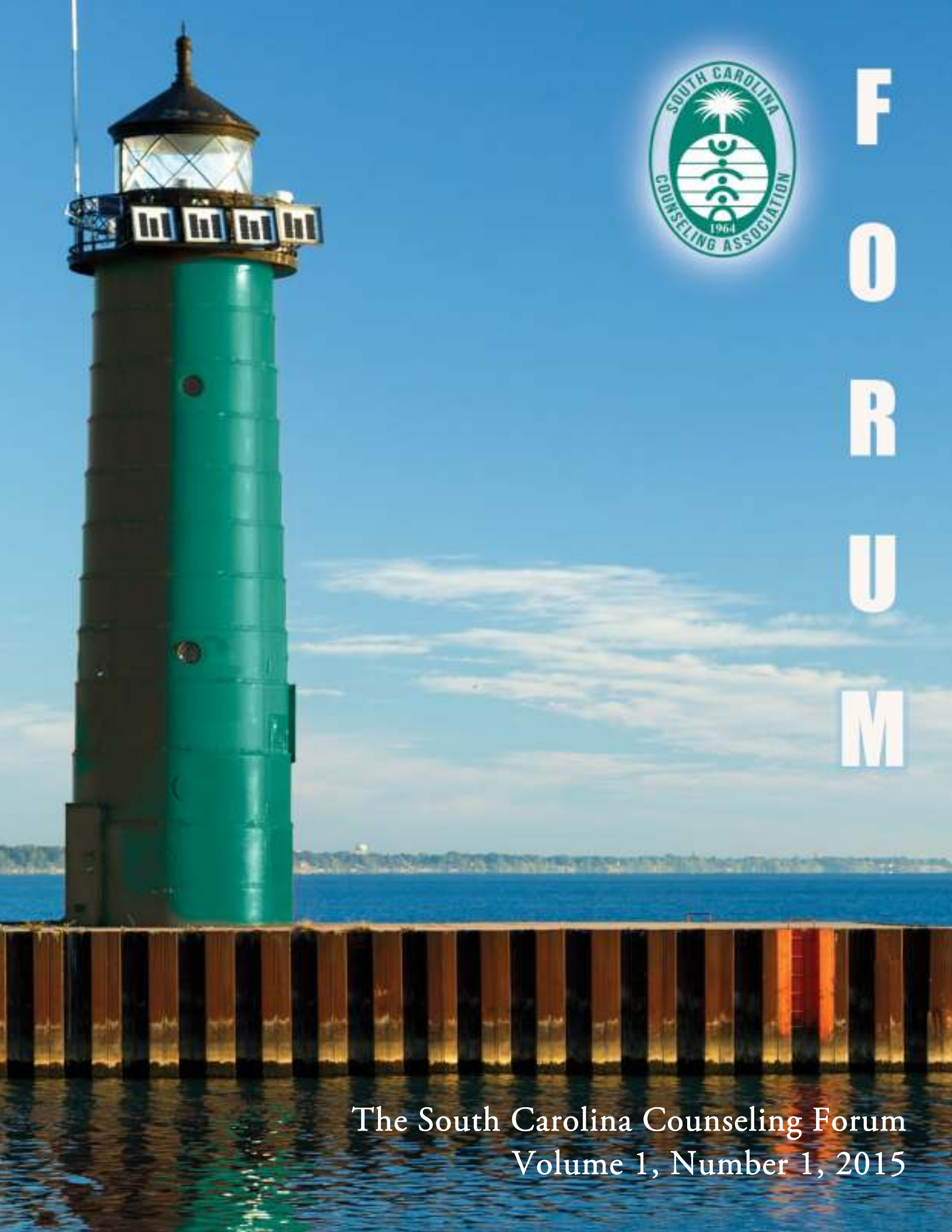

FORUM

The South Carolina Counseling Forum
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The *South Carolina Counseling Forum* is the official peer-reviewed publication the South Carolina Counseling Association (SCCA), a branch of the American Counseling Association (ACA). Information on making submissions to the South Carolina Counseling Forum can be found on the SCCA website under publications. Manuscript submissions should be sent to the editors electronically.

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Note from the Editors

Welcome to the launch of the *South Carolina Counseling Forum (Forum)*, a peer-reviewed publication of the South Carolina Counseling Association (SCCA). In preparation for the development of the journal, we were fortunate to take a look back in the history of SCCA (formerly known as the South Carolina Personnel and Guidance Association) through the lens of the association journal in 1982. Under the editorship of Walt Bailey and Johnnie McFadden, the journal, *South Carolina Personnel and Guidance Journal (SCPGA)* featured a Message from the President, Beatrice Thompson (President 1980-1981) who wrote:

> The 1982 edition of the *South Carolina Personnel and Guidance Journal* marks the fourth publication of a scholarly and professional periodical and provides a medium through which counselors can communicate their concerns and share their thoughts, ideas, research and expertise relative to the helping professions. Under the highly competent editorship of Walt Bailey and Johnnie McFadden the *Journal* has achieved a high degree of professionalism and maintained its reputation as a quality publication of which we are justifiably proud.
>
> The fourth edition comes at a time when our nation is experiencing the traumatic effects of economic, political, and social change. Numerous problems of grave concern to our nation's welfare challenge us to develop new, innovative and workable solutions to problems which we face. Such problems include the economic crisis, escalating inflation, energy concerns, the criminal justice system, needs of the elderly and poor, environmental protection, the defense of our country, human rights, unemployment and the future of public education. These problems cannot help but generate great concern and increase anxieties among those affected. To a great extent, everyone is affected.
>
> As members of the helping professions, we must be attuned to these issues and prepare ourselves, both collective and individually, to address the needs which impact upon our society and influence our behavior. It is evident that new directions are imminent, different modes of operation are emerging and changing philosophies are being formulated. As a result, goals and objectives for our society are being reassessed and redefined, significantly changing some of our attitudes and affecting future directions of our nation.
>
> All of these issues are related to changes which are transpiring in our society. Greater longevity among the elderly, changing employment patterns, and changing educational trends are examples of directions which will affect social change in our society. What does this social change imply as it relates to the daily concerns with which counselors must contend? We can realistically expect these transitions to impact upon our profession and influence our thinking and operational methods as we seek to define and develop better and more effective ways of serving our clients.

> The SCPGA *Journal* is an excellent means through which we may air our concerns, address relevant problems and share solutions, thereby contributing in a personal and professional way to the direction of our country. I encourage you to fully utilize this excellent medium of expression. We can help each other by sharing our helping skills and knowledge. At the same time, we will be perpetuating the continued professionalism of our organization. (Thompson, 1982, p. 2)

The era, in which Dr. Thompson penned her opening notes of the SCPGJ, seemed oddly familiar to current transitions that impact our profession, influence our thinking, and affect contemporary counseling practice. As an association, we have faced divisive membership concerns between mental health and school counselors that challenges the essence of identity as a professional counselor regardless of specialization or work setting. Still, we have achieved growth and renewed dedication of a membership that embraces and builds on the legacy of leaders from the past and moves forward to promote a new voice that advances knowledge, research, professional development, and practice. Against the backdrop of change and transition we envision the *Forum* as a scholarly voice that promotes and expands a broad panoramic view of professional counseling relevant to the interests of counselors who practice across various work places, specialty areas, and realms of our profession within South Carolina and beyond its geographical boundaries.

Appointed as co-editors of the *South Carolina Counseling Forum*, in February 2012, the goals of the journal were established to further the field of counseling by providing a publication for innovative research and professional scholarship. In addition, the *Forum* will solicit manuscripts that present counseling interventions, innovation, and critical thinking not supported by data; yet disseminates interventions and student educational experiences that have merit and are observed to be effective and consequential. The *Forum* is divided into three categories, each endeavoring to advance our commitment to continued growth and inquiry, research interests, and scholarship aspirations. The Counseling Research section will include literature reviews and quantitative and qualitative studies related to the training and development of professional counselors and to the professional practice in counseling as delivered in various roles and settings to various populations. The Counseling Practice and Perspectives section will focus on conceptual manuscripts developed for the presentation and discussion of cutting edge practice whether related to theory, interventions, ethical practice or other emergent topics in the counseling profession. The third section, Students Voices, will provide a forum that showcases the developing research, projects, professional and clinical growth and other traditions related to the journey of counselor education. In addition, this section provides a discourse for faculty and student collaboration that demonstrates mentorship in professional identity, skills, and practice.

Finally, words of thanks are appropriate as we embark on this new professional endeavor. We appreciate a dedicated group of individuals who volunteer their time to serve on the editorial board during the developmental period of the *Forum*. Their commitments to carefully review numerous

manuscripts and to prepare reviews that are helpful to authors warrant our deep gratitude. The editorial process is far from a simple operation and we look forward to working with an editorial board that is willing to contribute to this constructive and critical role in the success of the journal. You have created value in the pages of the *Forum*.

In this Issue

The role of advocacy for school counselors is an essential practice component. In the Counseling Research Section, the study conducted by Nava and Both Gragg seeks to understand how school counselor's perceived training and practice discrepancies inform the school counseling role for special education populations. Their findings highlight three primary themes that show preparatory needs in school counselor education and professional strength of practicing school counselors.

Highlighted in Counseling Practice and Perspectives, contemporary issues related to counseling clients with suicidal ideation are identified as inevitable, challenging, and complex. Bartlett and Forbes address the vital importance of proactive preparation, professional practice guidelines, documentation, ethical, and risk considerations that are imperative to improved counseling practice. With emphasis on informed legal and ethical parameters, the authors highlight the importance of assessment, risk formulation, and documentation styles that support acceptable standards of care as counselors respond to challenging clinical emergencies.

The training of future counselors often includes service learning projects as means to link academic content with experiential learning in community settings. In the Student Voices section, the authors present an Alaska Native celebration of successful ageing described through a counseling student's comparative reflection on the experience to theorists' views of aging. Powell and Renes reflect on the enriching power of living examples encountered through a service-learning project; bridging academic learning related to adult development theories.

