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# Core Competencies in Suicide Risk Assessment and Management: Implications for Supervision

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The recent publication of core competencies in suicide risk assessment and management (Suicide Prevention Resource Center, 2006) and the American Psychiatric Association's (2003) practice guidelines have raised concerns about how best to address these issues in clinical supervision of trainees. This article reviews the identified core competencies, addresses implications for supervision of trainees, and provides a general framework for applicable strategies for the supervision process to facilitate clinical skill development and refinement.

*Keywords:* suicide risk assessment, suicide risk, core competencies, supervision

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It is almost a certainty that psychologists-in-training (i.e., internships and practicum placements) will at some point be required to evaluate a patient presenting with some form of suicidality (i.e., suicidal thoughts, a suicide attempt, or a history of multiple attempts). Suicidality is the most frequently encountered emergency situation in mental health settings (Buzan & Weissberg, 1992) and is the most anxiety-provoking clinical scenario for practitioners (Pope & Tabachnick, 1993; Rudd, 2006), with an estimated one-quarter of all psychologists experiencing a patient suicide at some point in their careers (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; Pope & Tabachnick, 1993). Similarly, it has been estimated that almost 40% of psychology trainees will have a patient make a suicide attempt (29.1%) or will experience a patient's suicide (11.3%) during training (Kleespies, Penk, & Forsyth, 1993).

The challenge of responding to suicide risk in the clinical environment is not unique to psychologists, but is uniform across mental health specialties, with Chemtob, Hamada, Bauer, Torigoe, and Kenny (1988a) estimating that 50% of psychiatrists will lose a patient to suicide. McAdams and Foster (2000) reported that 23% of counselors had a client die by suicide during the course of treatment. Fawcett (1999) has estimated that up to one half of all suicides in a given year (more than 31,000 suicides per year; Hoyert, Heron, Murphy, & Kung, 2006) are by individuals currently in treatment. The impact of suicidal behavior, emotionally and professionally, on those providing clinical care is profound, with clinicians reporting shock, self-blame, guilt, and shame (Kleespies et al., 1993). The impact on those in training has been found to be even more significant. Kleespies et al. (1993) found that the earlier in training a patient suicide occurred, the more severe the impact and the more enduring the emotional consequences and distress.

What seems clear is that suicidality is a clinical scenario frequently, if not uniformly, encountered in clinical training environments. The recent publication of core competencies in the assessment and management of suicide risk (Suicide Prevention Resource Center [SPRC], 2006) and the American Psychiatric Association's (2003) practice guidelines have clear implications for the nature and process of supervision in clinical training settings. It is important for supervisors to be familiar with available standards and also consider strategies for ensuring thorough coverage and related skill development in the supervision process.

## Importance of Competency-Based Supervision

Falender and Shafranske (2007) recently provided a review and discussion of competency-based supervision practice in psychology. At the heart of their review is the issue that both the American Psychological Association (APA) ethics code (APA, 2002) and licensing board rules of practice (Association of State & Provincial Psychology Boards [ASPPB], 2003) require psychologists to practice within their identified and demonstrated areas of competence. Among their recommendations for best practices that have clear implications for the management of high-risk suicidal patients are the following (Falender & Shafranske, 2007, p. 238): (a) The supervisor examines his or her own clinical and supervision expertise and competency; (b) the supervisor delineates supervisory expectations, including standards, rules, and general practice; (c) the supervisor identifies setting-specific competencies the trainee must attain for successful completion of the supervised experience; (d) the supervisor collaborates with the trainee in developing a

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supervisory agreement or contract for informed consent, ensuring clear communication in establishing competencies and goals, tasks to achieve them, and logistics; and (e) the supervisor models and engages the trainee in self-assessment and development of metacompetence (i.e., self-awareness of competencies) from the onset of supervision and throughout. These recommendations for best practices articulate quite well that competencies for critical subareas of clinical practice, such as suicide risk assessment and management, need to be identified and targeted in the supervision process, with subsequent monitoring and refinement over the course of training. What is more challenging is how best to provide the essential content necessary as a foundation for clinical practice and identify the best process to build targeted clinical competencies during the training experience.

