Suicide Prevention and the Clinical Workforce: Guidelines for Training

Prepared by the
Clinical Workforce Preparedness Task Force
of the National Action Alliance for Suicide Prevention
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The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

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Executive Summary

It has been well documented in numerous studies and papers that clinicians from a wide range of professions routinely encounter individuals at risk for suicide. These professions include nurses, social workers, physicians, mental health professionals, and others. Studies have also shown that many of these individuals do not have a level of confidence in dealing with suicidal individuals due to a lack of training. Having a competent and confident clinical workforce is critical to reducing the rate of suicide.

Recognizing this imperative, the National Action Alliance for Suicide Prevention established the Clinical Workforce Preparedness Task Force to advance the competency of the broad clinical workforce and the settings within which they serve individuals at risk of suicide. The Task Force was charged with developing training guidelines that could be used as a framework in the development, adoption, and adaptation of training efforts for the clinical workforce in serving persons at risk for suicide. To advance this primary purpose, the work of the Task Force also included raising awareness of suicide as a major health priority with professional associations, educational institutions, and professional licensing entities and the role they play in addressing the matter, with an end goal of these clinical entities creating training programs worthy of accreditation. The result of the Task Force's work is intended to initiate dialogue among the disciplines on the need for this training and to affirm their support and also the support of accreditors through their standards addressing the need for training and practice in suicide prevention.

With these tasks in mind, the Task Force carefully and deliberately developed a core set of training guidelines through a three-step process. The current state of education and training for the professions comprising the clinical work force was assessed through an environmental scan that included a literature review and surveys of licensing entities, accreditation entities, and educational institutions. The results revealed no or very little requirements for suicide assessment and intervention training. The results of this review and a review of training materials from organizations and programs whose primary purpose is suicide prevention were used to identify similarities, gaps, and opportunities. This effort resulted in a draft set of training guidelines. These guidelines were incorporated into a survey that was sent to stakeholders first contacted during the scan for training requirements. Feedback received from this survey was reviewed and revisions were made to the guidelines. This second draft of the guidelines was then sent again for final review

and endorsement by the same target audience as the previous surveys. Receiving strong support from a broad range of professionals in the field, the guidelines contained within this report provide a template to construct a solid training program in suicide prevention for those disciplines in the clinical workforce.

The Task Force's work does not end with the creation of these guidelines and this report. Its focus must now turn to advancing the competencies of a broad health care workforce through securing support from and engagement of key stakeholders. It is anticipated this effort will require a three-phase change process to ensure a competent, enabled workforce. Phase 1 will require awareness of suicide as a major public health matter that professional medical and mental health guilds can and should address; acknowledgement of the gaps in training by educational institutions, licensing bodies, and professional associations; and affirmation that a key strategy in reducing suicide rates is the need for a minimum set of training guidelines for the clinical workforce. Upon adoption of the guidelines by a critical mass of key stakeholders, Phase 2 will be the adaptation of the guidelines by each discipline, educational institution, and licensing body, as necessary. Phase 3 is the evolution to a practicing environment where a majority of disciplines, educational systems, and licensing bodies require a minimum standard skill set to be present within the training of each discipline, with commonalities across disciplines. These efforts will advance the ultimate aspirational goal of the Action Alliance of saving 20,000 lives in the next five years.

1.0   Introduction

As the 10th leading cause of death in the United States in 2009,[9,11,17,29] suicide challenges the entire human services spectrum of clinical resources and the services they perform. The responsibility of the clinician to assess, intervene, and monitor suicidal behavior presents as a significant opportunity to save a life. Such a situation, however, can also present as a heavy burden if the clinician is ill-prepared for such a clinical situation.[16] It has been well documented in the literature that clinicians from a wide range of professions will encounter individuals at risk for suicide;[6,7,10,21,22] many do not have confidence in dealing with such challenges;[12,15] and a majority of clinicians, in various settings, have minimal to no training to competently deal with a clinical situation to prevent suicide.[2,17] In order to reduce suicide rates in the United States, a key objective is to ensure that a competent and resilient clinical workforce is trained and prepared for suicide risk assessment, intervention, monitoring, and follow-up.

The *2012 National Strategy for Suicide Prevention*[29] articulates four interconnected strategic directions, with thirteen (13) associated goals and sixty (60) objectives, to champion suicide prevention as a national health priority. The four strategic directions include:

1. Healthy and Empowered Individuals, Families, and Communities
2. **Clinical and Community Preventive Services**
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation[29]

The second strategic direction, Clinical and Community Preventive Services, specifically includes **Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors[29]** and two of the objectives under this goal follow:

> *Objective 7.3:* Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.[29]

The intent of this objective is for education and training programs, including continuing education, for health professionals to adopt core education and training guidelines addressing suicide prevention. These guidelines should also be adopted by all degree-granting undergraduate and graduate programs as part of their curricula. This effort is to "ensure that graduates achieve the relevant core competencies in suicide prevention appropriate for their respective disciplines."[29]

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.[29]

The intent of this objective is to ensure that health professionals achieve competence in "addressing suicidal behaviors and remain competent over time."[29] This can be accomplished through state requirements for licensing examinations and certification programs "in order to maintain active licenses and/or professional certifications."[29] Accrediting and credentialing organizations can "promote evidence-based and best practice suicide prevention training for the organizations and practitioners they accredit or credential."[29] Accreditation standards can be developed that require professionals be trained and tested on that content via certification and licensing exams.[29]

The *2012 National Strategy for Suicide Prevention* recognizes that one of the key steps to prevent and intervene competently with persons at risk of suicide is to ensure a ready and able clinical workforce that is prepared to assess and intervene when necessary. This goal is challenging given the varied health professions that need training, each with their respective scope of practice matters, the varied settings in which such services are delivered, and the ongoing requirements for maintaining practice currency. While initiated within the context of the previous iteration of the *Nation Strategy for Suicide Prevention* (NSSP 2001),[28] the National Action Alliance for Suicide Prevention (Action Alliance) established a Clinical Workforce Preparedness Task Force with the purpose of advancing the competency of the broad clinical workforce and the settings within which they serve individuals at risk of suicide.

2.0   Task Force Charge

2.1   Purpose

The Clinical Workforce Preparedness (CWP) Task Force was established by the Action Alliance to develop a training template or guidelines that could be utilized as a skeletal framework to accelerate the development, adoption, and adaptation of training efforts for the clinical workforce specific to serving persons at risk of suicide. The core training guidelines can be viewed as a pooled minimum set of training guidelines that can be used for expediting the development of training efforts for key stakeholders: educational institutions that wish to add to or expand their curriculum; professions for continuing education or additional certification; and, potentially, licensing bodies as acceptance to practicing in a state.

2.2   Supporting Purposes

With the primary purpose of establishing a universal set of suicide training guidelines or framework, the CWP Task Force also has supporting purposes that advance the notion that "zero suicide" is an aspirational national health priority that can be approached through a prepared and capable clinical workforce. These supporting purposes include the following:

- Raise awareness within the health disciplines, through the work of the CWP Task Force, that suicide rates present a major health concern and are a priority that needs the attention of the professional medical and mental health associations, education institutions and professional licensing entities, and about the role these associations, institutions and entities play in addressing this matter.
- Initiate and contribute to the discussion of reducing suicide with the development of "imperfect training guidelines."
- Initiate dialogue within and between disciplines regarding the consensus on the need for a required training commitment to ensure a competent, capable, and ready work force.
- Solicit support from a majority of the clinical disciplines and associations that the proposed universal training guidelines advance the overall basic preparedness of clinicians and generate a commitment to developing specific training—consistent with the scope of practice, licensing, and other regulatory and professional standards requirements for each of the respective disciplines.

- Enable organizations/entities to be accredited for comprehensive training program delivery
- Identify in their standards the need for training and practice standards in organizations and programs accredited for services to individuals
- Integrate CWP Task Force work with and support, as appropriate, the Zero Suicide Advisory Group and Faith Communities Task Force, and ensure that such work contribute to and/or support work-based or employer-based training efforts for both clinical and non-clinical participants.
- Encourage organizations utilizing these guidelines to consider how they apply in addressing specific needs of persons experiencing suicidal ideation, suicidal behavior, and loss due to suicide. The guidelines as written, while specific to the clinical disciplines, may complement and/or contribute to the pastoral disciplines as well. The Suicide Attempt Survivors Task Force and Survivors of Suicide Loss Task Forces are also developing more specific postvention guidance for assisting survivors, which clinical and pastoral providers are likely to encounter in the course of practice and care.

2.3   Objectives

The objectives of the Task Force included the development of curriculum guidelines for clinical training programs designed to improve the preparation of the clinical workforce to serve those at risk for suicide. The work of the Task Force was targeted to ensure that the training programs were content comprehensive to ensure a solid foundation of knowledge necessary to serve individuals at suicide risk and their families. Advanced training would enhance the capability and competency to provide the resilience necessary for health professionals in the field to repetitively cope with the various forms of stress in the field. Accreditation of training programs that might offer specific clinical practice certification or continuing education credits, as a supported purpose, would provide the independent third-party test to ensure that the training programs meet acceptable standards of training design and delivery.

2.3.1 Professional Population – Defined

The target population for the CWP Task Force includes professions of various disciplines from the health and human services industry that are licensed to practice their profession or discipline by state regulatory or licensing bodies and/or are governed by professional association requirements in order to practice in their discipline. As an illustration, professionals are those individuals who engage in direct service to individuals—such as nurses, social workers, physicians, and psychologists. Excluded in the scope of this effort were first responders and other, often critical, workforces that included community and faith-based resources, such as the clergy and community crisis lines staff and volunteers of community crisis lines. A list of the professions is included in Appendix B.

