Policy Priority: Training for Health Professionals in Suicide Assessment, Treatment, and Management

According to the latest (2023) data from the Centers for Disease Control and Prevention (CDC), suicide is the 11th leading cause of death overall in the U.S. and the second leading cause of death for youth, teens, and young adults ages 10-34 (CDC, 2025). Over 90% of people who died by suicide had a diagnosable mental health condition at time of death and would often come into contact with health professionals during their time of suicide risk (Arsenault-Lapierre, Kim, & Turecki, 2004).

Training for Mental Health Professionals

Approximately 32% of people who died by suicide had contact with mental health services within a year of their death, and 19% of people who died by suicide had 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 more wide-scale implementation of training among mental health professionals 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 patients, 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 patients about suicidal 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 health conditions and suicide risk receive while also increasing provider competence and ability to provide effective, life-saving treatment.

While mental health conditions are associated with suicide risk, treating these conditions 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 health conditions, 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 do utilize is also 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).

Training for Primary Care Professionals

Mental health professionals are not the only clinicians who treat people with mental health conditions, 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 most patients utilize their primary healthcare services as their mental healthcare services, yet primary care providers similarly lack 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 health conditions 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 suicidal 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 assess suicide risk and serve as “gatekeepers” who connect patients to further resources, but this can only be done effectively

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 — but in most states across the U.S., 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 health concerns 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 some of their most vulnerable patients.

Current State Laws

State Requires Training (12 states)

California, Connecticut, Indiana, Kentucky, Nevada, New Hampshire, Oregon (some professionals), Pennsylvania, South Carolina, Tennessee, Utah, and Washington currently mandate training in suicide prevention or 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.
    - *AB 1436 (adopted 9/19/18, effective 1/1/21).* Requires applicants for licensure as a marriage and family therapist *(Business and Professions Code § 4980.396)*, an educational psychologist *(Business and Professions Code § 4989.23)*, a clinical social worker *(Business and Professions Code § 4996.27)*, or a professional clinical counselor *(Business and Professions Code § 4999.66)*, 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.
- **Connecticut:** Requires that continuing education for licensed or certified advance practice registered nurses *(§ 20-94d)* and nurse's aides *(§ 20-102ee),* alcohol and drug

counselors *(§ 20-74t),* behavior analysts *(§ 20-185k),* chiropractors *(§ 20-32),* clinical social workers *(§ 20-195u),* community health workers *(§ 20-195ttt),* emergency medical services personnel *(§ 20-206mm),* marital and family therapists *(§ 20-195c),* occupational therapists *(§ 20-74h),* physician assistants *(§ 20-12j),* physical therapists (§ 20-73b), professional counselors *(§ 20-195cc),* and psychologists *(§ 20-191c)* include suicide prevention training and how to screen for conditions such as PTSD, risk of suicide, depression, and grief. The same is encouraged for licensed physicians *(§ 20-10b).*

- **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 (ISPNAC).
    - *§ 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), amended by AB 105 (adopted 5/26/17).* Requires psychiatrists *(NRS § 630.253),* psychologists *(NRS § 641.220)*, marriage and family therapists and clinical professional counselors *(NRS § 641A.260)*, social workers *(NRS § 641B.280),* clinical alcohol, drug, and gambling counselors *(NRS § 641C.150)*, detoxification technicians *(NRS § 458.025),* physicians, physician assistants, and anesthesiologist assistants *(NRS § 630.253),* advance practice registered nurses *(NRS § 632.343),* and osteopaths *(NRS § 633.471)* to receive instruction on suicide prevention and awareness as a condition to the renewal of their licenses or certificates.
- **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.