References

Thompson, B. (1982). Message from the president. *The South Carolina Personnel and Guidance Journal, 4*, p. 2.

School Counselors' Perception of Preparedness in Advocating for Special Education Students

Yuridia Nava and Janee Both Gragg

Abstract

This mixed methodological study explored school counselors' perception of preparedness in advocating for the unique needs of special education students within three urban school districts in southern California. Responses from 27 participants highlighted three primary themes related to whether school counselors felt prepared to advocate for the unique needs of special education students including: (1) academic knowledge; (2) professional development; and (3) resiliency. Implications for counselors and counselor educators included advocacy, training, and re-envisioned school counseling service models.

Introduction

According to the California Department of Education's *Data and Statistics*, the enrollment of students from 2000 to 2014 increased by 285,060 and has demonstrated a consistent growth every year (CDE, 2015). In the special education population there has also been an increase of 54,560 students from December 2000 to December 2013. As the public school student population increases and the complexity of student's needs continue to increase, school counselors are faced with a variety of challenges. There continues to be an increase in the number of students who qualify for special education services in programs around the country. A significant portion of these students fall within the at-risk classification and belong to various minority groups. According to Moore (2006), at-risk students are those; from a low socioeconomic status, experience low academic achievement, belong to minority subgroups, and deemed potential dropouts of high risk minority status. Given that school counselors are charged with advocating for *all students* (Trusty & Brown, 2005), it becomes especially vital that they not only attain the necessary skill set to promote academic, personal, social and career success for students with disabilities (Marshak, Dandeneau, Prezant, & L'Amoreaux, 2010) but also perceive themselves as prepared to advocate for students with special needs. The purpose of this study was to explore if practicing School counselors across two southern California school districts felt that they were adequately prepared to advocate for special education students.

Social Justice and Advocacy Counseling

In recent years there have been increased efforts through the counseling literature to embolden school counselors to practice from a social justice and advocacy perspective (Bemak & Chung, 2005; Ratts, DeKruyf, & Chen-Hayes, 2007; Stone & Dahir, 2006). The ideas and concepts embedded in social justice and advocacy counseling, themselves, are not new; however, there is a growing movement in the field toward this perspective. Counselors working from this lens are charged with assessing the unique needs of their students within the larger social, political and cultural context (Bradley & Lewis, 2000). Counselors then move beyond their work with the individual to simultaneously consider their role in creating larger systemic change.

Advocacy is a crucial part of a school counselors expected job duties. Advocacy allows counselors to give a voice to underrepresented students. For the purpose of this study, advocacy was defined as "the act of pleading, negotiating, recommending, and supporting of specific strategies, skills, curriculum, and/or goals in favor of students in the areas of academics, personal, psychological, social, and emotional growth and development (Center on Alliance for Justice, 2015)."

The American school Counselor Association's (ASCA) National Model states that it is the responsibility of the school Counselor to advocate for *all students* including those in special education (Bowers & Hatch, 2005). According to research from Geltner & Leibforth (2008) counselors are often confused about their role and unsure of the process when attempting to engage in Individualized Education Plan (IEP) meetings and in supporting its implementation. Given the steady rise in the number of students entering special education, school counselors must adapt their skills in order to close the achievement gap for students with special needs (Calhoun, 2000).

Educational Justice and Advocacy

An important consideration for school counselors in their advocacy efforts is that of educational equity. This has been defined as access to educational experiences that contribute to the student's learning (Nieto, 1996). Educational equity and access related to the high number of minority students being referred for special education services has been of specific concern (De Valenzuela, Copeland, Huaqing Qi & Park, 2006). For example, in looking at the enrollment data and special education enrollment data from the California Department of Education, *Data and Statistics* (2015) African Americans account for 6.2% of the student population. However they account for 16.9% of students with disabilities. Conversely, Hispanic students make up 53.3% of the student population, and 11.5% of the special education population. The fact that the African American population represents a higher number of special education students, even though they are a small percentage of the total California student enrollment, is a cause for concern. This

disproportionate number represents structural issues at the heart of our educational system that directly influences decision making and practice in the field of education and therefore must be addressed through academic research and policy development (Blanchett, 2006). Supporting such efforts is one way that school counselors can advocate for students in special education programs (Cox & Courtland, 2007) to address issues of educational equity including the achievement gap.

Advocacy for Special Education Students

Special education students often require additional services to support social, emotional, and psychological deficits in order to meet basic academic standards and requirements. Interestingly, Ysseldyke, Lehr, and Bulygo (2008) found that No Child Left Behind (NCLB) was inadequate at addressing the multidimensional needs of special education students, focusing instead on the academic performance of students exclusively. Because special education students' disabilities can range from mild, to severe (70-90 IQ range), their emotional, social, and behavioral development can also be affected (Hagborg, 1991). Specifically, their personal adjustment is characterized by weak self-control, attention deficits, low self-esteem, and poor interpersonal skills (Hagborg, 1991). These areas of psychosocial functioning, if left unattended, can adversely affect a student's academic performance and educational trajectory (McNeely, Nonnemaker & Blum, 2002, 2005; Shochet, Dadds Ham & Montague, 2006).

A frequently used tool within special education programs is the IEP. Individual Education Plans are developed for students who, through educational testing, are identified as having a specific learning disability. In their role as advocate, school counselors can serve as a *counterbalance* during IEP meetings fostering positive communication among stakeholders and helping to identify contextual influences outside of the academic environment that in turn can serve to assist special education students in their efforts to succeed academically (Geltner & Leibforth, 2008). However, because school counselors are not able to interpret special education tests due to a lack of formal training (Weston, Koller & Dunham, 2002) they too often find themselves underutilized during IEP meetings and the implementation process. Weston and his colleagues (2002) found that new counselors perceive these tests as both "challenging" and "frustrating," which if not read correctly can become an obstacle to student academic success as opposed to an effective assessment tool. Unfortunately, this gap in knowledge serves to severely hinder the ability of school counselors to adequately advocate for the specialized needs of students. This could be due to a number reasons such as insufficient training in credential programs, lack of employer based professional development, and large caseloads with scarce amounts of time for professional collaboration.

Similarly, the Behavior Support Plan (BSP) is another tool used in assisting students with disabilities. Shaw and Madaus (2008) found that, counselors only participated 19% of the time when a BSP/504 plan was being written. Nevertheless, special education student's IEP and [behavior

support plan] goals are set more realistically, and positively influence the classroom environment when school counselors are involved in the consultation process (Milsom, Goodnough, & Akos, (2007). These findings suggest that school counselors may lack the fundamental knowledge related to the purpose and process of both IEPs, and BSPs, and therefore may also lack the ability to effectively advocate for all students.

The professional plea to conceptualize and meet student needs from the lens of a social justice and advocacy perspective coupled with the continued increase of special education students (Calhoun, 2000), supposes that it would be advantageous to assess whether or not school counselors feel adequately prepared to advocate for all students including those with special needs. As a starting point, the goal of this study was to assess school counselors' perception of preparedness in advocating for special education students. Specifically, researchers wanted to know if counselors felt prepared in certain areas of special education, including: the Individual Education Plan (IEP); Behavior Support Plan (BSP); consultation; and advocacy.

This research is unique in that the study highlights current counselor needs, perceptions, and feelings related to meeting the requirements of the special education population amongst presently employed and practicing school counselors. Without addressing these training and practice discrepancies, the social and educational injustices of inadequately meeting the needs of the special education student population will be perpetuated.

Method

The purpose of this study was to learn about school counselor's perceptions of preparation to advocate for special education students. Specifically we were interested in exploring their perceived preparation to utilize and engage in the Individual Education Plan and Behavior Support Plan, as well as the role professional development played in their current perceptions of preparedness. We were also interested in determining if perceptions of preparedness differed across gender.

Participants

A total of 84 school counselors were invited to participate in the study. Of those, twenty-seven California counselors responded to the survey (12 males, 15 females, and two declined to respond) within three large southern California school districts. Ages ranged from 26-50 (M=47.83 and SD=7.89).

Materials

The instrument used was a three page electronic questionnaire formulated by the first author based on current literature and resulting knowledge about the responsibility school counselors have been charged with to advocate for all students including those with special needs.

Questionnaire. Counselors were asked to read a brief explanation of the study which included contact information, IRB approval, purpose of the study, and informed consent. By continuing with the survey, respondents acknowledged that they had been informed of the purpose of the study and were consenting to participate.

The survey contained a section on demographics including age, gender, race/ethnicity, education attained and two open ended questions (see below).

Qualitative Questions
1) Please tell us your thoughts and experiences in advocating for special education students?
2) Please tell us your thoughts/feedback regarding this survey?

Additionally, a five point Likert scale covering four areas of special education advocacy, derived from an extensive literature review, were included in the questionnaire totaling 26 items. The four areas assessed included: 1) Special Education Concepts (eight items); 2) Terminology, asking participants to indicate if specific special education terms had been covered within their graduate programs (five items); 3) Individual Education Plans, which included questions pertaining specifically to IEP's and BSPs (six items); and 4) Special Education Processes (seven questions).

Procedure. Letters of consent were mailed out to all the school districts in one southern California County, once IRB approval was obtained. Each participating district signed a letter of consent, indicating that their district's counselors were allowed to participate in the survey. School counselors were given information regarding consent in the first section of the survey which included the IRB approval number. By continuing with the study they were consenting to voluntarily participate. A list of school counselor emails (84) was gathered directly from school website contact information pages. All emails were then inputted into SurveyMonkey for delivery. School counselor participants were sent a link with a randomly assigned IP address to ensure no identifying information would be retained. After completion of the survey, participants were thanked and given the contact information to receive optional detailed information regarding the findings of the study.

