



**American
Foundation
for Suicide
Prevention**

State Laws: Training for Health Professionals in Suicide Assessment, Treatment, and Management

Overview: According to the latest (2017) data from the Centers for Disease Control and Prevention (CDC), suicide is the tenth leading cause of death overall in the U.S. and the second leading cause of death for youth and young adults ages 10-34 (CDC, 2019). Over 90% of people who die by suicide have a diagnosable mental health disorder at time of death and will often come into contact with health professionals during their time of suicide risk. Approximately 32% of people who die by suicide have contact with mental health services within a year of their death, and 19% of people who die by suicide have contact with a mental health professional in the month prior to their death (Luoma, Martin & Pearson, 2002).

Mental health professionals regularly come into contact with individuals who are at risk of suicide. Despite the comorbidity of mental health disorders and suicide, the vast majority of mental health professionals — a group that includes psychiatrists, psychologists, social workers, licensed counselors, and psychiatric nurses — do not typically receive routine training in suicide assessment, treatment, or risk management. This lack of expertise impacts their ability to provide comprehensive care for at-risk patients, despite evidence that “having a competent clinical workforce is critical to reducing the rate of suicide” (National Action Alliance for Suicide Prevention, 2014).

A key strategy in suicide prevention is the implementation of a minimum amount of training for suicide risk assessment and for treatment of suicidal behaviors. Mental health professionals treat at-risk patients who may eventually complete suicide, with one in two psychiatrists experiencing patient suicide and one in five psychologists experiencing patient suicide (Oordt, et al., 2005). Despite these occurrences, there are no nationally set standards or guidelines requiring mental health professionals to be trained to address and treat suicidal ideation and behavior in their clients, either during education and certification or during their professional career.

Evidence shows that initiating training programs in suicide risk assessment, treatment, and management is needed and valued by professionals. Training mental health professionals in current suicide prevention standards not only increases professional confidence in treating suicidal people but also updates professionals on the most effective, evidence-based treatment options. After attending a training symposium, mental health professionals reported an increased level of confidence to assess risk and manage suicidal behavior and a decreased level of hesitation to directly ask their clients about suicide ideation. Participants also reported changing suicide care practices and changing clinical policy in response to the training, and these results persisted at a 6 month follow-up (Oordt, Jobes, & Schmidt, 2009). Suicide-specific training enhances the level of care that people who experience mental illness and suicide risk receive while also increasing provider competence and ability to provide effective, life-saving treatment.

While mental illness is associated with suicide risk, treating mental illness alone does not necessarily treat suicidal behavior. This further emphasizes the need for standards in minimum training on suicide risk assessment, treatment, and management. Mental health professionals are trained and qualified in treating mental illness, but treating the suicide risk that patients experience requires suicide-specific training that many professionals do not have; the training and knowledge that some mental health professionals utilize is outdated, ineffective, and potentially harmful. Research has shown that addressing suicide risk through evidence-based, suicide-specific practices is the best way to prevent patient suicide and avoid any malpractice suits (Jobes & Bowers, 2015). Connecting suicidal individuals with quality mental health services is a vital element in preventing suicide deaths.

Mental health professionals are not the only clinicians who treat people with mental illness, nor do they make up the majority of prescribers of psychotropic drugs. Primary care providers are in fact the largest prescribers of psychotropic drugs – according to a one-year National Prescription Audit (NPA), while psychiatrists and addiction specialists prescribed 23% of all total psychotropic drugs, general practitioners and other non-mental health specialists prescribed 59% of all total psychotropic drugs (Mark, Levit, & Buck, 2009). This means that the majority of patients utilize their primary healthcare services as their mental healthcare services, yet primary care providers similarly lack the adequate training on how to assess, treat, and manage patients who are at risk of suicide.