2.3.2 Limitations, Sensitivities, and Pragmatics

The establishment of one comprehensive and thorough set of training standards to serve across all disciplines, discipline subspecialties, and the various settings in which the professions serve was quickly understood as an improbable Task Force goal. Professional standards or practice standards have a legal force that appropriately resides with postsecondary training institutions; professional associations; and licensing bodies who establish, monitor, and regulate the standard of practice for health disciplines. Accreditors offer quality standards that apply to organizations and the services or programs offered for persons in need of such care. The CWP Task Force, therefore, focused on developing training guidelines to be respectful of each disciplines self-regulation and to create a universal resource for each profession, subspecialty, and location in which they practice.

The CWP Task Force's core set of training guidelines were developed through a review of sources readily available to Task Force members during the design phase of the project. It is likely that the Task Force may not have reviewed or sourced all research and publications on this topic, so this report may not rise to the level of an academically publishable paper; however, the breadth of input and the core of the Task Force's survey input methodologies to extend the expertise of the panel, assures both the authors and reviewers of this report that the designs are

substantially supported both by literature and expert input sources. Hence, the Task Force came to an early decision that a universal design or a template for training in the form of guidelines would be developed to offer to those associations and other entities a minimum pooled set of training guidelines. The disciplines and entities could then take the general training guidelines and add the necessary specificity in order to adopt, adapt, and evolve their own professional standards to meet the needs of their disciplines and the locations in which they may serve persons at risk for suicide.

Pragmatically, draft guidelines offer a template to those entities who wish to embark upon a development effort for training, and the guidelines remove simple curriculum development barriers to entry. Therefore, to most on the Task Force, the guidelines are as "reasonable as possible" given the universality necessary for broad-based adoption. However, once adopted, and then adapted for the specific areas of the discipline or the setting in which services are delivered, the guidelines become owned by the discipline entity who has invested the time and effort to evolve the guidelines to influence training and development to advance practice competency. Guidelines can only accelerate to the "professional standards" of practice through and with the respective health discipline entities as a lead for each discipline.

3.0   Task Force Approach

3.1   Process

The initial work of the CWP Task Force was guided by the following key steps in the process:

1. **Identify current training guidelines** for the recognition of at-risk behavior, assessment, and delivery of effective treatment and management of suicide risk.
2. **Identify similarities, gaps, and opportunities** relative to current state of training guidelines.
3. **Define new core universal training guidelines**.

3.1.1   Identification of Current Training Guidelines

To accomplish the first task, the CWP Task Force needed to assess the current education and training of the many professions comprising the clinical work force. The Task Force began with an inclusive and broad environmental scan by surveying professional organizations and associations, individuals, licensing bodies, and institutions of higher education for information regarding whether specific training or education on suicide prevention and intervention is conducted or required for the various clinical professions.

Environmental Scan – Survey Methodology

The surveys were created and designed utilizing an external third-party survey system, Survey Monkey. The survey questions were developed under the guidance of research and scaling specialists with more than 20 years' experience in order to ensure the questions were developed correctly and would solicit the appropriate and necessary information. Survey participants were selected through several methods. An internet search was conducted to identify and gather contact information for all of the appropriate state licensure and regulatory boards in the United States, resulting in 167 contacts. Academic institutions were identified through the database of Accredited Postsecondary Institutions and Programs obtained from the United States Department of Education website.[27] The data were downloaded into an Excel spreadsheet and then reduced to include only those institutions with schools for the clinical professions previously identified. Because of the large number of academic institutions, a random sampling process was used to determine the distribution list. From this list, an internet search was conducted to find the contact for the dean of each school or program, resulting in 443 identified potential respondents. A list of accreditation bodies for academic postsecondary institutions was also obtained from the U.S. Department of Education website and an internet search was conducted to determine accreditation programs for specific clinical professions (nursing, physicians, social workers, etc.) identifying another 24 potential respondents. The surveys are included in Appendix C.

Environmental Scan – Survey Results

State credentialing and licensing boards were asked if they currently require course work or training in any aspect of suicide prevention for initial certification or licensure or for renewal. Seventy-five of the 80 respondents (93.75%) reported that

their board did not require specific training in suicide prevention prior to initial licensure or certification, and all reported that there was no specific training requirement for continuing education in suicide prevention.

Organizations that accredit degree programs for the preparation of health and mental health professionals within institutions of higher education were asked if they currently require course work in any aspect of suicide prevention. No responses to this survey were received; however, two organizations responded via e-mail that they accredit the institution as a whole and do not review or have specific requirements for programs. This was not an unexpected result of the survey and is supported in the other literature reviewed.

Institutions of higher education were also asked whether their programs for the initial preparation of health and mental health professionals currently require course work in any aspect of suicide prevention. Only 19 percent of the respondents reported that their degree programs preparing professionals for the clinical workforce required specific course work where the content was entirely about suicide prevention. Nursing programs rated the highest number of programs that required specific course work entirely focused on suicide prevention. However, 79 percent of respondents reported that suicide prevention was included as part of a related course, such as crisis prevention or intervention.

Environmental Scan –Literature Review

The Task Force also conducted an extensive literature review in addition to the surveys to assess and review what training programs exist from a range of professional organizations, settings, armed services, and accrediting bodies, and whether they were required for the professions. In addition to those sources already cited, these additional sources are listed in the References section of this report.[1,3,4,5,8,9,13,14,18,19,20,23,24,25,26] This review also included a scan of organizational websites. The websites reviewed are listed in Appendix D. The summation of these efforts revealed either an absence of or very little requirement for the professions to receive specific training in suicide assessment and intervention.

During its research, the CWP Task Force was mindful and respectful of scope of practice issues under which each profession operates and executes their duties, but the absence of identified, formalized requirements on specific training remains a continuously disappointing discovery.

3.1.2. Identification of Similarities, Gaps, and Opportunities

The results of the environmental scan were used in conjunction with a review of training materials from organizations and programs whose specific purpose is suicide prevention in order to identify similarities, gaps, and opportunities. After this review, a draft set of training guidelines was developed as a starting point for Task Force discussion during a face-to-face meeting. After significant discussion at the meeting, a small work group was tasked with review and modifications and/or additions to the guidelines. During a series of conference calls, this work group carefully and purposefully reviewed numerous resources of best practices in suicide prevention training and made revisions to the initial draft of the guidelines, with the goal in mind to ensure the guidelines would be universal in design and easily adoptable by the range of clinical disciplines for which they were intended. Once these revisions were made, it was determined that the guidelines were ready to be sent to stakeholders as an extended panel of the Task Force for feedback to determine support for and appropriateness of the guidelines.

3.1.3. Define Core Universal Training Guidelines

The first draft of the guidelines was sent to those individuals who received the first environmental scan survey for their response. The guidelines were also sent to other stakeholders who had been identified early on in the work of the Task Force. This included relevant professional associations for the identified clinical workforce disciplines and other health and human services entities involved with or having a strong interest in suicide prevention. In total, surveys were sent to nearly 1,000 individuals across the United States. It was also requested of all recipients to forward the survey to others they felt would find the survey of interest in order to broaden the audience of the survey. In this case, the survey design referenced competencies from other sources to provide the reviewer with context for the

guidelines and assurance that the guidelines were rooted in current practice. Respondents were asked to indicate whether or not they agreed with the guidelines and were allowed to provide comments. The feedback received was reviewed, and, based upon the feedback, further revisions were made to the guidelines by a small work group during another series of conference calls. Again, the work group was mindful of the wide scope of disciplines for which the guidelines are intended. This second set of revised guidelines was sent once again to those who had received the previous surveys for final review and endorsement. The respondents were asked to indicate their agreement with the guidelines and were allowed to provide comments. Over the two surveys, a cumulative 1,755 specific guideline responses were received to the survey questions, giving the Task Force confidence that each of the guidelines was reviewed beyond the 22 members of the Task Force.

The guidelines received more than a 90 percent agreement of support from respondents. The broad range of clinical disciplines for which the guidelines are intended were represented by the respondents. A list of these demographics is provided in Appendix E.

Most surprisingly, feedback was received from several credentialing/licensing boards stating that while they require continuing education, they do not require education on specific subjects, nor did they feel it was appropriate for them to respond to the survey.

With more than 90 percent agreement from survey respondents of the final survey, the guidelines were considered to be finalized and ready to be shared with the Action Alliance and to initiate Phase 1 of a longer-term effort to advance the clinical workforce competency in suicide prevention.

3.1.4. Limitations

Several limitations were noted during the Task Force's research and survey results:

- During the literature review, a limitation was noted that an organization's website might not reflect the current activity of the organization regarding suicide training standards. The information may

not be publically available on the website, or the organizations may use or purchase training programs developed by outside entities.

- Another limitation included the generation of survey respondents. Directed at deans of nursing schools, medical schools, credentialing and licensing boards, and accreditation entities, the individual to whom the survey was e-mailed may not have always been the most appropriate person to respond to the survey. To help mitigate this limitation, the recipients were asked to forward the survey onto others if they were not the most appropriate person to complete the survey.

- Some individuals responding to the survey felt they could not speak for their association or institution but only for themselves.

It is anticipated that the proposed Next Steps identified in this report (section 5.2) will further highlight limitations and barriers faced by the Task Force and also provide for solutions to initiate and sustain a long-term training effort.

4.0   Training Guidelines

The Task Force's efforts resulted in a set of guidelines that received strong support from a broad range of professionals in the field. The guidelines are a template to constructing a solid training program, worthy of accreditation. The guidelines are intended to be universal in nature and are not prescriptive so that they may be adopted, adapted, and evolved as needed for a particular profession to be trained. Intent statements and examples are provided when necessary to help give further clarity as to the intent of the guidelines and demonstrate how a training program can meet the guidelines. These intent statements and examples will likely be different for each of the disciplines and subspecialties and for locations of services. Many guidelines contain a list of factors. It should be noted that these lists are not all inclusive, and there may be additional considerations dependent upon the setting of the profession and/or organization receiving the training. It should also be noted that the guidelines are intended for continuing education programs and may not always be applicable to degree-granting institutions, in particular, the guidelines related to the structure of training. This "structure of training guidelines" may be particularly useful for employer-based training or association-based training that is created in-house or is an initial effort.

