Article 65

Counselor Training in Suicide Assessment, Prevention, and Management

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Abstract

Suicide claimed the lives of 41,149 individuals in 2013, which is equivalent to 113 suicides a day or one every 13 minutes. Research suggests that with suicide occurring so frequently, mental health professionals are likely to encounter suicidal clients; therefore, professionals must be prepared to address this form of crisis. This article examines mental health professionals' self-efficacy regarding suicide assessment, intervention, and management and the inadequate preparation in graduate programs. Implications for practitioners in effectively assessing suicidal clients are explored.

Keywords: suicide, crisis, competency, suicide assessment

Suicide is defined as self-inflicted harm against oneself resulting in a loss of life (Centers for Disease Control and Prevention [CDC], 2015a). According to the CDC (2015b), suicide is one of the top 10 leading causes of death in the United States for all ages, with a total of 41,149 suicides, or the equivalent of one every 13 minutes, in 2013. Suicide numbers increased in 2014 to 42,773 (CDC, 2014). As of 2014, suicide was the second leading cause of death for individuals ages 10–34; fourth leading cause of death for those ages 35–54; and eighth leading cause of death for those ages 55–64 (CDC, 2015b). Research on gender disparities and suicide indicates that females attempt suicide 2–3 times more frequently than do their male counterparts; however, males die by suicide at four times the rate of females (CDC, 2015b).

Suicide is a significant issue that impacts individuals across age, race/ethnicity, and gender (Knox, Burkard, Jackson, Schaack, & Hess, 2006). Research suggests that with suicide occurring so frequently, mental health professionals are likely to encounter suicidal clients. Therefore, helping professionals must be prepared to address this form of crisis (Foster & McAdams, 1999).

Suicide Rates Across Age Groups

Suicide has been shown to impact every age. As previously mentioned, suicide is the second leading cause of death among children ages 10–14 (CDC, 2015b). However, little research has been conducted on suicide among children, as it was once believed that children never committed suicide; however, suicide among children is on the rise (Granello & Granello, 2007). According to Granello and Granello (2007), every year approximately 12,000 children between the ages 5–14 are admitted to a psychiatric hospital for suicidal behavior. Granello and Granello indicated in one study that 33% of children between the ages of 6–12 had contemplated, attempted, or threatened suicide. Granello and Granello ranked adolescents as having the highest suicide rates between the ages of 15–19, estimating 11 teens per day. Furthermore, an estimated 60% of high school students reported experiencing suicidal ideations and 9% attempted suicide (Granello & Granello, 2007). The suicide trend continues to remain the second leading cause of death into early adulthood, through age 34 (Granello & Granello, 2007). Age remains a predictor for suicide throughout the lifespan, particularly among white males 65 years and older (Granello & Granello, 2007).

Societal Impacts of Suicide

Traditionally a source of moral debate among many cultural groups, suicide has now become a serious public health and social issue (Jackson-Cherry & Erford, 2014), as well as a criminal issue. Unfortunately, an increasing number of violent crimes, such as homicide, have included a person taking their own life. Suicide has actually been the "detonator" for some of the most devastating terrorist attacks across the world where multiple lives have been taken.

Cable News Network (CNN; 2015) detailed seven mass shootings in the United States that were followed by the suicide of the perpetrator. In 1986 in Oklahoma, a man armed with several handguns killed 14 postal workers and then committed suicide. In 1990, a 42-year-old man in Florida, outraged over having his car repossessed, killed nine people and then committed suicide. In 1999, at a local high school in Colorado, two teens killed 12 students and a teacher and then killed themselves in the school library. In 2005, a 16-year-old male killed his grandfather, three adults, and five students at a local Minnesota high school and then committed suicide. In 2007, a 23-year-old man shot 32 people on the campus of Virginia Tech and then committed suicide. In the same year in Nebraska, a 19-year-old male entered a local mall and killed eight people and then himself. In 2012 in Connecticut, a 20-year-old male killed his mother and then traveled to a local elementary school, where he killed 20 children, six adults, including teachers and staff, and then committed suicide. These stories demonstrate how an individual's decision to commit suicide can potentially affect hundreds of people and dozens of communities. Therefore, counselors and other helping professionals across the nation should receive

ample training to assess risk of suicide amongst clients of various ages, educational levels, socioeconomic statuses, and religious backgrounds.