Primary care providers are in a unique position to identify those at risk of suicide and enact appropriate intervention methods. Of people who die by suicide, 45% of individuals had contact with their primary care provider in the month before, and 77% of individuals had contact with their primary care provider in the year before death. Additionally, primary care physicians identified nearly one-third (30.3%) of their patients as “mental health patients” (Abed Faghri, Boisvert, & Faghri, 2010). This rate holds constant for children and adolescents, with one-third (30.4%) of youth patients accessing mental health treatments through primary care providers alone (Anderson, Chen, Perrin, & Van Cleave, 2015). Thus, primary care providers already treat mental illness and regularly encounter patients who may be at risk of suicide. Without proper training and awareness on suicide-specific skills, however, health professionals may miss warning signs and risk factors in their clients that indicate high suicide risk.

Suicide awareness and prevention training benefits both providers and patients. According to the American Academy of Family Physicians, “[s]creening for suicide risk and access to lethal means, even in apparently asymptomatic patients, is a critically important part of the family physician's role in reducing mortality and morbidity from mental illness” (2011). Due to the stigma associated with addressing mental health, especially suicide ideation, patients are more likely to have contact with a primary care provider than a mental health provider. This places primary care providers in an opportune position to serve and assess suicide risk and serve as “gatekeepers” who connect patients to further resources, but this can only be done consistently with proper training. Mental health screening and suicide risk assessment is congruent with the care that primary doctors already provide as part of their general health focus.

The need for this training exists — the mandate does not. With more attention being placed on mental health, patients will continue to utilize both their mental health and primary care providers in seeking treatment for mental illness and suicide risk. Professionals need consistent

training on effective means of suicide risk assessment, treatment, and management in order to provide lifesaving, suicide-specific treatment. Mandating standards for suicide prevention treatment ensures that health professionals maintain competency and consistency when treating their most vulnerable patients who deserve adequate service.

Current State Laws:

State Requires Training (9 states)

There are currently nine states (CA, IN, KY, NV, NH, PA, TN, UT, WA) that mandate training in suicide assessment, treatment, and management for health professionals:

- **California:**
 - [Business and Professions Code § 2915.4](#) (originally [AB 89](#), adopted 9/1/17, effective 1/1/20). Requires applicants for licensure as a psychologist to show that he or she has completed a minimum of 6 hours of coursework or applied experience under supervision in suicide risk assessment and intervention. The requirement must be either obtained as part of a qualifying graduate degree program, as part of applied experience, or by taking a continuing education course. Requires a minimum of 6 hours of coursework or applied experience under supervision in suicide risk assessment and intervention as a one-time requirement for licensees prior to first license renewal after 1/1/20.
 - [Business and Professions Code § 4980.396](#) (originally [AB 1436](#), adopted 9/19/18, effective 1/1/21). Requires applicants for licensure as a marriage and family therapist, an educational psychologist, a clinical social worker, or a professional clinical counselor to show that he or she has completed a minimum of 6 hours of coursework or applied experience under supervision in suicide risk assessment and intervention. The requirement must be either obtained as part of a qualifying graduate degree program, as part of applied experience, or by taking a continuing education course. Requires a minimum of 6 hours of coursework or applied experience under supervision in suicide risk assessment and intervention as a one-time requirement for licensees prior to first license renewal after 1/1/21.
- **Indiana:**
 - [§ 12-21-5-2](#) (originally [HB 1430, Section 2](#), adopted 4/28/17, amended by [SB 230, Section 1](#), adopted 3/13/18). Charges the division of mental health and addiction with the development and provision of a research-based training program for health care providers, including mental health and behavioral health providers, concerning suicide assessment, treatment, and management that is demonstrated to be an effective or promising program and is recommended by the Indiana Suicide Prevention Network Advisory Council (ISPNAAC).
 - [§ 16-31-3-2](#) (originally [HB 1430, Section 4](#), adopted 4/28/17, amended by [SB 230, Section 2](#), adopted 3/13/18). Requires certified or licensed emergency medical services personnel to successfully complete a research-based training

program concerning suicide assessment, treatment, and management that is demonstrated to be an effective or promising program and is recommended by the Indiana Suicide Prevention Network Advisory Council.