PART 1. STRUCTURE OF TRAINING

1. **The training program has a written plan that includes:**
   a. **The philosophy of the program.**
   b. **A description of the program that includes references to literature supporting the training design.**
   c. **The target audience for whom the training applies.**
   d. **The program's training goals.**
   e. **The program's training limitations.**
   f. **The content to be delivered.**
   g. **The length of the training.**
   h. **Evaluation of the training, including:**
      (1) **Training goals realized.**
      (2) **Performance of presenter.**
      (3) **Opportunities for improvement.**
   j. **Mechanism to address special training needs and/or accommodations.**

Intent Statements

These guidelines are intended for all disciplines in the clinical workforce. The philosophy of the program and other components of the written plan should reflect the respective discipline receiving the training.

Examples

1.h. Training may be evaluated through various methods, including pre- and post-training surveys, direct feedback from participants, satisfaction surveys, and certification or accreditation.

2. **The training program has identified personnel to:**
   a. **Coordinate the training.**
   b. **Deliver the training in an appropriate learning environment.**
   c. **Advise the host organization or participant on any follow-up training needs or supports.**

3. **The training program is conducted by an individual(s) who is qualified to train within the scope of practice parameters based on:**
   a. **Experience applicable to the:**
      (1) **Subject matter.**
      (2) **Target audience.**
   b. **Demonstrated qualifications of the trainer.**
   c. **Verified background and credentials, when necessary.**

Intent Statements

Selection of a trainer should consider the individual's experience in the clinical discipline pertinent to the training and extensive professional experience with the subject matter.

4. **The teaching methodology is commensurate with the level of skills expected to be developed by the trainees and employs the following methodologies, as appropriate:**
   a. **Classroom lectures and discussion.**
   b. **Workshops.**
   c. **Webinars and online, self-paced modules.**
   d. **Case study review.**
   e. **Simulations.**
   f. **Mentorship.**
   g. **Internship.**

Intent Statements

The teaching methodology should consider the clinical profession for which the training is being provided and the setting in which it is being provided (degree-granting institution or continuing education). The training is expected to be comprehensive and multi-modal and should incorporate multiple learning styles and methods.

Examples

4.e. Simulations should be appropriate to the profession and may include such activities as role-play, risk formulation, and treatment plan development.

5. **The training program considers accessibility issues and barriers to training, including:**
   a. **Attitudinal.**
   b. **Architectural.**
   c. **Any other barrier that may prevent successful training.**

Examples

5.a. Attitudinal barriers may include resistance to being required to take training and/or to the subject matter, terminology, or language used in the training (lack of support in the organizational culture), or a sense that one knows what they are doing when they may not.

5.b. Architectural barriers are generally easy to identify and may include accessibility issues for individuals who use wheelchairs, such as narrow doorways, steps preventing access, and inaccessible bathrooms.

6. **The training is provided in an environment that:**
   a. **Is safe, including:**
      (1) **Egress procedures that are shared with attendees.**
      (2) **A plan for responding to participants who may be emotionally reactive to elements of content and process.**
   b. **Is conducive to learning.**
   c. **Provides for confidential deliberation and discussion.**

Intent Statements

6.a.(2) Some participants may have personal or professional experiences with suicide that they may not have previously processed and integrated. A plan should be in place to respond to these types of situations.

7. **The training program includes an evaluative component to ensure that it continually improves, including:**
   a. **A review of:**
      (1) **Training goals met.**
      (2) **Training goals not met.**
      (3) **Identified opportunities for improvement.**
   b. **Feedback from the host organization and trainees on the:**
      (1) **Relevance of the training to identified goals and needs.**
      (2) **Depth of training content.**
      (3) **Quality of instructor delivery.**
      (4) **Quality of mentorship or internship, if applicable.**
   c. **An annual review that includes:**
      (1) **Feedback from participants.**
      (2) **Feedback from instructors.**
      (3) **Feedback from host systems or organizations, if applicable.**
      (4) **Literature reviews and review of changes in the environment, as needed.**
      (5) **Review of the training program and revisions, as needed or appropriate.**

Intent Statements

7.c.(4) Based on feedback from training participants, the programs elements should be reviewed and updated as necessary.

Examples

7.a.(1)–(2) Review of the training goals met and not met may include pre- and post-training tests.

7.c.(1) Feedback from participants may be solicited immediately following training with a subsequent follow-up to identify if they are retaining and using skills learned.

7.c. Materials are updated with more current and/or relevant examples for the specific target population trained.

Part 2: Training Content Guidelines

1. As relevant to the scope and target audience of the training program, suicide prevention training includes, but is not limited to:

    a. Reinforcement of the importance of establishing a therapeutic relationship with an emphasis on:

        (1) Respect for the rights and dignity of the person at risk.

        (2) The need to recognize the individual preferences, needs, and activities of the person at risk.

        (3) The need to establish a compassionate and empathetic relationship that allows for a collaborative approach to intervention, where the person is an active participant in any short- and long-term intervention.

    b. Suicide concepts and facts, including:

        (1) Language, concepts, and definitions of suicidality.

        (2) Facts and myths of suicide.

        (3) Data on suicide, including characteristics and demographics.

        (4) Exploration of participants' attitudes and beliefs.

        (5) Common risk factors, including:

            (a) Availability of lethal means.

            (b) Few available sources of supportive relationships.

            (c) High-conflict or violent relationships.

            (d) Family history of suicide.

            (e) Mental illness.

            (f) Substance abuse.

            (g) Previous suicide attempt.

            (h) Impulsivity or aggression.

            (i) Media portrayals of suicide.

            (j) Barriers to health care, such as lack of access to providers or medications.

            (k) History of physical, sexual, and/or mental abuse.

            (l) Life loss or crisis, such as a death or the loss of a relationship or job.

            (m) Serious illness.

            (n) Suicide cluster.

        (6) Protective factors, including:

            (a) Availability of physical and mental health care.

            (b) Creation safe practices to mitigate lethal means of suicide.

            (c) Safe and supportive school and community environments.

    (d) **Sources of continued care after psychiatric hospitalization.**
    (e) **Connectedness to individuals, family, community, and social institutions.**
    (f) **Supportive relationships with health care providers.**
    (g) **Coping and problem-solving skills.**
    (h) **Reasons for living, such as children in the home.**
    (i) **Cultural and religious factors.**
  c. **Legal and regulatory information, including:**
    (1) **Laws related to civil liability, including duty to protect/warn.**
    (2) **HIPAA, FERPA, and other privacy laws.**
    (3) **Scope of practice.**
    (4) **Confidentiality.**
  d. **Documentation requirements, including case records management and retention.**
  e. **Follow-up and transition matters.**
  f. **Cultural and local factors.**
  g. **Specific issues to the setting or organization of the training.**

Intent Statements

It is recognized that members of different clinical professions have different training needs for the range of roles they may need to perform, from early identification of suicide thoughts and first-aid safety plans to longer-term help and ongoing continuity of care. The concepts listed above should be included in suicide prevention training; however, the list is not exhaustive and the demographics of the population the discipline(s) are working with (e.g., youth, older persons, LGBTQ individuals, individuals with brain injuries, veterans, individuals with poly-trauma) must also be considered when adapting the guidelines. Entities are encouraged to expand on the basic list above.

1.a. It is recognized that practicing clinicians should have some fundamental skills in establishing a helping relationship with the persons at risk of suicide; however, the training reminds participants of the importance of this fact on intervention and long-term outcomes.

2. **Suicide first-aid and risk-assessment training:**
  a. **Emphasizes the importance of synthesizing both risk and protective factors in the development of individualized short- and long-term plans for the person at risk of suicide.**
  b. **Includes:**

  (1) **Exploration of warning signs and risk invitations, including:**
    (a) **Isolation.**
    (b) **Mood swings.**
    (c) **Concentration difficulties.**
    (d) **Difficulty sleeping.**
    (e) **General malaise, fatigue, boredom, or irritability.**
    (f) **Concurrent physical pain or symptoms.**
    (g) **Experience of being bullied.**
    (h) **Talk of suicide.**
    (i) **Acting out, including violence, outbursts, or fights.**
    (j) **Unusual cheerfulness.**
    (k) **Gifting of "prized possessions."**
    (l) **History of escalated risk taking.**
    (m) **Decline in mental abilities or functioning displayed at home, work, or school.**
  (2) **Screening for risk factors, including open and direct talk about:**
    (a) **Suicide thoughts or plans.**
    (b) **Intent to act on suicide plans.**
    (c) **Availability of lethal means.**
    (d) **Unbearable pain.**
    (e) **Resource isolation.**
    (f) **Prior suicide attempt.**
    (g) **Exposure to suicide.**
    (h) **Mental health issues, such as depression.**
  (3) **Screening for protective factors, including open and direct talk about:**
    (a) **Reasons for living.**
    (b) **Connectedness to individuals, family, community, and social institutions.**
    (c) **Supportive relationships with health care providers.**
    (d) **Active treatment.**

Intent Statement

When assessing risk and protective factors in formulating plans, the relevance and currency of the noted risk and protective factors in 1.b.(5) and (6) should be assessed against the individual case and current literature, which may add or detract relevant factors from the lists. The lists are intended to prompt clinicians to consider a myriad of complex factors.

