



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

WILLIAM M. SCHMITZ JR., PsyD, MICHAEL H. ALLEN, MD, BARRY N. FELDMAN, PhD, NINA J. GUTIN, PhD, DANIELLE R. JAHN, MA, PHILLIP M. KLEESPIES, PhD, PAUL QUINNETT, PhD, AND SKIP SIMPSON, JD

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 most mental health professionals in the assessment and management of suicidal patients is surprisingly limited. The extant literature regarding the frequency with which mental health professionals encounter suicidal patients is reviewed, as is 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.

WILLIAM M. SCHMITZ JR., Southeast Louisiana Veterans Healthcare System, Baton Rouge, LA, USA; MICHAEL H. ALLEN, Department of Psychiatry, University of Colorado Depression Center and the VISN 19 Suicide MIRECC, Denver, CO, USA; BARRY N. FELDMAN, Department of Psychiatry, University of Massachusetts Medical School, Worcester, MA, USA; NINA J. GUTIN, Didi Hirsch Mental Health Services, Pasadena, CA, USA; DANIELLE R. JAHN, Department of Psychology, Texas Tech University, Lubbock, TX, USA; PHILLIP M. KLEESPIES, VA Boston Healthcare System and Department of Psychiatry, Boston University School of Medicine, Boston, MA, USA; PAUL QUINNETT, Department of Psychiatry, University of Washington School of Medicine, Seattle, WA, USA; SKIP SIMPSON, Law Offices of Skip Simpson and University of Texas Health Science Center, San Antonio, TX, USA.

The views expressed in this article are solely those of the task force and do not necessarily represent the views of the Department of Veterans Affairs or the U.S. government.

Address correspondence to William M. Schmitz Jr., 7850 Anselmo Lane, Baton Rouge, LA 70810; E-mail: william.schmitzjr@va.gov

BACKGROUND

In 2009, suicide was the tenth leading cause of death overall and the third leading cause of death for youth aged between 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). 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).

When a mental health professional 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 (Calhoun, Selby, & Faulstich, 1980; Cerel, Roberts, & Nilsen, 2005; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; 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 article, we 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 professionals in the assessment and management of suicidal patients has been, and remains, woefully inadequate. We follow this with a review of the current state of training and competence among mental health professionals regarding suicide assessment and interventions. We 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. 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 fact, suicide has regularly been among the five most frequently reported sentinel events in recent years (i.e., an unexpected event in a

hospital that caused serious injury or death; Joint Commission, 2010b); insufficient or absent patient assessment is reported as the root cause in over 80% of 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). In addition, social workers encounter suicidal patients on a regular basis, with 87% of social workers in a random nationwide sample reporting 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 indicated 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, & Torigoe, 1988). Research has found that psychologists, social workers, and counselors experience somewhat lower rates of patient suicide. Between 22% and 30% of psychologists report experiencing a patient suicide (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Pope & Tabachnick, 1993), and investigations of patient suicides among social workers and counselors reveal numbers similar to those of psychologists (Jacobson, Ting,

Sanders, & Harrington, 2004; McAdams & Foster, 2000).

CURRENT STATUS OF THE FIELD

There have been numerous calls from national and international public, private, and governmental organizations to improve training in the assessment and management of suicide risk (e.g., Institute of Medicine [IOM], 2002; Joint Commission, 2010a; U.S. Department of Health and Human Services [USDHHS], 2001); World Health Organization 1996). 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 provided a vision that would lead to a cohesive and comprehensive national suicide prevention strategy (U.S. Public Health Service [USPHS], 1999). The strategy included having mental health professionals achieve competence in suicide risk assessment and management.

Competence has been defined by various authors in a number of different ways. 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 in the assessment of suicidality is an essential clinical skill that has consistently been overlooked and dismissed

by the colleges, universities, clinical training sites, and licensing bodies that prepare mental health professionals.

THE PREVALENCE OF TRAINING IN SUICIDE RISK ASSESSMENT AND MANAGEMENT

The lack of training available in the institutions that prepare mental health professionals has been documented for decades. Multiple studies have found that only approximately half of psychological trainees had received didactic training on suicide during their graduate education, and the training provided was often very limited (Dexter-Mazza & Freeman, 2003; Kleespies et al., 1993). 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. Nearly 76% of responding directors of graduate programs in psychology indicated that they wanted to include more suicide-specific training in their programs, but encountered a variety of barriers to doing so (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). Faculty and deans—directors of graduate social work programs reported that most students receive 4 hours or fewer of suicide-related education (Ruth et al., 2009). The lack of training is even more pronounced among professional counseling and marriage and family therapy training programs. Wozny (2005) found that suicide-specific courses were present in 6% of accredited marriage and family therapy programs and in

2% of accredited counselor education 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), in a national survey of directors of training in psychiatry, found that 94% of the responding directors reported some form of training in suicide risk assessment and intervention in their residency programs. However, the majority of directors reported that most of the training occurred in passive formats (e.g., therapy supervision, general seminar), and only 27.5% reported training via skill development workshops.