## Limited Suicide-Specific Training

More than 3 decades ago, Burstein, Adams, and Giffen (1973) identified deficiencies in professional training in suicide risk assessment. More recently and somewhat surprisingly, Bongar and Harmatz (1991) found that only 40% of graduate training programs in clinical psychology offered formal training (i.e., courses or specific training sessions) in the assessment and management of suicide risk. Similarly, Kleespies et al. (1993) found that 45% of former graduate students in clinical psychology reported no training specific to suicidality while in graduate school. In a national sample of psychologists, Guy, Brown, and Poelstra (1990) found a mean of 1 hr of formal training on the topic of suicidality and patient violence. This is not a isolated problem for clinical or counseling psychologists. More recently, Debski, Spadafore, Jacob, Poole, and Hixson (2007) surveyed practitioner members of the National Association of School Psychologists. They found that fewer than half reported graduate training in suicide risk assessment. Despite the lack of formal training, the majority of participants had conducted a suicide risk assessment in the past 2 years. Similarly, Reeves, Wheeler, and Bowl (2004) found that although suicide risk assessment was considered important in the training curriculum for counselors, courses were not specific to the topic and it was addressed primarily through unspecified supervision activities. The most troubling aspect of these findings is that clinicians will almost uniformly encounter suicidal patients in clinical training, regardless of setting (Pope & Tabachnick, 1993; Rudd, 2006).

In addition to the publication of core competencies in this area, the American Psychiatric Association (2003) has published practice guidelines, with both of these documents clarifying expectations and related skill sets in clinical practice. Although core competencies and practice guidelines do not establish the standard of care in a given area, they will certainly influence the process by which standard-of-care determinations are made (Rudd, 2006). Consistent with existing ethical principles (APA, 2002) and state board rules of practice (ASPPB, 2003), these publications should motivate those in clinical practice settings to address implications for supervision of trainees. This idea is certainly not new and has previously been identified in the literature. Sommers-Flanagan and Sommers-Flanagan (1995) noted a policy in clinical practice to assign practicum cases (i.e., supervision required) only to graduate students who demonstrated competence in suicide risk assessment procedures. Although they offered a systematic approach to intake interviewing with suicidal patients, they did not articulate a specific framework or model for supervision, nor did they identify possible strategies for accomplishing identified training goals.

Given the points summarized above, in this article we have three primary goals: (a) to provide a brief review of the recently published core competencies identified for suicide risk assessment and management (SPRC, 2006), (b) to identify implications for the content and process of clinical supervision with trainees, and (c) to provide a general supervision framework and related strategies that will facilitate establishing the identified core competencies in trainees. Our goal is not to provide a thorough review in each of the core competency areas identified. Rather, our goal is to discuss implications for supervision and offer strategies for use with trainees. The hope is that the net outcome will be a straightforward strategy for clinical supervision, one that allows trainees to become familiar with the essential content in suicide risk assessment and management, along with a process that facilitates the development of targeted clinical skills and refinement over the course of the training experience.

## A Brief Overview of the Core Competencies in Suicide Risk Assessment and Management: Identifying Supervisory Tasks

The core competencies in suicide risk assessment and management (SPRC, 2006) cover seven primary clinical skill set domains: attitudes and approach, understanding suicide, collecting accurate assessment information, formulating risk, developing a treatment and services plan, managing care (i.e., immediate response to identified risk level), and understanding legal and regulatory issues related to suicidality. The core competency training also includes a series of video clips that elaborate several clinical scenarios encountered in day-to-day care. There are a total of 24 competencies across the seven domains (see Table 1). These are only briefly reviewed here, with comments as to the most salient aspects of the competencies for clinical supervision. Formal training is required for a full and detailed understanding, along with a review of related reading materials. In addition to the identified domain, Table 1 also includes the core competencies and a column indicating the nature of the supervisory task, differentiating between trainee self-awareness, content mastery and targeted clinical skill acquisition and refinement. The Appendix provides a supplemental reading list across the various domains, something that will, we hope, make it easier for supervisors putting together the appropriate training sequence and materials. Although only a brief summary of the core competencies is provided here, the supplemental reading list provides thorough coverage of each domain and more-than-adequate resources to facilitate training and supervision.

The first domain revolves around the need for trainees to recognize and understand the importance of individual attitudes and beliefs, reconciling the potential conflict and adversarial position sometimes inherent to suicide risk assessment and maintaining a collaborative stance throughout the assessment and management process. In particular, this domain emphasizes the importance of recognizing the possible influence of the clinician's emotion (e.g., anxiety, anger, or frustration) in the assessment and management process (Shea, 2002). Similarly, the need to reconcile the potential conflict between a patient's goal to reduce psychological suffering by suicide and the clinician's goal to prevent a suicide is a central focus. This can be accomplished with a straightforward and simple

