Social Work Education in Suicide Intervention and Prevention: An Unmet Need?

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Research shows that social work graduate programs offer little education in suicide prevention and intervention, yet social workers' experiences and attitudes regarding suicide education are unknown. This Web-based survey of 598 social workers found that almost all respondents had worked with at least one suicidal client, but most received little, if any, training in suicide prevention or intervention while in graduate school. Respondents largely viewed their social work program's training in suicide prevention and intervention as inadequate. Implications for social work education and practice are discussed.

Suicide is widely recognized as a major public health problem (U.S. Public Health Service, 1999), with the number of suicides in 2002 (31,655) roughly equal to the amount of deaths from homicide and HIV combined (31,733) (Centers for Disease Control [CDC], 2004). As major providers of social services, social workers operate in a wide range of settings and thus are in a crucial position to intervene with suicidal clients. Suicidal behavior is perhaps most visible to social workers providing mental health services, because having a mental disorder substantially increases the risk for suicide (Harris & Barraclough, 1997), and most people who commit suicide are suffering from a mental disorder (e.g., Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Robins, Murphy, Wilkinson, Gassner, & Kayes, 1959). Yet the salience of suicide extends to virtually all areas of social work. In

schools, hospitals, child welfare agencies, shelters, and other areas, social workers commonly encounter clients who struggle with psychosocial problems such as substance abuse, unemployment, marital problems, negative life events, and physical illness (U.S. Dept. of Labor, 2001). Along with mental disorders, each of these psychosocial problems is among the 15 most common predictors of suicide listed by Maris (1992).

Training in the assessment and management of suicidal individuals has been linked to increased suicide intervention skills and knowledge (Elkins & Cohen, 1982); however, research indicates that graduate programs offer little education in suicide prevention and intervention to social workers and other professionals who frequently work with suicidal individuals. Based on the responses to a survey questionnaiare, only 29% of master's-level social work programs offer formal training (defined as "courses, seminars, etc.") in suicidology (Levin, 1994). Master's programs in marital and family therapy and doctoral programs in clinical and professional psychology fared better, with 40% offering formal training in the study of suicide (Bongar & Harmatz, 1991; Kubin, 1994). Surveys of psychology graduate students indicate that roughly half report having

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received graduate training related to suicide prevention and intervention (Dexter-Mazza & Freeman, 2003; Kleespies, Penk, & Forsyth, 1993). Even in psychiatry residency programs, where trainees often work on inpatient units with severely ill individuals, only 27.5% of the programs surveyed offered a skills workshop devoted to suicide intervention (Ellis, Dickey, & Jones, 1998).

The breadth of social workers' experience with and attitudes toward suicide education is unknown. The study examining suicidology training in MSW programs (Levin, 1994) queried only the directors of field placement programs. The current paper reports the findings of a national survey of social workers. The survey was undertaken with three goals: (1) to determine how many practicing social workers received formal training in suicide assessment and intervention and the amount of training social workers received; (2) to ascertain whether social workers viewed their graduate level training in suicide assessment and intervention as adequate; and (3) to explore social workers' views on the importance of suicide-related training in MSW programs.

Social workers need knowledge about suicide and nonfatal suicidal behavior for several reasons. Obviously, the most important reason is to save lives. The frontline nature of social work, both inside and outside the mental health profession, exposes social workers to children, adolescents, and adults with numerous psychosocial problems. It is unknown how many social workers have had a client commit suicide, but in national surveys 22% of psychologists (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b), 23% of professional counselors (McAdams & Foster, 2000), and 51% of psychiatrists (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988) reported a client suicide.

In addition to representing a tragic loss of life, a client's suicide can be a major trauma for the social worker. Mental health professionals who have lost a client to suicide reported experiencing, in the aftermath, intrusive thoughts of suicide, anger, and guilt (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988). Additionally, clinicians frequently worry about or experience legal consequences after a client dies by suicide (Simon, 2000). Suicide is the most common cause of malpractice lawsuits against mental health professionals, including social workers (Gutheil, 1999).

Social workers may also encounter loved ones of suicide victims in their work. An estimated 4 million Americans have survived the suicide of a loved one (Jobes, Luoma, Hustead, & Mann, 2000). Survivors of suicide frequently experience feelings of guilt, anger, and self-blame about their loved one's suicide, in addition to the devastating grief following any death of an intimate (Ness & Pfeffer, 1990). Worse, survivors of suicide often are blamed by others for their loved one's suicide (Jobes et al., 2000). Social workers' knowledge of the unique aspects of suicide bereavement can inform their work with survivors.

