Creating Suicide Safety in Schools: A public health suicide prevention program in New York State

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ABSTRACT

Suicide is a serious public health problem worldwide. The World Health Organization calls for collaboration among all sectors of society using a multi-tiered approach to address risk factors. Schools have played a central public health role in fighting infectious diseases, malnutrition, community violence, accidental injuries, and heart disease. Similarly, when it comes to youth suicide prevention, schools are critically important community institutions. Schools are central civic institutions for building the resilience and positive helping environment necessary for the prevention of suicide. In this paper we will describe a program called “Creating Suicide Safety in Schools” (CSSS), which was developed to address the need for more comprehensive and consistent suicide prevention training for school settings. The CSSS provides a framework for integrating school-based suicide prevention best practices, and the program is being implemented and evaluated in New York State. We will outline the CSSS model, the workshop, and how it is disseminated. The CSSS Workshop has been offered to school personnel for more than five years and individuals from several hundred schools have participated in this training opportunity. Preliminary findings of the program’s acceptability in terms of attitudes, knowledge, perceptions of administrative support, and sense of empowerment based on a survey of 93 participants, will be presented.

Selvomd er et stort folkehelseproblem verden over. Verdens helseorganisasjon (WHO) etterlyser samarbeid mellom alle samfunnssektorer ved å ta i bruk en flerinnstilnærmning for å adressere risikofaktorer. Skolen har hatt en sentral rolle innen folkehelse ved bekjempelse av infeksjonssykdommer, feilernæring, vold utenfor hjemmet, skader ved ulykker og hjertesykdommer. Også når det gjelder selvordsforebygging blant ungdom er skolen en avgjørende samfunnsinstitusjon. Skolen er en sentral kommunal institusjon for å bygge den styrken og det positive hjelpemiljøet som trengs for å forebygge selvord. I denne artikkelen vil vi beskrive et program kalt «Creating Suicide Safety in Schools» (CSSS), som ble utviklet for å etterkomme behovet for mer helhetlig og samkjørt selvordsforebyggingsstrenge i skolesammenheng. CSSS gir et rammeverk for å integrere skolebasert beste praksis i selvordsforebygging, og programmets blir implementert og evaluert i New York State. Vi vil beskrive CSSS-modellen, workshopen og hvordan formidlingen foregår. CSSS-workshopen har blitt tilbudt til skolepersonell i over fem år, og personer fra flere hundre skoler har deltatt i denne opplæringssmuligheten. Til slutt vil vi presentere foreløpige funn om programmets akseptabilitet hva angår holdninger, kunnskap, opplevelse av administrativ støtte og bemyndigelse basert på en spørreundersøkelse med 93 deltagere.
In order to effectively prevent suicide, multiple strategies must be employed on all levels of society. Community approaches grounded in public health prevention principles are critical. The World Health Organization calls for collaboration among all sectors of society using a multi-tiered approach to address risk factors. This multi-tiered approach includes: Tier 1 \textit{universal} strategies promoting awareness and positive coping and connectedness, reducing violence, drug abuse, mental illness and hopelessness across broad populations, Tier 2 \textit{selected} strategies like targeting groups at risk and training gatekeepers to identify and refer persons with thoughts of suicide, and Tier 3 \textit{indicated} strategies that improve treatment and pathways to care for suicidal individuals (WHO, 2014).

Schools have played a central public health role in fighting infectious diseases, malnutrition, community violence, accidental injuries, and heart disease by implementing such measures as immunization programs, health screenings, food programs, and health and safety education to name a few. These efforts seek to protect broad populations by education, inoculation, screening, and intervention across an entire school’s population. In each of these cases, schools have utilized the multi-tiered approach described above.

Similarly, when it comes to youth suicide prevention, schools are critically important community institutions. Schools are central civic institutions for building the resilience and positive helping environment necessary for the prevention of suicide. Students spend a good deal of their waking hours in school, and build strong peer connections and often strong connections to trusted adults. In many rural communities, where there is limited transportation and there are sparse mental health resources, school may be the only place children access health or mental health care. School-based mental health professionals are often the only resource readily accessible to at-risk children and youth in an immediate crisis (Schaffer, 2016). And, adults at school are in a good position to observe student behavior and recognize signs of psychological distress.