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Table 1
*Primary Domains, Core Competencies, and Supervisory Tasks*

| Core competencies | Nature of supervisory task (self-awareness, content mastery, skill acquisition and refinement) |
|---|---|
| **Working with individuals at risk for suicide: attitudes and approach** | |
| 1. Manage one's reactions to suicide. | Self-awareness (trainee insight and understanding):<br>■ Recognize potential influence of emotional reactions (e.g. anxiety, anger, frustration) in the assessment and management process<br>■ Identifying "personal" beliefs about suicide and their potential influence |
| 2. Reconcile the difference (and potential conflict) between the clinician's goal to prevent suicide and the client's goal to eliminate psychological pain via suicidal behavior. | Skill acquisition:<br>■ Provide an understandable model of suicidality and identify a common goal in treatment (i.e. relief of emotional pain and suffering) |
| 3. Maintain a collaborative, non-adversarial stance. | Skill acquisition:<br>■ Patience, empathy, understanding<br>■ Active listening<br>■ Acknowledge ambivalence about living<br>■ Contextualize (normalize) feelings of despair and hopelessness<br>■ Provide an understandable model of suicidality<br>■ Identify a common goal for treatment |
| 4. Make a realistic assessment of one's ability and time to assess and care for a suicidal client as well as for what role the clinician is best suited. | Skill acquisition:<br>■ Recognize the time and resource demands of high-risk patients<br>■ Articulate expectations regarding care for high-risk patients<br>■ Articulate and establish appropriate boundaries for high-risk patient caseload |
| **Understanding suicide** | |
| 1. Define basic terms related to suicidality. | Content mastery:<br>■ Terminology<br>■ Differentiate self-harm, suicide threat, suicide attempt (with and without injury)<br>■ Recognize the importance of multiple attempter status |
| 2. Be familiar with suicide-related statistics. | Content mastery:<br>■ Statistics and related facts |
| 3. Describe the phenomenology of suicide. | Content mastery:<br>■ Ability to articulate a biopsychosocial model for understanding suicide |
| 4. Demonstrate understanding of risk and protective factors. | Content mastery:<br>■ Articulate a framework for understanding risk and protective factors |
| **Collecting accurate assessment information** | |
| 1. Integrate risk assessment for suicidality early on in a clinical interview, regardless of the setting in which the interview occurs, and continue to collect assessment information on an ongoing basis. | Skill acquisition:<br>■ Interviewing skills |
| 2. Elicit risk and protective factors. | Skill acquisition:<br>■ Appropriate questions to address risk and protective factors |
| 3. Elicit suicidal ideation and behaviors. | Skill acquisition:<br>■ Appropriate questions to elicit suicidal ideation and behaviors |
| 4. Elicit warning signs of imminent risk of suicide. | Skill acquisition:<br>■ Familiarity with warning signs for suicide<br>■ Appropriate questions to elicit warning signs for suicide |
| 5. Obtain records and information from collateral sources as appropriate. | Skill acquisition:<br>■ Interviews with collateral information sources when available |
| **Formulating risk** | |
| 1. Make a clinical judgment of the risk that a client will attempt or complete suicide in the short and long term. | Skill acquisition:<br>■ Use a framework for formulating risk<br>■ Differentiate between acute and chronic risk elements |
| 2. Write the judgment and the rationale in the client's record. | Skill acquisition:<br>■ Develop a consistent approach to documenting suicide risk at intake and each follow-up contact as appropriate |

(*table continues*)

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Table 1 (*Continued*)

| Core competencies | Nature of supervisory task (self-awareness, content mastery, skill acquisition and refinement) |
|---|---|
| **Developing a treatment and services plan** | |
| 1. Collaboratively develop an emergency plan that ensures safety and conveys the message that the client's safety is not negotiable. | Skill acquisition:<br>■ Development of a safety plan (crisis response plan) that matches the patient's competency and skill level<br>■ Be sure the patient can accomplish each step (role play) |
| 2. Develop a written treatment and services plan that addresses the client's immediate, acute, and continuing suicide ideation and risk for suicide behavior. | Skill acquisition:<br>■ Develop a treatment plan targeting suicidality (thoughts and related behaviors) and associated symptoms |
| 3. Coordinate and work collaboratively with other treatment and services providers in an interdisciplinary team approach. | Skill acquisition:<br>■ Coordinate care as appropriate with other providers (e.g. physicians, psychiatrists) |
| **Managing care** | |
| 1. Develop policies and procedures for following clients closely, including taking reasonable steps to be proactive. | Skill acquisition:<br>■ Ensure that access to available method is restricted or eliminated |
| 2. Follow principles of crisis management. | Skill acquisition:<br>■ Use basic crisis management strategies |
| 3. Document the following items related to suicidality: informed consent, information that was collected from a biopsychosocial perspective, formulation of risk and rationale, treatment plan (well described and shown to be followed), and consultation with professional colleagues. | Skill acquisition:<br>■ Consider an informed consent approach that acknowledges the risks inherent to managing suicidal patients<br>■ Develop an approach to documentation that recognizes the importance of thorough documentation |
| **Understanding legal and regulatory issues related to suicidality** | |
| 1. Understand state laws pertaining to suicide. | Content mastery:<br>■ State laws related to suicide and high-risk patients |
| 2. Understand legal challenges that are difficult to defend against as a result of poor or incomplete documentation. | Content mastery:<br>■ Understand of standard-of-care issues with high-risk patients<br>■ Understand issues of malpractice and negligence in clinical care |
| 3. Protect client records and rights to privacy and confidentiality following the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that went into effect April 15, 2003. | Content mastery:<br>■ HIPAA |