- **Kentucky:** [KRS Section 210.366](#) (originally [SB 72](#), adopted 3/19/13). Requires 3-6 hours of training at least once every 6 years for certified or licensed social workers, marriage and family therapists, professional counselors, pastoral counselors, alcohol and drug counselors, psychologists, and occupational therapists.
- **Nevada:** [AB 93](#) (adopted 6/8/15). Requires psychiatrists, psychologists, marriage and family therapists, clinical professional counselors, social workers, and clinical alcohol, drug and gambling counselors and detoxification technicians to receive instruction on suicide prevention and awareness as a condition to the renewal of their licenses or certificates beginning on July 1, 2016. Also requires the professional licensing boards for certain physicians and advance practice registered nurses to encourage their licensees to receive training concerning suicide prevention, detection, and intervention as a part of their continuing education.
- **New Hampshire:** [RSA § 330-A:10](#) (originally [SB 33](#), adopted 5/7/15). Requires that at least 3 hours of the required continuing education units for biennial license renewal for pastoral psychotherapists, clinical social workers, clinical mental health counselors, or marriage and family therapists be from a nationally recognized, evidence-based or best practices training organization in the area of suicide prevention, intervention, or postvention and how mental illness, substance use disorders, trauma, or interpersonal violence directly impacts risk for suicide.
- **Pennsylvania:** 63 P.S. §§ 1221 – 1225 (originally [HB 64](#), adopted 7/8/16). Requires psychologists, social workers, marriage and family therapists, and professional counselors to receive at least one (1) hour of continuing education in suicide assessment, treatment, and management as a portion of the total continuing education required for license renewal. Titled the “Matt Adler Suicide Prevention Continuing Education Act.”
- **Tennessee:** [§ 63-1-125](#) (originally [SB 489](#), adopted 5/19/17, amended by [SB 204](#), adopted 4/15/19). Beginning 1/1/20, requires certified or licensed professional counselors, marital and family therapists, clinical pastoral therapists, social workers, alcohol and drug abuse counselors, and occupational therapists to receive at least 2 hours of training at least once every 4 years in suicide prevention, assessment and screening, treatment, management, and postvention. Training must count toward any applicable continuing education requirements for the profession. Requires the department of mental health and substance abuse services to create a model list of training programs. Titled the “Kenneth and Madge Tullis, MD, Suicide Prevention Training Act.”
- **Utah:** [HB 209](#) (adopted 3/23/15). Requires at least 2 hours of training in suicide prevention as a condition of licensure for recreational therapists ([§ 58-40-302](#)), social

workers ([§ 58-60-205](#)), marriage and family therapists ([§ 58-60-305](#)), clinical mental health counselors ([§ 58-60-405](#)), and substance use disorder counselors ([§ 58-60-506](#)).

- **Washington:** [RCW 43.70.442](#) (originally adopted into law 3/29/12 [[HB 2366](#)], was amended in 2013 [[HB 1376](#)], in 2014 [[HB 2315](#)], in 2015 [[HB 1424](#)], in 2016 [[HB 2793](#)], and in 2017 [[HB 1612](#)]). Requires 3-6 hours of training at least once every 6 years for certified or licensed advisers, counselors, chemical dependency professionals, marriage and family therapists, mental health counselors, occupational therapy practitioners, psychologists, advanced social workers, independent clinical social workers, and social worker associates. Requires a one-time training 3-6 hours in length for licensed chiropractors, naturopaths, licensed practical nurses, registered nurses, advanced registered nurse practitioners, osteopathic physicians, osteopathic physician assistants, physical therapists, physical therapist assistants, physicians, physician assistants, pharmacists, dentists, and dental hygienists. Titled the “Matt Adler Suicide Assessment, Treatment, and Management Training Act of 2012.”