However, despite the central role that schools can play in suicide prevention, they have often taken a piecemeal approach. The work is typically focused on the identification of persons at risk, or general aware-
ness. School-based mental health professionals admit to feeling underprepared to organize or engage in suicide prevention activities. Additionally, there is little clarity for school administrators regarding how various programs and trainings contribute to suicide safety in their school environment. As the issue of youth suicide has gained prominence, so have the number of programs and presenters. School leaders looking to address the problem can find it daunting to figure out where to invest limited resources. Even with access to handbooks and training programs, developing a suicide safety plan can evoke feelings of fear and uncertainty for professionals who feel ill-equipped to do so (Berman 2009; Debski, et al. 2007).

Another obstacle is concern about whether schools should be engaged in suicide awareness at all. Suicide can be a socially contagious behavior, especially among teens and children. Guidelines have been developed suggesting that some kinds of awareness activities may actually contribute to suicide contagion (Gould 2013). Attempts to address suicide awareness with teens can create a misleading impression that suicide is more prevalent than it is or it can create the impression that suicidal behavior is a teen culture norm, making it a more socially acceptable option to a desperate teen contemplating suicide. On the other hand, not addressing suicide awareness creates a culture of silence and perpetuates stigma that isolates sufferers and keeps students from reaching out for help. Striking the right balance and choosing programs that are grounded in safe messaging and contagion theory is important. (Center for Mental Health in Schools at UCLA 2016)

In addition, schools do not come to this work with the same capacity to participate. Schools are highly regulated institutions, subject to a complexity of national and state regulations coming from a variety of departments of government. They are also subject to local jurisdiction. The resources available to schools to do this work and the coordination of resources vary greatly from school to school. Some schools are in communities rich with resources that are highly coordinated and others are in communities with low social cohesion and poor coordination of fairly limited resources. Therefore, a prescriptive, one size fits all approach will likely have limited application to some schools.

In this paper we will describe a training program called “Creating Suicide Safety in Schools” (CSSS), which we developed to address the need for more comprehensive and consistent suicide prevention training for school settings. The CSSS provides a framework for integrating school-based suicide prevention best practice and the program is being evaluated in New York State. The CSSS is designed for schools at every level, elementary through high school. Since the developmental trajectory for later suicidal behavior can begin very early in life (Fergusson et al., 2000; Middlebrooks & Audage, 2008; Enns et al., 2006; Dube et al., 2001), educational institutions can do much to address prevention, even at the elementary school level (Wyman, 2014). In the U.S., though suicide deaths are rare among children under the age of 14, the rate of suicide death among children and adolescents aged 10 -14 years, has doubled in the past decade (CDC, 2016).

We will describe the CSSS model and how it is introduced and implemented in schools. Additionally, preliminary findings regarding the program’s acceptability in terms of attitudes, knowledge, perceptions of administrative support, and sense of empowerment, will be presented.

Creating Suicide Safety in Schools - The Model
The Creating Suicide Safety in Schools (CSSS) framework is based solidly in public health prevention. The underlying vision is one of a Competent and Caring School Community (Underwood, 2011) which recognizes that community is necessary. No one person can keep another person safe from suicide. Community is understood not as just people living within the same geographic area, but as individuals, families and organizations connected through networks of meaningful helping relationships. A caring community is one in which all are challenged to care about each other’s well-being and safety. When the issue is suicide, children are safest when they are connected to a safety net of helping resources working together. In a competent community everyone has a role to play: student services personnel, teachers, parents, students, administrators, school boards and community resource providers. All members need an understanding of their role and they need to acquire the competencies to perform their role. Everyone needs to know how, when, and where to access help; and they need to feel consistently inclined to do so. Some of the work will be defining roles and providing training for individuals specific to their role.