3. **Training on intervention includes:**

   a. **Determination of risk level to inform short- and long-term planning, including how to:**

      (1) **Make a clinical judgment of the risk that a person may attempt or complete suicide in the short- and long-term.**

      (2) **Document the judgment and the rationale in the person's record.**

      (3) **Develop a written treatment and services plan that addresses the person's immediate acute and continuing suicide ideation and risk for suicide behavior.**

      (4) **Determine appropriate treatment level referral.**

   b. **Assessment of issues related to imminent harm via lethal means or self-injurious behavior, including:**

      (1) **Access to and/or use of:**

         (a) **Medications, including prescription and recreational use.**

         (b) **Firearms.**

         (c) **Poisonous materials.**

         (d) **Motor vehicles.**

         (e) **Carbon monoxide.**

      (2) **Intoxication.**

   c. **Development of a safety plan based on the above through:**

      (1) **Agreements for safety.**

      (2) **Removal or disabling of the means of harm.**

      (3) **Connection with emergency resources.**

      (4) **Establishment of frequency of contact.**

      (5) **Plans for the at-risk individual to increase connectedness by contacting his or her family, community, and social institutions.**

      (6) **Protective activities.**

Intent Statements

   3.a.(4) The training includes guidelines for when to send someone to a hospital or other protective inpatient setting for an evaluation and when outpatient and crisis support services are appropriate.

4. **Training covers the development of a plan for continuity of care that:**

   a. **Secures:**

      (1) **Longer term, ongoing clinical care management by a professional that meets the safety plan needs of the person at risk for suicide.**

      (2) **Continuous assessment of suicide risk with adjustments to the safety plan and treatment plan as necessary.**

      (3) **Community resources and support that provide continuity of care support for the:**

                  (a)   **Individual at risk.**

                  (b)   **Family affected.**

                  (c)   **Affected others, as appropriate.**

         (4)   **Family support and education as necessary.**

         (5)   **Availability of emergency telephone numbers.**

    b.   **Is individualized for the unique needs and settings of the person at suicide risk.**

    c.   **Demonstrates involvement and knowledge of the person and/or his or her family support system.**

    d.   **Sets out expectations for:**

         (1)   **Follow through by the person.**

         (2)   **Communication with supervisory and/or other supportive professionals to ensure a smooth transition to the role of ongoing clinical care.**

    e.   **Includes plans for follow-up on commitments.**

Intent Statements

The long-term care plan should be developed once the risk assessment is conducted and ongoing clinical care for suicide risk is established.

5.0 Clinical Workforce Preparedness Task Force Progress on Purposes and Next Steps

5.1 Progress on Purposes

To manage the work of the Task Force to its stated project purposes, it is important to assess the work of the Task Force against its primary and supporting stated purposes in working towards its assigned long-term objectives (7.3, 7.4) as articulated in the *2012 National Strategy for Suicide Prevention*. The Task Force recognizes that any resulting outputs from this effort merely contribute to the necessary long-term sustained vision and corresponding commitment needed from many other key stakeholder groups to create a more prepared and competent workforce in its collective capabilities to service persons at risk for suicide. Table 1 represents a current snapshot assessment of progress against the Task Force stated purpose and supporting purposes.

Table 1. Summary of Stated and Supporting Purposes

Task Force Purpose	Activity Status	Results, Findings, & Comments
I. Primary Purpose	MET	
A. Develop a training template or guidelines to advance clinical workforce preparedness	- Reviewed literature – Various - Reviewed training programs – Various - Assessed professional associations websites - Conducted three structured surveys - Environmental scan - First draft - Second draft - Finalized guidelines - Developed by Task Force - Two reviews by extended survey panel	- Little requirement for suicide training: - In postsecondary - As part of licensing - For continuing education - Little recognition of suicide as a national health priority - Support for official "finalized" guidelines/requirements by panel > 90% support - No formal professional association support - No formal licensing board support - No formal educational curriculum commitment
II. Supporting Purposes		
A. Raise awareness that suicide is a national health priority	MET Task Force communication, surveys, Final Phase 1 Report	- Comments/Support for Task Force work in survey - Foundation and connections established for future communications

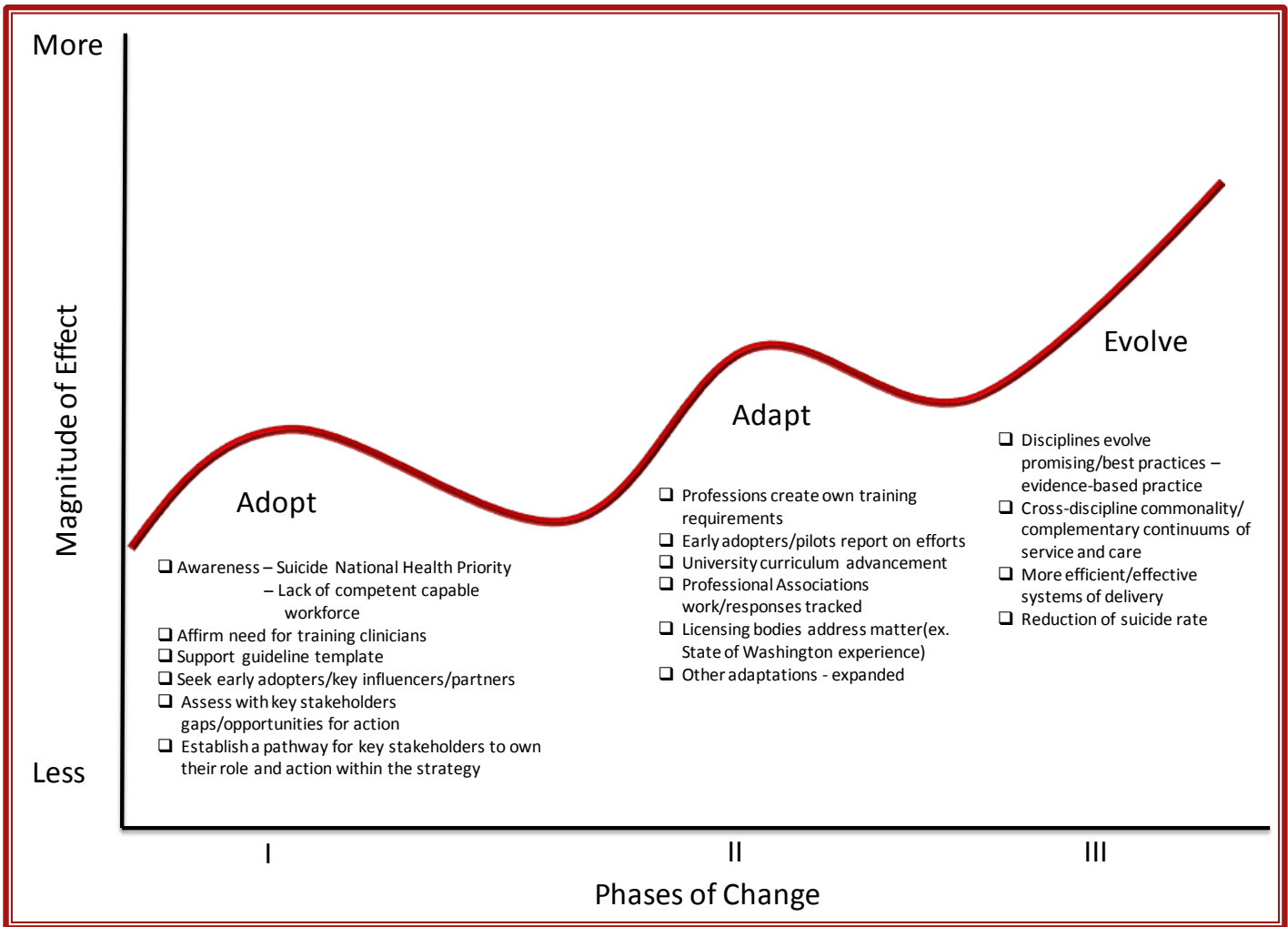|		
B. Create a dialogue within/between disciplines regarding clinical workforce preparedness	INITIATED Task Force communication, surveys, Phase 1 Report.	Comments/Support for Task Force work in survey – Many survey panel members sourced from professional associations, licensing authorities, and educational institutions, but none could officially represent their stakeholder group.
C. To attain support for a majority of clinical disciplines to advance dialogue and generate commitment to advancing practice in this domain	INITIATED Survey participants represented most disciplines and many settings and subspecialties.	Need to garner official association acknowledgement/support. Updates from disciplines on their work in this area. (Similar for educational and licensing entities.)
D. Organizations that evolve their training via enhancements to the guidelines and who deliver training can become recognized via external third-party accreditation	NOT MET Basic guidelines offer a starting point.	Accreditors will establish requirements in support of quality training standards congruent with guidelines. • Done in conjunction with expert panels • Often created by demand (i.e., regulatory requirements; e.g., licensing)
E. That accreditors support in their standards need for training in suicide prevention	PARTIALLY MET CARF and Joint Commission have such standards affirmed by Task Force subcommittee who reviewed available/current standards.	Could be expanded to other accreditors.
F. CWP Task Force work integrate with/support Clinical Care and Intervention and Faith Communities Task Forces	PARTIALLY MET Universal design of guidelines can be modified and used independent of discipline or setting—in both scope and scale—to meet developmental needs of non-clinicians.	Need feedback from representative Task Forces.

5.2   Next Steps

The Task Force's work is a long-term effort to advance the competencies of a broad health care workforce with the aid of this country's educational institutions and federal and state regulatory and licensing bodies, and more importantly with the full engagement and support of the health care disciplines and their respective associations. The very nature of this work is a long-term effort, with each phase representing a series of micro-transformations leading to a long-term view, which is to advance training efforts and the competency of clinicians across disciplines for a system effect on reducing suicide rates. The contemplated next steps of this effort anticipate the need to be equally patient, yet persistent, to advance the dialogue and mobilize micro-actions with key stakeholders who embrace the importance of recognizing suicide as a national health priority and wish to demonstrate their leadership in the country. The next step will be illustrated through a three-phase change process to manage the complexity of the process into measurable, tangible phases that creates order out of chaos and provides a story for teaching, promoting, and managing the Task Force's desired end state—a competent and enabled clinical workforce.