Even when no suicide occurs, working with suicidal clients can distress social workers. One study found that issues related to suicide were considered the most stressful part of the job among mental health professionals in general (Deutsch, 1984). Clients' suicidal feelings, because of their urgent and life-or-death nature, arouse anxieties and fear in clinicians (Neimeyer, 2000). Further, clients' discussions of suicidal feelings can trigger ethical and philosophical dilemmas for social workers, including whether to violate confidentiality to protect a suicidal client and how to reconcile a client's right to self-determination with the need to protect a client from self-harm (Mishna, Antle, & Regehr, 2002). Adding to these difficulties are feelings of anger and hatred that suicidal individuals, particularly those with seemingly intractable suicidality, can paradoxically elicit in the professionals who try to help them (Maltsberger & Buie, 1974).

These issues point to the importance of adequately preparing social work students for suicide assessment and intervention, both inside and outside the mental health profession. Indeed, in a national survey, school social workers ranked knowledge and skills related to suicide as "extremely important" and "very complex" (Allen-Meares & Dupper, 1998, p. 109). The current study surveyed a wider range of social workers about their experience and attitudes related to suicide education.

METHOD

The Survey Instrument

We developed the Social Work Education in Suicide Survey (SWESS) in order to examine the experiences with, and the opinions of, postgraduate social work professionals regarding their education in suicide intervention and prevention. The survey was designed for distribution to all social workers, regardless of the area of the profession in which they were employed. Several experts in suicide prevention education as well as social work practitioners provided input in developing the questionnaire. Questions from previous research examining social workers' and counseling psychologists' graduate training in suicide (Bongar & Harmatz, 1991, 1989; Levin, 1994) were also included after some modification.

The overall content of the SWESS was crafted, with assistance from the University of New Hampshire Survey Center, into questions designed to minimize possible bias in responses. The instrument went through several iterations and pilot tests in paper and pencil format prior to its eventual formulation as an electronic, Web-based survey. Pilot tests were again conducted once the survey was formatted electronically to illuminate potential problems for e-mail recipients. Psychometric tests measuring the survey's reliability and validity were not conducted. The final version of the survey questionnaire was reviewed and approved by the University of New Hampshire Institutional Review Board, Human Subjects Committee. The survey was administered during February and March of 2003. Survey questions relevant to the current investigation appear in the Appendix.

A Web-Based Survey Approach

The decision to conduct a Web-based questionnaire was based on several factors. The Internet and World Wide Web are widely used (Cook, Heath, & Thompson, 2000) and provide advantages over more traditional mail or phone techniques (Solomon, 2001). These advantages include reducing time and costs associated with survey implementation (Granello & Wheaton, 2004), as well as reaching a large population and obtaining rapid replies (Schmidt, 1997). Webbased survey methodology also allows researchers to easily transfer responses into a database for analysis (Solomon, 2001). Finally, e-mail access and use of the Internet for specific groups such as association members can be high (Schaffer & Dillman, 1998). Conversely, the Web-based approach has an inherent risk. Web-based surveys have yielded lower response rates than those obtained in surveys delivered by postal mail (Schonlau, Fricker, & Elliott, 2000) and other methods (Cook et al., 2000). Nonetheless, we used an electronic survey because of its overall logistical and economical advantages.

Sample Selection

The sample for this study derived from the 2002 membership roster of the National Association of Social Workers (NASW). A mailing list was purchased from a company authorized by NASW to distribute such information. The list included 143,817 active NASW members in the United States, all of whom had earned at minimum an MSW degree. Of that total, 55,795 members also provided an e-mail address, from which 3,000 names were randomly selected for participation in this study using a computer-generated randomization process conducted by the company providing the mailing list.

Consistent with previous research using the Web-based survey method (Dillman, 2000; Schaefer & Dillman, 1998), three separate e-mails were sent to the sample. First, an e-mail notified potential respondents of the research study. This e-mail contained an introductory message detailing the purpose of the research, identifying the study sponsors, describing an incentive to respond, and providing contact information for potential respondents' questions. The response incentive gave participants the option to be included in a raffle to win one of five free electronic personal digital assistant (PDA) devices. Once all nonworking e-mail addresses from the first distribution were eliminated, it was determined that 2,760 individuals (92%) would actually receive the e-mail link to the survey. After purging the nonworking e-mail addresses, a second e-mail was sent 2 days later. This e-mail again introduced the study, and included a link to an introduction page that more fully explained the study and provided a link to the Web-based questionnaire itself. The third and final e-mail was sent one week after distribution of the second, reminding potential respondents once more about the research and once again providing a link to the introduction page and the survey.