The two open ended questions in the study were analyzed using qualitative procedures as outlined by Foss and Waters (2003). Each answer was read and coded to determine categories of responses. Categories were later grouped together establishing themes representative of participant's responses. Descriptive statistics and a spearman's rank order correlation were run for the quantitative

component of the research following the guidelines of Gravetter & Wallnua (2012) in *Statistics for the Behavioral Sciences Quantitative Methods*.

Results

Quantitative Findings

Fifty percent of respondents reported that special education concepts were rarely or never covered in their graduation program. Results show 62% of respondents stated that they never or rarely reviewed special education standards. Just over half (53%) of respondents indicated that social challenges experienced by special education students were covered explicitly in their school counseling graduate program. However, only 45% of respondents stated that their graduate program covered information about the mental health challenges frequently associated with the special education population. Surprisingly, 62% of respondents indicated that special education curriculum was not covered in their graduate school counseling program, while 52% of respondents indicated that counseling techniques for special education students were never or rarely covered in their graduate program. See Table 1.

Questions designed to explore counselor's perceived preparedness to act as a special education advocate revealed that 62% of school counselors left their graduate programs knowing how to read an IEP. Additionally, just under half (46%) of respondents agreed that their graduate program never and/or rarely covered special education counseling techniques and that their graduate program never and/or rarely covered special education resources (53.9%). See Table 2.

The five point Likert scale revealed a number of areas where school counselors felt their knowledge about special education was inadequate. Data revealed the following areas as professional deficiencies related to working with students in special education: 1) how to write a behavior support plan (M=4.41, SD=.59); 2) how to write a 504 (M=4.36, SD=.64); 3) enrolling student based on disability (M=4.10, SD=.90); 4) determining for wrong class placement (M=4.03, SD=.97); 5) coordinating special education testing (M=3.86, SD=1.14); 6) knowledge of special education curriculum (M=3.83, SD=2.03); 7) interpreting the IEP (M=3.72, SD=1.28); 8) determining for further special education testing (M=3.72, SD=1.28); 9) reading the IEP (M=3.62, SD=1.38); and 10) knowledge of education code pertaining to special education (M=3.57, SD=1.43). See Table 3.

Researchers were interested to see if there were differences in perceptions of preparedness to advocate for special education students across gender. Although not statistically significant, both male and female counselors held similar perceptions about their preparedness to advocate for special education students. Specifically, both males and females identified nearly the same areas as being the greatest need for additional training. A Spearmen rank order correlation coefficient was used to compare the rank ordering of the 27 questions and the responses male versus female school

counselors. A value was calculated to be r=.8873 and the r^2=.7867 between the men and the women's rank ordering of the questions (See Table 4).

Lastly, participants felt that they had not learned enough about working with the special education population while in school. Opportunities for school counselors to learn on the job about the unique needs of special education students or to stay up-to-date on the current information and trends, was scarce as just over fifty percent (51%) of the respondents indicated that concepts such as special education counseling techniques, special education resources (59%) and interpreting/reading the IEP (62%) were never or rarely covered through graduate programs or through on the job training. Specifically, data indicated that the highest means of the 5 point Likert scale were for the following items: 1)counselors indicating how to initiate special education testing; 2) enrolling students based on disability; 3) determining for wrong placement; and 4) determining for further testing, which are procedures that can be learned on the job. However, given that the majority of counselors indicated that this training was never or rarely available, it is likely that such learning opportunities were not in fact accessible.

Qualitative Findings

Responses from participants highlighted three primary themes related to whether school counselors felt prepared to advocate for the needs of special education students. These themes included: (1) academic knowledge; (2) professional development; and (3) resiliency.

What emerged as a professional strength was the resiliency with which counselors managed their professional roles. Yet, the perception of preparedness to advocate for the needs of special education students among participants appeared to parallel research indicating that school counselors may be ill-prepared to engage fully in the advocacy efforts of students with special needs.

Academic Knowledge. Numerous participants in this study expressed that their graduate level training to enter the school counseling profession did not fully prepare them to work with and advocate for the special education population. One respondent stated, "*I feel like my grad program did not focus on [special education] at all. I feel like I could better assist my [special education] students if I had more knowledge."* This statement reflects the sense that lack of academic training was perceived as a barrier to school counselors being able to do their best work with special education students.

Participants reported that in their role as school counselors, they are often asked to contribute in IEP meetings as administrative designees. Furthermore, participants reported feeling, "uncomfortable" acting in this capacity given that their knowledge of special education needs and services were limited. One participant wrote, "… As a counselor I feel I do not have sufficient training or knowledge to adequately place my students in their classes." In this way, school counselors described their sense of being inadequately prepared, in some instances, to meet basic job requirements given their lack of knowledge about working with special education students.

Professional Development. Results from this study indicated that ongoing professional development and trainings on special education trends and techniques would be beneficial for school counselors. Although only three school districts participated, these districts were the largest in representation for southern California which according the US Census is the third most populous area in the state of California. Thus, this research offers a snapshot of the current perceptions school counselors in southern California are experiencing in regards to advocating for special education students. Respondents in this study described a lack of educational opportunities within their professional work environment, broadening the gap in their knowledge base. One participant stated, "*…more emphasis is needed for this topic as the needs are greater even though the population is smaller."* This statement highlights the perception that there may be a high level of unmet need among special education students and that raising awareness of special education issues may help. In addition, professional development opportunities focused on the unique needs of this population may serve to enhance the effectiveness of school counselors to act as advocates for the special education student population.

Given that the field of special education is growing and evolving rapidly, it is important for school counselors to have access to information and training that will keep their practice current and effective. While discussing the rapid pace with which the field is changing another participant stated, *"…districts should provide occasional "updates" on special education issues."* Likewise, several respondents indicated the importance of school based "updates" and "trainings" to facilitate staying abreast of the developments in working effectively with special education students. Unfortunately, with a gap in graduate level special education knowledge and limited post graduate professional training opportunities school counselors in this study were found in many instances to be simply "doing the best they could".

Resiliency. Interestingly, despite a general sense among participants that they felt ill-prepared to advocate for their special education students, respondents managed to find ways to navigate through their deficiencies. In some instances this meant they had to depend on others within the school environment to provide direction or interpretation of special education materials. For instance, one participant stated, *"…I rely on the district to interpret the IEP and determine the correct placement."* Unfortunately, these and similar dynamics may be placing school counselors at a clear disadvantage in their role as advocate while other stakeholders become key players in determining the best interest of the student. Another participant, responding to their own educational and training deficits explained, "*I have had to do my own research."* school counselors in this study consistently recognized their professional short comings and demonstrated resiliency in adapting to their work environment and professional roles. This process appears to have occurred as participants sought out academic knowledge about working with special education students. Another aspect of self-empowerment by the school counselors in this study included actively seeking

information about organizational based policies and procedures related to working with special education populations.

Discussion

School counselors are expected to advocate for the needs of all students, including those in special education. The need for counselor training in special education has been prominent in the literature since the 2000's (Roach, et al) signifying that for many years there has likely been very little change in the way graduate programs and school districts educate school counselors in the area of special education. Myers (2005) identified that this lack of training places current school counselors out of compliance with the American Association of school counselors, National Model, and the California Association of School counselors Standards for School counselors, which are set forth to ensure equality and advocacy for *all students* (ASCA, 2004; CASC, 2011).

Many school counselors today are involved in the special education students' Individual Education Plan. There has been a shift in having school counselors' act as the administrative designee during an IEP meeting. This can pose a great risk for the untrained school counselor. Of the 27 school counselor samples gathered, 96% of counselors reported their graduate programs rarely or never covered the counselor's role in the IEP meeting, how to read an IEP, interpret an IEP, or the IEP process. By lacking knowledge of Educational Code and terminology, school counselors are not able to interpret special education tests or reports. Thus, school counselors are not properly representing students at IEP meetings. This can pose a great disservice to the overall -purpose of the IEP, which is to come together as a team and provide multi-systemic support for the student's academic success.

In addition, because the IEP is a legal living document, any misinterpreted data which can lead to misplacement of services, can cause legal and ethical implications to the school counselor if major decisions are being made during the IEP meeting that have a direct impact on a student's academic/social/emotional development (ASCA/CASC Legal/Ethical Framework, 2012). Currently, the research conducted by Myers (2005) indicates that advocacy should be practiced amongst all students including those in special education. As of July 2008, California statute (2006) requires all teacher credential candidates to pass an assessment. This assessment is designed to measure the candidate's ability to appropriately instruct all P-12 students [including students with disabilities] in the Student Academic Content Standards. Other states can gain insight on the current state of counselor perceptions in special education in order to provide a proactive approach to the training and preparation of school counselors through graduate programs and employment. Counselors however, are not required to demonstrate such competencies. As a consequence, if school counselors do not need to show competency of special education topics upon completing a graduate program or

as part of their evaluation process once hired, this creates a gap in the bridge between special education students and the counselor's ability to successfully advocate for all.

Implications

A common theme in the literature is that school counselors are not meeting the needs of special education children through the Individual Education Plan or IEP (Weston et al, 2002). Since there has been a rise in special education students of minority descent, it can be challenging for educators to maintain empathy when faced with the social, emotional, and academic challenges of this population (Calhoun, 2000). Thus, school counselors should take an active role in participating in the IEP process seeking out information about both its interpretation and implementation without relying on stakeholders who may have other priorities to consider over the specific needs of the student. As many counselors know, the social and emotional needs of their students can easily be overlooked. The involvement of school counselors in the development of the IEP can provide a voice for the student and ultimately help to secure the needed accommodations. This study holds implications related to school counselors acting as special education advocates, innovations in school counselor academic training programs and re-envisioned district service delivery models.

