Workforce Competency in Suicide Prevention

Goal 5: One hundred percent of staff employed by the organization will receive training in suicide safe care, appropriate to their role in the care of individuals at risk.

Rationale

Suicide prevention is a core duty of behavioral health systems, with research demonstrating that 90% of individuals who die by suicide have a diagnosable behavioral health condition. With 25% of individuals who have died by suicide having reached out to a behavioral health care provider, all members of the workforce need to be prepared to identify and manage individuals at risk. In 2012, the Texas Department of State Health Services conducted a survey of over 3,800 staff in community mental health clinics and found that more than half did not feel that they had the training or skills that they needed to engage and assist people at risk for suicide. Following a concerted effort to train the workforce in 15 centers using Applied Suicide Intervention Skills Training (ASIST), only 13 to 18% of staff felt uncertain in their training and skills.

Staff and Level of Training

All Staff	Direct Care Providers	Specialty Providers
• safeTalk • ASIST	•CAMS or AMSR •CSSR-S •CTL •Safety Planning •CALM	• CBT-SP • DBT

Note: The trainings recommended for staff listed above are not an exhaustive list of best practice suicide prevention trainings. These are practices that are currently being recommended within the Texas public mental health system in an effort to promote consistency across agencies. A more comprehensive list can be found on the Suicide Prevention Resource Center website at http://www.sprc.org/bpr as well as for Zero Suicide specific trainings go to http://www.zerosuicides.org.

Core Competencies in Suicide Prevention

All staff within the organization should receive core competency training in suicide prevention. This includes direct care providers, managers, and support or administrative staff. Organizations may choose to offer Applied Suicide Intervention Skills Training (ASIST) to all staff or may opt to utilize ASIST with all direct care providers and offer safeTALK with non-providers. Staff should receive a refresher training (generally briefer) at least every three years.

Applied Suicide Intervention Skills Training (ASIST)
ASIST is an intervention that addresses immediate suicide risk and aims to increase support for the individual. ASIST trainers are certified by Living Works, Inc. This training has been used worldwide by clinical staff, non-clinical caregivers, and families. Training is provided in a two-day workshop. The training aims to enhance skills to:

- Identify individuals with suicidal ideation;
- Understand how a provider's own beliefs and attitudes impact interventions;
- Find a shared understanding of the suicidality and reasons for living;
- Review the current risk and create a plan to increase personal safety for a set course of time, and
- Follow-up on safety commitments, and receive additional help if needed. (New York State Office of Mental Health, 2014)

A list of certified trainers in ASIST is available from Jenna Heise at Jenna.Heise@dshs.state.tx.us. More information on ASIST can be found here.

safeTALK: Suicide Alertness
safeTALK is another gatekeeper intervention developed by Living Works, Inc. This three-hour training is appropriate for non-clinical and/or administrative staff members, psychiatrists, and primary care physicians. safeTALK prepares staff to identify individuals with suicidal thoughts and to connect them with suicide first aid assistance. Goals of the training are to:

- Decrease avoidance, dismissal, or misses of suicidal behaviors or thoughts;
- Identify individuals with suicidal thoughts;
- Apply the four steps of safeTALK – Tell, Ask, Listen, and Keep Safe;
- Connect individuals with suicide first aid providers.

(New York State Office of Mental Health, 2014)
Texas is developing certified trainers in safeTALK and a list is available from Jenna Heise at Jenna.Heise@dshs.state.tx.us. More information on safeTALK is available here. An iOS mobile application that summarizes key steps and resources is available for free download for individuals who have completed the safeTALK training.

Management of Suicidality

Staff who provide clinical services to individuals at risk of suicidality should also receive best practice training in assessing and managing suicide risk. Organizations may select from two best practice trainings – the Collaborative Assessment and Management of Suicidality (CAMS) or Assessing and Managing Suicide Risk (AMSR). As noted previously, there are other best practice trainings in management of suicidality.

The Collaborative Assessment and Management of Suicidality (CAMS)

The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework that can be utilized at the stage of assessment and can aid in organizing clinical treatment across multiple sessions. CAMS emphasizes the importance of creating a person-centered approach within the therapeutic alliance while managing suicide risk. The Suicide Status Form (SSF), used during the initial session to understand the details of the person's suicidality, outlines a course of intervention and is used to track and document symptoms throughout treatment (Jobes, 2009). Collaboration between the person and provider is used to develop a suicide-specific treatment plan that aims to eliminate suicide as a coping strategy while increasing reasons to live. Research has demonstrated the validity of the SSF and the effectiveness of CAMS through both quasi-experimental and experimental research (Jobes, 2012). A web-based training module, inclusive of technical assistance from model experts, will be available Fall 2014.

