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Preferred methods of assessing suicidality in youth

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Suicidality in Youth:
A Descriptive Study

ABSTRACT

Literature on youth suicide has identified this phenomenon as a national health problem and one that continues to be on the rise. Moreover, youth suicide has been identified as a serious problem for the last two decades. The purpose of this study was to determine if practice setting, specialized training, and/or graduate education influence both the method and frequency of suicide risk assessment by practicing clinicians who work with adolescents.

A descriptive study design using an on-line data collection service was utilized (SurveyMonkey) to reach a non-probability sample of clinicians. The on-line survey was comprised of two sections. The first section consisted of demographic questions. The second section of the survey was comprised of descriptive data questions, yes or no questions, and open-ended questions.

The sample was comprised of 40 clinicians. Looking at the sample the vast majority of participants were female (32 out of 40 respondents). The average age of the 40 participants was 41 years. Finally, participants' average length of time working with youth was 12 years.

The major findings of this study indicate that at least for this sample the vast majority of clinicians assess their adolescent clients on a regular basis; 39 % assess their clients at every clinical interview, and 39 % report that they assess their clients several times throughout the course of treatment. However, the majority of clinicians (82%) report that they do not use a standard assessment tool. This indicates that the development of a universal suicide assessment tool would be beneficial to clinicians working in this field, but also to the clients that we treat.

PREFERRED METHODS OF ASSESSING SUICIDALITY IN YOUTH:

A DESCRIPTIVE STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

"In this life it is not difficult to die. It is more difficult to live."

--Vladimir Mayakovsky, Russian revolutionary

(Died by suicide, 1931)

The purpose of this study was to explore how practicing clinicians assess for risk and

suicidality in the youth they treat. Literature on youth suicide has identified this phenomenon as

a national health problem and one that continues to be on the rise. Youth suicide has been

identified as serious problem for the last two decades.   As Smith and Crawford (1986) write,

"The expanding suicide rates among our young are only the most visible tip of an "iceberg"-like

problem of depression and self-destructiveness. The rates of death tells us we have a problem,

but not its size or complexity" (p. 313). Likewise, contemporary authors have identified youth

suicide as a modern day debacle. As Miller and Eckert (2009) write, "Youth suicide continues to

be a significant public health problem at a national level" (p. 153). Society has identified youth

suicide as a serious issue demanding the utmost attention and has made efforts to prevent youth

suicide. However, youth suicide remains one of society's current public-health crises.

Suicide is defined as "the act or an instance of intentionally killing oneself" (The Free

Dictionary, 2013). Therefore, the definition of suicidality is defined as: "the likelihood of an

individual completing suicide" (The Free Dictionary, 2013). It is up to practitioners and

clinicians to assess whether the clients they treat are experiencing suicidality. However, there is

no universal assessment tool to assess for risk and suicidality, leaving clinicians to implement

their own suicide and risk assessment practice. In light of the literature on this topic, therefore, that indicates inadequate attention to this area of study, the goal of this study was to examine the suicide assessment practices of clinicians working with youth, exploring specifically the frequency of assessments and also specific assessment practice.

The literature on the topic of youth suicide indicates that many clinicians feel that their graduate education does not prepare them to adequately assess for risk and suicidality. Chapter II, the Literature Review, explores this state of affairs. As Miller and Eckert (2009) and Singer and Slovak (2011) found, while social workers feel equipped to work with suicidal youth, neither social workers nor psychologists who responded believed that they had received adequate training in their graduate education program. However, we know that because of increased liability and best ethical practices, clinicians must assess their teenage clients for risk and suicidality. This discrepancy was also explored in this study by looking at specialized training and continuing education conferences attended by clinicians who participated. Finally, given that there is no universal assessment tool for assessing risk and suicidality in youth, the aim of this study was to also explore what assessment practices and suicide assessment tools are being used by clinicians.

The study utilized a descriptive design using an on-line data collection service called SurveyMonkey to reach a non-probability sample of clinicians whose practice fit the inclusion criteria of the survey. An on-line survey was designed consisting of two sections of questions. The first section included demographic questions. The second section of the survey was comprised of descriptive data questions, yes or no questions, and open-ended questions. The open-ended questions offered the survey participants opportunities to elaborate on some of their answers. The descriptive data responses provided an enhanced understanding of specialized

suicide assessment training that survey participants may have had, as well as suicide and risk assessment practices. The methodology of the study is described in detail Chapter III.

Chapter IV describes the characteristics of the sample and offers substantive findings. The sample for this study was 80 % female, and 20% male. The average length of time that survey participants had been in practice post graduate was 12 years. The average length of time that survey participants had been working with youth was also 12 years. Finally, the average age of the clinicians who participated in the study was 41 years old.

The major findings of this study indicate that vast majority of clinicians assess their adolescent clients on a regular basis; many clinicians assess their clients at every clinical interview, while others report that they assess their clients several times throughout the course of treatment. However, the majority of clinicians reported that they do not use a standard assessment tool. At least for this sample it is through the combination of experience and specialized training that clinicians develop their own suicide assessment practice.

The final chapter, Chapter V, offers a discussion of the findings and how they corroborate the current body of literature on youth suicide and suicide assessment. It identifies the strengths and limitations of the study.   Finally, it suggests possibilities for future study.

CHAPTER II

Literature Review

Introduction

The literature on youth suicide cautions that is a national public health problem. Both Miller and Eckert (2009) and Singer and Slovak (2011) found that while social workers feel equipped to work with suicidal youth, neither social workers nor psychologists who responded believed that they had received adequate training in their graduate education program. As Singer and Slovak (2011) write, "The near ubiquity of the experience of school social workers working with suicidal youths suggests that training in suicide intervention and prevention should be top priority, starting in graduate school and continuing throughout a social worker's career" (p. 224).

However, youth suicide is not a new problem, but an age-old problem that has reached epidemic proportion. Historically, in looking at the epidemic of youth suicide, authors Cimbolic and Jobe (1990) write:

> What may be surprising is that youth suicide is not a new social health crisis. Indeed,
> almost 80 (years) ago Sigmund Freud and the Vienna Psychoanalytic Society addressed
> the significant public health issue of alarming increases in student suicides in the year
> 1910 (Berman, 1986) (p. 3)

While these writers acknowledge that youth suicide is anything but a new issue, they do identify that the methods that youth use to commit suicide have changed. The authors write, "One alarming observation is that the firearms accounted for about half of completed suicides for males between the ages of 15-24, but by 1980, 65% of the suicides deaths for males of this age

were by gunshot" (p. 6). While these statistics may be outdated, they offer important historical information regarding youth suicide; mainly that it has, and continues to be a major national public health problem.

For the purpose of this study, the literature review identified many factors related to the phenomenon of youth suicide such as: suicide statistics of in the United States, risk factors, protective factors, predisposition, successful suicide intervention practices, historical suicide assessment practices, and contemporary suicide assessment practices. The literature has identified risk factors among youth in general, risk factors among youth minority populations, and risk factors among the LGBTQ youth population. This research also emphasized that assessment is the first crucial step in treating suicidality. As Cimbolic and Jobes (1990) emphasize, assessing suicidality and treating suicidality go hand and hand: "Treatment is closely linked to ongoing assessment of suicide risk. The continuous and dynamic synthesis of assessment and treatment is the essence of the effective management and eventual resolution of the youth's suicidal crisis" (p. 47). This point is paramount to the study that is the subject of this thesis; if one is not assessing suicidality, one cannot treat suicidality. In the same way practitioners provide routine screenings, clinicians need to make assessments to determine what treatment is necessary. Likewise, one would not treat for suicidality if an assessment did not indicate the need for treatment of suicidality. In spite of well-established risks, both Singer and Slovak (2011) and Miller and Eckert (2009), as well as other authors, have found that those working with youth in a school setting are of the opinion that their graduate education did not provide them with the skills to adequately assess suicidality and treat suicidal youth. This discrepancy between knowledge and practice preparation begs the question: How do clinicians assess risk and suicidality in their clinical practice with teenagers?