5.2.1   Three Phases of Change

The CWP Task Force recognizes that much work is necessary given the gap that exists in the current state of preparedness of clinicians and what should be the desired end state for broad-based clinician readiness—namely, all clinicians having a basic skill set in suicide risk assessment and intervention. To plan to engage and mobilize the "few and the many" stakeholders necessary to sustain progress toward the long-term desired end state of an enabled clinical work force, a three-phase model of change provides an overall plan for next steps, allowing for detailed tactical planning in the short term (2–3 years) while also creating a long-term endpoint consistent with the *2012 National Strategy for Suicide Prevention* and its objectives.

The three phases of the change effort necessary to develop an enabled system of a competent clinical workforce across disciplines and settings are illustrated in Figure 1.

Figure 1. Three Phases—Adopt, Adapt, and Evolve

More

Magnitude of Effect

Adopt

- Awareness – Suicide National Health Priority
  – Lack of competent capable workforce
- Affirm need for training clinicians
- Support guideline template
- Seek early adopters/key influencers/partners
- Assess with key stakeholders gaps/opportunities for action
- Establish a pathway for key stakeholders to own their role and action within the strategy

Adapt

- Professions create own training requirements
- Early adopters/pilots report on efforts
- University curriculum advancement
- Professional Associations work/responses tracked
- Licensing bodies address matter (ex. State of Washington experience)
- Other adaptations - expanded

Evolve

- Disciplines evolve promising/best practices – evidence-based practice
- Cross-discipline commonality/ complementary continuums of service and care
- More efficient/effective systems of delivery
- Reduction of suicide rate

Less

I   II   III

Phases of Change

5.2.1.1   Three Phases of Change - Phase I – Adopt . . . the Challenges

To ensure key stakeholder support for the universal training guidelines, it is vital that the following actions be taken to create the momentum for change to occur in the basic training requirements for suicide assessment and intervention by clinicians:

- Creating awareness of key stakeholders about the work of the Action Alliance, and the *2012 National Strategy for Suicide Prevention*, that identifies suicide as a major public health matter, with a goal to reduce suicide rates in this country

- Acknowledgement of the serious gap in training by a minimum of three key stakeholder groups:
  - Educational institutions
  - Licensing bodies
  - Professional associations
- Affirm that a key strategy to realizing a reduction in suicide rates is to close the training gap between the current state—which at a broad-based system level is inadequate—and a future state where basic skill sets are in place, with a set of professionally sanctioned minimum training standards.

It is anticipated that the above noted actions will provide the CWP Task Force with the backdrop for obtaining the support of national professional associations to disseminate the universal training guidelines with its stated intent to advance a broad-based clinical workforce to reduce suicide rates. Further, during the CWP Task Force's work, it was noted that some associations were developing training modules specific to suicide. Potentially, these entities may be not only supportive of the universal training guidelines but also early adopters and supporters of the CWP Task Force report and, potentially, pilot sites for testing the guidelines.

The CWP Task Force expects that Phase I will require two to three years to get a critical mass of key stakeholders to adopt the intent and direction of the CWP Task Force efforts in relation to the NSSP objectives. Proposed next steps for this phase with estimated datelines are shown in Figure 2.

Figure 2. Phase 1 Proposed Next Steps

Clinical Workforce Preparedness
PHASE I - ADOPT

Task	Activity	Date
CWP Task Force Report Accepted	❑ Submitted to Secretariat/Executive Committee for Acceptance	August 2014
Solicit Stakeholder Support for Report/"Sign-on" for the future	❑ Publish/disseminate report to key stakeholders/panel ❑ Personal communications to formal key stakeholders ❑ Solicit endorsement/publicly publish endorsing organizations ❑ Part of above solicitation – identify promising early adopters (education/professional/licensing entities)	September – November 2014

HRSA & SAMHSA Involved Stakeholders Forum	❑ Gather key stakeholders to:
	   o Affirm broad-based commitment
	   o Highlight efforts to date
	   o Highlight responses to date
	❑ Identify – showcase early adopters
	❑ Build on the dialogue
	❑ Create/monitor action chart
		December 2014 – February 2015

5.2.1.2   Adapt Guidelines and Actions for Long-Term Ownership

Post the identification of support (and potential dissent) and any resulting actions to address raised concerns, Phase 2 requires stakeholders to begin the "skills acquisition" phase of this project. Each discipline, education institution, and licensing body will ascertain what works for them as they embark upon the work committed to in Phase 2. The monitoring of various developments, such as early training pilots conducted by early adopters, can be shared with the CWP community as can licensing requirement changes and impacts (e.g., State of Washington ESHB 2366). A key element or task in this phase of the project is to monitor and publish the progress of the adaptation of the guidelines. The CWP Task Force/Action Alliance transitions to the role of an integrator of actions during Phase 2.

Figure 3. Phase 2 Next Steps

Clinical Workforce Preparedness
PHASE II - ADAPT

Task	Activity	Date
Action Chart Updates	❑ On a six month period update specific commitments made by key stakeholders with updated Action Chart ❑ Action Chart sustains commitment publicly, identifies lead/lag development ❑ Chart results are part of 2012 National Strategy measurement goals	January 2016 – December 2018
Gather "Results"	❑ As part of updates, gather information on 3 key stakeholder efforts and information to be shared to all to further dialogue/distribute/change in effect ❑ Gather key information from: ○ Educational Institutions ○ Licensing Bodies ○ Professional Associations ❑ Use information to advance the dialogue and ongoing evolution of practices	January 2016 – December 2018

5.2.1.3   Evolve Within and Between Disciplines and Systems

Phase 3 of the long-term plan will result in a practicing environment where a majority of disciplines, educational systems, and licensing bodies require a minimum standard of skill sets to be present within the training of each discipline—subject to scope of practice issues. Most importantly, cross-discipline intervention framework commonalities allow for interdisciplinary commonalities—all to better serve the person at risk of suicide with more responsive and enabled systems of care. It is hoped that the goal of reducing suicide rates in this country during this phase is demonstrated, in part, by a more competent clinical workforce.

References

1 - Accreditation Council of Continuing Medical Education. (n.d.) *Accreditation criteria.* Retrieved

    from http://www.accme.org/requirements/accreditation-requirements-cme-

    providers/accreditation-criteria

2 – American Association of Suicidology. (2013)*. Preventing suicide through improved training in*

    suicide risk assessment and care: A white paper addressing serious gaps in U.S. mental health

    training. Washington, D.C.: Author.

3 – American Association of Suicidology and Canadian Association for Suicide Prevention. (2011).

    Applicant's manual: Individual crisis worker certification. Retrieved from

    http://www.suicidology.org/c/document_library/get_file?folderId=251&name=DLFE-

    515.pdf

4 – Commission on Accreditation for Marriage and Family Therapy Education. (2011).

    Accreditation manual: Policies and procedures. Alexandria, VA: Author.

5 – Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009*

    standards. Retrieved from http://www.cacrep.org/wp-content/uploads/2013/12/2009-

    Standards.pdf

6 - Feldman, B. N., & Freedenthal, S. (2006). Social work education in suicide intervention and

    prevention: An unmet need? *Suicide and Life-Threatening Behavior*, *36*, 467–480. doi:

    10.1521/suli.2006.36.4.467

7 - Kleespies, P. M., Penk, W. E., & Forsyth, J. P. (1993). The stress of patient suicidal behavior during

    clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and*

    Practice, *24*, 293–303. doi: 10.1037/0735-7028.24.3.293

8- Liaison Committee on Medical Education. (2010). *Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the M.D. degree.* Retrieved from http://www.lcme.org/publications/functions.pdf

9 - Marine Corps Suicide Prevention Program. (2010). *NCO suicide prevention instructor training guide*. Retrieved from http://www.usmc-mccs.org/suicideprevent/

10 - McAdams, C. R., III, & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, *22*, 107–121.

11 – McIntosh, J., & Drapeau, C. (2014). *USA suicide 2011 official final data*. Washington, DC: American Association of Suicidology.

12–McCleod, E. (2013). Clinician's experience of suicide assessment from a qualitative perspective (Doctoral dissertation). Retrieved from http://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=1191&context=dissertations

13 – McNiel, D., Fordwood, S., Weaver, C., Chamberlain, J., Hall, S., & Binder, R., (2008). Effects of training on suicide risk assessment*. Psychiatric Services, 59*(12), 1462–1465.

14 - National Association of Social Workers. (n.d.) *Standards for continuing professional education*. Retrieved from http://www.naswdc.org/practice/standards/cont_professional_ed.asp

15 -Oordt, M. S., Jobes, D. A., Fonseca, V. P., & Schmidt, S. M. (2009). Training mental health professionals to assess and manage suicidal behavior: Can provider confidence and practice behaviors be altered? *Suicide and Life-Threatening Behavior, 39,* 21–32. doi: 10.1521/suli.2009.39.1.21

16 - Pope, K., & Tabachnick, B., (1993). Therapist's anger, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*, *24*, 142–152.

17 - Puntil, C., Limandri, B., Greene, P., Arauz, E., & Hobbs, D. (2013). Competency-based training for PMH nurse generalists: Inpatient intervention and prevention of suicide. *Journal of the American Psychiatric Nurses Association, 19*(4), 205–210. doi: 10.1177/1078390313496275.

18 - Quinnett, P. (2007). *QPR gatekeeper training for suicide prevention. The model, rationale and theory.* Retrieved from http://www.qprinstitute.com/theory.html

19 – Ramsay, R. F., Tanney, B. L., Lang, W. A., & Kinzel, T. (2010). *Applied Suicide Intervention Skills Training (ASIST): Trainer Manual (ed. X.1.6)*. Calgary, AB: LivingWorks Education.

20 – Rodgers, P. (2010). *Review of the Applied Suicide Intervention Skills Training Program (ASIST). Rationale, evaluation results and directions for future research*. Calgary, AB: LivingWorks Education.

21 - Ruskin, R., Sakinofsky, I., Bagby, R. M., Dickens, S., & Sousa, G. (2004). Impact of patient suicide on psychiatrists and psychiatric trainees. *Academic Psychiatry*, *28*(2), 104–110. doi: 10.1176/appi.ap.28.2.104

22 - Sanders, S., Jacobson, J. M., & Ting, L. (2008). Preparing for the inevitable: Training social workers to cope with client suicide. *Journal of Teaching in Social Work*, *28*(1/2), 1–18.