Helping Professionals and Suicidal Clients

Most helping professionals will work with suicidal clients during their careers. Knox and colleagues (2006), as well as McAdams and Foster (2000), identified suicide as a frequently-occurring emergency for mental health professionals. Dexter-Mazza and Freeman (2003) indicated that 22% of psychologists experience the loss of a client due to suicide. Sawyer, Peters, and Willis (2013) stated that 71% of mental health professionals will work with clients who have attempted suicide, and 23% will work with a client who commits suicide. According to Schmitz et al. (2012), approximately one third of individuals who committed suicide met with a mental health professional within the year prior to committing suicide, and 20% received services within the previous month. Mental health professionals have identified client suicide as an "occupational hazard" that is the most stressful part of their job due to its increasing frequency and significant impact both personally and professionally (Feldman & Freedenthal, 2006; Knox et al., 2006). The lingering impact on therapists can include feeling guilty, angry, depressed, and self-blaming (Knox et al., 2006).

In a national survey, 30% of college and university counseling centers reported that at least one student committed suicide in the 2000–2001 school year (Francis, 2003). In another study focused on the occurrence of suicide on college campuses, researchers found that 24% of a sample of 1,865 college students had experienced suicidal ideations and 5% had attempted suicide (Westefeld et al., 2006). According to the Suicide Prevention Resource Center (SPRC; 2014), suicide has become the leading cause of death for college students. Considering the high probability that mental health professionals will see a client considering suicide, counselors must be prepared to skillfully assess and manage suicide risks.

Suicide Intervention Training

McAdams and Keener (2008) suggested that when working with suicidal clients, inadequate treatment and care serve as the underpinning for most ethical concerns and malpractice litigation. Terms such as neglect (failure to exercise the standard practices of care), duty (obligation to conduct oneself with a standard of care to protect clients from unnecessary risk of harm), and harm (loss resulting from injury) highlight the importance of gaining competency in suicide assessment and intervention (Granello & Granello, 2007). Corey, Corey, and Callanan (2011) defined nonmaleficence as a moral principle to "do no harm" (p. 20). Without adequate training in suicide assessment and intervention, counseling students and professionals are under threat of creating unstable, dangerous situations that are potentially harmful to clients (Schmitz et al., 2012). Even so, many mental health professionals lack educational preparation related to suicide intervention (McAdams & Keener, 2008).

Graduate School Preparation

It is the ethical duty of graduate programs to prepare counseling students to develop skills necessary to provide effective crisis interventions in the field (Wachter

Morris & Barrio Minton, 2012). Wozny (2005) analyzed 50 Council for Accreditation of Counseling and Related Educational Programs (CACREP)-accredited programs and 50 Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)-accredited programs to determine whether each accredited program incorporated domestic violence and suicide in their curricula. Results showed that only 6% of COAMFTE-accredited programs and 2% of CACREP-accredited programs offered suicide assessment/interventions in their curriculum (Wozny, 2005). Wachter Morris and Barrio Minton (2012) studied 193 professional counselors, two thirds of whom graduated from CACREP-accredited programs. Results showed that 67% of these counselors indicated no crisis preparation course in their curriculum, and upon graduation, rated their self-efficacy as merely adequate in assessing suicide. Further, 31% of these counselors self-assessed only minimal self-efficacy in collaboration skills for crisis intervention, and 30% self-assessed similarly for suicide management/intervention (Wachter Morris & Barrio Minton, 2012). Thirty-two percent of the participants in this study recommended increased curricular attention to this important issue, advising graduate programs to increase instruction around suicide and crisis in their courses (Wachter Morris & Barrio Minton, 2012).