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intervention of defining a common goal, that is, to reduce the patient's suffering and emotional pain. If that happens, it is believed that the suicidality will also resolve. Also central to this domain is the notion of maintaining a collaborative stance, one that facilitates establishing and maintaining a good working alliance with the patient. It is believed that four relatively simple interventions will facilitate this effort: acknowledging the patient's ambivalence about living, contextualizing (normalizing) feelings of hopelessness within psychiatric illness or diagnosis (e.g., "It's not unusual to be hopeless when seriously depressed") and/or the patient's current life circumstances, providing an understandable and simple model of suicidality (i.e., an effort to eliminate psychological suffering), and identifying a common goal for treatment (i.e., reduction of emotional suffering and psychological pain). The final element of this domain revolves around helping trainees understand the time and resources required to care for high-risk patients and the need to articulate clear expectations and boundaries. The number of high-risk suicidal patients who can reasonably be managed at any one time in a training environment should be clearly communicated to the trainee.

The second domain, understanding suicide, is essentially content mastery. A central goal is to ensure that trainees are aware of (and that there is uniformity and agreement across trainees and the supervisor on) various terms used and statistics and related facts. In particular, it is recommended that trainees learn to effectively differentiate between suicide threats, self-harm, and suicide attempts with and without injuries (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007a, 2007b). As a part of this domain, it is expected that clinicians will be able to articulate an understandable biopsychosocial model of suicidality, one that can be related in simple and straightforward terms to patients and one that will lend itself to clear and straightforward treatment targets (i.e., suicidal thoughts and behaviors and associated symptoms such as depression, anxiety, hopelessness, and substance abuse). Perhaps most important, though, is the need for trainees to have a solid grounding in, and understanding of, risk and protective factors. The next two competency domains address the application of risk and protective factors in terms of actual clinical assessment and the formulation of risk.

The third and fourth domains address the need to collect accurate assessment information, with the emphasis on the word *accurate,* and formulate an understanding of risk. Those in training should be sensitive to resistance, hesitation, and ambivalence on the part of suicidal patients (Maltsberger, 2001). It is critical to emphasize the need for trainees to have access to a comprehensive list of recommended questions for assessing suicidality and associated symptoms (Rudd, 2006; Rudd, Joiner, & Rajab, 2004). As summarized earlier, the majority of those in training have not participated in suicide-specific instruction (Kleespies et al., 1993). In particular, it is important for clinicians to recognize the distinction between risk factors and warning signs (Rudd, Berman, Joiner, et al., 2006), along with differences between acute and chronic (or enduring) risk (Rudd, 2006). In terms of formulating risk, a range of approaches and frameworks are available in the literature; what is important from the supervision standpoint is that a comprehensive framework be selected and used consistently. The Appendix provides a number of alternatives currently available in the literature, all comprehensive and thorough in nature.

The next two domains, developing a treatment and services plan and managing care, are a response to the risk assessment and subsequent risk formulation. The most salient aspect for training is the recognition of and understanding that risk factors and warning signs identified in the assessment process need to be specifically targeted in treatment and immediate management. Additionally, steps need to be taken to reduce or, preferably, eliminate access to the method(s) identified for suicide. This can routinely be a part of the safety plan (or crisis response plan). The core competencies recommend against use of a generic no-suicide contract or safety plan as a definitive intervention without careful monitoring, periodic reevaluation, and behavioral practice of the skills essential to implement the plan. Rudd, Mandrusiak, & Joiner, (2006) have discussed the weaknesses inherent in its use and the complete lack of empirical support in the literature regarding the efficacy of no-suicide contracts. A standard and consistent approach to documentation of these is essential. Similarly, it is vital to coordinate care with other providers such as a prescribing physician or psychiatrist. Most, if not all, of the issues relevant to the management of high-risk suicidal patients are addressed during the informed consent process. Rudd, Williams, and Trotter (in press) recently discussed the need to provide a clear statement of risks during assessment and treatment unique to suicidal patients, recommending that the risk of a suicide attempt and death by suicide be clearly articulated in the document. Although potentially provocative, their argument is clearly grounded in the APA (2002) Ethics Code and related extant literature.