Risk factors for suicide are addressed through the lens of risk/resiliency theory (Jenson & Fraser, 2006), which understands suicide as a phenomenon influenced by the dynamic interplay of a complex mix of risk and protective factors. These risk and protective factors can be understood as occurring along a socio-ecological continuum (Bronfenbrenner, 1994). This continuum starts at the individual level, encompassing a person’s biology, psychology, and social history. Risk factors on this level might include things like depression, impulsively aggressive responses to stress, poor coping skills, substance abuse, experiences with death and trauma (Fergusson et al., 2000; Bruffaerts et al., 2010; Brodsky and Biggs, 2013; King et al., 2013; Brent, 2001). Additionally, risk is influenced by a person’s family and peer relationships. Risk factors like interpersonal violence, abuse or sexual assault, bullying, family loss, highly stressed family, no peer group, or loss of an important friend or family member, no access to mentors, loss of
a peer group, friend or family members who died by suicide, or having your help-seeking signals ignored by friends or family, are illustrative of interpersonal or relationship level risk factors (King et al., 2013; Goldblum et al., 2015). On the farther end of this social ecology are environmental risk factors. These include access to means to kill oneself, cultural acceptance of suicide, low community cohesion, poor coordination of community resources, access to places or means where others have died by suicide, and social rejection. (Wilkins et al., 2014).

Accordingly, the work of prevention is to identify and implement interventions that decrease risk factors and increase protective factors at varying points along this social ecology. The social ecology is often depicted as a set of concentric circles, denoting that the bulk of the work will be on the environmental level.
The CSSS provides a framework for integrating school-based suicide prevention best practices, helping school personnel to obtain training in best practices, and assisting schools in working with available and accessible resources to create a plan to improve school suicide safety. The framework offers six categories of assets that contribute to a suicide safer school environment. Schools implementing the model are challenged to look at comprehensive suicide safety as finding ways to acquire and integrate assets in the six categories. Schools are provided a sampling of templates, tools, trainings and web-based resources that meet these needs. The six categories include:

1. **Training for staff and faculty**
   All school staff are encouraged to receive basic training in the recognition and response to suicidal warning signs. This training should include some information about the prevalence of suicidal thinking and suicidal behavior in children and youth, some risk and protective factors, warning signs and the actions they are expected to take in response and how to engage school resources to respond. Staff should also be provided with a list of helpful community resources.

2. **Programs that build social emotional skills and resilience of students**
   There is a good deal of overlap between factors that protect against suicide and factors that protect against other social risks for students. Programs that reduce bullying, interpersonal violence, promote a culture of respect and acceptance of differences, activities that promote school connectedness, academic success, opportunities to contribute, youth development, help-seeking and mentoring all promote protection from suicide. Recent research points to a correlation between interventions that promote social emotional learning, particularly self-regulation, in elementary school and long-term decreased rates of suicide later in life (Wyman, 2014). A suicide prevention component to schools’ health curricula may be considered and should include: how to recognize the signs of suicide, acknowledge the seriousness of the situation and access help.

3. **A plan for helping students when they are at risk for suicide**
   Staff designated to manage students with suicidal thoughts or behaviors should be supported by policies and procedures that standardize assessment, collaborating and communicating with administrators, safety planning, parent notification and documentation of risk and follow up. The development of relationships with community providers is a considerable asset. Additionally, these staff members may want specialized training in community and school-based risk assessment, intervention skills and safety planning.

4. **A plan for recovery after a suicide death**
   Crisis team members and administration should have a plan to resolve crisis, maintain structure and control, provide support for affected school community members, deal with spontaneous and longer term memories, and prevent contagion. Postvention is the term that refers to intervention provided after there has been a suicide death to assist in recovery and to prevent further suicides.

5. **A strategy for engaging and educating parents**
   Having an effective safety net for at-risk students requires strategies that engage parents individually, when their child is at risk and as a stakeholder group to support and advocate for effective prevention efforts. The school could be the most immediate source of education about this for parents.

6. **Collaborative relationships with community health, mental health and human service providers**
   Although schools can take a leading role in creating communities that are safer against youth suicide, schools must work in collaboration with and have the support of their communities. Lines of communication that respect the privacy of the child and family and also create a shared sense of responsibility for the safety and support of the adolescent and their family are important. Throughout the course of the workshop and within the resource binder and PowerPoint slides, a variety of web-based resources, trainings, tools and templates are reviewed, sampled and discussed.

**School engagement and readiness – Preliminary steps**
As a starting point, the CSSS training recommends a review of school policy and the development of standardized protocols and procedures for suicide risk and suicide events, ensuring they are consistent with current practice. A next step is to make sure staff members know what is expected of them. Procedures for dealing with suicide risk might include:
- Mechanisms and expectations for referring students within the school
- Community referral guidelines
- Processes for collaborative risk assessment and safety planning
- Parental and administrative notification guidance
- Documentation guidance
- Crisis plans for responding to suicide deaths and suicide attempts
- School reentry following a suicide related hospitalization.
- Policies might also include expected training and competencies of various staff positions in suicide awareness and intervention.