In Sawyer et al.'s (2013) study, 34 master's-level counseling students, enrolled in a Crisis Intervention preparation course for Mental Health Responders, were administered the Counselor's Self-Efficacy Scale to measure participant self-efficacy concerning crisis situations, basic counseling skills, therapeutic responses to crisis and post crisis, and unconditional positive regard. Results before training showed that, regarding crisis situations surrounding suicide, 15% reported no confidence at all; 38% reported little confidence; 29% reported a fair amount of confidence; 3% reported much confidence; 12% reported very much confidence; and 3% reported complete confidence (Sawyer et al., 2013). After the training, 0% of the participants reported no confidence at all; 6% reported little confidence; 30% reported a fair amount of confidence; 18% reported much confidence; 36% reported very much confidence; and 9% reported complete confidence (Sawyer et al., 2013). These results suggest that suicide is an intense crisis management issue and that counseling professionals can benefit from continuous training even if they have taken a course in crisis preparation. Research has shown that those professionals who have taken at least one crisis training course indicate a higher confidence necessary to intervene if a client is experiencing suicidal ideations (Sawyer et al., 2013).

Allen et al. (2002) indicated that crises, such as suicide, interrupt the safety and stability of school environments and highlight the role of school counselors when such situations occur. Allen et al. defined the school counselor role as providing direct services during any crisis. Allen and colleagues further showed that among 236 practicing school counselors, 64% reported being exposed to crisis interventions through either graduate course work or practicum/internship field experiences. Forty-seven percent of participants reported specific courses related to crisis, and 28% of participants reported integrated topics on crisis. However, 57% of participants still reported feeling between minimally prepared and not at all prepared to intervene during a crisis (Allen et al., 2002). In the same study, 55% of school counselors reported that they were exposed to some form of crisis intervention in graduate school during their practicum or internship, including physical abuse, grief, violence, and suicide, and indicated that suicide was the

highest priority among all crises (Allen et al., 2002). Even though school counselors frequently encounter high-risk situations, according to Barrio Minton and Pease-Carter (2011), 30% of school counselors reported not receiving training in suicide during their master's programs, and 38% of school counselors reported feeling inadequate regarding their ability to recognize suicide risk among students.

In addition to counselors, other professionals, such as psychologists, social workers, and psychiatrists, have reported inadequate training in their programs (Schmitz et al., 2012). According to research, 76% of graduate programs in psychology across the United States provide insufficient training in suicide (Schmitz et al., 2012). Dexter-Mazza and Freeman (2003) studied 236 psychology students, 51% of whom stated that their programs offered formal training (lecture) in suicide. Eighty-five percent of the respondents indicated that suicide was incorporated within only two to five courses (Dexter-Mazza & Freeman, 2003). A national study indicated that 25% of social workers reported receiving training in crisis and suicide; however, this same group rated their training as inadequate (Schmitz et al., 2012). Another national study indicated that 94% of psychiatrists received instruction related to suicide assessment and intervention during residency via teaching methods such as supervision, seminar, and workshops (Schmitz et al., 2012). Fortunately, the American College of Psychiatrists' Psychiatry Resident-in-Training Examination, taken by all students pursuing a psychiatric specialty, incorporates questions regarding suicide (Schmitz et al., 2012). Although some helping professionals receive training related to suicide assessment and crisis intervention, it appears that all helping professionals should receive suicide-related training throughout their graduate degree programs and regularly participate in post-master's suicide-related continuing education trainings to increase their competence and self-efficacy when working with suicidal clients.