After survey completion, respondents were connected to a separate Web page that offered the opportunity to enter the raffle drawing, and/or to receive a free copy of the highlights of the research study, for which respondents supplied contact information. This information was thereby kept separate from any questionnaire responses to ensure anonymity. Only those individuals whose working e-mail address was randomly selected from the NASW roster were able to access both the link to the survey itself and the incentive registration/contact information Web page. Of the 2,760 e-mail recipients, a total of 598 social workers completed surveys, for a response rate of 22%.

Sample Characteristics

The sample contained 457 women and 131 men, in addition to 10 respondents who did not indicate their gender. Participants' ages ranged from 24 to 67, with an average age of 47 (SD = 10.0). On average, participants had graduated from their MSW program 15 years earlier (SD = 9.4). Most participants (78.7%) concentrated their MSW studies on clinical or direct practice, but 11% concentrated on community and administrative practice or policy, and the remaining participants specialized in other areas. The majority (82%) of the participants had a license to practice independently, and 20.5% supervised MSW students at the time of the survey. Ten percent of the respondents no longer had a social work job, although half of those had recently worked in social work.

The sample represented several areas of social work. Of those holding a social work job, almost one fourth (23.4%) worked in private practice, almost a fifth (18.0%) worked in outpatient mental health, and nearly a tenth (9.9%) worked at a nonpsychiatric hospital. Additionally, 7.1% of the sample worked in a school setting and 5.2% worked in child welfare. The remainder worked in other areas of social work, including nursing homes, substance abuse facilities, psychiatric hospitals, and home health agencies.

RESULTS

Social Workers' Experience with Suicidal Clients

Almost all respondents (92.8%) reported having worked with at least one suicidal client. More than a third of the social workers (37.1%) were working with at least one suicidal client at the time of the survey. Over half (53.4%) reported having worked with at least one suicidal client in the previous month, and nearly four-fifths (78.1%) had done so within the previous year.

Suicide-Related Training Received by Social Workers

Only 21.2% of participants indicated that they received any formal training related to suicide in their master's-level program. Over half (59.2%) indicated that at least one of their classes addressed suicide (this number overlaps with those whose MSW program provided them with formal training exclusively on suicide intervention/prevention). Of those receiving any suicide-related instruction at all, almost half (46.3%) reported 2 hours or less devoted to the topic.

Many participants (61.2%) also received suicide-related education in their field practica. Among those who were taught about suicide during their field placement, 24.6% reported receiving no more than 2 hours of both field and classroom instruction dedicated to suicide, 35.7% reported 3 to 6 hours, and 39.8% reported 7 or more hours. A summary of the suicide-related training received by social workers is presented in Table 1.

Assessment of Personal Education and Skills

Most participants judged the amount of suicide education they received in their MSW program to be inadequate. Asked to indicate their agreement to the statement, "I received enough training in graduate school for working with suicidal people," about twothirds (67.4%) either "somewhat" or "strongly disagreed." At the same time, about threequarters (72%) either "somewhat" or "strongly agreed" that, after graduate school, they had received "enough knowledge on suicide intervention to work as effectively as possible with suicidal clients." Almost 80% of participants reported feeling both competent and confident in working with suicidal individuals, and 59.8% noted that they feel comfortable in such situations. Table 2 details these findings.

Social Workers' Attitudes toward Suicide Education

Three out of four participants (75.2%) ranked the inclusion of suicide-related educa-

TABLE 1

Summary	of	Suicide-Related	Education	Received	by	Social	Workers
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Item	Response (%)
Did your MSW program offer any formal training—courses, seminars, etc.—not including field practica—that focused exclusively on suicide?	
Yes	21.2
No	78.8
Did you take any classes in which suicide intervention/prevention was addressed?	
Yes	59.2
No	40.8
If yes, how many hours do you recall being taught about suicide intervention/prevention in your MSW program considering course work alone?	
2 hours or less	46.3
3-4 hours	29.9
5–6 hours	7.9
7–8 hours	9.3
More than 8 hours	6.5
Were you taught about suicide intervention/prevention in your field placement internships?	
Yes	61.2
No	38.8
If yes, how many hours do you recall being taught about suicide intervention/prevention in your MSW program when considering both course work and field placement internships?	
2 hours or less	24.6
3-4 hours	22.3
5–6 hours	13.4
7–8 hours	17.0
More than 8 hours	22.8

Note. Totals do not equal 100% due to rounding.