School Counselors as Special Education Advocates

Often times it is primarily the school counselor that has an intimate knowledge of the unique obstacles or crisis affecting a student's academic performance given the role of the counselor and nature of the relationship. Much of this information should be taken into account when building social, emotional, academic, career, college, and/or vocational goals within an IEP. School counselors should not be hesitant to approach school administrators expressing their interest in meeting the needs of and advocating for the special education population on campus. Requests should be made of school administrators to provide on-site and district level trainings reflecting the most recent trends in the field of special education. In addition, school counselors can build collaborative relationships with education specialists and experts on campus to ensure success in their role as advocate.

Innovations in School Counselor Training Programs

In this same vein, school counselors in training must be encouraged to act as self-advocates on their higher education campuses by talking with administrators, sharing their concerns and asking for additional information, professional development opportunities, and academic training. Counselor educators cannot only prepare students to act as special education advocates on P-12

campuses but empower school counseling students to advocate for special education students at larger state and national levels.

In addition, counselor educators should consider how they can embed diverse curriculum into their programs and courses to decrease deficiencies in special education knowledge while increasing counselor preparedness to work effectively and equitably with special education students. School counseling, mental health counseling and education specialist program coordinators and chairs can begin to explore how each of their programs respectively represents important aspects of a single special education student's needs and experiences within the school setting. Sharing key aspects of curriculum across programs is likely to strengthen the academic training of school counselors by filling gaps in knowledge while ensuring adequate preparation and training to work with and advocate for the special education population.

Re-envisioned District Service Delivery Models

Finally, this study highlights the historic pattern of compartmentalizing the needs special education students, in P-12 settings. While there are certainly exceptions to this rule, schools in general, have not wanted to take responsibility for the whole child opting instead to focus solely on academic performance (Weist & Paternite, 2006). Yet, choosing a holistic, ecologically grounded approach to working with special education students would encourage multiple stakeholders to come together in new and innovative ways; decompartmentalizing the needs of special education learners. In fact, it may be that current trends in social emotional learning, found to maximize school performance (Elias, 2004), is a direction districts should consider exploring. Such an approach would allow for the supporting and empowering of administrators, teachers, education specialists, school counselors, campus mental health professionals, and community and family members in effectively meeting the needs of the special education population.

Conclusions

Given the literature on the importance of training school counselors to work with the special education population, it seems valuable to better understand the perceptions of school counselors regarding their perception of preparedness to work with and advocate for special education students. It is critical to bring to light that school counselors may feel ill-prepared to meet the needs of the special education population on their campuses in order promote increased research, training, and professional development. Regan (2009) found that when counselors are adequately prepared, either through their counseling program or additional professional development training, their attitudes and perceptions [regarding special education student's] change in positive ways.

Better understanding school counselor's perception of preparedness can guide counselor educators in providing enhanced special education training. Both P-12 organizations and academic institutions should consider how they can offer or update professional development trainings in the area of special education. Since special education is complex and rapidly evolving field requiring great knowledge of social, emotional, and academic strategies, it is important for school counselors to know legal and ethical policies in special education. Therefore, one suggestion to improve advocacy is to include graduate level training seminars on special education trends. University programs could also consider integrating special education topics into required coursework. With each school district having its unique policies regarding each counselor's role, districts should consider providing on the job training to counselors, in the area of special education. This type of specialized training would ensure that counselors are provided with the tools needed to competently perform their specific job duties while being kept up to date with special education trends.

Furthermore, collaboration between school counselors, teachers, and administrators, is another valuable approach to ensuring that school counselors do everything needed to advocate for all students. Collaborating with other stakeholders creates a safety net for new and seasoned counselors by way of being able to share frustrations, ideas, concerns, and other ideal program implementation resources. It allows the sharing of responsibility that is required when advocating for a subgroup at risk of marginalization. One that only represents a small population of schools but whose needs far exceeds those of mainstream education students.

Limitations

One of the limitations of the study is that the literature on school counselor's roles in advocating for the special education population is limited. New and seasoned counselors would benefit from more recent literature on this subject. Another limitation is that this study did not explore what graduate program participants attended. Although no identifying information was asked in order to keep the survey completely anonymous, districts, and institutions would appreciate this type of information for those institutions looking to provide a well-rounded curriculum. In addition, the sample size of this study was quite small as we set out to preliminarily explore counselors' perception of preparedness to advocate for special education students.

Future Studies

A similar study across multiple districts and ideally multiple states could strengthen our understanding of our strengths and weaknesses in preparing school counselors as special education advocates. Future studies should explore the perceptions of school counselor trainees regarding their training and preparation to work with and advocate for special education students.

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Table 1.

Special Education Concepts

	1	2	3	4	5	Mean
Special Education Codes	0.0% 0	14.3% 4	35.7% 10	28.6% 8	21.4% 6	3.57
Special Education State Standards	6.9% 2	20.7% 6	10.3% 3	41.4% 12	20.7% 6	3.48
Social Challenges	16.7% 5	36.7% 11	26.7% 8	13.3% 4	6.7% 2	2.57
Emotional Challenges	20.0% 6	33.3% 10	30.0% 9	10.0% 3	6.7% 2	2.50
Mental Health Challenges	13.8% 4	31.0% 9	31.0% 9	17.2% 5	6.9% 2	2.72
Special Education Curriculum	6.9% 2	6.9% 2	24.1% 7	20.7% 6	41.4% 12	3.83
Special Education Counseling Techniques	10.3% 3	13.8% 4	24.1% 7	24.1% 7	27.6% 8	3.45
Special Education Counseling Resources	10.3% 3	20.7% 6	10.3% 3	41.4% 12	17.2% 5	3.00

**Rating Scale

1= Always 2= Most of the Time 3= Sometimes 4= Rarely 5=Never

**Means are out of 5 point Likert scale.

Table 2

Knowledge of IEP, IEP Process, and BSP

	1	2	3	4	5	Mean
IEP Process	17.2% 5	10.3% 3	24.1% 7	20.7% 6	27.6% 8	3.31
Counselor role in IEP meeting	13.8% 4	13.8% 4	24.1% 7	17.2% 5	31.0% 9	3.38
Read an IEP	17.2% 5	3.5% 1	17.2% 5	24.1% 7	37.9% 11	3.62
Interpret an IEP	10.3% 3	10.3% 3	13.8% 4	27.6% 8	37.9% 11	3.72
How to write a Behavior Support Plan	0.0% 0	3.5% 1	13.8% 4	20.7% 6	62.1% 18	4.41

**Rating Scale

1= Always 2= Most of the Time 3= Sometimes 4= Rarely 5=Never

**Means are out of 5 point Likert scale.

Table 3

Special Education Procedures

	1	2	3	4	5	Mean
Initiating Special Education Testing	6.9% 2	13.8% 4	31.0% 9	24.1% 7	24.1% 7	3.45
Coordinating Special Education Testing	0.0% 0	10.3% 3	31.0% 9	20.7% 6	37.9% 11	3.86
Enrolling student based on disability	0.0% 0	10.3% 3	17.2% 5	24.1% 7	48.3% 14	4.10
Reading Special Education Tests	17.2% 5	3.5% 1	34.5% 10	24.1% 7	20.7% 6	3.28
Interpreting Special Education Tests	10.7% 3	10.7% 3	32.1% 9	25.0% 7	21.4% 6	3.36
Determining for further Special Education Testing	6.9% 2	13.8% 4	10.3% 3	37.9% 11	31.0% 9	3.72
Determining for wrong class placement	3.55% 1	6.9% 2	13.8% 4	34.8% 10	41.4% 12	4.03

**Rating Scale

1= Always 2= Most of the Time 3= Sometimes 4= Rarely 5=Never

**Means are out of 5 point Likert scale.

Table 4

Male and Female Mean Rank Ordering

	Mean		
Categories	Female	Male	μDiff
Coordinating special education testing	3.67	4.17	.5
Determining for wrong class placement	4.00	4.17	.17
Determining for further special education placement	4.00	3.83	.17
Enrolling student based on disability	4.13	4.17	.03
How to write a 504	4.33	4.50	.17
How to write a behavior support plan	4.60	4.25	.35
Interpret the I.E.P.	3.67	3.83	.67
Knowledge of Special Ed Curriculum	3.87	3.92	.05

Note: Means based on five (5.0) point Likert Scale

Legal and Ethical Considerations When Treating Suicidal Clients

Mary L. Bartlett and Laura L. Forbes

Abstract

In the United States, it is estimated that one million people attempt suicide annually. Mental health professionals cannot avoid encountering suicidal clients, yet this client base is most feared. Serving suicidal clients requires condition-specific training and periodic skill re-evaluation. Comprehensive assessments, risk formulation, and documentation contribute to effective case management. Attention to details may reduce litigation related to negligence and malpractice should a client die by suicide. Legal and ethical considerations are imperative to the assessment and care process. The authors will discuss legal and ethical best practices to effectively assess and document steps to treat suicidality in clinical settings.

Introduction

In the United States, suicide rates decline between 1980 and 2000; however between 2000 and 2011 annual rates have gradually increased. The highest annual suicide rates for the past decade were reported in 2011 (12.7 per 100,000). Annually, one million adults (0.5% of the adult population) will attempt suicide; and it is estimated that one in every twenty-five attempts will result in death. Alarmingly, suicide is the second leading cause of death for youth aged 15 to 24, and the 10th leading cause of death for all Americans. The most current data from 2011 indicates that suicide completions claimed more than 39,500, which equates to 108.3 suicide completions per day, or one every 13.3 minutes (American Association of Suicidology [AAS], 2014; Centers for Disease Control and Prevention [CDC], 2012a, 2012b).

Suicide has gained attention as an emerging public health issue; therefore, identifying and evaluating contributing factors is critical (CDC, 2012b; United States Department of Health and Human Services, 2010). Mental health services have received a decrease in federal funding from 2009 to 2011 in light of the economic downturn (National Alliance on Mental Illness [NAMI], 2011). In other words, the intersection of suicide prevention as a public health issue within the mental health profession has increased attention; but has been met with less financial momentum. The purpose of this article is to specifically inform mental health counselors about legal and ethical issues present when assessing and intervening with suicidal clients.

