Suicide Risk and Assessment: Increasing Self-Efficacy Among Students in Helping Professions

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Today’s Activities

• Our program
• Research on the student perceptions of suicide risk assessment preparedness
• Outcome data of 317 students in helping fields who have completed the WMU SPP training
WMU Suicide Prevention Program

Program Beginnings

• Established in 2006
• Original funding came from the Substance Abuse and Mental Health Services Administration (SAMHSA) under the Garret Lee Smith Memorial Act (2004)
WMU Suicide Prevention Program

**Program Mission:**
Our program aims to accomplish the following within the university community:

- Decrease stigma and increase awareness and understanding of mental health difficulties and suicide
- Educate students in health and mental health about their roles in suicide prevention
Program Presentations

In-person presentations include:

- Information to understand suicide including statistics, language, and phenomenology
- Confronting students fears, insecurities and lack of knowledge about suicide
- Suicide assessment “nuts and bolts”
- Encouragement to learn more
Research on student perceptions of suicide risk assessment preparedness

Suicidality is the most frequently encountered emergency situation in mental health settings

- 25% of psychologists experience a patient suicide at some point in their careers.
- 40% of trainees will have a patient attempt or will experience a patient suicide during training.
- Up to 50% of all suicides in a given year are by people who were in treatment.

*Rudd, Cukrowicz, & Bryan, 2008*
Research on student perceptions of suicide risk assessment preparedness

According to Quinnett (2010) competence in suicide risk assessment and management is defined as the capacity to conduct:

A one-to-one assessment/intervention interview with a suicidal respondent in a telephonic or face-to-face setting in which the distressed person is thoroughly interviewed regarding current suicidal desire/ideation, capability, intent, reasons for dying, reasons for living, and especially suicide attempt plans, past attempts and protective factors. The interview leads to a risk stratification decision, risk mitigation intervention and a collaborative risk management/safety plan, inclusive of documentation of the assessment and interventions made and/or recommended.
Pre-Doctoral Interns

Twenty-five years ago, 55% of psychology trainees received minimal training in suicide prevention and 45% of pre-internship graduate trainees received minimal training (Kleespies et al., 1993).

In a more recent study of 238 pre-doctoral interns:

- 99% of interns experienced at least one suicidal client and 11 reported experiencing the death of a client by suicide.
- 3 of the 11 who experienced a death did not receive specific formal training in managing suicidal clients.
- 3 of the 11 who experienced a death stated they received training after the suicidal behavior occurred.
- While 50% stated their program offered formal training (i.e., courses, seminars, workshops, practica), most reported that training was weaved into courses and many sought training outside their program.

When only 50% of students are receiving appropriate training, what happens to clients who are matched with the other 50%?

*Dexter-Mazza & Freeman, 2003*
School Psychologists

- From the 2015 Youth Risk Behavior Survey (YRBS) study, 17.7% of students seriously considered suicide and 8.6% attempted suicide one or more times in the prior year (out of 30 students, 5 will consider, 4 will have a plan, and 3 will attempt).
- Since the 1980’s suicide training for school psychologists has improved greatly.
  - 30-52% of directors reported that approximately 3-6 hours were devoted to addressing issues related to child/adolescent suicide.
- Program directors perspective
  - 97% of program directors indicated that their program dedicated a portion of instruction to covering risk assessment through lectures and discussion.
  - 78% said it was covered through internship or practica (although could be guaranteed) and the assessment of student competency was largely measured by site supervisors.
- Perceptions of overall student preparedness was positively correlated with number of class hours devoted to the topic.
- Overall, directors perceived their students to be somewhat or mostly prepared to assume professional responsibilities associated with suicide risk assessment, prevention, intervention, and post-vention. However, at individual item level they said their students are not prepared to facilitate hospitalization, help student reintegrate after hospital (which is the most crucial period), and conducting school-wide screenings.

* CDC, 2017; Liebling-Boccio & Jennings, 2012
MSW and MFT

Less than 25% of social workers reported receiving training in suicide prevention (Feldman & Freedenthal, 2006). For MFT students, suicide-specific courses were present at less than 6% of accredited MFT programs and in 2% of CE programs.