Next, it is important to assess school readiness and engage the support of school leaders. Support from
develop a school suicide safety plan.

with the resources currently available and accessible to programs, trainings and tools, and 3) learn how to work learn about current best practices and evidence based current suicide prevention and response readiness, 2) sist of the following: Participants will 1) review their school in their district. This District level team would in turn, provide District level implementation teams in larger school prevention. The workshop has also been offered to teachers; empowered to create a plan to improve school counselors, school psychologists, social workers, professionals; typically, some combination of school- 

Often school professionals imagine that addressing suicide prevention in schools means they must take on the role of providing mental health treatment or at least develop clinical assessment skills.

created an environment conducive to increased adoption of the CSSS model (NYC, 2016). While not the only tool being used in NYC schools, CSSS is seen as a framework on which to build. Through the ThriveNYC initiative, a multi-year, $850 million project aimed at improving the mental health of all New Yorkers, has

Creating Suicide Safety in Schools – The Workshop
The CSSS is offered as a full day workshop for planning teams. A planning team consists of 3 to 5 school professionals; typically, some combination of school counselors, school psychologists, social workers, administrators, nurses, school resource officers, and teachers; empowered to create a plan to improve school safety and implement best practices toward suicide prevention. The workshop has also been offered to District level implementation teams in larger school districts. This District level team would in turn, provide guidance and support to a leadership team in each school in their district.

The learning objectives for the workshop consist of the following: Participants will 1) review their current suicide prevention and response readiness, 2) learn about current best practices and evidence based programs, trainings and tools, and 3) learn how to work with the resources currently available and accessible to develop a school suicide safety plan.

Utilizing a PowerPoint presentation, video clips, case scenarios, web-based materials, a resource binder, worksheets, documentation templates, and small and large group discussion, the facilitator moves the participants through a series of learning activities designed to provide basic information about suicide and its prevention, assess their school's current school suicide prevention assets, expose them to free and low cost resources, engage them to problem-solve barriers to implementation, build their confidence, and develop the beginning tasks for the iterative process of improving their school's suicide safety.

The workshop begins with introductions that take on a conversational tone. This sets up the expectation that discussion is an important component of the workshop, preparing participants to explore how concepts they are learning about throughout the day interplay with their experiences and previous understandings.

Following introductions, a brief lecture lays out the theoretical foundation for school-based prevention. Often school professionals imagine that addressing suicide prevention in schools means they must take on the role of providing mental health treatment or at least develop clinical assessment skills. In CSSS we build on the aforementioned multi-tiered systems approach (Schaffer 2016), in which indicated level interventions (Tier 3) are done with significant support from community mental health, health care providers and parents, and the bulk of the work is Universal level (Tier 1) intervention. Participants are introduced to the Multi-Tiered Intervention model, risk resiliency theory, and the socio-ecological continuum. Additionally, contagion theory is briefly discussed. Risk factors for suicide and warning signs are also provided.

Participants then break out into small groups for an exercise using scenarios that are typical of the way that the problem of suicide presents itself in a school. One scenario describes a second year English teacher, Mr. Brown, who is beginning to notice some changes in a 10th grade student, Jakob. Jakob is a new student who recently transferred into Mr. Brown's third period class. Jakob has handed in a writing assignment depicting morbid themes, including suicide and the words “What if hope hurts” written in one corner. Mr. Brown recalls that Jakob often has his head down in class, appears sullen and doesn't interact with any other students. Participants are asked to develop a brief plan to address what they would want to see this teacher do about this concern and discuss some of the barriers that might interfere with Mr. Brown responding optimally. Through small group discussion, participants reach consensus and engage in problem-solving and then debrief. These processes are repeated multiple times throughout the workshop, as these are the processes that will be needed to continue the work of creating a suicide safer school environment once they leave the workshop and are back in their school buildings.
The CSSS model is then introduced beginning with a description of the Competent and Caring School community and its value of shared responsibility for creating a suicide safer community. Participants are introduced to the six categories of assets. Each category corresponds with a section in the resource binder. The resource binder is a compilation of articles, templates, program descriptions and informational documents. Participants also receive a packet of worksheets, with each worksheet corresponding to one of the six categories of assets. The workshop proceeds with active small group planning. A category is presented, best practice is described, and web-based resources, trainings and programs are introduced. Then using the worksheets and working with their planning team or in small groups, participants assess their current status compared to best practice, consider what steps they may take toward best practice, and begin to outline short term goals and tasks toward meeting these goals.