The final domain, understanding legal and regulatory issues related to suicidality, is essentially a content mastery task. Those in training, however, should be aware of the broader issue of the standard of care and related constructs of negligence and malpractice in clinical care. A number of relevant readings and approaches are provided in the Appendix.

## An Emerging Empirical Foundation for Core Competencies

Although very limited at this point, there is an emerging empirical foundation for core competencies in suicidality and the supervision strategies recommended, including the various aspects of assessment, management, and treatment. Empirical support comes from several sources, including a review of available treatment outcome studies (which always incorporate assessment and management tasks as a part of the initial and ongoing treatment process), the very limited number of studies specifically targeting the impact of clinician training and related supervisory tasks, along with the empirical literature specific to the targeted competency domains referenced above. Regardless of source, the empirical evidence available to date is compromised by several problems, including relatively brief follow-up periods and target outcomes not directly related to suicidality (e.g., depression and hopelessness rather than attempt rates and deaths by suicide). The low base-rate nature of the problem makes it difficult, arguably impossible when follow-up is brief, to accumulate the samples necessary to test the most critical outcomes of suicide attempts and deaths. Nonetheless, there are emerging data to provide a foundation for core competencies in suicidality, to include recommended clinical practice strategies.

There are just a handful of studies assessing the utility of suicide risk assessment and management training programs. Most important, Oordt, Jobes, Fonseca, and Schmidt (2007) found that core competency training could alter both clinicians' confidence in assessing and managing suicidal patients, along with specific behavioral changes in day-to-day clinical practice. Reeves et al. (2004) found that one-to-one supervision was the most critical element in helping trainees become skilled at assessment and management of suicide risk. Fenwick, Vassilas, Carter, and Haque (2004) reported that role plays using actors were viewed by participants as the most effective and important component of training in suicide risk assessment and management. Of concern, though, Morriss, Gask, Battersby, Francheschini, and Robson (1999) found that one-time training did not improve general clinical interviewing and assessment skills. It is important to recognize that this study addressed single-exposure training (i.e., workshop format), unlike the continuous core competency-based supervision model recommended here.

Perhaps the most compelling data for core competencies in suicidality come from available treatment outcome studies, particularly when the idea of identifying common elements of effective treatments are considered. Rudd et al. (2008) recently provided a review of all available controlled treatment trials in which suicidal behavior was targeted, with a specific focus on identifying common elements in effective treatments. Effective treatments are those that reduced subsequent suicide attempt rates. The results of available treatment outcome studies ($N = 53$, with a total of 4 found to reduce suicide attempt rates and all being cognitive–behavioral in orientation) have very specific implications for the content of the core competencies (i.e., models for understanding suicide, collecting the appropriate information in risk assessment and subsequent risk formulation, along with developing a treatment plan and managing care and related crises). Rudd et al. (2008) identified the following common elements of treatments found effective at reducing the frequency of suicide attempts (pp. 8–9).

### *Theoretical Models Easily Translated to Clinical Work*

All of the treatments have clearly articulated, well-defined and understandable theoretical models that are embedded in empirical research. The theoretical models all identify cognitions, emotional processing, and associated behavioral responses as critical to understanding motivation to die and associated distress (and symp-

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toms) and ultimately changing the suicidal process. Patients find the models easy to understand, distilling them down to thoughts, feelings, and behaviors that are associated with suicide risk and hopelessness. In short, these treatments have made it easy to sit down with a patient and explain in understandable language why they have tried or are thinking about killing themselves. This is an important consistency across effective treatments and prompts a number of important questions. When a treatment model is simple, straightforward, and easy to understand, does it facilitate hope, improve motivation, and result in better compliance? If so, the net outcome would be enhanced skill development, reduced symptom severity, and fewer subsequent suicide attempts. Future research will help answer these questions.

### *Treatment Fidelity*

In all of the treatments referenced above, treatment fidelity was a critical factor. This includes ongoing assessment, monitoring, and management. This translates to clinicians being trained to a target standard of competence and supervised throughout (with variable formats). For the most part, the treatments were manual driven, with a clear sequence and hierarchy of treatment targets, with a reduction of suicidal behavior as a central and primary focus. Rather than focus on peripheral or associated symptoms (e.g., depression, hopelessness, or anxiety), effective treatments target suicidality specifically. Effective psychological and behavioral treatments view suicidality as, at least to some degree, independent of diagnosis. Targeting suicidal behavior as a treatment outcome clearly seems to lend itself to positive changes in subsequent attempt rates.

