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This was my first formal training in suicide prevention and intervention. I have done Master's in Counseling Psychology from India and currently pursuing School Counseling degree at PSU. At both the places, I learned that suicide is a high risk phenomena and most of the people are directly or indirectly affected by it.

Before this training, I was aware that anyone talking about suicide should be taken seriously and that most people before attempting suicide tries to communicate to someone about their thoughts. There are also several causal risk factors associated with the act of suicide such as depression or other mental and physical health concerns, loss, identity confusion, etc. This was learned through reading and trainings but I had never experienced suicidal event personally or professionally. My fundamental concept was that people contemplating suicide ask for help verbally and I should act. This concept was understood better after the ASIST training. The verbal nature of asking for help got replaced by identifying flags and invitations, hinting towards ending life and to add asking in my role. Not just asking using the words harming/ hurting self but to use the word 'suicide' or 'death'. To make sure that I, as a counselor, am on the same page as the person at risk and both of us are aware about the risk and necessity to make a safety plan. To talk openly about suicide became one of the forefront of my counseling practice now.

Another concept that was stretched was that I had learned in my counseling training that *assessment* and *safety plan* are the key concepts to work with suicidal clients. Which involves keeping the client safe and calling the emergency services. Also, to explore some resources for the clients if they found themselves with an urge to kill. In ASIST training I learned the whole process of intervention at first hand and also learned to work on creating the ambivalence

between death and life. It is logical and the person takes charge of the safety plan. In my classes, I also heard in discussions that the underlying meaning of creating a safety plan was more for the protection of the counselor ethically and legally more than protecting the client. Also, research showed that creating just a safety plan doesn't work. Hence, I felt unprepared to deal with clients in my practicum, with suicidal ideation. After the training, I learned that *understanding* the person with suicidal thoughts is a big step in the intervention that is supported by research. It is more than imposing the safety on the person. It allows the person to be felt heard and understood. Often, that is what most people want. Individuals/clients are under pain and someone helping them to relieve that pain by listening and understanding could directly affect the thought process.

For a counselor, it also includes not to rush to fix the problem for their assurance. I do not have to freak out myself. If I am freaking out and nervous then there is less likelihood that they would share with me. Person at risk would be willing to talk to someone who can remain calm and empathetic while listening.

Being said that, counseling is more of a Western American concept. Although, counseling for suicide is a need for everyone everywhere. Whether it is done by family, non-government organization (NGO), police or State/National agency is a different thing based on place and culture. There are several questions that, according to me, needs more exploration in my training to prevent someone from attempting suicide. Some of these would be raised while in action. Those would be the moments of quick decisions. In a country like India with over a billion of people, one in every 60 individuals are affected directly or indirectly by suicide (Vijatkumar, 2007). On the other hand, there are only about 3,500 psychiatrists. Field of psychology and counseling are yet to be fully established in terms of uniform training and licensing. Most of the cases of suicide are dealt by police, NGOs or just the extended family. In this scenario, I wonder if we could make suicide a priority for the everyday people along with high

rates of poverty, lack of education, malnutrition and high corruption? Witnessing some of the case studies published in newspapers from time to time, I perceive social and economic pressure are high risk factors along with individual predisposition. Joint families and communities used to be the support system which is now breaking up due to mobilization of economy and modern infrastructure. I wonder how a society, in transition, like that and yet developing, could provide good prevention and intervention to it's people.

As a starting step, I do want to contribute to the prevention and intervention of suicide as much as I can. I am not very clear what my future work position looks like! As I am pursuing my studies in school counseling in US and I plan to stay here for a while and go back to India may be after 3-4 years!

Currently, I would assume that I would be working as a school counselor as well as have my private practice in India in future. Based on current scenario, there is hardly any training and resources for suicide prevention and intervention for mental health practitioners especially school counselors. Most schools are privately run and so the standards of the schools differ widely. Most of the time suicide incidents are dealt by doctors and police. Helplines are run by NGOs with State/ Center support. As evident from the conclusion of a study by Vijaykumar (2007), "In India, suicide prevention is more of a social and public health objective than a traditional exercise in the mental health sector. The time is ripe for mental health professionals to adopt proactive and leadership roles in suicide prevention and save the lives of thousands of young Indians." Hence, my goal could be to create more awareness about the issue of suicide, intervention and prevention and lead people to talk about it as a serious issue that needs intervention. May be train some of the people in the intervention process.

To start at the school level, I could start by surveying the teachers and parents who are informed about suicide prevention or who are interested in learning about it in the beginning of the academic year. Finding community members is an important step to empower the

community. Hence, I will form my team, at least 20 adults, whom I could train with the basic suicide intervention model in about one month. Then for next two months we focus on gathering data related to suicidal ideation and suicide within the middle and high school population. Once, we know the data, the team meets twice in a month to chart out objectives for intervention. As an objective to spread awareness in the entire school, we would have 'suicide prevention' as a theme for a week. The team will talk about suicide in the middle and high school assemblies. Students would learn the risk factors for themselves and others through stories, films and discussions. Parents/ teacher could talk to students in small groups or one-on-one. Students would learn how to approach an adult or an non-government organization or police helpline for help as other services are minimum as of now. Those students who have been identified as having suicidal ideation, would meet with one member of the team for further exploration to identify the need for intervention or referral. In addition to this, the team will constantly check-in with students with high risk factors throughout the year. If we have a success in this approach we could implement it in nearby schools and try to make community aware, stronger and self-sufficient to deal with suicide. That way my community will find it's own support system which will fight against suicide.

Reference

Vijaykumar L. (2007). Suicide and its prevention: The urgent need in India. Indian J Psychiatry. 49(2): 81–84. doi: 10.4103/0019-5545.33252