23 - Shea, C. (2009). Suicide assessment. Part 1: Uncovering suicidal intent a sophisticated art and Part 2: Uncovering suicidal intent using the chronological assessment of suicide events (CASE approach) *Psychiatric Times*, *26*(12), (1-6/1-26), Retrieved from http://www.suicideassessment.com/pdfs/PsychiatricTimesArticleparts1-2PDF.pdf

24 - Suicide Prevention Resource Center, Education Development Center, Inc. (2008). *Assessing and managing suicide risk: Core competencies for mental health professionals participant manual.* Newton, MA: Author.

25 - Tanney, B. L. (2012). *SuicideCare participant workbook*. Calgary, AB: LivingWorks Education.

26 – United States Air Force. (2006). *Suicide and violence prevention education and training*. (Air Force Instruction 44–154). Retrieved from http://www.e-publishing.af.mil/

27 – U.S. Department of Education. (2011). Database of accredited postsecondary institutions and

    programs[data file]. Retrieved from

    http://ope.ed.gov/accreditation/GetDownLoadFile.aspx

28– U.S. Department of Health and Human Services. (2001). *National strategy for suicide prevention:*

    Goals and objectives for action. Retrieved from

    http://www.ncbi.nlm.gov/books/NBK44281/pef/TOC.pdf

29- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and Action

    Alliance for Suicide Prevention. (2012). *2012 national strategy for suicide prevention: Goals*

    and objectives for action. Washington, DC: HHS. Retrieved from

    http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-

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Appendix B

CLINICAL WORKFORCE PROFESSIONS FOR WHICH THE GUIDELINES ARE TARGETED

- ❖ Based on individual professional guidelines and license to practice parameters
- ❖ Varying by location (e.g., school, emergency care, community center)
- ❖ Varying by specialty (e.g., physicians, family nurse practitioner, pediatrician, pastoral counselor, counselor)
- ❖ Examples of professions follow:
  - Nurses
  - Physician assistants
  - Physicians
  - Counselors
  - Social workers
  - Psychologists
  - Employee assistance program (EAP) professionals
  - Academic and curriculum entities
  - County program administrators
  - State program administrators
  - Federal program administrators
  - Accreditors

Other professionals which may find some of the guidelines relevant for suicide prevention training:

- Clergy
- Educational faculty and staff
- Correctional workers
- Divorce and family law and criminal defense attorneys

Appendix C

SURVEYS SENT TO ACCREDITING, CREDENTIALING, AND ACADEMIC INSTITUTIONS REGARDING CURRENT TRAINING

NAASP CWP Survey for Accreditation Bodies

1. Demographic Information (optional):

Name: [ ]

Company: [ ]

Address: [ ]

City/Town: [ ]

State: [▼]

ZIP: [ ]

Email Address: [ ]

Phone Number: [ ]
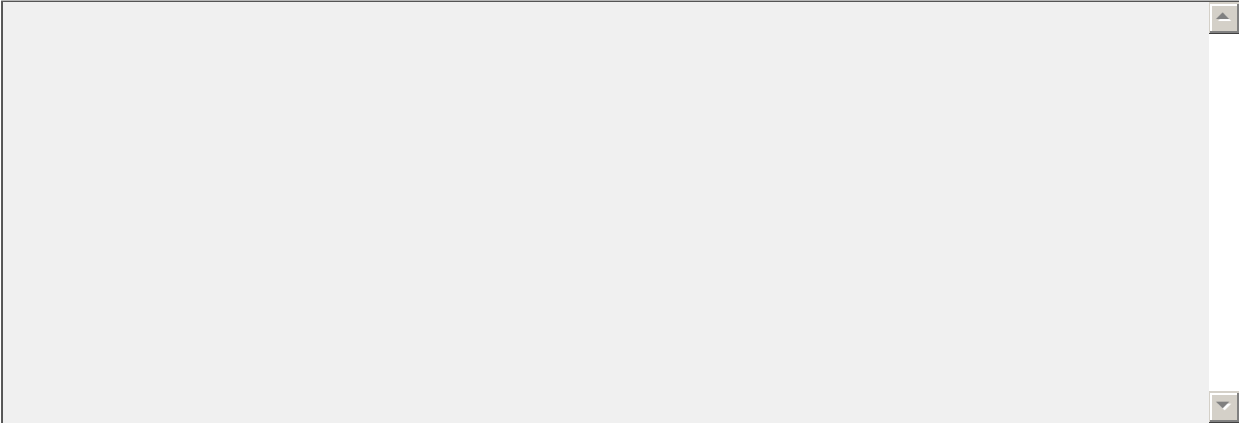
2. Please list all degree programs that you accredit to prepare professionals for the clinical workforce:

[ ]

3. Does your organization require that specific coursework in suicide prevention be in the curriculum for programs you accredit that prepare professionals for the clinical workforce?

○ Yes

○ No

○ For some programs, but not all

4. Please list below the degree programs for which you do require coursework in suicide prevention:

5. Please list below the degree programs for which you do not require coursework in suicide prevention:

6. Is the coursework required or an elective?

○ Required

○ Elective

7. If you require specific coursework, do you require coursework in: (check all that apply)

☐ Assessment of suicide risk and lethality

☐ Intervention for those identified as at risk

☐ Ongoing management of the suicidal client/patient

☐ Other (please specify)

8. How many credits of coursework in suicide prevention are required as part of the degree program?
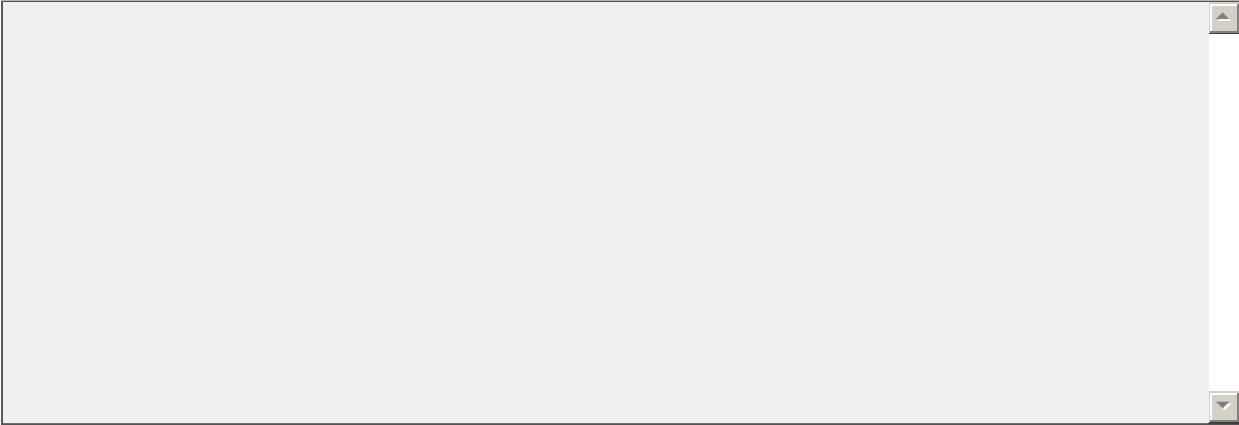
○ 1 credit

○ 3 credits

○ More than 3 credits

○ Other (please specify)

9. If there is no specific curriculum for suicide prevention, is suicide prevention required to be included as part of another related area such as crisis prevention/intervention?

○ Yes

○ No

○ For some programs, but not all

10. Please list below the degree programs that do have course content in suicide prevention as part of another related course:

11. Please list below the degree programs that do not have course content in suicide prevention as part of another related course:
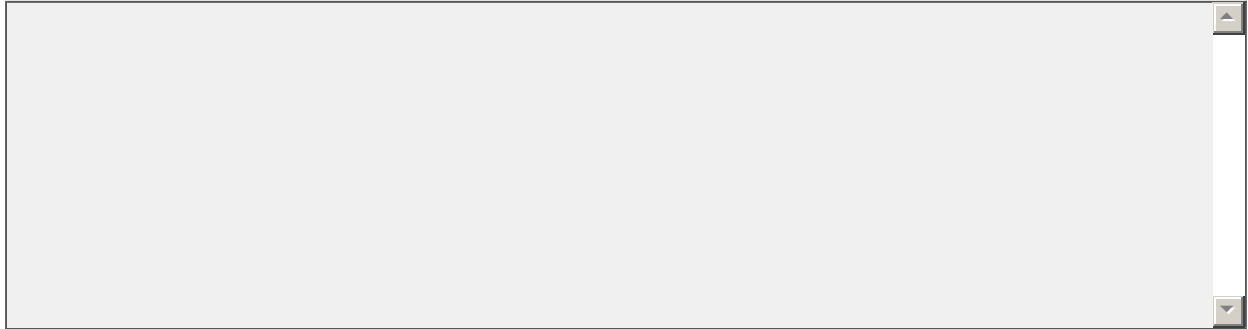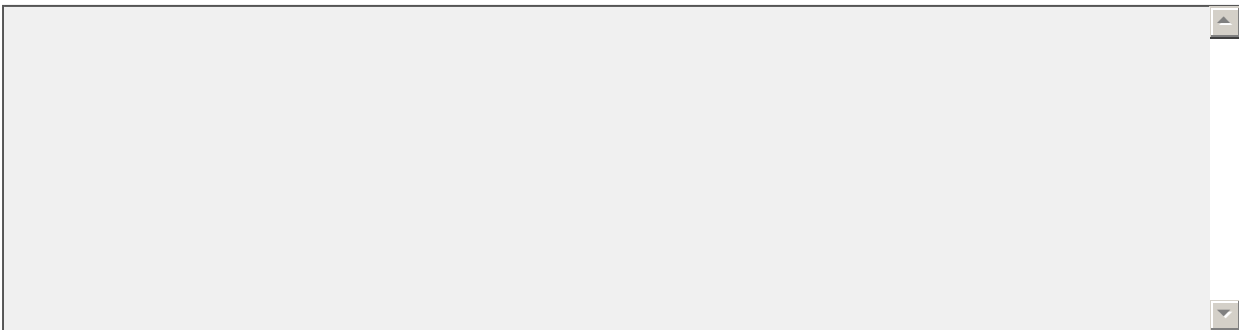
12. Do you provide accreditation to continuing education programs in suicide prevention for professionals who are already practicing?