### *Compliance*

Effective treatments also targeted treatment compliance in specific and consistent fashion. More specifically, all had specific interventions and techniques that targeted poor compliance and motivation for treatment. Treatment is only effective if the patient is active, involved, and invested. Obviously, this cuts across many different domains. It is clear from effective treatments that compliance with care needs to be a central and primary focus, with clear plans about what to do if noncompliance emerges, recognizing that noncompliance can be a marker of risk escalation. Just as suicidal behavior needs to be a primary target, motivation and investment in care is important. When motivation, investment, and involvement drop, they need to become a primary treatment target until effectively resolved.

### *Targeting Identifiable Skills*

Consistent with easy-to-understand theoretical models of suicidality driving the assessment and treatment process, effective treatments targeted clearly identifiable skill sets (e.g., emotion regulation, anger management, problem solving, interpersonal relationships, and cognitive distortions). In these treatments, patients understand what is wrong and what to do about it to reduce suicidal thinking and behaviors. They also have the opportunity to practice and build skill sets over time.

### *Personal Responsibility*

Consistent with each of the above points, effective treatments emphasized self-reliance, self-awareness, self-control, and issues of personal responsibility. Effective treatments are clear in the goal that if patients developed appropriate skills, the distress and upset tied to early events would diminish, as would associated suicidal urges. Consistent with this goal, patients assumed a considerable degree of personal responsibility for their care, including crisis management. Again, this is consistent with the issue of improved compliance and motivation for care. Although there are a range of models available for facilitating compliance and crisis management, we would encourage clinicians to consider use of the commitment-to-treatment agreement (cf. Rudd et al., 2006).

### *Easy Access to Treatment and Crisis Services*

Effective treatments emphasize the importance of crisis management and access to available emergency services during and after treatment, with a clear plan of action being identified. Additionally, effective treatments more often than not dedicate time to practicing the skill sets necessary for effective crisis management, with patients learning to identify what characterizes a crisis or emergency, using a safety or crisis management plan and learning to use these services in judicious and appropriate fashion. This means that patients and clinicians alike become familiar with a set of symptoms or warning signs that need to be monitored to assess variations in risk status and respond accordingly.

As is evident, data from treatment outcome studies have implications for the following core competency domains: understanding suicide, collecting accurate assessment information, formulating risk, developing a treatment plan, and managing care. Although the data are not directly related to the all of the strategies summarized for the various core competencies, it is important to apply what we know about suicidality to day-to-day clinical practice. Certainly, much more work is needed, particularly studies targeting the efficacy of competency training, including not only investigation of attitude and behavioral change on the part of clinicians, but also whether such strategies reduce the frequency and severity of adverse events (i.e., suicide attempts and deaths). Regardless, though, available data provide a foundation for current efforts and directions.

### *Strategies for Accomplishing Supervisory Tasks*

As evidenced in Table 1, there are three essential supervisory tasks: improving trainees' self-awareness and understanding, ensuring content mastery, and monitoring and refining skill acquisition during the supervision experience. There are a range of strategies that can be used to facilitate development of the necessary skills in the supervision process. With respect to content mastery, naturally, reading outside of supervision is essential. The Appendix provides a solid reference list on which to build. In addition to individual reading, targeted group supervision and seminars are recommended to clarify areas of concern.

### *Strategies for Addressing Self-Awareness and Understanding*

One of the more important elements of supervision is supervisor–trainee trust and an open and collaborative relationship. As indicated previously, trainees will feel scared, vulnerable, and often overwhelmed by the tasks associated with suicide risk assessment and providing treatment to patients at risk for suicide

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(Kleespies et al., 1993). Disclosing these feelings can be quite difficult in the context of an evaluative relationship. To facilitate honest discussion of emotional experiences, the supervisor must create an atmosphere of safety and trust. This is accomplished by maintaining an open, nonjudgmental stance, normalizing the trainees' emotional experience, and maintaining appropriate boundaries. It is especially important for the supervisor to help the trainee learn the most important elements of risk assessment and therapy provision in an atmosphere that accepts that these tasks can be done well in a variety of ways (Rudd, 2006). Understanding one's personal beliefs about suicide can be facilitated by some simple questions, including

- Why do you think people kill themselves (helps uncover the clinician's personal theory)?
- Is it possible to prevent suicide (probes the issue of professional role)?
- Is it ever acceptable to die by suicide (probes personal beliefs and values)?
- Do people who access care want to die (addresses the issue of intent and the reality that it waxes and wanes for patients throughout care, but ordinarily is weighted in the direction of survival when the patient is actively engaged in treatment)?
- As a clinician, what are your responsibilities (provides the chance to think clearly about clinical responsibilities and boundaries)?