Counselor Preparation—Accreditation

Competence in suicide assessment is an essential clinical skill needed for counselors; however, research shows that graduate programs, licensure boards, and credentialing bodies do not require evidence of student competency and preparation in suicide assessment, intervention, and management (McAdams & Keener, 2008; Schmitz et al., 2012). CACREP (2016) requires counseling graduate programs to provide instruction in eight core areas. According to the CACREP 2016 standards, four core areas include standards for preparation in crisis management: Professional Counseling Orientation and Ethical Practice, Human Growth and Development, Counseling and Helping Relationships, and now Assessment and Testing (CACREP, 2016). In the first core area, Professional Counseling Orientation and Ethical Practice, one objective states "counselors' roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams" must be addressed in the curriculum (CACREP, 2016, p. 9). Although, not specifically mentioned in the 2016 CACREP standards, ethical practice also encompasses the ethical duty of counselors to protect clients from harm to self and others, and evaluating and managing suicide risk by engaging in suicide risk assessment (Remley & Herlihy, 2014). Crisis and suicide are connected in that suicide can be seen as a form of crisis and/or result from a crisis. In the core area of Human Growth and Development, one curriculum objective includes the "effects of crisis, disasters, and trauma on diverse individuals across the lifespan"

(CACREP, 2016, p. 11). For the Counseling and Helping Relationships core area, "suicide prevention models and strategies" and "crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid" must be addressed in the curriculum (CACREP, 2016, p. 12). Likewise, for the Assessment and Testing core area standards, "procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide" must be addressed in the curriculum (CACREP, 2016, p. 12). CACREP also requires that the specialty areas of Clinical Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, Marriage, Couple, and Family Counseling, and School Counseling should highlight knowledge surrounding crisis and suicide in respective curricula; however, neither crisis nor suicide are required topics for addictions and career counseling or practicum and internship (CACREP, 2016).

In addition to the 2016 CACREP standards, the 2012 National Strategy for Suicide Prevention released a plan for suicide prevention, consisting of 13 goals and 60 objectives organized into four strategic directions: (1) Healthy and Empowered Individuals, Families, and Communities, (2) Clinical and Community Preventive Services, (3) Treatment and Support Services, and (4) Surveillance, Research, and Evaluation (U. S. Department of Health and Human Services [DHHS], 2012). Under the second strategic direction of clinical and community preventive services, goal seven states that training related to the prevention of suicide and related behaviors should consist of five objectives (DHHS, 2012). The objectives are: (1) training on suicide prevention to community groups; (2) training to both mental health and substance abuse providers on recognition, assessment, and management of suicidal behaviors; (3) developing and promoting core education and training on the prevention of suicide within graduate and continuing education; (4) promoting core education and training on the prevention of suicide by credentialing and accrediting bodies; and (5) developing and implementing protocols for mental health professionals, supervisors, and other staff that encounters such crisis on how to manage suicide risk (DHHS, 2012). The 2016 CACREP standards and the 2012 National Strategy for Suicide Prevention highlight the importance of crisis management and suicide prevention and the need to address this issue through adequate counselor preparation.

Suicide Assessment

Since mental health professionals will likely encounter suicidal clients, there is a need for professionals to be able to identify signs/severity levels and risk and protective factors. Mental health professionals need to assess clients by using a suicide risk assessment. A major step for prevention of suicidal behavior is the assessment (Ribeiro, Bodell, Hames, Hagan, & Joiner, 2013). Suicide risk assessment is a major component in working with distressed clients and is the first step in treating suicidal clients (Huh et al., 2012; Regehr, LeBlanc, Bogo, Paterson, & Birze, 2015). Assessing suicide is complex and there is no absolute way of predicting who will complete suicide; however, there is belief that some suicides are preventable if they are foreseeable (Granello & Granello, 2007). The risk of attempting or completing a suicide is increased with the more signs or symptoms a client presents (Kanel, 2015). "Suicide is usually preceded by a warning" (Kanel, 2015, p. 84), but individuals who are suicidal do not always directly report their

intentions; therefore, it is imperative that mental health professionals recognize warning signs and severity, and risk and protective factors (Kanel, 2015).