State Encourages Training (4 states)

There are currently four states (IL, LA, MT, OR) that encourage training in suicide assessment, treatment, and management for health professionals:

- **Illinois:** [410 ILCS 53/30](#). Encourages the Director of Public Health to ensure that pilot suicide prevention programs include health provider and physician training and consultation about high-risk cases.
- **Louisiana:** [R.S. 37:24 through 27](#) (originally [SB 539](#), adopted 6/9/14). Requires the Louisiana Department of Health and Hospitals to offer certified, licensed or registered mental health counselors, social workers, psychiatrists, medical psychologists, nurses, physicians’ assistants, and addiction counselors access to an online list of training programs in suicide assessment, intervention, treatment, and management. These training hours can be counted towards continuing education or continuing competency requirements for professionals.
- **Montana:** [MCA 53-21-1101](#). Requires the state suicide prevention officer to direct a statewide program that includes training for medical professionals and social service providers (among others) on recognizing the early warning signs of suicidality, depression, and other mental illnesses.
- **Oregon:** ORS § 676.860 (originally [SB 48](#), adopted 6/29/17). Requires boards who license clinical social workers, marriage and family therapists, professional counselors, psychologists, occupational therapists, regulated social workers, school counselors, certified registered nurse anesthetists, chiropractic physicians, clinical nurse specialists, naturopathic physicians, nurse practitioners, physicians, physician assistants, physical therapists, and physical therapist assistants to, in collaboration with the Oregon Health Authority, adopt rules to require their licensees to report completion of any continuing education regarding suicide assessment, treatment, and management. Those boards are also required to document the number of licensees who complete the continuing

education, the counties in which those licensees practice, the percentage of all licensees who complete the continuing education, and contact information for those licensees willing to share it. Said documentation must be reported to the authority and the interim committees of the Legislative Assembly related to health care on or before March 1 of each even-numbered year (biennially). The authority may use this information to develop continuing education opportunities and to facilitate improvements in suicide risk assessment, treatment, and management efforts in the state. The Oregon Health Authority must also develop a list of continuing education opportunities and make said list available to each board.

Advocacy Efforts: The American Foundation for Suicide Prevention (AFSP) recognizes that the training of health professionals in suicide assessment, treatment, and management is a crucial step toward reducing the rate of suicide among people in the U.S., and has therefore made mandated suicide prevention training for these key gatekeepers a public policy priority. Currently, AFSP is focused on supporting state-level legislation and regulatory efforts in order to reach the end goal for all 50 states to require such training for health professionals.

AFSP's Public Policy Team in Washington, DC (advocacy@afsp.org) maintains connections with legislators and stakeholders in many of the states that have adopted health professional training laws, and can connect interested legislators and stakeholders to those individuals upon request.

Training Resources:

- The National Action Alliance for Suicide Prevention released a report in 2014 called [*Suicide Prevention and the Clinical Workforce: Guidelines for Training*](#) that can serve as a guide for the development of training programs for health professionals.
- The Suicide Prevention Resource Center (SPRC) offers a training workshop entitled *Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (AMSR)*. Visit <http://www.sprc.org/training-institute/amsr> to learn more.
- The American Association of Suicidology (AAS) offers several programs for health professionals; visit www.suicidology.org to learn more:
 - *Recognizing & Responding to Suicide Risk: Essential Skills for Clinicians*
 - *Recognizing & Responding to Suicide Risk: Essential Skills in Primary Care*
 - *Recognizing & Responding to Suicide Risk for Correctional Facility Clinicians*

Clinical Interventions: The following suicide specific interventions have demonstrated reductions in patient suicide risk; training resources and literature are available for clinicians at the following links:

- [Dialectic Behavior Therapy DBT](#) (Linehan)
- [Cognitive Behavioral Therapy for Suicidal Patients CBT-SP](#) (Beck, Brown)
- [Collaborative Assessment and Management of Suicidality CAMS](#) (Jobes, Comtois)
- [Attachment Based Family Therapy ABFT](#) (Diamond)
- [Safety Planning Intervention SPI](#) (Stanley, Brown)

Online & Print Resources:

- [Now Matters Now](#) online DBT skills for individuals struggling with suicidal thoughts (Whiteside)
- [Is Your Patient Suicidal?](#) Poster (SPRC)
- [Guide for ED Evaluation and Triage](#) (SPRC)

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