Although simple and straightforward, these questions probe individual feelings, beliefs, and values related to the potentially provocative question of suicide. In particular, the issue of the variable nature of suicide intent is particularly relevant. Regardless, though, it is critical to find an avenue to help a trainee recognize, understand, and monitor personal feelings in treating suicidal patients.

Within a trusting relationship, it is critical for the supervisor to regularly ask the trainee direct questions related to the attitudes and approach domain core competencies in Table 1. For example, in one clinical case, valuable information was gained by the supervisor regarding a trainee's reaction to a patient by asking how he was feeling at the start of a risk assessment when the patient answered "I'm not going to do that" in response to the query about thoughts of suicide. A trainee who feels particularly anxious or uncertain may be inclined to end a suicide risk assessment at that point, concluding that the patient's statement indicates low risk. This response would necessitate a discussion that includes (a) the trainee's knowledge of suicide risk assessment, to ensure that the trainee is aware of the additional steps and strategies that were warranted; (b) an open dialogue about the trainee's perceived ability to intervene in the event that the patient was in need of greater intervention or hospitalization; and (c) the trainee's feelings about suicide and the impact this has on his or her comfort in these assessment and treatment exchanges. The trainee may draw support and encouragement from a supervisor who normalizes any anxiety present during the assessment and reinforces the elements of the assessment process that were particularly effective in eliciting relevant information. This supervisory process increases the likelihood that the trainee will continue to probe for suicide risk as described above with a more thorough evaluation of the patient's thoughts and associated risk factors. In the above-mentioned case, the trainee's heightened self-awareness and understanding of suicide enabled him to avoid ending the assessment prematurely and instead provide additional information to the patient to contextualize suicidal thinking, which reduced the patient's resistance and anxiety, allowing for a more thorough and accurate exploration of the problem.

Assisting trainees in understanding the time and resources required to care for high-risk patients is of critical importance. This open dialogue will help prevent trainees from feeling burned out, frustrated, and resentful of patients who require a lot of time and energy (e.g., emergent sessions and after-hours phone calls). A critical element of this discussion includes determining each trainee's individual boundaries and his or her interest in being more or less available to patients. Within the typical training clinic setting, it is not reasonable for trainees to provide on-call crisis or skills coaching because of other responsibilities, including educational demands. Trainees should be advised to use caution and seek supervision when they feel pressured to provide additional sessions and associated crisis management for clients. Regardless of whether supplemental contact is indicated, trainees should make these decisions with the guidance and knowledge of their supervisor. It is clear that consultation with the supervisor is essential to handling those extra demands in an efficient and effective fashion. Without active consultation with a supervisor, maintenance of appropriate time boundaries with high-risk patients can be particularly challenging.

Related to the time demands of providing care for suicidal patients is the importance of trainees working with their supervisor to recognize, understand, and differentially respond to acute versus chronically suicidal patients (cf. Rudd, 2006). The two circumstances pose different challenges across most aspects of care, including maintaining a good working relationship, conducting an assessment of risk, and ongoing management and treatment (Linehan, 1993; Rudd, 2006).

### *Strategies for Ensuring Content Mastery*

The primary strategy for ensuring that trainees are aware of terms, statistics, and facts associated with suicide is didactic presentations and shared reading assignments. Group discussions can then be conducted that aid trainees in mastering the differences between behaviors such as self-harm and suicide attempts. As indicated previously, trainees should be provided an understandable biopsychosocial model of suicidal behavior that can be shared with patients (the Appendix provides ample resources). Group didactic presentation of different models will not only provide trainees with additional content knowledge, but will also provide them with greater mastery through group discussion and application to case examples. This type of discussion will also help trainees to gain comfort in talking about these behaviors and may be a setting in which role plays can be conducted. Role plays lead to mastery of content knowledge by requiring trainees to use what they have learned in an interaction with a patient (or fellow role player) and to follow that with questions that result in a deeper understanding of the problem. The use of role-play techniques will help trainees to identify content areas of weakness and information they feel less confident in presenting. For example, although trainees may feel that they are familiar with several models of suicidal behavior, they may discover that presenting the model to a patient is much more difficult and that they have questions about parts of the model. Role playing a suicide risk assessment will also aid in facilitating a trainee's ability to discriminate between different types of suicidal behavior and to assess precipitants and consequences of these behaviors. In addition, trainees should be

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encouraged to take part in opportunities to use suicide risk assessment instruments and structured interviews with patients or to participate in multidisciplinary treatment teams that routinely conduct these assessments to increase competence.