Evaluation
The CSSS Workshop has been offered to school personnel for more than five years and individuals from several hundred schools have availed themselves of this training opportunity. While systematic evaluation of the workshop’s effectiveness in achieving its objectives has only recently been undertaken, preliminary results of an ongoing investigation suggest that participation in the training is a promising avenue for enhancing schools’ suicide safety.

Participants
Ninety-three individuals (6 from Arkansas and 87 from New York) have attended the CSSS workshop and completed surveys allowing for the evaluation of the workshop’s effectiveness in improving attendees’ attitudes, knowledge, confidence, and feelings of support surrounding the adoption of suicide safety measures. Most of the workshop participants were female (86.5%) and represented schools in urban communities (85.4%) that were generally of low (48.3%) or mixed (39.3%) socioeconomic status. Approximately two-thirds (64.4%) of participants were school counselors. Other professions represented to a lesser extent included school social workers, building-level administrators (e.g. principals, assistant principals), superintendents, teachers, nurses, and counseling interns. Almost two-thirds of participants (63.3%) reported that they had participated previously in suicide prevention-related training and one in four attendees reported that their school had recently been affected by suicide. Approximately two-thirds (64.1%) of participants attended the workshop alone, while 35.9% indicated at least one additional individual from their school/district was present.

Instruments
Prior to workshop participation, attendees were administered a 32-item “Pre-Workshop Survey” assessing their suicide-related attitudes and knowledge, perceptions of school-based support for adopting practices designed to improve suicide safety, feelings of confidence/empowerment to move forward with such measures, reasons for attending the workshop, previous suicide-specific training, and demographic information. At the completion of the full-day interactive presentation, participants were asked to complete a 40-item “Post-Workshop Survey.” This measure included items assessing participants’ suicide prevention-related attitudes, knowledge, perceived support, and confidence/empowerment, as well as questions pertaining to the usefulness of the CSSS Workshop and anticipated barriers to implementation of suicide safety measures in their school settings. Participants who provided contact information and consented to participate in the follow-up phase of the investigation were emailed an online questionnaire three months after completion of the workshop. The follow-up survey assessed movement toward the implementation of suicide-related initiatives subsequent to participation in the CSSS Workshop, factors that have facilitated and impeded the adoption of suicide safety measures recommended during the training, and goals that participants’ schools had yet to achieve in the areas of suicide prevention, intervention, and postvention.

Procedure
The investigation utilized survey methodology within a pre-post group design with additional 3-month follow-up assessment to examine changes in participants’: 1) attitudes about the importance of suicide prevention, 2) knowledge of best practices and resources for enhancing suicide safety, 3) perceptions of administrative support for enacting suicide safety measures, and 4) feelings of empowerment regarding being able to implement suicide-related initiatives. Recruitment of workshop attendees was accomplished through dual solicitation strategies involving web-based announcements and targeted identification of schools in need. Specifically, the CSSS Workshop was advertised online by the Suicide Prevention Center of New York. In addition, the New York City Office of School Health coordinated logistics to train school mental health managers and consultants as well as to offer the training to pupil services staff throughout the city. Once attendees arrived at the workshop location, they were given a name tag indicating their first and last names and a 3-digit identification number. Before the workshop formally began, attendees were notified about the research study being conducted and provided with a form detailing all the necessary elements of informed consent. All attendees were given the “Pre-Workshop Survey” and asked to complete the questionnaire only if they desired to be included in the investigation. In order to
maintain confidentiality, each participant was asked to include only his or her participant ID number at the top of the Pre-Workshop Survey (a master list of names and corresponding ID numbers was retained by the investigators). At the conclusion of the full-day CSSS training, participants were asked to complete the “Post-Workshop Survey” and reminded to write their ID number on the survey measure. They were also instructed to complete a contact form if they were interested in participating in the follow-up portion of the study. Individuals who provided contact information were emailed a follow-up questionnaire via SurveyMonkey three months subsequent to their participation in the workshop. At the time of these analyses, 19 participants had completed the follow-up questionnaire.