Legal and Ethical Considerations

Provider Fear Related to Suicide

Fear of litigation is a common reaction to a client suicide attempt or death (Roberts, Monferrari, & Yeager, 2008). A legitimate concern given that, "malpractice related to suicide is the sixth most frequent claim brought against psychologists and is the second most costly" (Bongar, Maris, Berman, & Litman, 1998; Jobes & Berman, 1993, p.92), the frequency of claims and escalating costs for suicide related malpractice is increasing throughout behavioral health care specialties including counselors (Bongar, 2002; Granello & Granello, 2007). According to the Suicide Prevention Resource Center (SPRC) and the AAS (2008), providers often mismanage their emotions, in particular fear and anger, when working with suicidal clients. When this happens, it can affect how the provider assesses and manages the treatment of suicidal clients, thus leading to the possibility of justified litigation.

Mental health providers often lack sufficient education on legal aspects of the assessment, management, and malpractice and associated with patient suicides. Over the course of a mental health career, approximately 25% of mental health counselors will experience a client who dies by suicide. Unfortunately, one in four of these counselors are in training at the time of a client suicide. This leaves both the provider and the clinical supervisor open to dealing with the loss of a client on a personal level, as well as potential litigation (Foster & McAdams, 1999; Granello & Granello, 2007; Weiner, 2005; Foster, Hard, Talbott-Forbes, & Bartlett, 2014). Given that outpatient counselors are undertrained in the area of suicidology, the legal burden has expanded in scope to include all health care professionals (Schmitz et al., 2012, Farrow, Simpson, & Warren, 2002; Jobes & Berman, 1993; Range et al., 2002; McAdams & Foster, 2000; Neimeyer, 2000; Neimeyer & Pfeiffer, 1994).

Further, it is not uncommon for loved ones to file malpractice claims against mental health providers following suicide completion (Berman & Cohen-Sandler, 1983; Jobes & Berman, 1993; Foster & McAdams, 1999; Peterson, Luma, & Dunne, 2002). These claims often stem from a range of emotions including anger and guilt which are experienced by loved ones.

Previously, hospitals were the primary targets for such lawsuits which is no longer the case. However, over the course of the last decade a shift has been noted in which it is now, not uncommon for family members to blame the counselor for the loss of their loved one by suicide. Family members may project feelings of anger and frustration onto the providers who they believe were supposed to have prevented a tragedy of this nature (Bongar, 2002; Kleespies et al, 1998; Ruben, 1990). Society is litigious, and as a result bereaved survivors often seek compensation for perceived negligence of the mental health provider.

Suicide Litigation. Suicide litigation has resulted in many of the largest financial settlements awarded to plaintiffs. The act of suicide is deemed preventable by law, and as a result malpractice suits brought against practitioners are pervasive. Malpractice suits are often grounded on the basis of failure to warn of imminent risk or reasonable care standards (Roberts, Monferrari, & Yeager, 2008). Table 1 provides a listing of definitions to guide counselors in understanding legal parameters they will be held accountable for when working with suicidal clients.

As noted in Table 1, courts evaluate claims of malpractice based on terms such as foreseeability and standards of care when deciding if negligence has occurred. Emphasis on comprehensive documentation is the cornerstone of a counselor's defense in court; therefore, retaining client records is advised for treatment, administrative, licensure, or ethical proceedings. Statute of limitations for retention of records differs by state, agency, and insurance company. Retention of clinical notes should be maintained according to the statute of limitations in case a malpractice claim arises (Simon, 2004). When legal and ethical standards are implemented, counselors, clients, and families are best protected.

Legal and ethical implications encompass a wide array of professional considerations which a counselor needs to include in their practice prior to working with suicidal clients. Counselors are wise to ensure they have an understanding of: (a) suicide prevention, intervention, and postvention; (b) both their own professional and/or employer-based malpractice policies, benefits and coverage; (c) when to consult an attorney if a suicide attempt or completion occurs; (d) how to maintain comprehensive clinical documentation; and (e) when and how to avoid public statements related to client suicide (Simon, 2004). For counselors to work with suicidal clients without clear knowledge of these implications, it leaves them open to litigation. Further, it is not a question of "if" a counselor will work with a suicidal client, but rather "when". While counselors may consult and communicate with other professional or managed care case workers when treating a suicidal client, it is important to emphasize that the ultimate legal responsibility for the welfare of the client rests with the counselor (Granello & Granello, 2007).

Risk Management. When treating suicidal clients, counselors must develop and execute a plan that meets the specific needs of the client. Common risk management intervention errors include not completing an adequate assessment, poor treatment planning, inappropriate management of care, and failure to document (Simon, 2004; SPRC, 2008). This practice evidences that foreseeability and standards of care were considered.

Standards of care are constantly changing and differ between states. Since there is not one agreed upon response when a suicidal client presents, potential risks and benefits exist for each clinical decision made. Historically, mental health providers including psychiatrists, psychologists, social workers, counselors, and marriage and family therapists, referred highly suicidal clients for hospitalization often resulting in a two to three week stay, reassessment of psychotropic medications, and the reduction of severe suicidal behaviors through cognitive-behavioral interventions and patient

education. Further, it was common for *No-Suicide Contracts* to be used in the treatment process (Bartlett, 2006). Presently, managed care organizations have dictated many changes in the care process of suicidal clients by determining the course of treatment based on severity of self-harm, specifying admission to inpatient vs. outpatient facilities, and reducing the length of stay and course of treatment a person receives if hospitalized. Many changes are not clinically practical but rather relate to cost savings for insurers (Simon, 2004). Further the use of *No-Suicide Contracts* is now a questionable standard (Bartlett, 2006; Bartlett, Carney & Talbott, 2009; Rudd, 2006) as the contracts have little empirical validity in the actual prevention of suicide among clients.

Providers should note that conflicts exist between professional organizations (e.g. American Psychiatric Association, American Psychological Association, National Association of Social Workers, and the American Counseling Association); a discussion that is beyond the scope of this paper. Therefore, it is recommended that mental health providers consult national and state ethical guidelines, and employer policies related to treatment protocols for suicidal clients.

As a result of changing trends and standards, periodic re-evaluation of clinical methods is essential, especially given the litigious nature of society. The best defense against liability tort should a client die by suicide is for the counselor to have followed acceptable standards of care to guide interventions, and carefully documented all clinical actions. According to Coombs, et al. (1992) "Given increasing *malpractice litigation* for wrongful death following a suicide, it is striking that clinicians often fail to ask about, thoroughly assess, and document a patient's suicide risk" (p.289). Further, the ACA (2014) states:

> The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and *foreseeable* harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception...(p.7).

Agencies that govern the counseling profession and other behavioral health specialties give minimal direction about how practitioners should assess and treat suicidal clients. This paucity leaves much to be interpreted, increasing the susceptibility of counselors to *negligence* and possible *malpractice*. The following practice guidelines are complimentary when used in conjunction with each other.

Assessment. Not every client is suicidal, but there is both a legal and ethical responsibility for counselors to determine if a threat exists with both new and continuing clients. The comprehensive assessments of clients to determine potential for suicide begins when a counselor meets the client and ideally works collaboratively to determine and rule out emergency risk by conducting multiple assessments. If a client is in an emergen48cy situation such as a suicidal crisis, as opposed to a life crisis such as unemployment, a more immediate course of action is taken to get the client to a place of safety.

Therefore, it is suggested that the assessment process include frequent evaluations early and often to identify warning signs, frequency of suicidal ideation, risk and protective factors, potential lethality of client behavior, and making inferences about imminent risk. Additionally, counselors should request records from collateral sources to compile a client profile and consult with experienced practitioners so the mental health counselor is not making decisions in isolation (SPRC, 2008). An explanation of these steps in the suicide risk assessment process including examples are provided in Table 2.

Formulating Risk. Since there is no universal standard of care, risk formulation is a clinical judgment requiring counselor training and experience. It is incumbent on the counselor to obtain appropriate training. Determination of suicide risk as low, medium, or high is imperative to making appropriate clinical decisions. Once collateral information and evidence is obtained and considered, it must be prioritized. For example, if collateral information indicates a client has attempted suicide multiple times, this client would be considered high risk. The client's current *suicide intent* and lethality significantly determines the counselor's perception of risk and action steps (Jobes, 2007). Other considerations are the client's psychopathology, coping skills and available resources, and willingness to comply with counselor directives.

Documentation. Counselors should document their rationale for determining risk level and preventive actions taken. A counselor needs to justify and articulate his or her decisions via detailed client notations (Jobes, 2007) in a timely manner. Assessment and treatment methods are extremely important should a postvention lawsuit arise. Counselors unable to demonstrate how and when assessment information was obtained and utilized may invite a charge of negligence. The formulation of risk is not possible to prove in court if the appropriate level of documentation does not exist; the request for documentation in court is to be expected, and inadequate documentation of clinical procedures utilized and actions taken leaves the practitioner susceptible to adverse litigation (Bongar et al., 1998; Jobes, 2007; Simon, 2004).

A landmark case that demonstrated the need for adequate documentation was *Meier v. Ross General Hospital* (1968). In this case the plaintiff (Meier), sued the admitting hospital and shift nurse on duty for negligence to provide reasonable and attentive care, including failure to keep accurate records. Undetected by staff, Meier left the hospital she was admitted to in a delusional state and had sex with a person whom she believed to be "Jesus." The court ruled in favor of the defendants, citing the action did not meet the definition of medical malpractice or negligence, in that while clinical documentation was not the strongest the hospital staff could have maintained, they did not intentionally place the plaintiff in danger.