Historical View of Suicide Prevention

According to the National Strategy for Suicide Prevention (2012), Americans began their efforts to prevent suicide in the 1950s when a group of clinicians became interested in understanding the phenomena. In 1960 the International Association for Suicide Prevention was founded. In 1967 the National Institute of Mental Health (NAMI) established their first center for suicide prevention. The year 1968 brought the edition of the first national conference on suicidology held in Chicago Illinois, and the American Association of Suicidology (AAS) was founded. In 1971, The Journal *Suicide and Life Threatening Behavior* published its very first issue. National Institute of Mental Health (NIMH) published *Suicide Prevention* in 1973. In 1976 the AAS launched the first crisis-center accreditation program, and subsequently the first accredited crisis center opened. In 1987, the American Foundation for Suicide Prevention (AFSP) was founded. In 1989, the first National Suicide Memorial event was held in St. Paul, Minnesota. The National Suicide Memorial event was put on by Suicide Awareness Voices of Education (SAVE). The year1989 also brought the publication of the *Report of the Secretary's Task Force on Youth Suicide* by the Department of Health and Human Services (HHS). Lastly, 1989 also brought the first "Healing After Suicide" conference held by the AAS. From 1950 through the1990s we see that there is a recognition of a need for suicide intervention and prevention initiatives.

The 1990s brought an increase in the development of suicide prevention efforts and associations (U.S. Department of Health and Humans Sevices (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, September 2012). In 1992, the Centers for Disease Control and Prevention (CDC) published *Youth Suicide Prevention Programs: A Resource Guide*. In 1994, the Yellow Ribbon Suicide Prevention Program was

founded (p.95). In 1995, Lifekeeper Foundation was established (p.95). In 1996 the World

Health Organization (WHO) published *Prevention of Suicide: Guidelines for the Formulation*

and Implementation of National Strategies. In 1997, the Jason Foundation was founded by Clark

Flatt, a father who had lost his son to suicide (Jason's Story, 2013). Also in 1997, Congress

passes S. Res. 84 and H. Res, 212 recognizing suicide as a national problem, which in turn

prompted the CDC to establish the National Center for Injury Prevention and Control. In 1998

the Trevor Project was established. In 1999, the First National Survivors of Suicide Day was

held. In 1999, the National Hopeline Network (1-800-SUICIDE) went live. Also in 1999, HHS

publishes the *Surgeon General's Call to Action to Prevent Suicide,* and the National Council for

Suicide Prevention is established. Lastly, 1999 brought the induction of the National Council for

Suicide Prevention.

The following decade brought the birth of many suicide crisis lines such as the creation

of the national crisis line in 2001 sponsored by Substance Abuse and Mental Health Services

Administration (SAMHSA) (U.S. Department of Health and Humans Sevices (HHS) Office of

the Surgeon General and National Action Alliance for Suicide Prevention, September 2012). In

2001, HHS published *National Strategy for Suicide Prevention.* In 2002, SAMHSA established

the first national Suicide Prevention Resource Center (SPRC). The first *Out of the Darkness*

overnight walk was held in 2004; this walk raises money for education, outreach, and awareness

of suicide, and the proceeds benefit the American Foundation for Suicide Prevention (AFSP)

(About the Walk, 2013). Also in 2004, the Garrett Lee Smith Memorial Act was signed into law.

This Act was named in honor of Senator Gordon Smith's son, Garrett Lee Smith, who had

committed suicide a year before in 2003 (Top Story, 2013). Senator Smith and his wife worked

tirelessly following the death of their son to enact this law, which enables states, Indian tribes,

colleges, and universities to develop suicide prevention and programs (Top Story, 2013). NAMI executive director, Michael Fitzpatrick, stated," Senator and Mrs. Smith have turned a personal tragedy into positive public action" (Top Story, 2013). This commitment to providing suicide prevention initiatives was significant, because Senator Smith's mission demonstrated that suicide does not discriminate. If an elected public official could lose his son to suicide, then surely all our children could be at potential risk.

The year 2005 brought the introduction of the National Suicide Prevention Lifeline by SAMHSA (U.S. Department of Health and Humans Sevices (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, September 2012). In 2006 the Federal Working Group on Suicide Prevention formed.

Honoring the suicide of veteran, Joshua Omvig, Congress passed in 2007 the Joshua Omvig Suicide Prevention Act (Iraq and Afghanistan Veterans of America, 2013). This act called for the provision of tracking veterans who seek mental health care and additionally, flagging them in the background check system check required when purchasing a gun (Iraq and Afghanistan Veterans of America, 2013). Also in 2007, the Veterans Suicide Prevention Hotline was launched (U.S. Department of Health and Humans Sevices (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, September 2012).

Thorough the above-mentioned decades we can see the advancement in suicide-prevention initiatives. Society responded to an obvious need to provide crisis intervention to people who were at potential risk for suicide. However, given the increase in youth suicide that continues today, it would seem that all the above-mentioned efforts to prevent suicide are insufficient.

Current State of Affairs

Looking at current suicide statistics for the United States, The American Foundation for Suicide Prevention (2012) writes that suicide is the fourth leading cause of death among 5-14 years old, and the third leading cause of death among those 15-24 years old. Overall, 38,000 people in the United States die by suicide every year. A person dies by suicide every fourteen minutes. Ninety percent of people who die by suicide have a diagnosable psychiatric disorder at the time of their death. There are four male suicides to every female suicide, but three times as many females as males attempt suicide. Lastly, firearms account for 50% of all suicides and is the fastest growing method of suicide (Facts and Figures, 2012).

The American Foundation for Suicide Prevention (2012) indicates that between the mid-1950s and the late 1970s, the suicide rate among US males aged 15-24 more than tripled. With youth suicide drastically on the rise for the last half century, it would seem that the need to develop a standardized assessment practice would be of utmost importance to our society as a whole. If we as a society are to decrease the rate of suicide among males 15-24, we need to develop a sound screening and assessment practice in order to identify those at risk for suicide and provide the necessary crisis intervention.

Research

Literature about the risk factors related to youth suicide has established solid evidence for clinicians awareness. For instance, Miller and Eckert (2009) identify the following as risk factors: presence of psychopathology, previous suicide attempt and /or previous suicidal ideation, presence of hopelessness, biological deficits in serotonin functioning, limited access to mental health care services, poor coping and problem solving skills, low self-esteem, problems in the family or home life, parental psychopathology, culture or religious beliefs, and exposure to

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violence (p. 156-157). The authors also caution that minorities may be affected by other factors that Caucasian youth may not face including discrimination, acculturative stress, passive coping skills, and fatalistic philosophies (p. 157). They also argue that comorbidity of psychopathology cannot be ignored, reflecting general agreement across a large body of literature establishing the presence of very clear youth suicide risks. Additionally, the literature emphasizes that it is not only the identification of risk factors but also how individual predilection indicates when suicide assessment is necessary.

In considering risk factor that predispose one to suicidality, Sapytka, Goldston, Erkanli, Daniel, Heilbron, Mayfield, and Treadway (2012) illustrate that suicide can be predicted by past attempts. The authors conducted a longitudinal study of adolescents following their discharge from a psychiatric inpatient facility. Their findings indicate that although contrary to popular belief, a person's most recent suicide attempt's lethality is not indicative of the lethality of future attempts. Instead, the study found that the most lethal previous attempt was indicative of the possible lethality of further attempts:

> The most severe level of suicide ideation ever experienced was the best predictor of eventual death by suicide than current levels of suicide ideation at intake evaluation. Similarly, the most severe level of suicidal plans was found to be a strong predictor of eventual suicide than current plans or desire to make suicide attempt among outpatients with suicide ideation. (p. 4)

Miller and Eckert (2009) also emphasize the connection between suicidality and psychopathology: "The consistent finding of the substantial presence of comorbid forms of psychopathology strongly indicates that suicide does not occur in isolation but rather is the by-product of other mental health problems" (p. 157). The authors conclude that because adolescent suicide has increased in the last decade, it is likely to continue to increase. This demands that

school personal and school-based mental health professionals have knowledge of suicide prevention techniques as well as suicide-assessment skills and intervention skills.