○ Yes

○ No

13. If yes, does it include required training in (check all that apply):

☐ Assessment of suicide risk and lethality

☐ Intervention for those identified as at risk

☐ Ongoing management of the suicidal client/patient

☐ Other (please specify)

14. The Task Force is considering developing a set of universal guidelines for preparing clinical professionals in suicide prevention. The guidelines could be used by academic institutions and continuing education providers to build their own training model. Would your organization support the use of universal guidelines for clinical preparedness for suicide prevention?
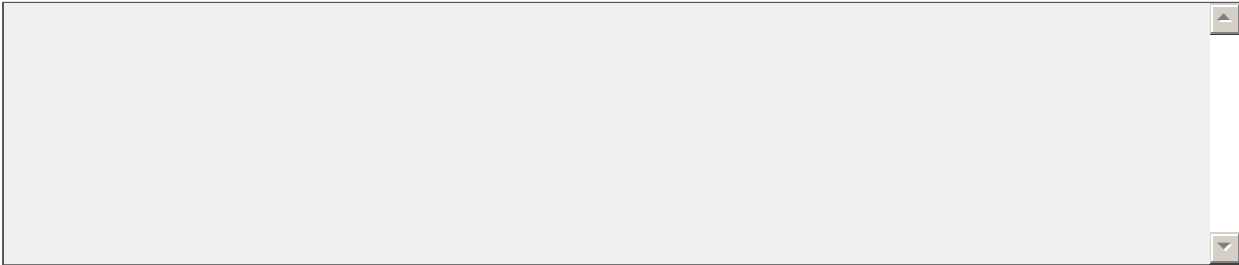
○ Yes

○ No

Comments:

15. Would your organization be willing to review guidelines if developed and provide feedback?
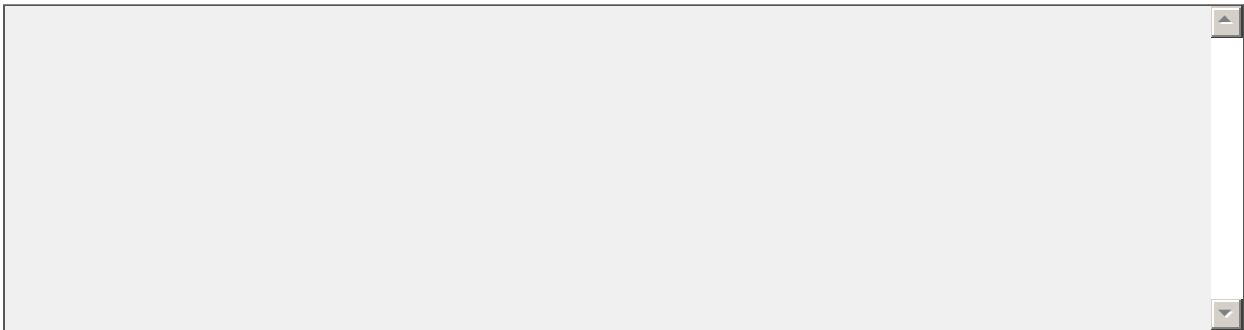
○ Yes

○ No

Comments:

16. General Comments:

Thank you for taking the time to complete this survey!

NAASP CWP Survey for Credentialing Bodies

1. Demographic Information (optional):

Name:
Company:
Address:
City/Town:
State:
ZIP:
Email Address:
Phone Number:

2. Does your Board require coursework in suicide prevention for initial certification/licensure?

○ Yes

○ No

3. If yes, does it include required coursework in: (check all that apply)

☐ Assessment of suicide risk and lethality

☐ Intervention for those identified as at risk

☐ Ongoing management of the suicidal client/patient

☐ Other (please specify)

NAASP CWP Survey for Credentialing Bodies

4. How many credits of coursework are required?

○ 1 credit

○ 3 credits

○ More than 3 credits

○ Other (please specify)

5. Does your Board require continuing education in suicide prevention for certification/licensure renewal?

○ Yes

○ No

6. If yes, does it include requirements for continuing education in: (check all that apply)

☐ Assessment of suicide risk and lethality

☐ Intervention for those identified as at risk

☐ Ongoing management of the suicidal client/patient

☐ Other (please specify)

7. How many in-person hours (not credit hours) of continuing education are required?

○ 1 - 3 hours

○ 4 - 8 hours

○ more than 8 hours

8. The Task Force is considering developing a set of universal guidelines for preparing clinical professionals in suicide prevention. The guidelines could be used by academic institutions and continuing education providers to build their own training model. Would your Board support the use of universal guidelines for clinical preparedness for suicide prevention?

○ Yes

○ No

Comments:

9. Would a member of your board's staff be willing to review guidelines if developed and provide feedback?

○ Yes

○ No

Comments:

10. General Comments:

Thank you for taking the time to complete this survey!

NAASP CWP Survey for Academic Institutions

1. Demographic Information (optional):

Name:

Company:

Address:

City/Town:

State:

ZIP:

Email Address:

Phone Number:

2. Please Indicate all degree programs that prepare professionals for the clinical workforce:

☐ M.D./D.O.

☐ Physician Assistant

☐ Psychology

☐ Nursing

☐ Social Work

☐ Counseling

Other (please specify)

3. Please indicate relevant non-degree programs that prepare professionals for the clinical workforce:

4. Do your degree programs that prepare professionals for the clinical workforce require specific coursework where the content of the course is entirely about suicide prevention?

○ Yes

○ No

○ For some programs, but not all

5. Please list below the degree programs that do require specific coursework where the content is entirely focused on suicide prevention:

☐ M.D./D.O.

☐ Physician Assistant
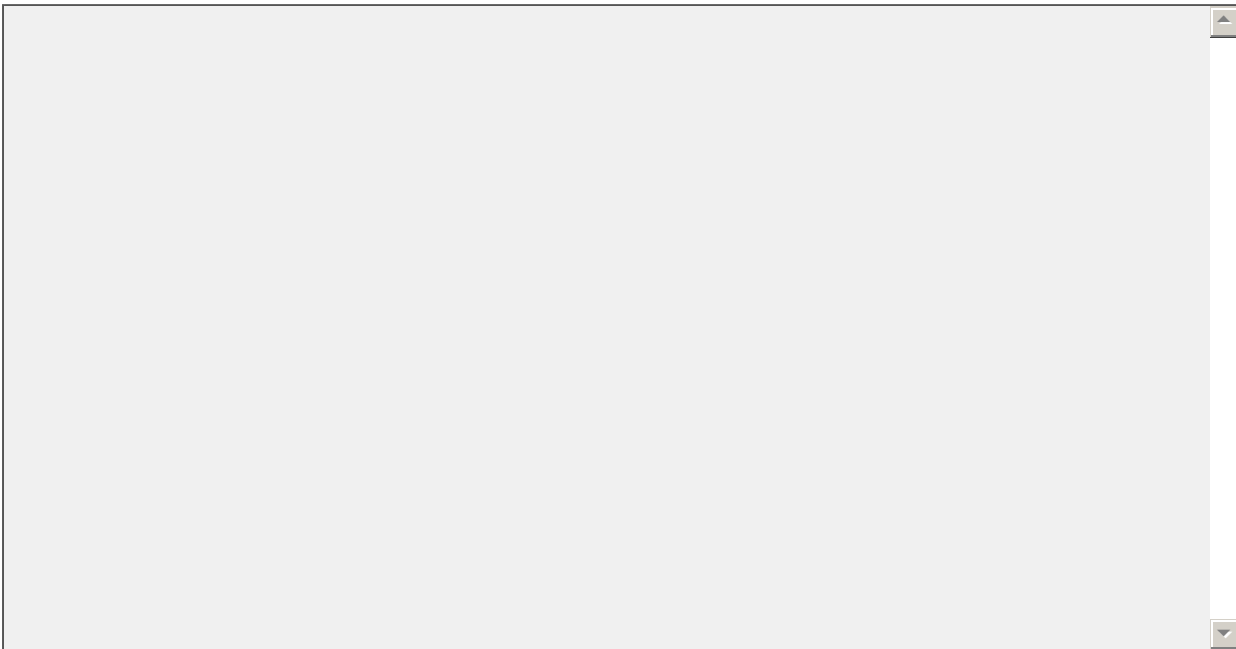
☐ Psychology

☐ Nursing

☐ Social Work

☐ Counseling

Other (please specify)

6. Please list below the degree programs for which you do not require coursework in suicide prevention:

- ☐ M.D./D.O.

- ☐ Physician Assistant

- ☐ Psychology

- ☐ Nursing

- ☐ Social Work

- ☐ Counseling

Other (please specify)

7. Of those that do require specific coursework where the content is entirely focused on suicide prevention, does the coursework include: (check all that apply)

☐ Assessment of suicide risk and lethality

☐ Intervention for those identified as at risk

☐ Ongoing management of the suicidal client/patient

☐ Other (please specify)

8. How many credits of specific coursework where the content is entirely focused on suicdie prevention are required as part of the degree program?

○ 1 credit

○ 3 credits

○ More than 3 credits

○ Other (please specify)

9. If there is no specific coursework where the content is entirely focused on suicide prevention, is suicide prevention included as part of another related course, such as crisis prevention/intervention?

○ Yes

○ No

○ For some programs, but not all

10. Please list below the degree programs that do have course content in suicide prevention as part of another related course:

☐ M.D./D.O.