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Summary of Assessment of Personal Training and Skills

Item	Response (%)
I received enough training in graduate school for working with suicidal patients.	
Strongly disagree	39.6
Somewhat disagree	27.8
Neither agree nor disagree	10.0
Somewhat agree	18.9
Strongly agree	3.7
After graduate school, I gained enough knowledge on suicide prevention to work as effec-	
tively as possible with suicidal clients.	
Strongly disagree	8.5
Somewhat disagree	12.4
Neither agree nor disagree	7.1
Somewhat agree	45.6
Strongly agree	26.4
I feel confident regarding my current knowledge and skill set pertaining to suicide assess-	
ment/prevention.	
Strongly disagree	3.9
Somewhat disagree	9.1
Neither agree nor disagree	7.8
Somewhat agree	41.8
Strongly agree	37.4
How competent would you feel helping a suicidal person who has both the means to commit	
suicide and a suicide plan?	
Very incompetent	4.6
Somewhat incompetent	9.1
Neither competent nor incompetent	6.4
Somewhat competent	46.1
Very competent	33.8
How comfortable would you feel helping a suicidal person who has both the means to com-	
mit suicide and a suicide plan?	
Very uncomfortable	9.3
Somewhat uncomfortable	24.0
Neither comfortable nor uncomfortable	6.9
Somewhat comfortable	39.9
Very comfortable	19.9

Note. Totals do not equal 100% due to rounding.

tion in MSW programs as "very important" or "somewhat important." Conversely, a substantial number (22.6%) ranked suiciderelated education in MSW programs as "very unimportant." The remaining participants indicated they viewed suicide education as "somewhat unimportant" or "neither important nor unimportant."

Postgraduate training in suicide educa-

tion was also viewed as "very important" or "somewhat important" by almost three out of four participants (72.9%). Mirroring their assessments of MSW-level education in suicide, 22.7% of participants ranked such training in postgraduate years as "very unimportant." Despite the substantial minority of participants who assessed suicide education as "very unimportant," most of the sample

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(86.1%) indicated that social workers should be required to have continuing education at least once in the clinical management of suicidal patients.

Additionally, participants ranked what they considered the "most important means for teaching intervention skills to social workers." Graduate course work was mentioned most often (31.5%), while 28.8% of respondents chose field work and 23.2% picked supervised post-master's work experience. The remainder viewed other methods, such as formal and informal discussions with clinicians and peers, as the most important method for imparting suicide education. These findings are presented in Table 3.

The major findings consistent with the three main objectives of our survey are summarized and presented in Table 4.

DISCUSSION

Methodological Considerations and Future Directions

This study has several limitations. First and foremost, the response rate of 22% restricts the generalizability of the results. As noted earlier, response rates for Internet surveys are not as good as those for traditional surveys (Schonlau et al., 2000). Additionally, the perceived importance of suicide training as a topic of interest for social workers could have affected the response rate. Some individuals randomized to receive the survey may have opted to not participate based on disinterest in the focus of the research (Dillman & Bowker, 2001).

Other methodological issues related to

TABLE 3

Summary of	Social	Workers'	Attitudes	Toward	Suicide	-Related	Education
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Item	Response (%)
How important is the study of suicide in the graduate training of social workers?	
Very unimportant	22.6
Somewhat unimportant	1.5
Neither important nor unimportant	.7
Somewhat important	13.5
Very important	61.7
How important is the study of suicide in the post-graduate training of social workers?	
Very unimportant	22.7
Somewhat unimportant	2.7
Neither important nor unimportant	1.7
Somewhat important	14.9
Very important	58.0
Do you think all licensed social workers should be required to have continuing education at	
least once in the clinical management of suicidal patients?	
Yes	86.1
No	13.9
Of the ways for social workers to get training in managing suicide issues, which ONE would you say is the MOST important? (Indicate one only.)	
Graduate course work	31.5
Field placement internships as part of graduate training	28.8
Supervised post-masters experience	23.2
Informal discussions with clinicians	1.5
Formal discussions with clinicians (Peer Supervision)	8.5
Other	6.4

Note. Totals do not equal 100% due to rounding.

TABLE 4

Summary of Key Findings in Relation to Study Goals

Goal I	Goal II	Goal III
Determine how many practicing social workers received formal suicide-related training and how much was received	Ascertain social workers' views about the adequacy of their MSW suicide-related training	Explore social workers' attitudes on importance of suicide-related training in MSW programs
Key Findings	Key Finding	Key Findings
• 79% received no formal train- ing in MSW program	• 67% reported they received in- sufficient training in MSW program	• 75% feel graduate training "very important" or "impor- tant"
• 76% received 4 hours or less when formal training was pro- vided	1 0	• 32% view MSW courses "MOST important" to pro- vide training
• 61% learned about suicide in field placements		• 29% view field placements "MOST important" to pro- vide training

Note. Percentages have been rounded.

the use of e-mail addresses to contact potential participants affected sample selection. For example, only those NASW members who provided accurate and current e-mail addresses as part of their NASW membership information were included in the sample. Additionally, incompatibilities in computer hardware and/or software or concerns about computer viruses may have prevented some recipients from opening the e-mail, because the e-mail sender was unknown to recipients (Dillman, 2000).