Unfortunately, most licensing boards do not require CE credits in this area and there are not questions on the licensing exams.
Training and Confidence

- Research has shown the importance of counselors knowing how to address suicide with clients.
- The question becomes when do we train students?
  - There is not a consensus on when counseling programs should provide suicide-response training.
- Confidence and suicide-response training are significantly correlated.
  - Those with no prior training reported less confidence than those who had training in the classroom, than those who had experience from outside the classroom, and from those who had both.
  - No differences between those receiving training in their program vs. receiving outside experience. However, those who had both had significantly greater levels of confidence than those who only received it in the program. But not from those receiving it from outside the program.
- Providing students with at least one lesson on suicide response intervention before practicum is one way to ensure that students enter practicum feeling more confident and less anxious.

*Binkley, & Leibert, 2015; Paulson & Worth, 2002*
# WMU SPP Data

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Frequency (N)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>272</td>
<td>79.8%</td>
</tr>
<tr>
<td>Male</td>
<td>62</td>
<td>18.2%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1.5%</td>
</tr>
<tr>
<td>Did not answer</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
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<tr>
<td>White</td>
<td>263</td>
<td>77.1%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>42</td>
<td>12.3%</td>
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<tr>
<td>Asian</td>
<td>12</td>
<td>3.5%</td>
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<tr>
<td>Multi-racial</td>
<td>10</td>
<td>2.9%</td>
</tr>
<tr>
<td>Did not answer</td>
<td>9</td>
<td>2.6%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

*N = 341*
<table>
<thead>
<tr>
<th>How likely are you to pursue further training in suicide awareness, prevention, and/or assessment?</th>
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</thead>
<tbody>
<tr>
<td>Not at all likely</td>
</tr>
<tr>
<td>Somewhat likely</td>
</tr>
<tr>
<td>Most Likely</td>
</tr>
<tr>
<td>Did not answer</td>
</tr>
<tr>
<td>$N = 339$</td>
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</tbody>
</table>

<table>
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<tr>
<th>How much is suicide prevention relevant to your non-professional roles?</th>
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</thead>
<tbody>
<tr>
<td>not at all relevant</td>
</tr>
<tr>
<td>moderately relevant</td>
</tr>
<tr>
<td>very relevant</td>
</tr>
<tr>
<td>$N = 90$</td>
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</tbody>
</table>

<table>
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<tr>
<th>How much is suicide prevention relevant to your professional role?</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all relevant</td>
</tr>
<tr>
<td>moderately relevant</td>
</tr>
<tr>
<td>very relevant</td>
</tr>
<tr>
<td>$N = 94$</td>
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Before and After Assessment

There was a significant difference in scores in *how to recognize suicidal behavior before* (M=2.51, SD=.63) and *after* (M=3.31, SD=.32) the workshop: t(334)= -21.44, p < .05.

There was a significant difference in scores in *how to respond to suicidal individuals before* (M=2.17, SD=.82) and *after* (M=3.18, SD=.45) the workshop: t(335)= -24.28, p < .05.
WMU SPP Data – Qualitative Responses

Most important thing I learned?
– 101 responses (students from MSW field placements, Counseling Technique courses, and Counseling Practicum courses)
– 5 themes emerged:

<table>
<thead>
<tr>
<th>1. Questions</th>
<th>2. Assessment</th>
<th>3. Intervention/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ask</td>
<td>• Risk</td>
<td>• What</td>
</tr>
<tr>
<td>• Best way</td>
<td>• Warning signs</td>
<td>• How</td>
</tr>
<tr>
<td>• Being direct</td>
<td>• Reasons for suicide</td>
<td>• Safety planning</td>
</tr>
<tr>
<td>• Don’t be scared</td>
<td></td>
<td>• When</td>
</tr>
<tr>
<td>• Language</td>
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4. Resources

5. Statistics
What would make the workshop more useful?

– 85 responses (students from MSW field placements, Counseling Technique courses, and Counseling Practicum courses)
– Four themes emerged:

1. **Resources**
   - Handouts
   - Local/community resources

2. **Examples**
   - Cases
   - Personal stories

3. **Time**
   - More of it

4. **Activity**
   - Role play
   - Safety planning
   - Modeling
Questions and Discussion
References