In a study of adolescents who had committed suicide, researchers Brent, Pepper, Moritz, Allman, Friend, Roth, Schweers, Balach, and Baugher (1993) conducted a study to determine what psychiatric risk factors where present prior to their deaths. What these researchers found was that those who committed suicide were three times more likely to meet criteria for a DSM III diagnosis than the control group (p. 523). These authors write, "In this study, we confirmed our initial predictions that affective disorder, most specifically, major depression, was the single most significant risk factor for completed suicide in adolescents" (p. 524). This study supports the findings of Miller and Eckert (2009) that the precense of psychopathology increases the risk of suicidality in adolescents (Brent, et al., 1993).

Likewise, the World Health Organization (2005) conducted a study to determine if the prescence of a DSM diagnosis increased the risk for suicidality in youth. They looked at English-speaking countries and studied adolescents who had committed suicide. Fleischmann, Manoel Bertolote, Belfer, and Beautrais (2005) write, "Mood disorder was the most frequent diagnosis (42.1%) of all 894 cases identified, followed by substance–related disorders with a similarly high proportion (40.8%). The third most prominent diagnosis was disruptive behavior diagnosis, which accounted for 20.8%" (p. 671). The authors note that Disruptive Behavior Disorder includes Conduct Disorder, Attention-Deficit Disorder, Identity Disorder and Oppositional Disorder (p. 677). When it comes to comorbidity, the authors write, "In general, the most common pattern seemed to be that of mood disorders and/or substance-related disorders with disruptive behavior disorders or personality disorders" (p. 679). Lastly, the authors do caution that there is limited information about the identification of psychiatric diagnoses in

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suicides completed by adolescents (Fleischmann, Manoel-Bertolote, Belfer, & Beautrais, 2005, p. 682).

Looking at minority populations, Pena, Matthieu, Zayas, Masyn, and Caine (2010) found that Black males had the highest rate of suicide attempts, followed by Hispanic females. The authors identified that there "is increasing evidence that problems with substance use, violent aggression, and depressive symptoms co-occur in a large population of youth who attempt to die by suicide" (p. 30). Their study aimed to look at these factors and how race, ethnicity, and gender influenced the likelihood that a youth will experience suicidality. The authors addressed the disparity of suicide attempts among white people and people of color as follows:

> This disparity may be in part due to disparities in access to care as well as differences in cultural perspectives on mental health treatment. Second, strain caused by contextual problems, such as discrimination and institutionalized racism, family poverty, community stigma related to mental illness, and community violence may lead to higher rates of suicide attempts among Hispanic and Black youth without co-occurring problems (p. 38)

The authors also warn that Whites receive higher levels of treatment for mood disorders, which can also contribute to the disparity (Pena, Matthieu, Zayas, Masyn, & Caine, 2010).

Another population identified at being at risk for depressive symptoms and suicidal ideation are children in the welfare system who are placed outside their home. Anderson's (2011) longitudinal study attempted to identify a relationship between the type of placement and depressive symptoms resulting in suicidal ideation. Anderson (2011) found the following: "The associations between clinically significant depressive symptoms, in-home versus out-of home placements, and suicidal ideation found at baseline of the National Survey of Child and Adolescent Well-Being (NSCAW) do not indicate casual relationships" (p. 794). The author

indicates that further study is needed to distinguish the risk factors for entry into the child welfare system from the risk factors for mental health problems in general.

One of the most arguably at-risk populations for suicide is the LGBTQ youth community. Their risk is twofold as youth they are at risk for suicide and also because they identify as gay, lesbian, bisexual, or transsexual (Gibson, 1989). While there have been additional studies since Gibson's article was published, more research is required to distinguish who among LGBTQ community possesses the greatest risk for suicidality. As Gibson (1989) writes:

> With all of the conflicts they face in accepting themselves, coming out to families and
> peers, establishing themselves prematurely in independent living and, for young gay
> males, confronting the haunting specter of AIDS, there is growing danger that their lives
> are becoming a tragic nightmare with living only a small part of dying (p. 114).

Implications for Treatment

While there are factors that put adolescent at risk for suicidality, there are also protective factors that can prevent adolescents from experiencing suicidality and other high-risk behaviors. U.S. Department of Health and Human Services (2001) identify the following protective factors for suicide:

> Effective clinical care for mental, physical, and substance abuse disorders, easy access to
> a variety of clinical interventions and support for help seeking, restricted access to highly
> lethal means of suicide, strong connections to family and community support, support
> through ongoing medical and mental health care relationships, skills in problem solving,
> conflict resolution, and nonviolent handling of disputes, and cultural and religious beliefs
> that discourage suicide and support self-preservation (p. 35).

Knowing that an adolescent is at risk for suicide is crucial to providing a successful intervention. Therefore, having a suicide assessment tool can make the difference between a

successful intervention and an unsuccessful one. Cimbolic and Jobe (1990) identified a number

of different assessment practices that providers can use to assess risk in people of all ages.

However, they caution that there is not one specific assessment practice that can be used across

the board. They write,

> Based on our review, the Scale for Suicide Ideation, the Suicide Intent Scale, and the
>
> Hopelessness Scale are recommended for clinical use. With an adolescent population,
>
> the Hilson Adolescent Profile can be used with a school and juvenile delinquent
>
> population, and the Suicidal Ideation Questionnaire is appropriate with a school
>
> population. However, neither scale is recommended for clinical use with psychiatric
>
> adolescents (p. 28).

One tool that is often used for risk assessment by a primary care physician is the

HEADSS interview instrument (Biddle, Sekula, & Puskar, 2010). "(O)ften referred to simply as

'HEADSS'," this scale "represents the domains of Home, Education, Activities, Drug use, and

abuse, Sexual behavior, and Suicidality and depression" (Biddle, Sekula, & Puskar, 2010, p.

153). Their study looked specifically at whether HEADSS could accurately assess suicidality in

rural youth and was the first to look at if the HEADSS interview was as appropriate assessment

for suicidality in rural youth. The authors caution, "No studies exist concerning the value of

suicide assessment in primary care" (p. 156). While their study had several limitations, and was

a secondary analysis of qualitative date, it did indicate implications for future modifications to

the HEADSS instrument. The authors identified the possible need for two additional domains:

Death, and Safety (p. 164). Thus, while the HEADSS interview assessment looked at many

important factors, it neglected to assess to other very important risk factors: death and safety

(death, i.e., had the adolescent had any recent losses of relationships in their life; and safety, i.e.,

whether the youth was at risk for self-harming behaviors). The findings of this study

demonstrate that the standardized assessment tools in use still leave something to be desired when it comes to completing a complete risk assessment for an adolescent.

Shea (2011) purposes the use of the Chronological Assessment of Suicide Events (CASE) interview strategy. The CASE strategy examines the presenting suicidal ideation, any recent suicidal ideation, past suicidal ideation and immediate suicidal ideation with future intent to implement. Shea (2011) emphasizes that extreme significance of understanding a client's feelings regarding past suicide attempts and that this information can give a clinician an accurate assessment of a client's current risk of suicide. As Shea (2011) writes, "The answers seem to lie in the process of entering the client's world at the time of the suicide attempt and understanding how a client feels about the fact that he or she did not die" (The practical art of suicide assessment, p. 154).

In 2001, the Public Health Service acknowledged the need for a standard suicide assessment practice and issued a call to arms in its National Suicide Prevention Strategy Report (2001):

> Better awareness that suicide is a serious health problem results in knowledge change, which then influences beliefs and behaviors (Satcher 1999). Increased awareness coupled with the dispelling of myths about suicide and suicide prevention will result in a decrease in the stigma associated with suicide and life-threatening behaviors. An informed public awareness coupled with a social strategy and focused public will lead to change in the public policy about the importance of investing in suicide prevention efforts at the local, State, regional, and national level (Mrazek & Haggerty, 1994). (U.S. Department of Health and Human Services, p. 44)

This report detailed many goals among them the goal to develop guidelines for assessment of risk in suicidality in the primary care setting, emergency departments, specialty mental health

clinics, and substance abuse treatment centers by the year 2005 (U.S. Department of Health and Human Services).