In the case of *Abille v. United States* (1980), the plaintiff admitted himself into the hospital for depressive neurosis and hypertension as a result of medication. He was given a "S1" status (e.g. highly restrictive status allowing movement with staff supervision). After four days, he was allowed to shave and go to mass unsupervised which met the classification for a "S2" status (e.g. given to

patients thought not to be at suicidal risk). The plaintiff was found dead shortly after receiving a razor for shaving privileges. The court ruled in favor of the plaintiff. The psychiatrist had changed (lowered) the classification of risk, but failed to accurately note the change by modifying the medical order. The shift nurse followed his verbal change of the risk level although it was undocumented. The court determined that the nurse acted beneath the standard of care because she followed the verbal order without confirming that the risk level was assessed and documented by the psychiatrist. The psychiatrist's decision was determined to be within the standard of care; however his failure to adequately describe, report, and explicitly document the rationale for risk-level change constituted negligence.

Clinical documentation demonstrates the actual work of the mental health professional. If a suicide assessment and formulation of risk process is not comprehensively documented, courts may postulate that preventative actions were not established (Granello & Granello, 2007; Remley, 2010; Simon, 2004). "In malpractice litigation, or administrative, or ethics proceedings, an adequately documented, legible patient record is the clinician's 'best friend'" (Simon, 2004, p. 212). Some counselors believe less documentation when treating suicidal clients is more protective when in fact the exact opposite is true.

There are multiple methods for denoting suicide risk and preventative actions should litigation arise. A widely used risk-benefit model is that of VandeCreek, Knapp, and Hertzog (1987) who suggest documenting: (a) a description of a comprehensive assessment of risk; (b) information obtained alerting the counselor to the risk; (c) indication of which high and low risk factors are present; (d) what questions were asked of the client and responses given; (e) how the clinical information directed the actions of the counselor; and (f) why other actions were rejected.

Another proposed suicide documentation model by Simon (2004) suggests that risk level be noted and reclassification of safety evaluated. This model suggests that practitioners assess and document suicide risk factors as low, moderate, or high, and document any noticeable protective factors and assess them as low, moderate or high. Once risk and protective factors are rated on a continuum, Simon also suggests that practitioners document the overall suicide risk level as low, moderate, or high to determine if the treatment and management *interventions* informed by the assessment are accurate. This process will enable the counselor to adapt treatment modalities to the specific needs of the client, and continue evaluate any change in risk-level as they continue to evolve.

There are multiple documentation styles that likely meet the burden of proof and evidence that appropriate standards of care are demonstrated. Mental health counselors are responsible to select a documentation format that is setting-appropriate. The style of documentation incorporated is often dependent on licensing requirements, mental health governing bodies, and professional organizations.

No-Suicide Contracts. A form of documentation that mental health counselors have used in the past is a No-Suicide Contract. These documents have been incorporated into medical,

nursing, psychiatric, primary care, and mental health communities (Bartlett, Carney, & Talbott, 2009; Kelly & Knudson, 2000; Weiss, 2001). Before a counselor uses any intervention with a suicidal client it is wise to evaluate its validity for practice. No-Suicide Contract are not empirically driven and should be utilized with caution if at all (Bartlett, Carney, & Talbott, 2009; Davidson, Wagner, & Range, 1995; Kelly & Knudson, 2000; Maltsberger, 1991; Stanford, Goetz, & Bloom, 1994; Weiss, 2001). For a list of alternate treatment modalities that are empirically endorsed and suggested throughout literature as best practice, see Table 3.

While some literature suggests using a No-Suicide Contract may have therapeutic advantages (Davidson, Wagner, Range, 1995; Davis, Williams, & Hays, 2002; Mothersole, 1996, 1997), legal and ethical ramifications should be considered when incorporating a No-Suicide Contract with an at-risk client (Bartlett, 2006; Bartlett, Carney, & Talbott, 2009; Bongar, 1991, 2002; Lee & Bartlett, 2005). There is consensus that a No-Suicide Contract is not a legal document and does not protect against *litigation* (Miller, 1999; Miller et al., 1998; Range et al., 2002; Reid, 1998; Simon, 2004; Weiss, 2001).

Discussion

Encountering suicidal clients is inevitable for mental health counselors and is reported as the most challenging clinical emergency (Ewalt, 1967; Knapp & VandeCreek, 1983; Shein, 1976). The importance of documentation, risk formulation, and assessment are areas that mental health providers can be protective and guard against incompetence generated by lack of preparation when encountering suicidal clients. The professional has the duty to be cognizant of professional practice guidelines when dealing with and treating suicidal clients. Given that mental health professionals across the board are undertrained in working with suicidal clients, this is an area ripe for advocacy. Inadequate training, and the lack of a universal standard of care, creates treatment ambiguity and perpetuates suicide-related malpractice litigation (Granello & Granello, 2007; Reid, 2004).

By familiarizing themselves with nomenclature relevant to legal and ethical terminology, evidence-based assessment protocols, professional consultation, and adequate training, providers improve their understanding of suicidal clients and legal complications (Hard, Talbott-Forbes, & Bartlett, 2013). In expanding their capacity to evaluate risk, counselors can better assess foreseeability of suicide. Integrating a broader scope of empirically-based techniques will improve intervention skills and work to prevent suicide. Lawsuits are prevalent with suicidal clients and counselors are remiss if they are not familiar with legal and ethical guidelines. In proactive preparation, counselors strengthen their confidence, improve their clinical practice, and best protect the client.

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Table 1
Legal and Ethical Definitions

Foreseeability: The reasonable and comprehensive assessment of risk. It is not predictability or preventability.

Intervention/Treatment: Actions designed to change the thoughts, behavior, mood, environment, or biology of individuals and help them satisfy their needs without self-destructive behaviors.

Lethality: Potential for death associated with the means used to attempt suicide.

Litigation: To dispute, quarrel or conduct an act of carrying out a lawsuit. Legal proceedings brought against a mental health provider for negligence or malpractice.

Malpractice: A tort committed as a result of negligence by physicians or other health care professionals that leads to injury to a patient in their care.

Negligence: Something which he or she should not have done or omitting to do something which he or she should have done. Deviations from the standard of care are referred to as negligence.

No-Suicide Contract: A therapeutic agreement negotiated between the client and counselor for the client to agree not to act on any thoughts or impulses which might harm or cause the death of the client, usually identifying a specified time and contingencies in case the client becomes unable to keep the agreement.

Postvention: Actions taken after a suicide has occurred to help family, friends, coworkers, or others cope with the loss.

Prevention: Actions designed to stop suicide attempts or completions by focusing on at-risk individuals, environmental safeguards, or availability of means.

Standard of Care: The reliable and appropriate implementation of interventions or precautions which a reasonably prudent person or professional should exercise in same or similar circumstances, based on foreseeability.

Statute of Limitation: The period within which legal action may be taken.

Suicide Intent: An individual's desire to die and expectation that death would result from the action.

(AAS, 2008; Bartlett, 2008; Black, 1979; Bongar et al., 1998; Jobes & Berman, 1993; Simon, 1998; SPRC, 2008)

Table 2

Steps in the Suicide Risk Assessment Process

Infuse Risk Assessments Early on to Identify Warning Signs

Example: Risk assessment begins when a mental health provider first meets a client and continues at regular intervals throughout work together. It is recommended to inquire about suicide ideation, medication compliance, and access to means at every meeting, as well as to engage in a meaningful discussion about presenting thoughts of self-harm, purposelessness, hopelessness, grief, and depression which can be precursors to suicidal thinking.

Empirically based assessments are recommended at regular intervals and may include measures such as the Adult Suicide Ideation Questionnaire, Beck Scale for Suicide Ideation, Positive and Negative Suicide Ideation Inventory, Adolescent Suicide Interview, Child Suicide Potential Scales, Suicide Ideation Scale, etc. To review a list of potential instruments see www.neurotransmitter.net/suicidescales.html

Elicit Risk and Protective Factors to Intervene

Example: Risk Factors include, but are not limited to, mental and physical illness, substance abuse, relationship and financial instability, childhood trauma, family history of suicide, previous suicide attempts, perceptions of suicide, poor support system, suicide rehearsal, access to weapons, parasuicide and self-harm behaviors, recent life changes, confusion about sexual orientation, disconnect from peers, and access to care.

Protective Factors include, but are not limited to, family cohesion, extended supports, pets, access to care, problem solving and coping skills, community connection, limited access to means/firearms, optimistic outlook, resilient character, and spirituality.

For additional information on risk and protective factors see website for the AAS at www.suicidology.org or other national suicide prevention websites.

Elicit Information about Imminent Risk, Ideation, and Behavior to Determine Lethality

Example: Determining risk level is a clinical subjective decision based on completed risk assessments, secondary data sources (e.g. case notes, assessment of previous treatment, discussions with previous providers, etc.), and evaluating presenting, recent, past, and immediate symptoms. Combined, this information guides a mental health practitioner in determining whether a client is a no, low, moderate, severe, or extreme risk. The risk (or lethality) level guides the practitioner in terms of treatment interventions and appropriate treatment setting.

Obtain Records from Collateral Sources to Complete the Client Profile

Example: Be sure to include a variety of measures such as verbal reports from client, collaborative information from identified family and friends, information from additional treatment providers (e.g. past therapist(s), psychiatrist, primary care physician, etc.), past testing and assessments, prior hospitalization and discharge reports, and age appropriate pen and paper assessments.

Consult with Experienced Practitioners so Treatment Decisions are not Made in Isolation

Example: Discuss suspicions and concerns about client suicidality with experienced mental health providers in treatment facility, as well as other treatment team members, clinical supervisors, psychiatric nurses providing care, and appropriate professional organizations to discuss clinical and ethical concerns when proceeding with cases.