Another limitation lies in the retrospective nature of the survey. Respondents had been out of social work school for, on average, 15 years, so their ability to accurately recall whether they received training in suicide intervention may be limited. One might also question whether social work programs have added more suicide content to their curriculum in the intervening years. However, an increased emphasis on suicide prevention is unlikely, given that in surveys of students in a related field of practicepsychology-the proportions of graduate students who received formal training in suicide prevention were similar (50-55%) between 1993 and 2003 (Dexter-Mazza & Freeman, 2003; Kleespies, Penk, & Forsyth).

The current survey does not examine the scope and breadth of suicide education received. Neimeyer (2000) notes that most suicide intervention training in graduate psychology programs concentrates on knowledge of demographic, diagnostic, and dispositional risk factors, not on specific methods and skills in suicide prevention and intervention. Given that most of the respondents who did have courses that addressed suicide education received only several hours of instruction, it is unlikely that methods and skills training were thoroughly covered.

IMPLICATIONS FOR SOCIAL WORK EDUCATION, PRACTICE, AND RESEARCH

Despite the limitations of the current study, it is a significant finding that among almost 600 social workers, only a minority received more than a couple hours of education in suicide intervention and prevention, and almost all regretted not having received more such training in graduate school. Most respondents received only a few hours of classroom instruction when it was provided, which is not enough time to disseminate such

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important and often complex material about a social work issue that can have a fatal outcome. The findings also suggest that many social workers are entering the field with little or no education related to suicide and nevertheless working with suicidal clients. With a problem as grave as suicidal behavior, it is irresponsible to have such skills imparted to social work students haphazardly, if at all.

Our study indicates that field placement supervisors are often relied upon to provide on-the-job training to graduate students. Unfortunately, the study results also indicate that many of these same supervisors apparently failed to receive adequate suicide training while in their own graduate programs, and thus may lack the knowledge and experience to provide proper training to student interns. Depending on the clientele at a given agency, some internship settings may not provide any opportunities for MSW students to work with suicidal clients. Given this reliance on field supervisors, social work educators need to consider both the lack of consistency and the quality of training in suicide management that future social work professionals receive.

Our study results illuminate several areas for future research. Future studies would do well to include newer social workers, social workers who do not belong to NASW, and social workers holding solely undergraduate-level degrees. Because so many respondents indicated that they now feel competent in working with suicidal clients, despite the lack of graduate-level training in suicide intervention, it would be helpful to study social workers and other mental health professionals' perceived and actual competence with suicidal clients. Another area meriting further study are the means by which social workers improve their suicide intervention skills after receiving their MSW degree. Finally, a remaining research question concerns whether the proportion of graduate programs in social work and other fields offering suicide-related education increased by 2005, which was a stated objective of the *National Strategy for Suicide Prevention* (U.S. Dept. of Health and Human Services, 2001).

With limited room and time in social work curricula to include topics of everybody's interest, any call for the inclusion of a specific topic such as suicide intervention and prevention is likely to encounter resistance. Already, numerous authors have written about the need to include in social work education a diverse array of topics ranging from the broad to the specific, including gerontology (Lubben, Damron-Rodriguez, & Beck, 1992); end-of-life issues (Kramer, Pacourek, & Hovland-Scafe, 2003); domestic violence (Danis & Lockhart, 2003); disability and rehabilitation (Quinn, 1995); legal issues (Kopels & Gustavsson, 1996); group work (Birnbaum & Auerbach, 1994); rural practice (DeWeaver, Smith, & Hosang, 1988); psychotropic drugs (Bentley, Farmer, & Phillips, 1991); online therapy (Finn, 2002); and entrepreneurial training (Bent-Goodley, 2002). Obviously not everything can be taught to everybody. At the same time, suicidal behavior is so dangerous that to send social workers into the field without adequate training does a disservice to client and practitioner alike. Moreover, the social work Code of Ethics emphasizes that a social worker's primary responsibility is to promote the wellbeing of clients and that the interests of clients are primary (Reamer, 1999). The preservation of human life clearly falls within this key ethical tenet.