When working with patients with elevated suicide risk, the trainee's evaluation is based on an empirically supported model of risk assessment that includes biological, psychological, and social factors contributing directly to suicide. Ensuring that trainees have a firm knowledge of these areas contributes to the trainee's comfort and confidence in risk assessment, which enhances therapeutic relationships and leads to more accurate assessment. This knowledge base can be acquired through didactics, supervisor modeling, case discussions, and observation by supervisors. Most important, role playing between trainee and supervisor on how to contextualize suicidality and, it is hoped, to diffuse resistance, can prove invaluable. Additionally, a simple role play on helping the patient understand why or how suicide became an issue would prove useful.

### *Strategies for Monitoring and Refining Skill Acquisition*

Following didactic presentation of content information regarding suicide, one of the more effective strategies to ensure mastery is to refer back to this information regularly and to ask trainees questions regarding their patients that require them to apply this information. For example, following an initial interview, the trainee should be expected to provide information regarding the presence of thoughts of suicide, self-harm, suicide threats, suicide attempts, plans to engage in suicidal behavior of any kind, any preparations made to facilitate this behavior, history of the above behaviors and thoughts, protective factors, warning signs, and risk factors. The trainee (either alone or in consultation with the supervisor) can then integrate this information with known facts about suicide to determine current risk status. Discussion of this assessment process during group supervision allows other trainees to think through these risk decisions simultaneously and assist in reviewing the selected safety plan and initial treatment plan.

Supervisor demonstrations (either in role plays or with actual patients) are essential to skill development and refinement, and use of video- or audiotaping can provide a chance for group review and discussion (along with individual review outside of supervision). Videotape can be used to record role plays addressing multiple themes, including targeting ambivalence, overcoming resistance, providing an explanatory model, clarifying terminology, identifying treatment targets, engaging a patient in an agreement for care, and developing a crisis response plan. Use of standardized suicide risk assessment forms that include predetermined outlines for assessment questions is another useful training strategy, as it minimizes the likelihood of overlooking critical areas for assessment and provides the opportunity to behaviorally practice sequencing and wording of questions. As the trainee becomes increasingly familiar with the questions to be asked, he or she will develop greater confidence in risk assessment skills, increased flexibility when interacting with suicidal patients, and greater accuracy in clinical decision making.

### *Some Concluding Thoughts*

Although by no means comprehensive, this article provides a general framework addressing the issue of supervision of trainees seeing actively suicidal patients. Among the critical elements addressed are a keen awareness of current core competencies and some clarity about a supervision strategy targeting skill development and subsequent refinement. What is clear is that one size does not fit all; indeed, there are many and varied approaches to address the relevant issues in supervision. What is unavoidable, though, is that these issues must be addressed because it is a certainty that trainees will see suicidal patients. Graduate training programs and training sites that do not provide competency-based supervision are neglecting a key area of a psychologist's responsibility in clinical practice.

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# Appendix

## Supplemental Reading List for Assessment and Management of Suicide Risk

### Domain 1: Working With Individuals at Risk for Suicide: Attitudes and Approach

Bongar, B. (2002). *The suicidal patient: Clinical and legal standards of care* (2nd ed.). Washington, DC: American Psychological Association.

Linehan, M. M. (1993). Relationship strategies. In *Cognitive-behavioral treatment of borderline personality disorder* (pp. 514–519). New York: Guilford Press.

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Simon, R. I. (2004). *Assessing and managing suicide risk: Guidelines for clinically based risk management*. Washington, DC: American Psychiatric Press.

### Domain 2: Understanding Suicide

Institute of Medicine. (2002). *Reducing suicide: A national imperative.* Washington, DC: National Academies Press.

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Maris, R., Berman, L., & Silverman, M. (2000). *The comprehensive textbook of suicidology*. New York: Guilford Press.

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Wise, T. L. (2003). *Waking up: Climbing through the darkness*. Oxnard: Pathfinder Publishing of California.

(*Appendix continues*)

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## Domain 3: Collecting Accurate Assessment Information

Academy of Child & Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 40,* 24S–50S.

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Shea, S. (2002). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors.* Hoboken, NJ: Wiley.

## Domain 4: Formulating Risk

Academy of Child & Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 40,* 24S–50S.

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## Domain 5: Developing a Treatment and Services Plan

Academy of Child & Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 40,* 24S–50S.

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## Domain 6: Managing Care

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## Domain 7: Understanding the Legal and Regulatory Issues Related to Suicidality

Bongar, B. (2002). *The suicidal patient: Clinical and legal standards of care* (2nd ed.). Washington, DC: American Psychological Association.

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Applicable guidelines from the appropriate state board and related mental health laws.

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