Risk Factors

Warning signs are described as behaviors that warn of imminent risk (e.g., giving away possessions, writing a will; Granello & Granello, 2007; Kanel, 2015). James (2013) identified four categories of suicide clues: verbal, behavioral, situational, and syndromatic clues. Verbal clues are direct spoken or written statements such as "I'm going to kill myself" (James, 2013). Behavioral clues are behaviors that hint of suicide such as purchasing a gun. Situational clues are a wide range of conditions that change one's life such as death of a love one, divorce, or terminal illness (James, 2013). Syndromatic clues are symptoms associated with suicide such as depression, hopelessness, and loneliness (James, 2013). Risk factors are ongoing client characteristics that increase risk (e.g., depression, substance abuse, isolation; Granello & Granello, 2007). Proper suicide assessment consists of a thorough evaluation of factors that contribute to the risk of suicide, which include, but are not limited to: history of suicidal thoughts, behavior, plans or intent; lethality of intent; signs or symptoms of psychiatric disorders or substance use; psychosocial features and stressful events such as low socioeconomic status; physical illness, abuse, or neglect; cultural or religious beliefs; psychological features; and demographic features (American Psychiatric Association, 2003; CDC, 2015c; Fowler, 2012). A helping professional should encourage clients to identify and celebrate their protective factors to decrease the influence of these risk factors. Typical protective factors against suicide and suicide ideation include effective therapeutic care, family and support, positive social networks, skills in problem solving, psychotropic medications, cultural beliefs that disapprove of suicide, and having children in the home (CDC, 2015c; Fowler, 2012).

Assessment Tools

A variety of instruments and models have been developed for use during a clinical interview to help identify suicidal ideations and behaviors (James, 2013). Within the instruments and models developed, risk factors and warning signs are identified. The following section will identify and describe instruments and models designed to assess the ideations and risks of suicide.

James (2013) highlighted the Beck Depression Inventory, Beck Hopelessness Scale, and Psychological Pain Assessment Scale as useful assessment tools. Other suicide assessment instruments include the Beck Scale for Suicide Ideation, Hamilton Depression Rating Scale, Reasons for Living Inventory, and Suicidal Assessment Checklist (McGlothlin, 2008). In addition, there are intervention techniques comprised of crisis response planning, safety planning, and no-harm contracting to ensure safety (Ribeiro et al., 2013). The American Psychiatric Association (2003) guideline on suicidal behaviors suggested that effective treatment modalities include: somatic interventions, including antidepressant treatment or psychotropic medications; interpersonal psychotherapy; cognitive behavioral therapy; psychodynamic therapy; and dialectical behavior therapy. Stanley and Brown (2012) recommended utilizing a safety planning intervention (SPI). An SPI is a brief intervention for those clients who do not require immediate psychiatric hospitalization. SPIs utilize specific coping strategies and sources of support when client

suicidal ideation emerges. Components of the SPIs are: identifying warning signs; identifying internal coping strategies; utilizing social contacts as a representation of a distraction; contacting family or friends for support; contacting mental health professionals; and reducing potential or lethal means (Stanley & Brown, 2012). The aforementioned instruments and strategies are helpful; however, risk assessment is most effective when instruments are followed by a clinical interview (James, 2013).

The Substance Abuse and Mental Health Services Administration Suicide Assessment Five-Step Evaluation and Triage (SAFE-T), based on recommendations from the American Psychiatric Association's Practice Guideline (2003), is an assessment strategy to overcome risk factors while simultaneously providing protective factors to alleviate suicidal behavior (Fowler, 2012). The SAFE-T approach consists of five steps: (1) identify risk factors, (2) identify protective factors, (3) determine suicidal thoughts, plans, behaviors, and intents, (4) ascertain level of care for appropriate interventions, (5) document risk and rationale for chosen interventions, and (6) conduct a follow up (Fowler, 2012). Granello (2010) recommended utilization of the Roberts's Seven-Stage Crisis Intervention Model, which promotes seven practical strategies for working with suicidal clients. The seven step model consists of: (1) assessing for lethality, (2) establishing rapport, (3) listening to the story, (4) managing feelings, (5) exploring alternatives, (6) using behavioral strategies, and (7) following up (Granello, 2010). Roberts's crisis intervention model has crisis theory as its theoretical foundation, and suicidology research and practice ground the intervention strategies (Granello, 2010). Within each step of the model, concrete suggestions are offered for how to execute the intervention.