APPENDIX 1

Selected Questions from Social Work Education in Suicide Survey (SWESS)

First, have you ever worked with a client who was suicidal?

__ Yes

_No

__ Don't know/Not sure

If you said yes to the question above, how many suicidal clients have you worked with ...

In the past month: _____

In the past year: _____ Do you currently work with at least one client who is suicidal?

____Yes, currently

_____No, not currently

__ Don't know/Not sure

Did your MSW program offer any formal training—courses, seminars, etc.—not including field practica—that focused exclusively on the study of suicide?

__ Yes

__ No

_ Don't know/Not sure

If you said yes to the question above, in what form was this formal training? (Check all that apply.)

__ Colloquium (informal group discussions)

__ Lecture

__ Seminar

__ Other

Did you take any classes in which suicide intervention/prevention was addressed?

__ Yes

__No

__ Don't know/Not sure

If you said yes above, how many classes did you take in which suicide intervention/prevention was addressed?

___ Number of classes

Were you taught about suicide intervention/prevention in your field placement internships?

___Yes

__No

__ Don't know/Not sure

How many **hours** do you recall being taught about suicide prevention and/or intervention in your MSW program, when considering **course work alone**?

___ None, 0 hours, was not taught about suicide prevention

____1-2

_____3__4

____5-6

___7-8

___ More than 8 hours

__ Don't know/Don't recall

How many **hours** do you recall being taught about suicide prevention and/or intervention in your MSW program, when considering course work **and** field placement internships?

___ None, 0 hours, was not taught about suicide prevention

___1-2

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_____3__4

____5-6

___7-8

____ More than 8 hours

__ Don't know/Don't recall

How important is the study of suicide in the graduate training of social workers?

- ____ Very unimportant
- __ Somewhat unimportant
- __ Neither important nor unimportant
- __ Somewhat important
- ____ Very important

How important is the study of suicide in the postgraduate training of social workers?

- ____ Very unimportant
- __ Somewhat unimportant
- ___ Neither important nor unimportant
- __ Somewhat important
- __ Very important

Do you think all licensed social workers should be required to have continuing education at least once in the clinical management of suicidal patients?

___Yes

- __No
- __ Don't know/Not sure

How important are each other following as ways for social workers to get their training in managing suicide issues? (Click one per row.)

	Very unimportant	Somewhat unimportant	Neither important nor unimportant	Somewhat important	Very important
Graduate course work					_
Field placement internships as part of graduate training		_	_	_	_
Supervised post-masters experience			_		_
Informal discussions with clinicians					_
Formal discussions with clinicians (Peer supervision)		_	_	_	_
Other				_	_

Of the ways for social workers to get training in managing suicidal issues, which **ONE** would you say is the **MOST** important? (Check one only.)

- __ Graduate course work
- ___ Field placement internships as part of graduate training
- __ Supervised post-masters experience
- __ Informal discussions with clinicians
- ____ Formal discussions with clinicians (Peer Supervision)
- __ Other

How important were the following to **YOUR** current knowledge level of suicide issues? (Click one per row.)

	Very unimportant	Somewhat unimportant	Neither important nor unimportant	Somewhat important	Very important
Graduate course work			_		
Field placement internships as part of graduate training					_
Supervisor(s) at your workplace	_		_		
Postgraduate training (e.g., continuing education)	_	_	_	_	_
Reading(s) independent from formal coursework		_			_
Other		_	_		

Of the ways that contributed to YOUR current knowledge of suicide issues, which **ONE** would you say was the **MOST** important? (Check one only.)

- __ Graduate course work
- ___ Field placement internships as part of graduate training
- ____ Supervisor at your workplace
- ___ Post-graduate training (e.g., continuing education)
- ___ Reading(s) independent from formal coursework
- __ Other

Please indicate how much you agree with each of the following statements concerning your knowledge and training in suicide intervention/prevention. (Click one per row.)

	Strongly disagree		Neither agree nor disagree	Somewhat agree	Strongly agree
I received enough training in graduate school for working with suicidal patients.		_	_	_	_
After graduate school, I gained enough knowl- edge on suicide intervention to work as effec- tively as possible with suicidal clients.		_	_		
I feel confident regarding my current knowl- edge and skill set pertaining to suicide assess- ment/intervention.					
ment/mervention.	—		—		

Imagine yourself in a situation where you might be able to help a suicidal person who has both the means to commit suicide and a suicide plan. Please answer the following two questions by checking the option that best describes how comfortable and competent you would feel in this situation.

How comfortable would you feel helping this suicidal person?