The state of Tennessee implemented a statewide suicide prevention program based on the approach outlined in the National strategy for suicide prevention: goals and objectives for action (U.S. Department of Health and Human Services, 2001). The authors report that the State reviewed literature and identified that children in the welfare system and children in the juvenile justice system were both populations at high risk for suicidality. The Tennessee Suicide Prevention Network (TSPN) is divided into eight regions and includes community agencies, private practice settings, universities and public agencies, consumers, and advocates. Keller, Puddy, Stephens, Schut, Williams, McKeon, and Lubell (2009) write, "These statistics prompted the team to review interventions that could reach varied populations of youth who at elevated risk for suicide. Gatekeeper training was selected because of its transportability across child-serving systems and its potential for reaching large numbers of youth" (p. 127). This study concluded that training has a long-term effect on the efficacy of suicide prevention, self-efficacy, and attitudes about suicide.

Smith and Crawford (1986) looked at "normal" Midwestern adolescents and administered the Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and a survey of behaviors. Looking at students who had made suicide attempts the authors write, "Only 12.1% of the attempters received medical treatment following their attempt. This suggests that almost *90% of the actual number of adolescent suicide attempters will be missed by the process of identifying them through medical contacts*" (p. 316). The authors also found that those who plan suicide and are more of a "loner" fit the profile of a more inhibited, more

internalizing-style person, which is consistent with adults who commit suicide. The author

concludes as follows:

> (1) Those who have only thought about suicide are similar to those that have never
>
> thought about it;
>
> (2) Those who have made plans about how they might kill themselves and those who
>
> have actually attempted to do so are similar
>
> (3) Those who have planned but never attempted suicide are similar to high-risk adults
>
> (p. 324).

The author closes by saying, "It has become clear that if we wish to be of help to troubles

adolescents we need not target our efforts solely at the seriously suicidal young person's; it

seems that most high school student may need our attention" (p. 324).

Langhinrichsen-Rohling, Hudson, Lamis, and Carr (2012) looked specifically at

adjudicated youth and try to determine if there was a specific screening tool that was successful

at assessing youth who were at high risk for suicide. They state,

> The Life Attitudes Schedule: Short Form (LAS:S; Rohde, Lewinsohn, Langhinrichsen-
>
> Rohling, & Langford, 2004) is a self report measure that was originally developed to
>
> screen for suicide proneness in youth located in school settings. However, unique
>
> properties of the LAS:S suggest it may provide a valuable way to screen for suicide
>
> proneness in adjudicated youth (Rohde, et al., 2004, p. 324).

The authors caution that this is a population that is at high risk for suicide and that there are

several factors that make this the perfect population to utilize to develop a successful screening

tool, such as the fact that this group is high risk, that suicide prevention efforts are lacking with

in the juvenile system, and lastly, that the issue of liability is an important consideration for

institutions that serve at-risk children and youth (p. 325). Ultimately, this study did find that the

LAS:S has potential to be a successful screening tool for adjudicated adolescents at risk for suicidality.

The U.S. Department of Health and Human Services (2001) writes, "By promoting effective clinical practice in the assessment, treatment, and referral for individuals at risk for suicide the chances are greatly improved for preventing those individuals from acting on their despair and distress in self-destructive ways" (p. 87). The report goes on to say that clinical studies have shown the effectiveness of training ED (emergency department) staff to properly treat suicide attempts often results in the completion of treatment on the part of the patient, consequentially reducing the possibility of further suicide attempts by the patient (p. 89).

Karver, Tarquini, and Caporino (2010) conducted a study that specifically looked at the accuracy and agreement in assessing the future risk of suicide related behavior of helpline counselors. Surprisingly, the authors found that that helpline counselors were highly accurate in assessing the risk for suicidal related behaviors (SRB): "Our findings indicate that, although clinicians in general appear to have difficulty with numerous clinical judgments and decisions, helpline counselors may be able to reliably and accurately determine future risk for engaging in SRB" (p. 278). The authors did caution that their study was limited in that the counselors did not engage in actual phone calls; instead, they interacted with computerized information. Nevertheless, this study indicates that those clinicians who receive specialized training may be better equipped to assess the risk of suicidality than those who do not (Karver, Tarquini, & Caporino, 2010).

In 2012 the Surgeon General followed up with another National Strategy for Suicide Prevention Report, again calling for action:

> More than a decade has passed since Surgeon General David Satcher broke the silence
> surrounding suicide in the United States by issuing *The Surgeon General's Call to action*

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to Prevent Suicide. Published in 1999, this landmark document introduced a blue print

for suicide prevention and guided the development of the National Strategy for Suicide

Prevention (p.10).

While acknowledging the significance of the original report, the authors also acknowledge that

there is much more work to be done and detailed new goals and objectives to meet in the next

coming decade. Some of these new goals include addressing the need of high risk populations,

fostering public dialogue, promoting systematic changes, promoting efforts to reduce access to

lethal means for high risk individuals, bringing together public health and behavioral health, and

applying the most up-to-date knowledge of suicide prevention (September 2012). While the

National Strategy for Suicide Prevention identifies a variety of goals, it remains to be seen if and

when these goals will come to fruition. The one thing that is clear is that now, more than ever,

there is a need to make systematic changes in how we as a society provide screening for suicidal

ideation and behavior and how we can provide treatment and crisis interventions.

Conclusion

In closing, this review of literature indicates that there are as many methods to assess

suicide as there are ways to commit suicide. The success of the screening tool often seems to

depend on the population being screened, and there are limited studies on the effect of one

screening tool on multiple populations. The absence of evidence of successful interventions that

work on multiple populations and the evidence that youth suicide continues to rise indicates the

need for the development of a universal screening tool to assess suicidality and risk and youth

continues.

CHAPTER III

Methodology

Formulation

The present study explored how practicing clinicians assess for risk and suicidality in the youth they treat. For the purpose of this study, youth were defined as children from the ages of 13-18 years. The goals of this study were to determine if there is a preferred suicide and risk assessment tool, or practice, among clinicians working with youth. Research indicates that many clinicians feel that their graduate education did not prepare them to adequately assess risk and suicidality in the clients they treat (Miller & Eckert, 2009; Singer & Slovak, 2011). However, because of ethical practice policies and increased liability, clinicians must regularly assess the clients they treat for risk and suicidality. Therefore, despite the fact that clinicians may not feel prepared to assess risk and suicidality, they are in fact doing suicide and risk assessments. Given that there is no universal assessment tool for assessing risk and suicidality in youth, the aim of this study was to explore what assessment practices and suicide-assessment tools are being used by clinicians. The study looked at a variety of clinicians in varied practice settings.

Research Design

The purpose of this study was to explore risk and suicide-assessment practices of clinicians working with youth. A descriptive design using an on-line data collection service (SurveyMonkey) was utilized to reach a non-probability sample of clinicians whose profile fit the inclusion criteria outlined in the section below on the sample. On-line surveys are less time

consuming, afford larger samples, are less expensive than face to face interviews and as well, provide automatic data entry Rubin & Babbie, 2010).

The survey was comprised of two sections of questions. The first section included demographic questions (Appendix A). The second section of the survey was comprised of descriptive data questions, yes or no questions, and open-ended questions (see Appendix B). The open-ended questions offered the survey participants the opportunity to elaborate on some of their answers. The descriptive data responses were coded for themes that provided an enhanced understanding of specialized suicide assessment training that survey participants may have had, as well as suicide and risk-assessment practices.

