THE NEED FOR SUICIDE RISK & INTERVENTION COURSEWORK IN GRADUATE CLINICAL PROGRAMS

June 2020

Overview—

Suicide is the 10th leading cause of death in the U.S., a public health issue more commonplace than automobile accidents. Losses of celebrities like Robin Williams and Anthony Bourdain, along with popular media portrayals of suicide (*13 Reasons Why*, as an example), have brought suicide to the forefront of public consciousness. Suicide awareness campaigns and PSAs encouraging those experiencing suicidal thoughts to reach out for help have become increasingly common.

Unfortunately, the reality of finding help is complicated. While mental health clinicians across disciplines are nearly guaranteed to come into contact with people at risk for suicide, in-depth graduate level training on suicide risk and intervention is rare. Some programs offer limited training; others, none at all.

This results in mental health care providers who are not competent at assessing risk, intervening, or providing continuing care post-crisis. Clinical competence in suicide risk assessment is an important skill often overlooked by graduate programs and licensing bodies. This requires providers to be self-motivated in seeking appropriate training to achieve competence, which can be limited by fear, a lack of time, lost income, or limited access to expensive trainings that vary in quality.

Fear—

Clinicians' number one fear is losing a client to suicide. Despite this fact, most report that the training they received, if any, is inadequate.

When a clinician caring for a suicidal client responds out of anxiety or worries around liability, this can result in potential harmful outcomes which have unintended consequences for the client such as:

- non-consensual welfare checks (particularly dangerous if client is a Black, Indigenous, and/or Person of Color (BIPOC), or identifies as LGBTQ+)
- unexpected/unwanted interaction with law enforcement
- involuntary hospitalization with potential for forced treatment
- unexpected medical and/or transport bills

Sometimes clinicians won't work with suicidal clients at all.

Clinicians who have not received adequate training are at risk for compassion fatigue and burnout when they lose a client to suicide.

Clinicians who feel their training is adequate exhibit lower fear of client death, greater comfort working with suicidal clients, and greater overall skill and knowledge.

Courtney McKay · Dese'Rae Stage · Ramona Williams · Quan Yuan || Questions/comments? des@livethroughthis.org

SNAPSHOT: SUICIDE & CLINICAL TRAINING

SUICIDE RATES

Suicide rates have been on the rise since 2003.

48,344 Americans died by suicide in 2018, the highest rate in 50 years. Over 1.4 million suicide attempts were documented that year.

SUICIDE EXPOSURE

Approximately 51% of Americans have been exposed to suicide in their lifetime.

135 people are exposed to every suicide death in the U.S., or 5.5 million in a 12 month period. A person is "exposed" when they know or know of someone who died by suicide.

CLINICIAN INTERACTION WITH SUICIDAL CLIENTS

90%+ of mental health professionals encounter patients who are suicidal.

97% of graduate psychology students have worked with suicidal clients. 87% of clinical social workers have worked with suicidal clients and 55% have worked with a client who attempted suicide.

CLIENT LOSS TO SUICIDE

Suicide deaths of clients significantly impact clinicians' personal and professional lives.

51% of psychiatrists have had more than one patient die by suicide. Psychologists experience client suicide loss at a rate of 22-30%; social workers and counselors report similar rates.

TRAINING IS LIMITED

Calls for training have been repeatedly ignored by universities and licensing bodies.

76% of program directors reported encountering barriers to including training in their graduate psychology curricula. Graduate directors of social work programs indicated students received 4 or less hours of training. Suicide coursework is included in 6% of marriage and family therapy programs and 2% of counseling programs. Psychiatry is an exception, with 94% of directors indicating that training is included in residency programs; however, the training has been described as limited, passive, and vague by residents.

REFERENCES: HTTPS://BIT.LY/LTTMSWPTF

Licensure—

Goal 7 of the National Strategy for Suicide Prevention published in 2012 called for training of community and clinical service providers; as of 2017, only 10 states required clinicians to complete training in suicide-related course-work. Policies in seven states encourage training, but don't require it. The length and regularity of training required under state policies varies, from one hour of training upon license renewal, to six hours every six years. The quality, depth, and breadth of content covered is also inconsistent.

Ethics—

The lack of mandated training is an egregious oversight by the mental and behavioral health fields. Section 1.04 of the National Association of Social Workers' Code of Ethics dictates that clinicians only practice in areas where they have appropriate training and supervised experience. If clinicians provide care without training, they violate ethical codes and potentially put clients in harmful situations. If they don't provide care, it could be a matter of life and death for those experiencing suicidal intensity.

There is a dearth of qualified faculty to teach suicide risk and intervention in graduate programs, and those left to teach it in the wake feel deep discomfort. This is one reason programs may not include—or avoid increasing—this content in their curricula. Suicide rates will likely keep rising. If awareness programs continue to encourage suicidal people to reach out for help, but there's no one there for them, are we not at a moral and ethical crossroads?