- ___ Very uncomfortable
- __ Somewhat uncomfortable
- ___ Neither comfortable nor uncomfortable
- ___ Somewhat comfortable
- ____ Very comfortable

Considering your current knowledge and skills, how **competent** would you feel helping this suicidal person?

- ___ Very incompetent
- __ Somewhat incompetent
- ____ Neither competent nor incompetent
- __ Somewhat competent
- __ Very competent

REFERENCES

ALLEN-MEARES, P., & DUPPER, D. R. (1998). A national study of knowledges, skills, and abilities: Curriculum development for practicing social work schools, *Journal of Teaching in Social Work*, 17, 101–119.

BENT-GOODLEY, T. B. (2002). Defining and conceptualizing social work entrepreneurship. *Journal of Social Work Education*, *38*, 291–302.

BENTLEY, K. J., FARMER, R. L., & PHILLIPS, M. E. (1991). Student knowledge of and attitudes toward psychotropic drugs. *Journal of Social Work Education*, 27, 279–289.

BIRNBAUM, M. L., & AUERBACH, C. (1994). Group work in graduate social work education: The price of neglect. *Journal of Social Work Education*, 30, 325–335.

BONGAR, B., & HARMATZ, M. (1989). Graduate training in clinical psychology and the study of suicide. *Professional Psychology: Research and Practice*, 20, 209–213.

BONGAR, B., & HARMATZ, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life-Threatening Behavior*, 21, 231–244.

BRENT, D. A., BAUGHER, M., BRIDGE, J., CHEN, T., & CHIAPPETTA, L. (1999). Age- and sex-related risk factors for adolescent suicide. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 1497–1505.

CENTERS FOR DISEASE CONTROL AND PRE-VENTION. (2004). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. Retrieved June 15, 2005 from www.cdc.gov/ ncipc/wisqars.

CHEMTOB, C. M., BAUER, G. B., HAMADA, R. S., PELOWSKI, S. R., & MURAOKA, M. Y. (1989). Patient suicide: Occupational hazard for psychologists and psychiatrists. *Professional Psychology: Research and Practice*, 20, 294–300.

CHEMTOB, C. M., HAMADA, R. S., BAUER, G. B., KINNEY, B., & TORIGOE, R. Y. (1988). Patient suicide: Frequency and impacon psychiatrists. *American Journal of Psychiatry*, 145, 224– 228.

CHEMTOB, C. M., HAMADA, R. S., BAUER, G., TORIGOE, R. Y., & KINNEY, B. (1988). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice*, 19, 421–425.

Соок, С., НЕАТН, F., & ТНОМРSON, R. (2000). A meta-analysis of response rates in Webor Internet-based surveys. *Educational and Psychological Measurement*, 60, 821–836.

DANIS, F. S., & LOCKHART, L. (2003). Domestic violence and social work education: What do we know, what do we need to know? *Journal of Social Work Education*, *39*, 215–224.

DEUTSCH, C. J. (1984). Self-reported sources of stress among psychotherapists. *Profes*-

sional Psychology: Research and Practice, 15, 833-845.

DEWEAVER, K. L., SMITH, M. L., & HOSANG, M. (1988). Has social work education abandoned preparation for rural practice? *Human* Services in the Rural Environment, 11, 28–32.

DEXTER-MAZZA, E. T., & FREEMAN, K. A. (2003). Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening Behavior*, *33*, 211–218

DILLMAN, D. (2000). Mail and Internet surveys: The tailored design method (2nd ed.). New York: Wiley.

DILLMAN, D. A., & BOWKER, D. K. (2001). The Web questionnaire challenge to survey methodologists. In U. Reips & M. Bosnjak (Eds.), *Dimensions of Internet science*. Lengerich, Germany: Pabst Science Publishers. Retrieved June 16, 2005, from http://survey.sesrc.wsu.edu/dillman/zuma_ paper_dillman_bowker.pdf

ELKINS, JR., R. L., & COHEN, C. R. (1982). A comparison of the effects of pre-job training and job experience on nonprofessional telephone crisis counselors. *Suicide and Life-Threatening Behavior*, 12, 84–89.

ELLIS, T. E., DICKEY, III, T. O., & JONES, E. C. (1998). Patient suicide in psychiatry residency programs: A national survey of training and postvention practices. *Academic Psychiatry*, *3*, 181– 189.

FINN, J. (2002). MSW student perceptions of the efficacy and ethics of Internet-based therapy. *Journal of Social Work Education*, 38, 403–420.