A more recent national survey of chief psychiatry residents by Melton and Coverdale (2009) found that, despite 91% of the residency programs offering some teaching on the care of suicidal patients, 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 nondescript. Many of the respondents were of the opinion that the focus on suicide intervention was insufficient (Melton & Coverdale, 2009).

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, “[b]y 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 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 (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 NSSP (USDHHS, 2001) had been implemented. The *2010 Progress Review of the National Strategy* (SPRC & SPAN, 2010) findings regarding the current standards for clinical training were disheartening. After reviewing the standards for 11 different mental health professional groups, “[o]nly 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).

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. Again, only psychiatry has made some efforts in this regard. 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, not a single state or mental health licensing body requires continuing education addressing suicide, suicide risk, or other behavioral emergencies.¹

¹Our review of state continuing education (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. Among states that maintain CE requirements for licensure, our review indicated that none require any suicide-specific CE credits.

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 states 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 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 training programs, especially those that included supervised skill demonstration and rehearsal, significantly affected health care providers' behavior (Bloom, 2005). However, a recent review has raised questions about the efficacy of training in workshop formats for improving the clinical care of the suicidal patient (Pisani, Cross, & Gould, 2011). Despite this review, studies have shown improvements in knowledge and skills because of 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 workshop on evidence-based assessment of

suicide risk significantly improved the ability of psychiatry residents and psychology interns to identify risk factors for suicide and also improved their specificity about the significance of risk and protective factors when developing plans for intervention. Allgaier, Kramer, Mergl, and Hegerl (2009) found that 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 et al. (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.

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 6-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).

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 have been demonstrated to be effective in increasing suicide-specific knowledge and skills. The depth and breadth of these evidence-based training programs vary in length from 6 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 up to 4 months after training (Jacobson & Berman, 2010).

Systems-Level Problems Affecting Training

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., USDHHS, 2001; USPHS, 1999), virtually nothing has been done by licensing boards, training programs, and professional organizations. 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).

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 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 (SPAN, 2011). 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. 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 sui-

cidal 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 even higher risk for suicide.

The lack of training required of mental health professionals regarding suicide has been an egregious, enduring oversight by the mental health disciplines. 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, over the years, numerous authors have specifically called into question the ethics of mental health professionals who, without adequate training, provide service to suicidal patients (e.g., Bongar & Harmatz, 1991; Feldman & Freedenthal, 2006; Jacobson et al., 2004; Rudd, Cukrowicz, & Bryan, 2008). 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 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, 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. The system of training mental health professionals 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. 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. 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 literature and based on the task force members' collective administrative, 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 the 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., the 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 aid in ensuring that the longstanding gap in the training of mental health professionals is finally closed.

This 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. We recognize that this summit is a starting point for a change process that will continue to evolve.

Recommendation #1: Accrediting organizations must include suicide-specific education and skill acquisition as part of their requirements for postbaccalaureate 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, 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 scientific literature and are considered essential for assessing and managing suicide risk (SPRC, 2006). To aid in the process, Rudd et al. (2008) have provided detailed guidelines for facilitating the adequate education of mental health trainees regarding these competencies. 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. 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).

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 and maintain their knowledge of suicide risk and develop their skills in assessment 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 ser-

vices 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 presumably benefit. Thus, it has been demonstrated that a required continuing education area is feasible to implement without being overly burdensome to mental health professionals.

Recommendation #3: State and federal legislation should be enacted requiring health care 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. It is incumbent on health care facilities that receive state and federal funds 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. Medical centers, hospitals, and health care 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 then U.S. Representative Patrick Kennedy (D-RI; H.R. 5040, 2010). While the bill was not enacted prior to the conclusion of the legislative session, had it passed, agencies that provide health care 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 (2002) report and the *NSSP* (USDHHS, 2001).

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.

Hospitals and emergency departments cannot be considered safe havens from suicide. The Joint Commission (2010a) has noted the presence of systemic shortcomings that contribute to suicide in the hospital and emergency department setting, specifically noting problem areas of “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” (p. 2).

To protect the health and safety of suicidal patients who are in hospital, medical center, and emergency department settings, health care 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. 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) and state regulatory bodies will motivate facilities to address this problem area. Thus, requiring accredited 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.

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. 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. 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.

Graduate and residency programs that adequately train their graduates consistent with Recommendation #2 are the logical and most qualified venues to ensure that mental health professionals obtain these skills.

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 indicates that accrediting bodies, licensing organizations, and training programs have not taken the numerous recommendations and calls to action seriously. The recommendations given earlier, if implemented, would address the deficits in training documented in this report. The positions presented here are consistent with those of other organizations (e.g., IOM, 2002; USDHHS, 2001), but fur-

ther 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 *NSSP* (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. 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. This task force concurs with and reinforces Jobs (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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Manuscript Received: February 7, 2012

Revision Accepted: February 21, 2012