- **Oregon:** *ORS § 676.866 (originally HB 2315, adopted 6/11/21).* Requires professionals licensed by a state Board, including marriage and family therapists, professional counselors, psychologists, clinical social workers, regulated social workers, and school counselors, as well professionals regulated by the Oregon Health Authority (OHA), including qualified mental health associates, qualified mental health professionals, certified alcohol and drug counselors, prevention specialists, problem gambling treatment providers, recovery mentors, community health workers, personal health navigators, personal support specialists, peer wellness specialists, doulas, family support specialists, youth support specialists, and peer support specialists, to complete either 2 hours every 2 years or 3 hours every 3 years of continuing education related to suicide risk assessment, treatment, and management, and report the completion of said training to the regulating board or OHA. Those boards and OHA are required to document the number and percentage of licensees who complete the continuing education, the counties in which those licensees practice, and contact information for those licensees willing to share it. Said documentation must be reported biennially to OHA and the legislature. OHA may use this information to develop continuing education opportunities and to facilitate improvements in suicide risk assessment, treatment, and management efforts in the state; OHA must also develop a list of continuing education opportunities and make said list available to each board.
- **Pennsylvania:**
    - *Act of Jul. 8, 2016, P.L. 476, No. 74 (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."
    - *Act of Jul. 23, 2020, P.L. 670, No. 69 (originally HB 1459, adopted 7/23/20).* Requires that EMS providers receive trauma and suicide awareness and impact training as a component of initial and continuing education and that the training be made available to other emergency responders.
- **South Carolina:** *SB 408 (adopted 5/29/24)*. Requires licensed professional counselors, marriage and family therapists, and addiction counselors *(§ 40-75-250)*, licensed psycho-educational specialists *(§ 40-75-540),* and licensed social workers *(§ 40-63-250)* to complete at least one (1) hour of continuing education in suicide assessment, treatment, and management treatment as a portion of the total continuing education required for license renewal.
- **Tennessee:** *§ 63-1-125 (originally SB 489, adopted 5/19/17, amended by SB 204, adopted 4/15/19).* 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), amended by SB 26 (adopted 3/19/24).* Requires at least 2 hours of training in suicide prevention as a condition of initial 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).* In addition, *(§ 26B-5-116) (originally HB 336, adopted 3/17/21, amended by SB 41, adopted 3/15/23, effective 5/3/23)* requires the state's Division of Substance Abuse and Mental Health to administer a program to solicit applications from health organizations for the purpose of providing suicide prevention training to between one and six Utah health care organizations a year.
- **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], in 2017 [HB 1612], in 2020 [HB 2411], and in 2023 [HB 1134, HB 1678]).* 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; the second training must either be an advanced training that is focused on suicide management, suicide care protocols, or effective treatments, or a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy. 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, dental hygienists, dental therapists, optometrists, and acupuncture and Eastern medicine practitioners. Requires the Secretary and the disciplining authorities to develop, and update once every two years, a model list of training programs; six-hour trainings must include content specific to Veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors, three-hour trainings for pharmacists or dentists must include content related to the assessment of issues related to imminent harm via lethal means, and both types of trainings must include content specific to the availability of and the services offered by the 988 crisis hotline and the behavioral health crisis response and suicide prevention system. Titled the "Matt Adler Suicide Assessment, Treatment, and Management Training Act of 2012."

State Encourages Training (4 states)

Louisiana, Minnesota, Montana, and Oregon (some professionals) currently encourage training in suicide assessment, treatment, and management for health professionals:

- **Louisiana:** *R.S. § 37:24 through 27*. 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.
- **Minnesota:** *Minn. Stat. § 145.56*. To the extend funds are appropriated, requires the commissioner of health to establish a grant program to fund community-based programs to provide evidence-based suicide prevention and intervention to public school nurses, school social workers, emergency medical technicians, advanced emergency medical technicians, paramedics, primary care providers, and others.
- **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*. Requires boards who license occupational therapists, 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 (OHA), adopt rules to require their licensees to report completion of any continuing education regarding suicide assessment, treatment, and management. Boards are 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 biennially reported to OHA and legislature. OHA may use this information to develop continuing education opportunities and to facilitate improvements in suicide risk assessment, treatment, and management efforts in the state; OHA 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 health professionals 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 and D.C. to require such training for health professionals.

AFSP's Public Policy Team in Washington, D.C. (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 American Foundation for Suicide Prevention has partnered with SafeSide to increase the number of primary care professionals trained in suicide assessment, treatment, and management. Contact your local AFSP Chapter to learn more about bringing this training to healthcare practices in your community.
    - SafeSide Primary CARE training is a group video-based training that provides a framework for responding to suicide concerns within the time and resource constraints of primary care.
- 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 sprc.org/training-institute/amsr to learn more.
- The American Association of Suicidology (AAS) offers several programs for health professionals; visit 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

- Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe (National Action Alliance for Suicide Prevention)
- Suicide Prevention Portal (The Joint Commission)
- 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)
- Zero Suicide Toolkit (Zero Suicide Institute at EDC)

- Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care (National Action Alliance)
- Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth (Substance Abuse and Mental Health Services Administration)

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