GRANELLO, D. H., & WHEATON, J. E. (2004). Online data collection: Strategies for research. *Journal of Counseling and Development*, 82, 387–393.

GUTHEIL, T. G. (1999). Liability issues and liability prevention in suicide. In D. G. Jacobs (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (pp. 561–578). San Francisco: Jossey-Bass.

HARRIS, E. C., & BARRACLOUGH, B. (1997). Suicide as an outcome for mental disorders: A meta-analysis. *British Journal of Psychiatry*, 170, 205–228.

JOBES, D. A., LUOMA, J. B., HUSTEAD, L.A.T., & MANN, R. E. (2000). In the wake of suicide: Survivorship and postvention. In R. W. Maris, A. L. Berman, & M. M. Silverman (Eds.), *Comprehensive textbook of suicidology* (pp. 536–561). New York: Guilford.

KLEESPIES, P. M., PENK, W. E., & FOR-SYTH, J. P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*, 24, 293–303.

KOPELS, S., & GUSTAVSSON, N. S. (1996). Infusing legal issues into the social work curriculum. Journal of Social Work Education, 32, 115–125.

KRAMER, B. J., PACOUREK, L., & HOVLAND-SCAFE, C. (2003). Analysis of end-of-life content in social work textbooks. *Journal of Social Work Education*, *39*, 299–320.

KUBIN, M. (1994). The study of suicide in the marriage and family therapist training curriculum. Unpublished manuscript.

LEVIN, C. (1994). Graduate training in clinical social work and suicide. Unpublished manuscript.

LUBBEN, J. E., DAMRON-RODRIGUEZ, J., & BECK, J. C. (1992). A national survey of aging curriculum in schools of social work. *Journal of Gerontological Social Work*, 18, 157–171.

MALTSBERGER, J. T., & BUIE, D. H. (1974). Countertransference hate in the treatment of suicidal patients. In J. T. Maltsberger & M. J. Goldblatt (Eds.), *Essential papers on suicide* (pp. 269– 289). New York: New York University Press.

MARIS, R. W. (1992). Overview of the study of suicide assessment and prediction. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *The assessment and prediction of suicide* (pp. 3–22). New York: Guilford.

McAdams, III, C. R., & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, 22, 107–121.

MISHNA, F., ANTLE, B., & REGEHR, C. (2002). Social work with clients contemplating suicide: Complexity and ambiguity in the clinical, ethical, and legal considerations. *Clinical Social Work Journal*, 30, 265–280.

NEIMEYER, R. A. (2000). Suicide and hastened death: Toward a training agenda for counseling psychology. *The Counseling Psychologist*, 28, 551–560.

Ness, D. E., & PFEFFER, C. R. (1990). Sequelae of bereavement resulting from suicide. *American Journal of Psychiatry*, 147, 279–285.

REAMER, F, G. (1999). Social Work Values and Ethics (2nd ed.). New York: Columbia University Press. ROBINS, E., MURPHY, G. E., WILKINSON, R. H., GASSNER, S., & KAYES, J. (1959). Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. *American 7YLnal of Public Health*, 49, 888–899.

QUINN, P. (1995). Social work education and disability: Benefiting from the impact of the ADA. *Journal of Teaching in Social-Work*, 12, 55–71.

Schaffer, D. R., & DILLMAN, D. A. (1998). Development of standard e-mail methodology: Results of an experiment. *Public Opinion Quarterly*, 62, 378–397.

SCHMIDT, W. (1997). World-Wide Web survey research: Benefits, potential problems and solutions. *Behavior, Research Methods, Instruments,* & Computers, 29, 274–279.

SCHONLAU, M., FRICKER, JR., R. D., & ELLIOTT, M. (2000). *Conducting research surveys via e-mail and the Web*. Santa Monica, CA: Rand.

SIMON, R. I. (2000). Taking the "sue" out of suicide: A forensic psychiatrist's perspective. *Psychiatric Annals*, *30*, 399–407.

SOLOMON, D. J. (2001). Conducting Webbased surveys. *Practical Assessment and Research Evaluation*, 7. Retrieved 6/16/05 from http://cog prints.ecs.soton.ac.uk/archive/00002357/01/Web_ Survey_Article.pdf.

U.S. BUREAU OF LABOR STATISTICS. (2001). Occupational outlook handbook. Washington, DC: Author.

U.S. DEPT. OF HEALTH AND HUMAN SER-VICES. (2001). National strategy for suicide prevention: Goals and objectives for action. Rockville, MD: Author.

U.S. PUBLIC HEALTH SERVICE. (1999). The surgeon general's call to action to prevent suicide. Washington, DC: Author.

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