Sampling Techniques

Following project approval from the Human Subjects Review Committee (HSRC) at Smith College School for Social Work (see Appendix C for copy of HSRC's approval letter for this study), a convenience sample of practicing clinicians was recruited through this researcher's personal contacts, as well through the Smith Community (Appendix D). Additionally, this researcher reached out to fellow Smith students through a Facebook advertisement (Appendix E). In addition to the original mailing, two follow up mailings were sent in order to develop as large a sample as possible, the result of which was the final sample of 40 clinicians qualified to participate.

The request for participation distributed via email (Appendix D,) explained the purpose of the study and how the clinician could help by participating. The email prefaced that in order to be eligible to participate in the on-line survey the participant must have a graduate degree in a human services related field including but not limited to psychology, social work, pastoral counseling, mental health counseling, or family and marriage counseling. The email also

explained that in order to participate, clinicians had to have been in post-graduate practice for at least three years and currently be working with youth aged 13-18. Additionally, the email asked clinicians to forward the email to other clinicians who could have been interested in completing the survey. Lastly, the email included a link to the screening questions on the SurveyMonkey site (Appendix F).

The first two emails that were sent out were sent in error to the Smith community at large. In trying to reach clinicians who would qualify to participate in the study, this researcher's thought was to extend this invitation to as many potential participants as possible. However, the researcher was soon alerted to the fact that the manner in which the email was sent was not sensitive to the study's goal of anonymity. After much discussion with Smith College Administration, it was determined that no ethics violation had been perpetrated, and this study was able to continue in recruiting participant. At that point, recruitment exclusively focused on individual personal and professional contacts rather than large list-serve systems.

The Facebook advertisement (Appendix E) used to recruit participants was posted on the Smith School for Social Work (SSW) student organization page and The Smith School for Social Work Unofficial Official Quantitative study page. The advertisement asked if participants were clinicians currently working with youth 13-18 years of age; if they had a graduate degree in the human services related field including but not limited to psychology, social work, pastoral counseling, mental health counseling, or family and marriage counseling; and if they had been in post-graduate practice for at least three years. If the clinician met all of these requirements, the advertisement then asked him or her to participate in the survey. The advertisement also stated that by participating in the survey, these clinicians would be helping this researcher with the

completion of a Smith College School of Social Work master's thesis. Finally, the advertisement included a link to the screening questions (Appendix F).

Because the study's data were derived from a method of nonprobability convenience sampling, the results are not generalizable and are not representative of all practicing clinicians working with youth. However, the data collected have provided insight into the suicide and risk-assessment practices of clinicians who did participate in the study, helping to advance knowledge and provide ideas for future research.

Sample

Selection criteria

The selection criteria for the sample were as follows: individuals who (a) had a graduate degree in a human services related field including but not limited to psychology, social work, pastoral counseling, mental health counseling, or family and marriage counseling; (b) had been in practice for at least three post-graduate years; and (c) were currently working with youth ages 13-18 years.

These criteria excluded individuals whose clients had committed suicide. The rationale behind this exclusionary criterion was that participating in this survey could potentially cause them particular distress.

The data-collection process was designed to include all people who initiated the survey and not just participants who concluded the survey, which, unfortunately, while providing information otherwise unattainable, made it difficult to discern why such a large number of participants did not complete the survey. Also unfortunately, no mechanism was built into the process to understand the lack of completion.   Thus, 90 clinicians initiated the survey, but only

40 completed the survey. Fortunately, this number still permitted an interesting and informative yield for analysis.

Many of the personal contacts to whom the invitation was extended were current MSW students or recent graduates. It is possible that some of the email recipients may have started the survey only to find out that they did not qualify because they had not been in post-graduate practice long enough to qualify.

Of the 40 participants who completed the survey, 82% are female. Only a handful of men participated in this study, making up 20% of the total number of participants. Of all survey participants, there was a total of 130 years of experience with an average of 12 years of experience working in the clinical field. The participant with the most experience in the field had a total of 39 years, and the participant with the least amount of experience in the field came in with three years' experience.

Participants had varied lengths of time working specifically with youth. One survey participant had been working with youth for 33 years. However, the average length of time that participants had been working with youth was12 years. The average length of time participants had been at their current practice setting was six years, and the two most common practice settings were (1) community based mental health practices and (2) schools. Finally, of the full sample (N=40), 42% had a master's degree in social work at the time they completed the survey. The other 58% represented the following fields: clinical psychology, counseling psychology, and marriage and family counseling.

Data Collection Instrument

The data were collected for this study using an on-line survey instrument divided into three sections: screening and exclusionary criteria questions; demographic questions; and

alternating yes or no and open-ended questions. Participants were able to access the survey

using SurveyMonkey at this address: https://www.surveymonkey.com/s/7MC2KTH

provided in the email and Facebook advertisements.

Informed Consent Procedures

Before viewing the survey, participants were provided with prescreening questions (see

Appendix F). If the participant answered, "No I Do Not Meet One or More of the Above

Criteria" in response to the prescreening questions, then the participant was automatically

redirected to the Disqualification page (see Appendix G). If the participant answered, "Yes I

Meet All of the Above Criteria" then he or she was directed to the Informed Consent page (see

Appendix H). The Informed Consent page contained information describing the purpose of the

study, eligibility requirements, protections related to anonymity and confidentiality, and the risks

and benefits of participation. Participants were then able to electronically indicate that they

consented to participate in the study by selecting "I AGREE" or "I DISAGREE." Participants

were encouraged to print a copy of the informed consent letter before taking the survey. After

choosing whether to print the informed consent form, the clinicians who agreed to participate in

the survey were then automatically brought to the survey's first demographic question (see

Appendix A). Following the demographic questions, participants were forwarded to the last

page of the survey by clicking the "Next>>" button. The final page of the survey, Section 2,

included the descriptive data questions of the study (see Appendix B).

Screening Process and Exclusionary Criteria

The first pages of the survey instrument contained the pre-screening questions and were

designed to address the exclusionary criteria. Participants were forwarded to the Disqualification

page (see Appendix G) for any of the following disqualifications: (1) they did not have a

graduate degree in a human services related field; (2) they had not been in post-graduate practice for a minimum of three years; (3) they were not currently working with youth; or (4) they had had a client who had died as a result of suicide.

Reliability and Validity of the Measurements Employed

Demographic Questions

Upon accepting the Informed Consent, participants were then forwarded to the first section for the survey, which was the demographic questions. The demographic questions related to (a) participant's gender, (b) participant's age, (c) length of time in post-graduate practice, (d) length of time working with youth, (e) length of time at the current practice setting, (f) type of practice setting they worked in (at the time of the survey), and (g) nature of their formal graduate education.

Descriptive Data Questions

Part two of the survey asked the participants the following questions:

(1) Have you had specialized training in assessing risk and suicidality in youth?

(2) If so, what specialized training?

(3) Please check the following option that best describes the frequency of suicide assessment in your clinical practice with teens:

- o *I assess my teen clients for suicide risk at every clinical interview.*

- o *I assess my teen clients for suicide risk at several intervals throughout the course of treatment.*

- o *I assess my teen clients for suicide risk at the initial clinical interview.*

- o *I assess my teen clients for suicidal risk at the initial clinical interview and at the end of their course of treatment.*

o *I only assess for suicide risk in teen clients who are being seen for suicidal behavior*

ideology.

o *I do not routinely assess for suicide risk when working with my teen clients who present*

for non-suicide related issues.

(4) Is there a particular standardized assessment tool that you use?

(5) If so what tool do you use?

(6) If you do not use a standardized assessment tool to assess risk and suicidality, can you please

describe the method you do use?

(7) Please feel free to leave to general comments and feedback.

Analysis of the Data

After the data collection period ended, the data, which were completely anonymous, were

downloaded for analysis and submitted to the Smith College statistician. This study used

descriptive statistics to analyze the demographic data and a thematic coding "scheme" to analyze

the answers the open-ended questions. The following chapter will explore the study's

substantive findings in greater depth.