(Sources: AAS, 2008; Lee & Bartlett, 2007; Shea, 2002; SPRC, 2008)

Table 3

Treatment Interventions for Use with Suicidal Clients

- Medication
- Discuss Contributing Stress Factors
- Improvement in Lifestyle Health
- Increase Number of Appointments
- Openly Discuss Suicidal Thoughts
- Improvement in Problem-Solving Skills
- Increase in Social Activities
- Improvement in Self-Control Planning Skills
- Identification of Alternate Responses to Suicide
- Participation in Faith-Based Activities
- Hospitalization
- Establishing 24-hour Availability of Counselor
- Assessment of Living Environment Safety
- Collaboratively Revise Treatment Plan
- Increase Counseling Session Length
- Frequent Evaluation of Suicide Risk
- Contact Family Members
- Create a List of Emergency Contacts
- Participation in Group Counseling
- Establish a Check-in System
- Use of Formal Survey(s)

(Bartlett, 2006; Chiles & Strosahl, 1995; Ewalt, 1967; Joiner, Walker, Rudd, & Jobes, 1999; Kleespies, Deleppo, Gallagher, & Niles, 1999; Lee & Bartlett, 2005; Mahrer & Bongar, 1993).

Yukegtaaq "Person of the Year" Celebration: A View of Successful Ageing

Powell and Renes

Abstract

This article describes successful ageing from an Alaska Native perspective, comparing it to traditional views of aging as defined by Erikson (1997), James and Zarrett (2006) and others. The Yukegtaaq "Person of the Year" Celebration serves as the stage for this discussion. The first author assisted in this celebration as part of a service-learning project for the graduate program in Community Counseling at the University of Alaska Fairbanks. The Tundra Women's Coalition in Bethel, Alaska sponsors the annual Yukegtaaq Celebration, which honors a community member of the Yukon-Kuskokwim Delta who exemplifies the successful ageing qualities of self-respect, equality, family, community, peace, the right to self-determination, and the worth of every person.

Yukegtaaq "Person of the Year" Celebration: A View of Successful Ageing

The Tundra Women's Coalition (TWC) in Bethel, Alaska sponsors the annual Yukegtaaq Celebration, which honors a community member of the Yukon-Kuskokwim Delta who exemplifies the qualities of self-respect, equality, family, community, peace, the right to self-determination, and the worth of every person. The 2012 recipient was Winifred Beans, a 94-year-old elder from Asaacarsaq (Mountain Village), Alaska and Negeqliq (St. Mary's), Alaska. Ms. Beans has seven surviving children, 14 grandchildren, 16 great-grandchildren, and 4 great-great-grandchildren (see *Appendix* for full biography). The event was truly a celebration of family, with five generations together to honor the matriarch. The Yukegtaaq Person of the Year event is more than just honoring the life of an elder: it brings together community members from different cultures and backgrounds to celebrate a shared humanity. The celebrations supports the belief that it is not a matter of the specific choices, lifestyles, or paths one takes, but rather accepting these steps without regret and feeling that life has been worthwhile when it leads to integrity.

Ms. Beans was honored, in part, for successful aging, as defined by the Yup'ik people of Alaska. The Yup'ik people are Eskimo people of western and southwestern Alaska extending from southern Norton Sound south along the coast of the Bering Sea and the Yukon-Kuskokwim Delta (including Nelson and Nunivak Islands), along the northern coast of Bristol Bay, and east as far as Nushagak Bay and the Alaska Peninsula at Naknek River and Egegik Bay. The word Yup'ik comes

from the Yup'ik word *yuk* meaning person plus *pik* meaning real or genuine; thus, Yup'ik means real people (Fienup-Riordan, 2001).

Lewis (2010), an Alaska Native researcher, interviewed individuals from six Alaska Native tribal groups (Aleut, Athabascan, Inupiaq, Tlingit, Sugpiaq, and Yup'ik) and found successful aging defined as "taking responsibility for one's own health and wellbeing, being active in the community, and passing down knowledge and wisdom" (p. 393). Abstinence from drugs and alcohol was considered integral to this process. Those interviewed for Lewis' study described aging as a holistic process involving "physical, emotional, cognitive, and spiritual" health (p. 386). Elder status is not automatically gained through age: it is achieved through the way one lives. Those interviewed emphasized the importance of self-respect, respect for others, and an active lifestyle as key components of healthy aging.

Both the Alaska Native concepts of successful aging and Erikson's (1982) concept of integrity fit with the qualities of the Yukegtaaq Person of the Year: self-respect, equality, family, community, peace, the right to self-determination, and the worth of every person. This makes these celebrations potentially a cross-cultural experience for those who did not grow up learning the Yup'ik traditions of successful aging. Combining the Yup'ik worldview with the Western worldview has the potential to both recognize commonalities and expand an understanding of the world for all who attend.

Integrated Learning

According to Erikson (1997), older adults are typically in the final stage of development, which involves the conflict of integrity versus despair. James and Zarrett (2006) define integrity as "assigning order and meaning to the whole of one's life" (p. 62). According to Santor and Zuroff (1994), there are several components of integrity: the ability to adapt to the positive and negative aspects of life, spirituality, acceptance of the past and of others, a sense of peace about death, integrated emotions, and an overall contentment with one's life. Achievement of integrity was found to be associated with emotional closeness to adult children, self-acceptance, healthy relationships, psychological wellbeing, and the willingness to accept help, while it is negatively correlated with depression (James & Zarrett, 2006). Older adults may come to terms with death by recognizing that their legacy will live on through future generations (Kail & Cavanaugh, 2013). To arrive at integrity rather than despair, adults undergo a life review in which they reflect on their life experiences and the major events that have shaped who they are. Yukegtaaq "Person of the Year" Celebration honors an individual who has successfully resolved developmental conflicts. The public celebration shares the individual's accomplishments as an example of healthy adult development to the community. Concepts of aging and development from Alaska Natives provide yet another perspective of successful aging. Erikson's theory was based on a population of middle class, educated people and

the work of James and Zarrett (2006) and Santor and Zuroff (1994) was conducted exclusively using a sample of women of European descent.

Learning from the Community

Celebrating the life of an elder like Ms. Beans who has truly shared her many assets with her community and family throughout her life, also serves as an example to the guests and greater community for how to develop into healthy adults and elders. Helping the community to celebrate the qualities demonstrated by the Yukegtaaq brings those qualities into greater awareness. This event encourages all attendees to strive to develop such assets as commitment to oneself, dedication to one's community, love of family, and respect for others. Ms. Beans serves as a role model to the children and teenagers as well as the adults who live in this region of Alaska.

Those hoping to develop assets in cross-cultural collaboration learn from working together with adults from backgrounds similar to and different from their own (Laszloffy & Habekost, 2010). For those helping professionals who came from the outside of the state to work in an Alaska Native area, it is essential to get involved in the community and learn about the culture in order to be effective in their work (Reimer, 1999). On a professional level, one goal of a service-learning project is to develop cultural competency. A second goal is to help students grow as individuals, especially developing an ability to interact comfortably with several different groups of people, finding similarities but also appreciating differences. Events such as the Yutaqunnt offer professionals an opportunity to grow both personally and professionally through this cross-cultural experience.

Collaborative Development and Management

The 2012 program marked the 11th annual Yukegtaaq Celebration. A committee came together months in advance to brainstorm all the tasks that needed to be done. The planning process involved several components. Nomination forms for the Yukegtaaq- Person of the Year were distributed throughout the Yukon-Kuskokwim Delta: some were faxed to the neighboring villages, and they were available at the Alaska Commercial Company store in Bethel and distributed to many workplaces. To draw in community members to attend the celebration, the event included a three-course sit-down meal and a silent auction, ticket sales, planning the meal, and getting donations for the silent auction were other major planning tasks. In order to fund the event (the food, venue, decorations, and travel costs for Ms. Beans and her family members), sponsorships were needed from the local businesses. A program was also created that included a brief biography of Ms. Beans' life and accomplishments, pictures of Ms. Beans and her family (see *Appendix*), and acknowledgement of the sponsors.

In gathering sponsorships from local businesses, some potential sponsors dismissed the idea of contributing immediately. However, substantial conversations occurred between a TWC volunteer and three rather prominent professionals in the community. All of these professionals were European American men, and out of this process emerged another important aspect of the project: facilitating an opportunity for professionals in positions of power to support the Yup'ik culture and contribute to the community. The collaborative effort and legwork shared by so many people led to a very special celebration for Ms. Beans, her family, and the community.

Engagement and a Sense of Community Responsibility

Social and political systems greatly influence the environments in which individuals develop, and thus play a significant role in development at all ages. According to Bronfenbrenner's ecological systems theory (as cited in Kail & Cavanaugh, 2013), development can only be understood in the context of one's environment, from the immediate interactions with the family extending out to the dominant cultural values and beliefs, social structure, and social policies. While individuals usually do not interact directly with the power structures governing the outer levels of the environment, these forces nonetheless profoundly influence their lives.

From a social and political perspective, honoring and celebrating the Yup'ik culture and giving its members a voice is extremely important. Erikson considered integrating one's identity to be a critical developmental task, the completion of which he believed was necessary before advancing to other stages of development (intimacy, generativity, and integrity in adulthood) (as cited in Kail & Cavanaugh, 2013). On the local and regional levels, many adults in Bethel and around the state have suffered cultural oppression by European American outsiders (Feinup-Reardon, 2005). While current research suggests that identity continues to develop into adulthood and co-develops alongside Erikson's other stages (Whitborne, Sneed, & Sayer, 2009), it is clear that having one's way of life oppressed and a different culture imposed would confuse one's identity development and lead to problems and suffering.

While the blatant disregard and oppression of Alaska Native cultures appears to have lessened, the consequences of such disruption can still be seen and felt (Fienup-Riordan, 2005). In Bethel, it seems that a majority of professionals are European American and come from outside of Alaska to work. Clearly, the potential still exists to continue the oppression of Alaska Native cultures through professionals' imposition of worldviews from the dominant culture. For example, definitions of health and wellbeing, concepts of appropriate family structure, and ideas of individual or group responsibility may differ between Western and Yup'ik worldviews. Because European-Americans tend to hold professional positions of power in Bethel, Western worldviews may be imposed; this often occurs outside of one's awareness by very well intentioned individuals (Sue, 2010).

