting quality standards are likely not appropriate for bachelor’s degree-level individuals because these trainings require prior knowledge and skills that are not consistent with an undergraduate education. Thus, anyone without formal training who has not been taught the requisite skills embodied in the core competencies as recognized and embodied in those programs designated best practices by SPRC referred to above and has not demonstrated these competencies in practice settings under proper supervision should not be responsible for potentially suicidal patients. The task force stresses the goal of enabling and facilitating quality training to current providers and providers-in-training which should, ultimately, save lives. By recommending competence-based training, we do not intend to deter professionals from engagement with the topic of suicidality, far from it. As previously
noted, such training is easily accessible, not excessively time-consuming, and is available from a variety of excellent sources.

Suicide risk assessments, treatments targeting suicidality, and management of suicidal patients require specific, specialized skills and abilities (Knesper et al., 2010). Only those individuals with the requisite training, education, and supervision experiences discussed previously should be performing these critical and specialized services. The most likely environment in which this specialized training can be undertaken is through graduate and professional training programs in the mental or medical health fields. Only through specialized post-baccalaureate training conducted by competent, professional supervisors will providers and practitioners-in-training acquire the knowledge, skills, and training experiences that are essential for intervening with individuals in acute suicidal crises. Graduate and residency programs that adequately train their future graduates consistent with recommendation number two are the logical and most qualified venues to ensure that mental health professionals obtain these skills. However, we recognize that many mental health professionals who are currently providing care to patients have not received this training. Thus, the best options for these professionals are the programs that are included on the Best Practices registry noted previously.

**Concluding Remarks**

Improving the training and competence of mental health professionals is one of the most logical ways to prevent suicide and save lives. The current state of training within the mental health field, however, indicates that accrediting bodies, licensing organizations, and training programs are not taking the numerous recommendations and calls to action seriously. There has been minimal progress made toward improving
competence thus far. The recommendations given earlier, if implemented, would address the deficits in training noted in this report. The positions presented here are consistent with those of other organizations (e.g., IOM, 2002; USDHHS, 2001), but further elucidates the crisis in training that has continued to be overlooked and dismissed. The American Association of Suicidology considers this a critical problem, and this task force strongly supports the implementation of the recommendations in this report and those included in the National Strategy for Suicide Prevention (USDHHS, 2001).

The recommendations that have been articulated will require national leaders from the various mental health disciplines, legislative powers, and accrediting and certifying organizations to come forward promptly and move swiftly to address this longstanding deficit. It is understood that these changes will not occur immediately. Unfortunately, the research over the past 30 years has clearly demonstrated that those within the mental health disciplines have been reluctant to address the oft-cited insufficient training in the assessment and management of suicidal patients. Irrespective of the changes called for in this document, it is incumbent on every mental health professional to only provide services that lie within his or her area of competence. As such, each provider is ethically accountable to the public whom they serve and to themselves to be informed and educated about the most commonly occurring behavioral emergency encountered in mental health settings, suicide.

This task force concurs with and reinforces Jobes' (2011) assertion that "a huge challenge to clinical suicide prevention is the actual competency of clinical practitioners" (p. 389). Now is the time to act. Those responsible for ensuring the competence of mental health professionals have overlooked the topic of suicide for far too long.
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