Fowler (2012) discussed Collaborative Assessment and Management of Suicidality (CAMS), which is a collaborative approach describing a plan to de-escalate a crisis, negotiating mutual responsibility between client and clinician, and establishing parameters for exploring the crisis. CAMS is designed to enhance the therapeutic alliance and increase client's motivation to be an active participant in treatment (Jobes, Lento, & Brazaitis, 2012). CAMS is guided by a clinical assessment, treatment plan, and outcome tool called a suicide status form (Jobes et al., 2012). The suicide status form allows the mental health professional to identify and measure areas of psychological pain, self-hatred, hopelessness, stress, and emotional agitation necessary to take action resulting in ending their pain (James, 2013).

The SAD PERSONS scale was developed using the first letters of ten suicide risk factors:

> (1) **S-**sex (e.g., males receive one point), (2) **A-**age (e.g., 19 years or younger and 45 years or older receive one point), (3) **D-**depression (e.g., people who are depressed receive one point), (4) **P-**previous attempt (e.g., people with a previous attempt receive one point), (5) **E-**ethanol abuse or drugs (e.g., people abuse alcohol or drugs receive one point), (6) **R-**rational thing loss (e.g., people who demonstrate impaired judgment, are delusional, or experience hallucinations receive one point), (7) **S-**social support lacking (e.g., people who isolate themselves, have few significant others, and do not regularly interact with others receive one point), (8) **O-**organized plan (e.g., people with a specific, organized suicide plan receive one point), (9) **N-**no spouse (e.g., people who are separated, divorce, widowed, or single parents receive one point), (10) **S-**sickness (e.g.,

people who have a chronic, debilitating, or severe illness receive one point). (Granello & Granello, 2007, pp. 197–198)

Scoring guidelines consist of 0–2 (consider sending the client home but follow up), 3–4 (monitor closely but consider referring to a hospital), 5–6 consider referring to a hospital depending on follow-up arrangements), and 7–10 (commit to hospital; Granello & Granello, 2007).

The American Association of Suicidology developed IS PATH WARM to remember the warning signs of suicide and is referred to as one of the most comprehensive mnemonic devices (Jackson-Cherry & Erford, 2014; McGlothlin, 2008). The mnemonic device IS PATH WARM stands for Ideation, Substance abuse, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, and Mood changes (McGlothlin, 2008). Another intervention used in assessing suicide is the Applied Suicide Intervention Skills Training (ASIST), which is a 2-day training workshop providing suicide first aid to participants to assist them in recognizing risk factors for suicide, teaching individuals how to intervene to increase safety for any individual experiencing suicidal ideations, and linking to community resources (Smith, Silva, Covington, & Joiner, 2014).

Lastly, recognizing the potential severity or lethality of suicidal ideations was previously mentioned as a necessity when assessing suicide. The SIMPLE STEPS model, which was developed by McGlothlin (2008) assesses client's potential suicide lethality. SIMPLE STEPS stands for suicidal?, ideation, method, pain, loss, earlier attempts, substance use, troubleshooting, emotions and diagnosis, parental and family history, and stressors and life events (McGlothlin, 2008).

The first step, which is "suicidal?," allows the interviewer to assess suicidal intent by asking the question "Are you thinking about killing yourself?" (McGlothlin, 2008). It is extremely important to directly ask the question whether an individual is thinking about killing him or herself or planning on killing him or herself in order to assess the level of risk (Granello & Granello, 2007). McGlothlin (2008) suggested that "the wording of this question is the only way to ask a question intending to identify suicide intent" (p. 38).