Honoring the voice of each person encountered, trying to see the world as they see it, and regarding their worldviews with a genuine interest promotes understanding and respect and communicates value and acceptance (Frey, 2013). Within the social and political dynamics of Bethel, when coming from outside of Alaska to provide services, understanding and respect will be further advanced by:

- acknowledging any existing privilege and striving to provide care that is desired by the people, based on their definitions of wellbeing and healthy development;
- listening to what clients need and incorporating culturally appropriate interventions;
- helping to advocate for those whose voices have been silenced in the past to be heard in social and political systems; and
- with knowledge of healthy identity development, ensuring not only that people's cultural identities are not oppressed, but also that they have opportunities to celebrate and honor all aspects of their identities. (Frey, 2013; Sue, 2010)

The injustices like those suffered by the Yup'ik Eskimos have existed throughout history and still exist in the global arena (Feinup-Reardon, 2005).

Contemplation

Throughout the process of planning, implementing, and participating in the Yukegtaaq Celebration, multiple themes emerged related to adult development: celebrating and publicizing the integrity and successful aging of Ms. Beans, providing a role model for positive adult development to the community, and bringing together diverse groups to honor the Yup'ik culture. Creating a forum to celebrate a woman's successful aging and integrity at age 94, where her achievements, spirit, and legacy were acknowledged and honored is a type of community public recognition that often occurs in the Western world only after someone has passed; how great to share these memories and affirmations while a person is still alive.

This celebration possibly served as a life review for Ms. Beans to reflect on her experiences and accomplishments. Yukegtaaq celebrated her life as a whole: her family, work, culture, volunteerism, and character. To present the award, Ms. Beans' granddaughter, who was named after her, and her great-great-granddaughter went up on stage. The granddaughter, Winnie, spoke of her grandmother's kindness and the love she has shared with her children, who have gone on to give to the world and raise their own wonderful families. While Winnie was speaking, the great-great-granddaughter hid behind her. Five generations were present through speeches by family members and simply observing the large family gathering, it was clear that Ms. Beans will leave a lasting legacy and has already contributed greatly to future generations, a major component Alaska Native

definitions of successful aging (Lewis, 2010) and Erikson's stage of integrity (Kail & Cavanaugh, 2013).

Another theme of integrity, adapting to the negative aspects of life (James & Zarrett, 2006), was highlighted throughout the night. Several speakers emphasized Ms. Beans' ability to deal with tough times and move past them. She has experienced considerable loss in her life, including her first husband and five of her children, yet she continues giving to others and embracing the family she has left. The biography in the program described Ms. Beans' sense of humor in the assisted living home in Anchorage where she now resides. It seems that rather than dwelling on the losses that have occurred throughout life and in old age, Ms. Beans has chosen to focus on the positive.

Spirituality, another aspect of Alaska Native successful aging (Lewis, 2010), was evident during the celebration. One of the most powerful parts of the evening for those attending was when Ms. Beans' family was invited up to the stage to sing the Lord's Prayer together in Yup'ik. Five generations were together, including her children, some of whom are elderly themselves, all the way through great-great-grandchildren who shyly sang as they hid behind their family members. Alaska Native drumming and dancing took place later, where again multiple generations participated, with granddaughters watching their grandmothers for cues and instructions.

This event was a very real example to all the guests in attendance of positive human development and a healthy aging process. Ms. Beans' family said that this occasion inspired a family reunion, complete with their own feasts and celebrations leading up to Yukegtaaq. We hope that the public recognition given to Winifred Beans helped her feel a sense of peace about her life. For her family, it appeared to help them celebrate their matriarch, express their love, and inspired them to continue to share Winifred's love with their own children and grandchildren. For all the attendees at the celebration, they found a positive role model and inspiration for how to age successfully and live a good life, as well as an appreciation of the Yup'ik culture.

The Yukegtaaq Celebration brought together many different groups of people. The staff members who planned the Yukegtaaq Celebration are predominantly European American, including the executive director, president of the board, and over half of the staff, while several staff members are Yup'ik. A group of Alaska Native adolescents involved in Teens Acting Against Violence worked as meal servers, along with two youth from the Bethel Youth Facility, and four members of the National Honor Society. About 25 members of Beans' family attended the celebration, as well as many professionals who moved to Bethel for work. A Yup'ik drummer, Myron Naneng put it well when he said, "Many of us moved to Bethel from the villages to find jobs. Many of you came from other places for the same reason. In that way, we're not that different."

The event served a particular purpose for the professionals who attended, including doctors, lawyers, Alaska State Troopers, and mental health clinicians. Many who come to Bethel for jobs encounter negative issues on a daily basis that can falsely be attributed to the culture, such as alcoholism and domestic violence. These professionals often do not expose themselves to the positive

aspects of the culture, since their jobs are mostly based on people experiencing problems. The Yukegtaaq Celebration is an opportunity for non Yup'ik people from outside to distinguish between the culture and the problems they see here.

Evaluation and Disclosure

Living examples are powerful form of learning for many people. Seeing the example of someone who has truly lived in a positive way and achieved the highest of all of Erikson's developmental stages leaves a lasting impression. The Yukegtaaq Celebration means a lot to the community, as evidenced by TWC continuing to put forth so much effort to make it happen. TWC received a lot of recognition for their work during the event, and hopefully that appreciation helped uplift the staff's energy in their challenging work with victims of domestic violence. Above all, Winifred Beans and her family learned that they are truly valued and appreciated.

What was gained most from this experience was an attitude in how to approach cross-cultural work, volunteerism, and any future counseling work. An open mind and a willingness to learn from others are important attitudes in the counseling profession. Knowledge about adult development drove an appreciation for the event's importance, and an attitude of flexibility determined how to fit into this collaborative effort.

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Appendix

Winifred Beans' Biography from the Yukegtaaq Program

Yukegtaaq Biography:

Angivran Winifred Beans

Angivran Winifred Beans was born August 10, 1917 in Kasigluk (of Kasigluk Mountain) near Black River below Mountain Village. She grew up there with her parents, Joseph and Anna Joe. She attended Aklurak Mission School in the lower Yukon area through 3rd or 4th grade. At age 17, she married Frank Kelly and moved to Mountain Village. Together, they had three sons and four daughters: Edward Kelly (deceased), twin boys William and Frank Kelly (both deceased), Clara Kelly-Rondeau, Nancy Kelly (deceased), Susie Mike, and Agnes Bostrom. Frank Kelly passed away from tuberculosis. Later, Winifred married Billy Beans in 1947 and together they had three daughters and two sons: Bridget Kline, Larry Beans (deceased), Mary Beans, Norby Beans, and Bay Johnson. Today, Winifred has six surviving daughters and one son, seven grandsons, seven granddaughters, nine great grandsons, seven great granddaughters, one great great grandson, and three great great granddaughters.

Throughout her adult life, Winifred has been very involved in her communities. She helped teach school in Alakanuk to some of the youngest kids. Even today, her now adult students remember her as being their first teacher. Winifred also was a midwife, learning her skills from other midwives. In this role, she, on occasion, had to physically turn breech babies. Winifred also used her hand skills in native crafts. She is a very experienced and beautiful skin sewer. She made her children otter, squirrel, and muskrat parkas, mukluks, and fur hats. She was also a commercial and subsistence fisherwoman.

Winifred spent time in Mountain Village, St. Mary's, and in Bethel. While her kids were growing up, their family lived in St. Mary's in the winter for school and in Mountain Village in the summer for subsistence. After her last child graduated from high school, Winifred moved to Bethel and worked for YKHC Behavioral Health as a translator Yup'ik/English interpreter and mental health worker. At that time, she worked directly under the one and only Bethel psychiatrist, Dr. Verner Stillner.

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To this day, her clients will come to her and thank her from helping them with their mental health issues and helping them recover from substance abuse. People even come up to her children and tell them how grateful they are for Winifred's work. As a result from all of this challenging and meaningful work, Winifred was honored with a Lifetime Counselor's Certificate from YKHC Behavioral Health. Furthermore, because of her work, Winifred has served on both the YK Behavioral Health board (approximately 1986-2008) and the Calista Elders Council (1990-2008).

After about a decade of this work in Bethel, Winifred returned to Mountain Village, then moved to St. Mary's in 1994. In both villages, people continued to seek her out as a mentor and valued counselor. She has experienced many losses in her life and her way of dealing with them has helped her become a helpful person for others going through their own losses. In this way, throughout her adult life, Winifred has been known for how deeply and actively she cares for people. Additionally, she was a foster parent for three children and was very active with her Catholic faith and community; always helping the church in any way she could, especially as a translator.

In August of 2010, Winifred moved into assisted living home in Anchorage., where four of her children live. Even here, she continues to care for people and keep a sense of humor. In her placement, she does not feel out of place, but instead feels useful and is still contributing. Here she has assumed a natural position of leadership. One story about Winifred is that whenever they take her for an outing, she tells the caretakers, "Now don't do anything while I'm gone; just take a break. I'll help you when I come back. Do you want me to get anything for you?" Winifred is known to be a balance of compassion and strong will, so that, as her children say, "even when she's quiet, she's loud". Her presence is powerful, and her caring is beyond measure.

Winifred Beans receiving her Lifetime Counselor's Certificate from YKHC Behavioral Health in 2008.

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Winifred at the original TWC at a Safety in Villages conference in the early 80's.

Winifred Beans (front, center) with seven of her children at her granddaughter's wedding in 2010. Back row: Clara Kelly-Rondeau, Norby Beans, Mary Beans, Bay Johnson. Front row: Susie Mike, Bridget Kline, Agnes Bostrom.

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