Assessing and Managing Suicide Risk (AMSR)

The Assessing and Managing Suicide Risk program is a research-informed and skills-based training for mental health professionals that was created by the Suicide Prevention Resource Center (SPRC) and the American Association of Suicidology (AAS). Training workshops are one day and cover 24 empirically-based core competencies. Evaluations have demonstrated gains in participant knowledge and self-reported competence in assessing and managing individuals with suicide risk. More information can be found on the SPRC website.

Additional Staff Competencies

Additional staff training is recommended for staff involved in screening and assessing suicide risk. Information on training for the Columbia Suicide Severity Rating Scale (C-SSRS) is contained within the Screening chapter of the toolkit, and information on training for the CASE Approach is contained within the Risk Assessment chapter. Additionally, information on training for Counseling on Access to Lethal Means (CALM) and Safety Planning is incorporated in the chapter on Safety Planning. Additional staff competencies should be considered based on the role of the staff member in identifying or reducing suicide risk.

Evidence Based Treatments

Organizations should ensure the availability of at least one evidence-based treatment for suicidality, and specialty providers of these practices should have appropriate training and monitoring of treatment fidelity. Availability is likely to involve access to the service within the organization, but may also be demonstrated though formal agreements with providers of these services within the community. The two current evidence-based treatments for suicidality are Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP; Stanley et al, 2009) and Dialectical Behavioral Therapy (DBT).

Cognitive Behavioral Therapy for Suicide Prevention

Traditional CBT approaches target specific disorders or symptoms, such as depression or anxiety. Although this may be a critical step for reducing distress and improving quality of life, a provider's immediate goal for an individual at risk for suicide should be to keep the individual safe long enough to benefit from treatment. Therefore, interventions must directly target skills to prevent suicide. Cognitive behavioral therapy for suicide prevention (CBT-SP) is an adaptation created to directly prevent or reduce the risk for suicide attempts or reattempts. When tested in a clinical trial, CBT-SP consisted of a 12-week acute treatment phase focusing on safety planning, understanding the circumstances and vulnerabilities that lead to suicidal behavior, and building life skills, followed by a maintenance continuation phase.

Dialetical Behavior Therapy

Dialectical Behavior Therapy (DBT; Linehan, 1993) was created as a cognitive behavioral treatment to treat suicidal individuals with Borderline Personality Disorder. The therapy emphasizes the dialectics of acceptance and change and teaches individuals coping skills in addition to the traditional CBT model. One of the core elements of DBT is teaching skills that help the person to regulate and tolerate their emotions. DBT most importantly validates the individual's experience and emotional pain while ensuring safety and supports in the environment. Treatment is organized into four progressive stages, first addressing behaviors that could lead to an individual's death, then behaviors that could lead to premature termination. Following these critical steps, treatment then addresses behaviors that negatively impact the individual's quality of life and then focuses on the acquisition of alternative skills.

Both online and in-person training opportunities are available through the Linehan Institute and Behavioral Tech at http://behavioraltech.org/index.cfm. This site also includes a registry of DBT providers within Texas.

Moving Beyond - Community Expansion

Community members and individuals outside of the healthcare system are most likely to benefit from training in a suicide gatekeeper program, such as ASK about Suicide to Save a Life. ASK is a 1.5 to 4-hour workshop for adults that provides an overview of the epidemiology of suicidal behavior and trains participants to recognize warning signs and intervene with an individual who may be at risk for suicide. Many local communities have certified ASK trainers; for more information about ASK training, please contact txsuicideprevention@mhat.org.

Additional training may be warranted for community agencies providing health and behavioral health care. The competency of the behavioral health workforce to assess and manage individuals with suicide risk extends beyond the public mental health system. Mental health agencies with certified trainers in best practice curricula should consider expansion of these trainings to include behavioral health providers in other organizations and systems within their community. Providing trainings that include both internal and external staff can foster networking and collaboration across agencies. Additionally, trainers can partner with technical schools, colleges, and universities to offer training within professional training programs. Many higher education programs welcome guest lecturers and opportunities for students to hear from community leaders. In addition, student interns can gain valuable experience through exposure to evidence-based interventions to prevent suicide within practice settings.

References

Linehan, M. M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.

Stanley B, Brown G, Brent D, Wells K, Poling K, Curry J, et al. (2009). Cognitive behavior therapy for suicide prevention (CBT-SP): treatment model, feasibility and acceptability. *Journal of the American Academy of Child and Adolescent Psychiatry*. 48(10): 1005-1013.