☐ Physician Assistant

☐ Psychology

☐ Nursing

☐ Social Work

☐ Counseling

Other (please specify)

11. Please list below the degree programs that do not have course content in suicide prevention as part of another related course:

☐ M.D./D.O.

☐ Physician Assistant

☐ Psychology

☐ Nursing

☐ Social Work

☐ Counseling

Other (please specify)

12. Do you provide continuing education in suicide prevention for professionals who are already practicing?

○ Yes

○ No

13. If yes, does it include training in (check all that apply):

☐ Assessment of suicide risk and lethality

☐ Intervention for those identified as at risk

☐ Ongoing management of the suicidal client/patient
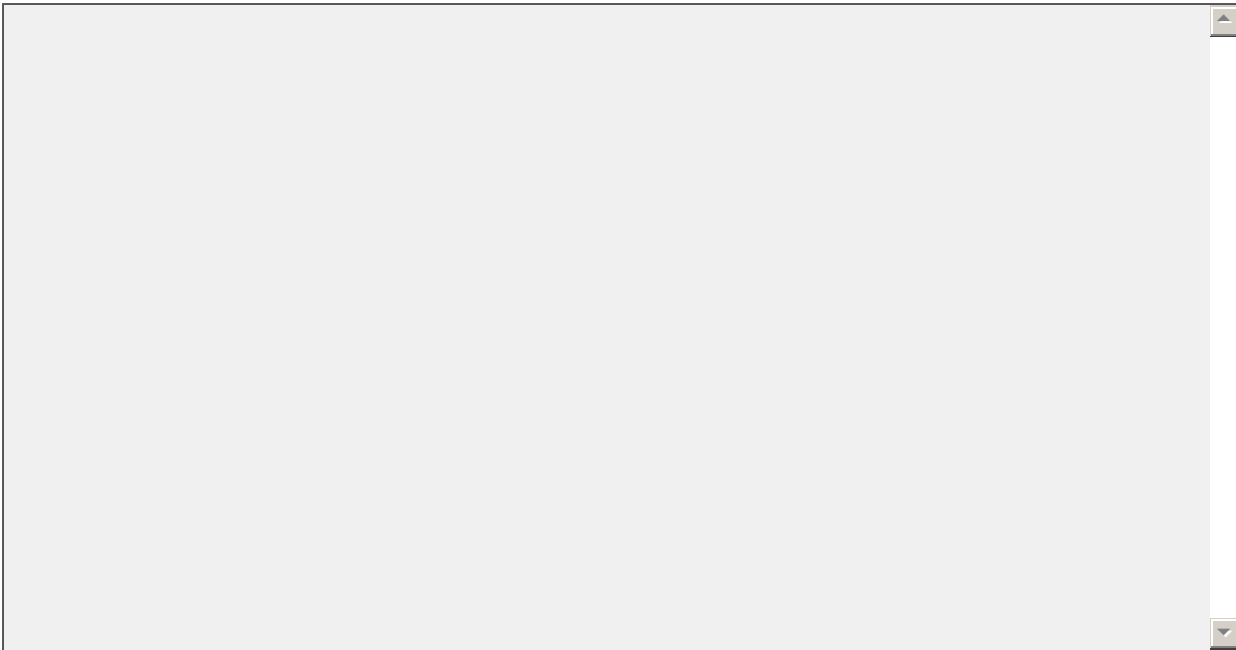
☐ Other (please specify)

14. The Task Force is considering developing a set of universal guidelines for preparing clinical professionals in suicide prevention. The guidelines could be used by academic institutions and continuing education providers to build their own training model. Would your institution support the use of universal guidelines for clinical preparedness for suicide prevention?
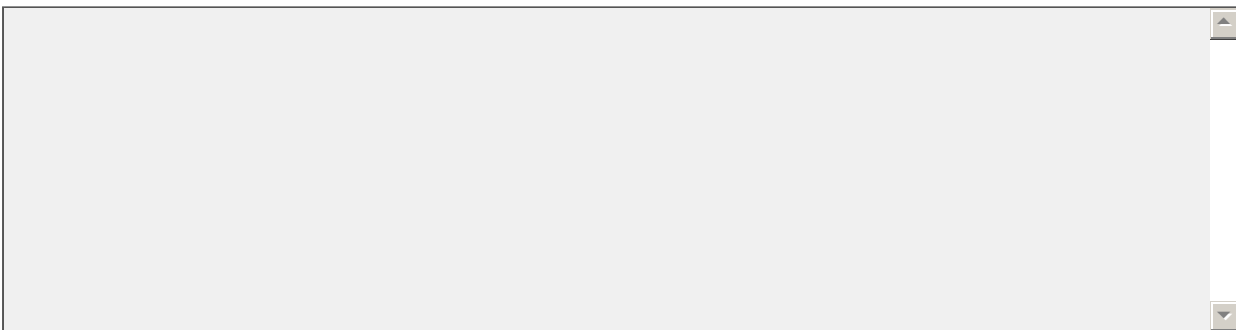
○ Yes

○ No

Comments:

15. Would you be willing to have a representative from your institution review standards if developed and provide feedback?

○ Yes

○ No

Comments:

NAASP CWP Survey for Academic Institutions

16. General Comments:

NAASP CWP Survey for Academic Institutions

Thank you for taking the time to complete this survey!

Appendix D

WEBSITES REVIEWED FOR TRAINING MATERIAL

Accreditation Council for Graduate Medical Education

Accreditation Review Commission – Physician Assistant

Air Force Suicide Prevention

American Academy of Child and Adolescent Psychiatry

American Association for Emergency Psychiatry

American Association of Colleges of Nursing

American Board of Emergency Medicine

American Medical Association

American Nursing Association/Mental Health Nursing

American Osteopathic Association

American Psychological Association

American Psychiatric Association – Inpatient Psychiatry

CARF Behavioral Health Standards Manual

Commission on Collegiate Nursing Education

Council for Accreditation of Counseling and Related Educational Programs

Council on Accreditation for Children and Family Services

Council on Social Work Education

Emergency Medical Resident's Association

Emergency Nurses Association

Healthcare Facilities Accreditation Program

Institute for Credentialing Excellence

Joint Commission (Acute Care Hospitals and Behavioral Health)

Liaison Committee on Medical Education

National Association for Alcoholism and Drug Abuse Counselors

National Association of School Nurses

National Association of Social Workers

National Commission on Correctional Health Care

National League for Nursing Accrediting Commission

Northwest Commissions on Colleges and Universities

Psychiatric – Mental Health Nurse Practitioner Competencies

Screening for Mental Health/American Psychiatric Association

Southern Association of Colleges and Schools

Suicide Prevention Resource Center

Transnational Association of Christian Colleges and Schools

United States Air Force

United States Army

United States Coast Guard

United States Marines

United States Navy

Western Association of Schools and Colleges

Appendix E

SURVEY DEMOGRAPHICS

Professional Disciplines of Respondents:
Alcohol/Drug counseling
Counseling
Marriage/Family therapy
Medicine
Nurse practitioner
Nurse
Psychology
Psychiatry
Social work
Educational leadership and policy
Music Therapy
Health services administration
Sociology
Attorney
Psychiatric nurse practitioner
Psychiatric nursing
Genetics
Educational doctorate
Criminal justice
Human communication
Education and family studies/Adult development
Counseling education
Nursing administration
Public health
Master of divinity/theology/pastoral care/advocacy

Professional Settings:
Association (those listed below were provided by the respondents, not all may be listed)
American Medical Colleges
Music Therapy Association
National Association of School Nurses
The JED Foundation
American Association of Suicidology
American Academy of Nursing
Emergency Nurses Association
American Speech-Language-Hearing Association
Emergency department/Hospital
Primary care office
Primary school
Private practice
Degree-granting institution (college or university based)
Mental health/Behavioral health clinic
Rehabilitation
Board of physicians
Graduate education
Regulatory agency
Colorado medical board
State injury prevention
Public health department – board of nursing
State mental hospital
Law enforcement
Crisis center
Suicide prevention education agency
Parish minister
Nonprofit agency
School of nursing
Medical school
Federal government
Direct practice with elderly and disabled clients

Appendix F

SUICIDE PREVENTION RESOURCES
(Provided by Survey Respondents)

Additional resources are available.
This list was provided by the respondents and is not intended to be comprehensive.

Websites with resources:

American Association of Suicidology
http://www.suicidology.org/resources/
media-professionals

LivingWorks Education
http://www.livingworks.net/

Suicide Prevention Resource Center Best
Practice Registry
http://www.sprc.org/bpr

Substance Abuse and Mental Health Services
Administration
http://www.samhsa.gov/samhsanewsletter/
Volume_18_Number_5/ResourcesAtAGlance.
aspx

QPR Institute
http://www.qprinstitute.com/

Douglas Flemons and Len Gralnik's Risk and
Resilience Factors
http://www.contextconsultants.com/suicide-
assessment

Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org/

Mental Health First Aid
http://www.mentalhealthfirstaid.org/cs/

National Association of School Psychologists
http://www.nasponline.org/resources/crisis
_safety/suicide-resources.aspx

Psychiatric Times
http://www.psychiatrictimes.com/

American Psychiatric Nurse Association:
APNA
http://www.apna.org/i4a/pages/index.cfm?
pageID=1

American Psychiatric Association: APA
http://www.psych.org

Community Resiliency Project
http://www.crproject.org

Papers and Books:

Rudd, M. D., Cukrowicz, K. C., & Bryan, C. J.
(2008). Core competencies in suicide risk
assessment and management: Implications
for supervisors. *Training and Education in
Professional Psychology, 2*(4), (219–228).

The works of Drs. Edwin Shneidman, Robert
Litman, and Norman Farberow of Los
Angeles, as well as Dr. Jerome Motto of San
Francisco.

Books by David Jobes, Shawn Shea, Marsha
Linehan, and Aaron Beck.