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Letter to the Editor
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Letter to Editor - Open Journal of Public Health

Quinnett P*

QPR Institute, USA

Letter to the Editor

Not long ago, a recent graduate from a well-known university posted a very personal story of having lost his very first patient to suicide. He was crushed, if not broken, and wondered if he should quit his new profession before he even finished his internship.

Nothing is more fearsome to a mental health professional than to lose a patient to suicide. Something of an occupational hazard, patient death by suicide is their number one fear.

Asked if his training program had prepared him to work with patients who had attempted suicide or were planning to, he said, "No. The word suicide had not been mentioned in any of his master's level classes or seminars."

Suicide is a leading cause of preventable death in the world and mental illness is the leading risk factor. This is not news. The popular press runs stories every day on suicide, citing the scope of the problem in the sidebar.

In a 2012 White Paper, the American Association of Suicidology found that, with few exceptions, most mental health degree-producing training programs in the U.S. teach very little (read nothing or next to nothing) about suicide prevention. Nor do they teach the evidence-based clinical skills necessary to conduct screenings and assessments or to manage or treat suicide-at-risk patients.

Right now, the public believes that if they take a suicidal loved one to a licensed therapist or physician, they will be rigorously assessed for risk and treated with evidence-based interventions. They think their loved ones will not die by suicide. The public is mistaken, and their faith is misplaced. Approximately 20% of at-risk patients die by suicide while in active care or within 30 days of last contact with a mental health professional. In primary care, the recency of last contact numbers before death by suicide are worse, with three in four suicide victims having had contact with a primary care provider within a year of their death, many of them within the last week.

Despite recommendations from the Institute of Medicine, the National Strategy for Suicide Prevention, and the Surgeon General, academic leadership – with few exceptions - seems unable to get suicide prevention curriculum into schools of social work, counselling, and psychology – let alone nursing and medical schools.

Too few subject matter expert professors are part of the problem, but the walls of resistance to the subject of suicide are tall, strong, and historic, built with great stones of ignorance cemented together by taboo and indifference.On the public health problem of suicide, higher education is a fortress of denial surrounded by a moat of fear.

Trying to get a suicide prevention curriculum across the moat and into the fortress requires not only a secret password to lower the draw bridge but a fierce persistence.

I know. I've tried. For more than 30 years. I have a flat spot on my forehead from using my noggin as a battering ram against the walls of academia, and I've memorized the excuses:No one teaches that on our faculty; yes, it's important, but, sorry, the curriculum is full. The dean is not interested, not our job; students are already slammed; we cover it in a seminar, I think; not to worry, they will learn what they need on internship; this subject does not fit into our domains of required knowledge for a degree.

Bottom line? When trying to get essential suicide prevention skill training into schools preparing professionals for the workforce, it is easier to get a meeting with the Pope than a dean of any graduate school. The upshot of this resistance is that thousands of practitioners will enter the field again this year only to provide substandard care to their suicide-at-risk patients.Some of those patients will die while in care or within days or weeks of last contact, traumatizing their providers and triggering a mental health crisis that could end their careers and further shrink our workforce.

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Correspondence:
Paul Quinnett, QPR Institute, USA

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Of course, evidence-based training in this area of clinical practice is available online from recognized international experts at modest cost, but this would require referring students out of the fortress with the acknowledgement by leadership that their faculty don't know everything – something the academic ego cannot abide.

There is an old saw in medicine, "You can't treat what you don't know."

With suicide and intentional opioid overdoses taking the lives of hundreds of Americans each week, is it not time graduate school leadership ask themselves, "Is there anything we don't know?"