CHAPTER IV

Findings

The purpose of this study was to determine if placement setting, specialized training, and or graduate education influence both the method and frequency of suicide risk assessment of practicing clinicians who work with adolescents. The major findings of this study indicate that a vast majority of clinicians who participated in this study do assess their adolescent clients on a regular basis: 39% reported that assess their clients at every clinical interview, and 39% reported that they assess their clients several times throughout the course of treatment. However, the majority of participants (82%) reported that they do not use a standard assessment tool. This would indicate that it is through specialized job-related training and experience that clinicians develop their own suicide-assessment practices.

The Sample and its Characteristics

The demographics of this study were as follows:

Table 1:   The Sample's Gender Demographics

What is your gender?		Frequency	%	Valid %	Cumulative %
Valid	Female	32	80.0	80.0	80.0
	Male	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

As the above table shows, vast majority of participants in this study are female (32 out of 40). The average age of the 40 participants was 41 at the time of the survey. The race and

ethnicity of participants was not examined, which could be considered a limitation of this study and suggesting another variable to consider in a future study on this topic.

The average length of time that participants had been in post-graduate practice at the time of the study was 12 years. Participants' average length of time working with youth was also 12 years. The average length of time that participants were at their current practice setting (at the time of study) was six years. These findings indicate that it is common for survey participants to be working with youth for many years and also to remain in the same practice setting for many years at a time.

Forty-two percent of the participants had a master's degree in social work at the time of study, which is probably because the survey was extended primarily to social workers. However, some of the other participants indicated that they have graduate degrees in counseling psychology, marriage and family therapy, clinical psychology, mental health counseling, and education.

Current Practice Setting

As Table 2 below demonstrates, the most common practice setting (37%) for participants at the time of study was community-based mental health services. The next most common practice setting was school-based practice settings. Residential mental health services and private practice settings each accounted for 12% of participants' practice settings. Lastly, crisis services accounted for 10% of the practice settings. That the findings of this study identify most of the respondents as working in community based, school based, or residential settings, it appears that the majority of respondents were carrying out their work in the community rather than in a private practice, at least at the time they participated in the survey.

Table 2: The Sample's Current Practice Setting

What is your current practice setting	Frequency
Valid Community Based	37
School Based	25
Residential Based	12
Private Practice	12
Crisis Services/ Emergency Services	10

Substantive Findings

Specialized Training in Suicide Assessment

When participants were asked if they had had specialized training in risk assessment for youth (see Table 3 below), 60% (24) of participants indicated that they had specialized training, while, 35% (14) indicated that they had not had any such training.

Table 3: The Sample's Specialized Training in Suicide Assessment

Have you had specialized training in assessing risk and suicidality in youth?	Frequency	%	Valid %	Cumulative %
Valid Yes	24	60.0	63.2	63.2
No	14	35.0	36.8	100.0
Total	38	95.0	100.0	
Missing System	2	5.0		
Total	40	100.0		

This finding again supports the literature that indicates that the majority of graduate programs do not adequately prepare clinicians to assess risk and suicidality. Feldman and Freedenthal (2006) found that graduate programs were often critiqued for failing to provide an adequate education in suicide intervention. Likewise, these findings support the conclusions of both Singer and Slovak (2011) and Miller and Eckert (2009), who found that many school social workers did not believe that their graduate education prepared them to adequately assess for

suicidality and risk. As Miller and Eckert (2009) write, "Because there is a lag in the perceived needs of SSW (school social workers), and implementations, SSWs should be proactive in gaining this knowledge through other training programs or outlets" (p. 227). The current study also found that only 5% of the sample indicated that their training for suicide assessment occurred during their graduate education.

Types of Training History

Table 4: Specific Type of Specialized Training

What type of specialized training have you had?		Frequency
Valid	Specialized Educational Trainings/ Seminars, and/or Workshops	35
	Through ER/ Crisis Services Training	12
	Graduate Education	5
	Total	38
Missing	System	2
Total		40

As Table 4 shows, the majority of specialized training that participants had was through continuing education conferences or agency-sponsored training. This would indicate that post-graduate training is essential for many professionals in order to adequately assess for risk and suicidality. As Singer and Slovak (2011) write, "The near ubiquity of the experience of school social workers working with suicidal youths suggests that training in suicide intervention and prevention should be top priority, starting in graduate school and continuing throughout a social worker's career" (p. 224). However, an alarming 35% (14 of 40 in this study) indicated that they had not had specialized training in suicide assessment. This finding is of particular interest, because in almost all states, continuing education is required to maintain professional licensure, begging the question, *In what areas are professionals seeking continuing education*? Looking at

the areas in which professionals expand their knowledge base through continuing education is another area that this study has identified for future study.

Participants were also questioned about the frequency of their suicide assessment when working with teens. As Table 5 indicates, the majority of clinicians in this sample assess their youth clients for risk of suicide on a regular basis.

Frequency of Suicide Assessment

Table 5: Frequency of Suicide Assessment

The frequency of suicide assessment in your clinical practice:		Frequency	%	Valid %	Cumulative %
Valid	I assess my teen clients at several intervals throughout treatment	15	37.5	39.5	68.4
	I assess my teen clients at every clinical interview	15	37.5	39.4	78.9
	I only assess my teen clients who are being seen for suicidal behavior ideology	2	5.0	5.3	84.2
	i do not routinely assess for suicide risk with teen clients who present for non-suicide related issues	6	15.0	15.8	100.0
	Total				
		38	95.0	100.0	
	System	2	5.0		
Missing		40	100.0		

As Table E above indicates, when questioned about their suicide assessment practice, an alarming 82% of participants indicated that they do not use a standardized assessment. This finding could be because there currently is not one specific standardized assessment tool that is

recommended for assessing youth. Likewise, none of the current assessment tools are indicated for assessment in varied practice settings. Instead, specific assessment tools are recommended for specific practice settings.

Assessment Tools

Table 6: Use of a Particular Standardized Assessment Tool

Is there a particular assessment tool that you use?		Frequency	%	Valid %	Cumulative %
Valid	yes	5	12.5	13.2	13.2
	No	33	82.5	86.8	100.0
	Total	38	95.0	100.0	
Missing	System	2	5.0		
Total		40	100.0		

As Table 6 indicates, the vast majority of participants (82%) who did not use a specific standardized assessment tool indicated that their assessment includes the identification of risk factors including the client's history, suicidal intent, plan, and means. This finding supports those of Sapytka, Goldston, Erkanli, Daniel, Heilbron, Mayfield and Treadway (2012), who found that a client's most lethal suicide attempt is more indicative of the risk of lethality of a future suicide attempt than it is of the most recent suicide attempt. In other words, a clincian should use a client's most lethal suicide attempt as an indicator of future risk rather than level of lethality related to their most recent attempt.   One particpant described his/her method of assessment as follows: "I base my interview questions on the answers given by the youth to assess intent, plan & means at each session. I always take into consideration previous attempts, family history, and rescue-rate of plans to assess current mental status."

Interestingly, only 5% of participants who utilize their own method of risk assessment take into account a client's protective factors. U.S. Department of Health and Human Services (2001) identifies the following protective factors for suicide:

> Effective clinical care for mental, physical, and substance abuse disorders, easy access to a variety of clinical interventions and support for help seeking, restricted access to highly lethal means of suicide, strong connections to family and community support, support through ongoing medical and mental health care relationships, skills in problem solving, conflict resolution, and nonviolent handling of deputes, and cultural and religious beliefs that discourage suicide and support self-preservation (p. 35).

.   One survey participant who reported inquiring about protective factors during assessment for risk and suicidality described the practice as follows," risk assessment based upon prior attempts, impulsivity, mood, mental status, means, intent, gender, age, ideation, plan, protective factors, future oriented, hopeless/helpless feelings, etc." The limitations of this study make it impossible to determine the significance of the identification of protective factors during the suicide assessment, but this does identify yet another area for future study. Of the study's participants who indicated that they do use a standardized assessment tool (see Table 7), *Beck's Youth Inventories* was identified as the most commonly used standardized assessment tool (5%). Other standardized assessment tools used by this sample include the CANS (2%), the ASEBA youth self-report (2%), the Safe Talk Method (2%), and the CBC, DCI, and SRI (2%).