The second step, "ideation," is a follow up from the first question and allows the interviewer to assess the thought process of suicide or tells the interviewer whether the client has a plan or not. McGlothlin (2008) suggested asking, "on a scale from 1 to 10 (1 being not likely at all and 10 being definite), how likely are you to commit suicide within the next 72 hours?" (p. 37). Additional questions that could be asked include: When did you begin having thoughts of suicide?; How often do you think about committing suicide?; and Does you have the ability to control your suicidal thoughts? (McGlothlin, 2008).

The third step, "method," assesses suicide intent and the means to complete the suicidal attempt. McGlothlin (2008) provided three components: lethality of the method, availability of the means, and specific details of the plan. Three questions to ask include: How are you going to kill yourself?; How are you thinking about killing yourself?; What are you going to use?; and Are the means available? (McGlothlin, 2008). Within determining the means, one can determine the lethality or risk level from lowest risk to highest by the thought process. McGlothlin indicated that lowest risk has no thoughts of death; low risk has nonsuicidal thoughts; elevated risk has some suicidal thoughts but

without a specific plan; and highest risk has suicidal thoughts with a specific plan. Mental health professionals must take necessary actions depending on the risk level to ensure the safety of the client.

Step four, "pain," assesses emotional pain or perturbation, which is stress that influences suicide. McGlothlin (2008) suggested using the scaling question to pinpoint the level (e.g., on a scale from 1 to 10, 1 being no pain and 10 being the highest level of pain, how much pain are you in?). Follow-up questions would be "What would increase your level to a 10" and whether a 10 means a higher suicidal ideation (McGlothlin, 2008).

Step five, "loss," assesses experience of loss and questions asked center around if the person has experienced the loss and how it has negatively impacted them.

Step six "earlier attempts," assesses previous suicide attempts as prior attempts predict future attempts (McGlothlin, 2008). Questions could include, "Have you ever attempted to kill yourself before?": in addition, if the individual answered yes to the question, follow-up questions would be: "What made you attempt suicide?"; "How did you attempt to commit suicide?"; or even "What caused it not to work?" (James, 2013; McGlothlin, 2008).

The seventh step, "substance abuse," assesses any current alcohol and/or drug use and the lack of compliance with prescription medications. Questions that can be asked include: "Do you drink or use drugs?"; "What medications are you taking and are you taking them as prescribed?"; "Are taking prescription drugs that are not prescribed?"; and "When you contemplate suicide, are you drinking or using drugs?" (James, 2013; McGlothlin, 2008).

The eighth step, "troubleshooting," assesses problem solving abilities and questions that could be asked include: "Are you willing not to kill yourself?"; "What have you tried in the past to resolve any issues?"; "What might change to stop?"; and "If a miracle occurred to resolve your problems, what would your life look like?" (James, 2013; McGlothlin, 2008).

The ninth step, "emotions and diagnosis," assesses five suicidal emotions and any relationship to mental illness that include: hopelessness, depression, impulsivity, helplessness, worthlessness, and loneliness (McGlothlin, 2008). Questions that could be asked include: "Have you been diagnosed with a mental illness or physical illness?"; "How are you currently feeling, and have you felt this way previously?"; and "Are you currently seeing a clinician or therapist?" (James, 2013; McGlothlin, 2008).

The tenth step, "parental/family history," assesses any history and prevalence of suicide and mental illness among the family. Questions that could be asked include: "Has anyone in your family thought about or completed suicide?" and "Has anyone in your family been diagnosed with a mental illness?" (James, 2013; McGlothlin, 2008).

The eleventh step, "stressors and life events," assesses current or prior life stressors and questions that could be asked include: "What is going on in your life that leads to suicide or suicidal ideations?" and "Which of these stressors are currently most stressful?" (James, 2013; McGlothlin, 2008).

No matter which model or instrument is used during a clinical interview, it is imperative to at a minimum cover suicidal intent, details of plan, means of plan, accessibility of the means, history of prior attempts or ideations, stability of mood, family history of attempts or completions, as well as mental illness in order to examine mental

status and assess warning and risk signs (Granello & Granello, 2007). However, neither a checklist nor an instrument can replace a clinician's clinical judgment (Granello & Granello, 2007). A clinician's clinical judgment consists of their clinical experience, rapport and relationship with clients, and knowledge and training in suicide risk assessment (Granello & Granello, 2007).

Implications for Counselor Educators

Counselor educators should consider enhanced teaching and learning programmatic experiences to better prepare students for managing crises such as suicide or suicide ideation. Sawyer et al. (2013) insisted upon the need for beginning counselors to be better prepared for practice, including competency in crisis management/suicide management. Exposing students to the various suicide risk assessment instruments during their counseling courses is a reasonable first step in preparing them for work with future clients. Beyond simply discussing the instruments, it may be more helpful to allow students to take one or more of these assessments in class and to then discuss and practice interpreting the results. Due to the potential high cost of purchasing multiple assessments and limited institutional budgets, it may only be possible for a counselor educator to administer just a couple of instruments to their students each term. Also, if a student's results on an assessment are concerning (e.g., several suicidal thoughts or behaviors identified), a counselor educator must be prepared to refer the student to the on-campus counseling center and to follow up with the student individually.

Curriculum Infusion

Mitchell et al. (2012) described a teaching and learning method known as curriculum infusion that might also be effective for suicide risk assessment training. Curriculum infusion allows students, faculty, and mental health counselors to promote suicide prevention, mental health promotion, and illness prevention by addressing factors that contribute to suicidal thoughts and behavior, all while encouraging students to see the connection between academic content and real life experiences of mental illness and suicide (Mitchell et al., 2012).

Curriculum infusion is an educational approach that pulls material from multiple subject areas to educate faculty and students about a specific topic (Mitchell et al., 2012). In Mitchell et al.'s (2012) study, the overall goal was to infuse teaching and learning around the issue of suicide prevention. However, this approach could help counselor educators facilitate activities and prepare assignments that would provide their trainees with focused training on suicide assessment, intervention, and management. This training could seemingly fit well in core counseling courses such as assessment and testing, counseling methods, multicultural counseling, human development, ethics, and substance abuse.

To benefit from this approach, counselor educators could potentially infuse content from other fields such as psychology, social work, art therapy, and psychiatry in their courses to cover suicide assessment and related topics. For example, faculty could assign their counseling students to assess mock clients using the SAFE-T model and/or to design an art project for future clients that could be used to reveal risk factors and/or risk level for suicide. Consultation with faculty or professionals working in the field in these

other helping professions would better ensure counselor educators' appropriate development, usage, and assessment of these assignments.

Conclusion

Suicide has been identified as a frequent crisis that mental health professionals will encounter. Therefore, it is imperative to prepare mental health professionals with the necessary training and skills to assess suicidality. Remley and Herlihy (2014) suggested that if counselors are not adequately prepared through their graduate programs, then counselors must ensure that they obtain such competency in crisis assessment, intervention, and management through independent learning (e.g., reading literature, attending workshops, and conferences). Accordingly, mental health practitioners are compelled to ensure competency related to suicide, suicidal behaviors, risk factors of suicide, assessment, treatment modalities, referral methods for crisis, crisis management, crisis prevention, legal and ethical considerations, and coping strategies (Granello & Granello, 2007). Research does not imply a time frame in which mental health professionals are able to obtain a sense of competency; but the literature implies that one will gain a competency through continued knowledge, training, and experience (Granello & Granello, 2007). However, obtaining a Clinical Mental Health Counseling or Clinical Rehabilitation Counseling master's degree from a CACREP-accredited institution is a good starting point for every counselor-in-training. Professional counselors can also maintain their expertise and currency by engaging in professional conferencing (e.g., American Counseling Association) and continual completion of advanced training. The frequency of suicide, combined with the irrevocable and painful outcomes associated with suicide, places this issue front and center among helping professionals. Proper training and continued education are a must. The true helping professional would do no less. Furthermore, instruments and models have been developed to assist mental health professionals in assessing suicidality. Obtaining training in utilizing the various instruments and models increases mental health professionals' ability to address suicidality.

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