Table 7: Specific Standardized Assessment Tools

		Frequency	%	Valid %	Cumulative %
Valid		32	80.0	80.0	80.0
	ASEBA Youth Self-Report Beck's Youth Inventories	1	2.5	2.5	82.5
	Becks	1	2.5	2.5	85.0
	CANS	1	2.5	2.5	87.5
	CBC, CDI and SRI-25	1	2.5	2.5	90.0
	Crisis Eval MSE	1	2.5	2.5	92.5
	n/a	1	2.5	2.5	95.0
	SafeTalk Method	1	2.5	2.5	97.5
	SI/HI learned in Psych ER. not sure if its standarized but appeares so. (more below)	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

Summary

In summary, this study found that the majority of its participants have developed their own personal suicide and risk-assessment practice based on the identification of a client's risk factors without the utilization of any particular suicide assessment tool. This study was unable to discern any relation between practice setting and suicide assessment practice. Of course, due to its small sample size, the findings of this study cannot be generated to a larger populations of clinicians who work with youth. However, the study did identify some important areas for future study, such as (1) the potential relationship between practice setting and suicide assessment practice, (2) whether the certain types of graduate education better prepare than others professionals for suicide and risk assessment, and (3) if identifying protective factors in the suicide/risk assessment influence the outcome of a suicide assessment and if so how.

CHAPTER V

Discussion

Introduction

      This chapter will examine the study's findings as they relate to the current state of affairs surrounding youth suicide. Using the current body of literature, research conducted will be compared to the findings of this study. Implications for practice based on this study's findings will be presented. Lastly, areas for future research will be identified.

Discussion and Implications for Practice

      This survey's findings indicate that about one-third of participants have had training and/or attended continuing educational conferences specifically in suicide and risk assessment, while only 5% of the participants indicated that they learned how to assess for suicide and risk during their graduate education. This finding supports the work of Feldman and Freedenthal (2006), who found that graduate programs were often critiqued for failing to provide an adequate education in suicide intervention. Likewise, these findings support the research of both Singer and Slovak (2011) and Miller and Eckert (2009), who found that that many school social workers do not believe that their graduate education prepares them to adequately assess for suicidality. Thus, the findings of this study appear to corroborate the current literature on this topic, which indicates that a great number of clinicians do not feel prepared by their graduate education to adequately assess for suicide and risk. The research also indicates, however, that there is no universal assessment practice. One must ask, therefore, how the profession can expect clinicians to be prepared to work in this area of practice without offering them the commensurate

professional tools? In the absence of a universal assessment tool, clinicians are forced to develop

their own personal practice, making the process all too highly subjective. Likewise, this study

found that at least the clinicians who participated determine the frequency of their assessment

based on their clinical experience rather than any formal guidelines from the profession. This

finding suggests that it would be helpful for clinicians to have a method to examine their suicide

and risk-assessment practices to help them to identify the risk related and protective factors for

which they are screening.   Finally, it is hoped that clinicians who work in this area can utilize

the results of this study to measure the quality of their suicide assessment practice against those

who participated in this survey.

Strengths and Limitations of the Study

The limitations of this study are the small sample size, which means that the findings of

this study cannot be generalized. The study was also limited because of the limited amount of

time in which the study could be conducted. Furthermore, because this study was offered on-line

so that participants could access it only by computer, it is possible that some clinicians who

qualified could not or chose not to participate. Additionally, this study did not ask clinicians to

identify their race or ethnicity, both of which variables could potentially influence social work

practice and thus influence suicide-assessment practice. Future large studies should take into

account practitioners' race and ethnicity along with other variables, such as culture, in order to

examine the possibility of their influence on youth suicide assessment practice.   Lastly, this

study did not correlate length of time in practice with suicide assessment approach.

The fact that the survey was designed to ensure anonymity is another strength. Another

strength of this survey is that it provided opportunity for participants to explain in their own

words their approach to practice. The survey also provided participants the chance to leave their

general thoughts and feedback regarding the subject.   Finally, this study, though small in scope, adds to the literature on this topic, around which there is still little knowledge.

Suggestions for Future Research

This study's findings clearly suggest that at least some clinicians may benefit from more research on this topic. Studies such as this one may lay the groundwork for developing a universal assessment tool to assess suicidality and risk in youth in all practice settings.

It could be useful to also compare the assessment practices of new graduates and clinicians who have been in practice for some time. Considering that the literature indicates that the majority of clinicians do not feel that their graduate education has prepared them for adequately assess for risk and suicidality, it would be useful to explore whether graduate education is trying to better preparing new practitioners to assess for suicidality and risk. Lastly, this study adds to the knowledge about the influence of practice and specialized training on assessing for risk and suicidality.

Another potential future study is an exploration of the impact of client loss on suicide assessment practices. This research design made it possible to monitor how many people initiated the survey, which indicated that twice as many people started that survey as completed it. Feedback from some clinicians indicated that at least some could not participate because they had lost a client to suicide. What has become clear is that sadly, if one works in this field long enough, the chances of losing a client to suicide greatly increase over time. It seems that the risk of losing a client to suicide is a tragic hazard of the job.

Looking at the assessment practices of the survey participants, it is easy to see how subjective the approach to suicide assessment can be across clinicians. Ultimately, a clinician can never be certain that that a client is in fact 100% safe and will not act on suicidal ideation.

As a clinician one must utilize experience, assessment, and professional intuition regarding a client's intentions. Even if social work did possess a standardized assessment tool, it is fair to assume that the tool could not be a 100% accurate predictor of suicidal risk. Thus, a good deal of the assessment is still left to the clinician's interpretation and professional judgment. It would be interesting to study the differences in approaches to suicide assessment as they may or may not correlate with professional judgment based on training. One way to study this, for example, would be to have one client present similarly to two clinicians and then compare the two clinical assessments. Such a study could look at experience, professional judgment, whether the clinician has lost a client to suicide, and if that experience in any way influences the practice.

Finally, it could be beneficial to explore how suicide assessment practices change over time. For example, what factors influence and change approach to assessment over time? Might a clinician's assessment practices change throughout the years of work in this field? If so, is or was there any specific circumstance that acted as a catalyst for that change?

Summary and Conclusion

The purpose of this study was to explore risk and suicide-assessment practices of clinicians working with youth. A quantitative research design was used with an on-line data-collection service to reach a non-probability sample of clinicians whose profile fit the inclusion criteria. The survey collected demographic data and also examined the frequency of assessment for risk and suicidality and whether clinicians utilized a specific assessment tool and if so which one. Finally, clinicians were asked to describe their suicide and risk-assessment practices. The survey had total of 40 participants. While the small sample size does not allow for generalization, it does confirm the literature, which indicates that many clinicians frequently assess for risk and suicidality in their teenaged clients but do so without

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the use of a standardized assessment tool. Hopefully, the results of this study will help clinicians to evaluate their own suicide-assessment practices in comparison to the assessment practices of others as increasing knowledge in this area is gained. The findings of this study have also identified a number of important areas for future study.

In closing, this study offers additional information about the serious public health epidemic of youth suicide. Suicide is the third leading cause of death for people aged 15 to 24, and it has been on the rise for at least the last two decades (Facts and Figures, 2012). It is imperative that society works to reduce the number of teenage suicides and that it significantly improves its suicide prevention efforts. If this study can help to save the life of just one teenager, then it has accomplished more than what could have been hoped for.

If children are the future, then society must work to ensure that they have a future. Clinicians in the helping professions must work to ensure that they offer the best suicide prevention and interventions to guard against tragic suicides of children. As clinicians, we are responsible, and hopefully, this study can help to direct society toward a better and safer future for all children through better suicide-assessment and prevention practices.

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Appendix A

Part 1: Demographic Questions

1.   What is your gender?
(Comment Box)

2.   How old are you?
(Comment Box)

3.   How long have you been in practice?
(Comment Box)

4.   How long have you been working with youth?
(Comment Box)

5.   What is the length of time you have been working at your current practice setting?
(Comment Box)

6.   What type of setting do you practice in?
(Comment Box)

7.   What was your formal graduate education?
(Comment Box)

Appendix B

Part 2: Survey Questions

1. Have you had specialized training in assessing risk and suicidality in youth?
   Yes
   No
2. If so, what specialized training have you had?
   (Comment Box)
3. Please check the following option that best describes the frequency of suicide
assessment in your clinical practice with teens:
   1.   ___I assess my teens clients for suicide risk at every clinical interview
   2.   ___ I assess my teen clients for suicide risk at several intervals throughout the
   course of treatment.
   3.   ___I assess my teen clients for suicide risk at the initial clinical interview
   4.   ___I assess my teen clients for suicidal risk at the initial clinical interview and at
the end of their course of treatment
   5.   ___I only assess for suicide risk in teen clients who are being seen for suicidal
behavior ideology
   6.   ___I do not routinely assess for suicide risk when working with my teen clients
who present for non-suicide related issu
4. Is there a particular standardized assessment tool that you use?
   Yes
   No
   1. If so what standardized assessment?
      (Comment Box)
   2. If you do not use a standardized assessment tool to assess risk and suicidality, can you
      please describe the method you do use?
      (Comment Box)
   3. Please feel free to leave to general comments and feedback
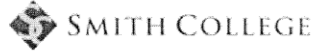   (Comment Box)

Thank You for your Participation!
Thank you for taking the time to complete this survey. Your time and participation is greatly
appreciated!
Please feel free to share this survey with others who are eligible to participate by forwarding

this link https://www.surveymonkey.com/s/7MC2KTH via email or Facebook.

Appendix C

HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

February 17, 2013

Corina Fisk

Dear Corina,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Dominique Steinberg, Research Advisor

Appendix D

Email Recruitment

Dear _____,

Will you please help me find participants to complete a survey for my thesis? I am exploring how clinicians who work with youth assess risk and suicidality. Clinicians must have been in practice for at least three years post graduation. 2) participants must have a graduate degree in a human services related field: including but not limited to: psychology, social work, mental health counseling, family and marriage counseling, or pastoral counseling, and 3) must be currently working with youth ages 13-18yrs. The survey consists of yes/no questions, and open response questions.   The survey should only take a maximum of 10 minutes of your time to complete.

Would you please forward this email to anyone who might be interested in completing my survey?

Thanks for your time and help!

Please click on the following link to complete the survey: (insert survey link)

Corina Fisk

MSW Candidate

Smith school for Social Work

cfisk@smith.edu

Appendix E

Facebook Recruitment

Hello Facebook Friends!

Are you a clinician who is currently working with youth ages 13-18 years of age? Do you

have a graduate degree in a human services related field including but not limited to;

psychology, social work, mental health counseling, family and marriage counseling, or

pastoral counseling? Have you been in practice post-grad for at least 3yrs? If so, please help

me out with my Master's Thesis by completing a brief survey that explores how practicing

clinicians assess risk and suicidality in youth. Speak up and share your practice experience!!!

The survey should take more than 10 minutes to complete. Your feedback is crucial! Thank

You for taking the time to complete the survey, we need all the help and information we can

get to properly help at-risk youth.

Access Survey at the following link:

https://www.surveymonkey.com/s/7MC2KTH

Appendix F

Screening Questions

4. Do you have a graduate degree in a human services related field: including but not limited to: psychology, social work, mental health counseling, family and marriage counseling, or pastoral counseling?
5. Are you a clinician who has been in practice for at least 3 years?
6. Do you currently work with youth ages 13-18 years of age?
7. I have never had a client of any age who has committed suicide?

Yes I Meet all of Above Criteria   No I do not meet one, or more of the
        ___   Above Criteria   ____

Appendix G

Disqualification Page

Thank You!

Thank you for your time and interest in this study. Unfortunately, your answers to one or more

of the previous questions indicate that you are not eligible to participate.

Please share this survey with others on Facebook or by forwarding the survey link

 https://www.surveymonkey.com/s/7MC2KTH via email or through Facebook

To exit, simply close the browser window.

Appendix H

Informed Consent

Dear Clinician,

I am currently a Smith School of Social Work student pursuing my Master's degree in Social Work in Northampton, MA. I am conducting a quantitative study to fulfill my thesis requirement. The results of this study will be used for my thesis, presentation, and publication. In this study, I will be looking at the phenomenon of youth suicide. The study I am proposing is to address the following research question: How do clinicians assess risk and suicidality in their clinical practice with teens? This study will be in the form of an internet survey. The first part of the survey includes seven demographic questions. The demographics will include: (gender, length of time working at the agency; etc.) The second part of the survey includes six questions addressing your suicide risk assessment practices when working with teens.

To participate in this study you must have at a graduate degree in a human services related field, must be a clinician who has been in practice for at least 3 years, and you must currently be working with youth ages 13-18 years of age

The study is voluntary, and you may choose at any time to opt out of the study. Your participations and your answers to the survey will be anonymous. The only people who will have access to the survey answers are myself, my research advisor, and the statistical analyst at Smith College. The survey should take a maximum of 10minutes to complete. You may choose to withdraw from the survey before completion of the survey at anytime by closing your browser window, or navigation away from any of the survey pages. Any incomplete data will not be saved.

The exclusionary criterion of this survey is if you have had a client of any age that had committed suicide. Due to the sensitive nature of suicide and its emotionality, I feel it best that clinicians who have lost a client to suicide not participate.

Once you agree to participate in the survey you will be brought to the first part of the survey; the Demographic Data Questions page. Once you complete the Demographic Data Questions page you will then be brought to the second part of the survey; the Survey Questions page that includes six questions addressing your suicide risk assessment practices when working with teen clients. The completion of this page concludes the survey. The only risks

for the participants of the survey are that the questions could possibly evoke strong feelings regarding the clients you have treated. Suicide, by its nature is a delicate subject that evokes emotions from most people. Because the survey is voluntary, any clinician who feels that it would cause more harm to participate, may opt out at any time by closing your browser window, or navigating away from the survey pages.

It is my belief that the benefits to participants of the survey outweigh the risks. As survey participants, it is my hope that your participation will help social workers working with youth understand how clinicians practice risk assessment, and suicide assessment in the youth that they treat. The information gathered through the survey will be shared with my colleagues. It is also my hope that participants can take personal pride knowing that they contributed to my colleagues and my knowledge of suicide risk assessment practices. The survey can also provide participants the opportunity to personally reflect on their own suicide risk assessment practices. While participation is greatly appreciated, participants shall not be compensated for their participation.

Your anonymity will be protected. The survey will be designed so that the software will not collect names, e-mail addresses, IP addresses, or any other identifying information. Your responses will be available only to me through the use of password protection. My research advisor will have access to the data after any identifying information has been removed from the write-in responses. Please do not include any identifying information about yourself. This way, your anonymity can be assured and protected. In any publications or presentations, the data will be presented as a whole, in brief illustrative quotes or vignettes. No identifying data will be presented. All data will be kept in a secure, password protected, location for a period of three years as required by Federal guidelines. After that time, if the data are no longer needed for research purposes the completed surveys will be destroyed. If the surveys are needed for research purposes they will continue to be kept secured for as long as they are needed, and when they are no longer needed they will be destroyed.

If you agree with this Informed Consent, you will be automatically directed to the first part of the survey; the Demographic Questions page

If you have any further questions regarding participation in this survey, please feel free to contact me at _____ . Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me, or the Chair of the Smith College

School for Social Work Human Subjects Review Committee at (413)585-7974. I sincerely

thank you for your time and consideration.

Sincerely,

Corina L Fisk, MSW Candidate

BY CHECKING THE BOX BELOW THAT SAYS "I AGREE," YOU ARE INDICATING
THAT YOU HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS
ABOUT
THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE
TO PARTICPATE IN THE STUDY. PLEASE PRINT A COPY OF THIS PAGE FOR YOUR
RECORDS.

_____ I DISAGREE   ___ I AGREE