Results

Table 1 presents pre- and post-scores representing participants’ attitudes, knowledge, perceptions of administrative support, and sense of empowerment regarding working collaboratively for the purpose of improving their schools’ suicide safety. Composite scores were created by summing participants’ responses to individual items assessing attitudes (2 items), knowledge (5 items),

<table>
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<th>Area Assessed</th>
<th>PRE M (SD)</th>
<th>POST M (SD)</th>
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<tr>
<td>Attitudesa</td>
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<tr>
<td>All participants</td>
<td>9.13 (1.33)</td>
<td>9.58 (1.08)</td>
<td>79</td>
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<td>9.29 (1.61)</td>
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<td>.095</td>
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<td>Attended alone</td>
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<td>.007**</td>
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<td>9.64 (0.70)</td>
<td>24</td>
<td>2.42</td>
<td>.024*</td>
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<td>All participants</td>
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<td>25</td>
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<td>Attended alone</td>
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<td>22</td>
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<td>.000**</td>
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<tr>
<td>All participants</td>
<td>22.61 (3.93)</td>
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<td>2.02</td>
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<td>42</td>
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<td>24.91 (2.91)</td>
<td>21</td>
<td>2.75</td>
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<td>4.20 (0.68)</td>
<td>74</td>
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a Scores range from 2 to 10. b Scores range from 5 to 25. c Scores range from 6 to 30. d Scores range from 1 to 5. *p < .05. **p < .01
and perceived support (6 items). One item examined participants’ feelings of empowerment to work with colleagues on implementing school-based suicide safety measures. All items were rated on a 5-point scale, where 1 was equivalent to “Strongly Disagree” and 5 represented “Strongly Agree.” Analyses of preliminary data revealed that CSSS Workshop attendees demonstrated significant improvements from pre-test to post-test in all four areas.

Additional paired samples t-tests were conducted to examine changes reported by attendees who had not participated previously in suicide prevention-related training and those who had received some form of prior instruction. Participants without previous training demonstrated significant positive changes in knowledge, support, and empowerment, yet improvement in attitudes regarding the importance of suicide prevention was not significant. Participants who had received some form of training in the past showed significant increases from pre- to post-workshop in all areas assessed. Thus, while some participants had taken part in suicide prevention-related training on at least one earlier occasion, these individuals nevertheless appeared to benefit from attendance at the CSSS Workshop.

Although the workshop was developed with the intention of assisting school-based interdisciplinary teams with their suicide prevention and response planning, many attendees were the sole representatives of their school or district. Notwithstanding the workshop’s emphasis on group activities and collaborative strategizing, solitary attendance was associated with increases in all areas evaluated (as indicated in Table 1). In contrast, individuals who attended the workshop with others from their school/district demonstrated improvements in attitudes, knowledge, and perceptions of support, but no significant changes in feelings of empowerment to work with colleagues on improving their school’s suicide safety. Considering the presumed advantages of partnering with others and functioning as a team, this finding was unexpected and may reflect some degree of diffusion of responsibility among school staff members regarding the championing of suicide prevention efforts.

Participants expressed high levels of satisfaction with the CSSS workshop (see Table 2), with all attendees agreeing or strongly agreeing that they found the workshop to be useful and relevant to their jobs. In addition, 97.5% of participants indicated that they had learned a great deal from attending. All participants reported that they would recommend the workshop to others and most reported that a follow-up consultation would be helpful.

Analysis of responses to the follow-up survey completed three months after completion of the workshop revealed that approximately half of participants indicated that their schools demonstrated improved responding to at-risk students compared to before the workshop and 38.9% reported that their schools were doing a better job of preventing suicide. More than half of attendees (55.6%) claimed that involvement in the workshop helped to enhance their schools’ efforts at suicide safety. Participants’ success in translating the workshop’s recommendations into overt action was facilitated by the provision of administrative support, the championing of initiatives by specific individuals, and the perception of an overwhelming student need. Nevertheless, barriers to implementing suicide safety initiatives were also reported (see Table 3). The most common obstacles cited by participants were insufficient time to devote to these efforts and the continued existence of stigma surrounding talking about suicide.

Results to date suggest that the CSSS Workshop is a potentially effective means of promoting suicide safety in schools by improving the attitudes, knowledge, and confidence of educational personnel to address youth suicidality. However, broader systemic obstacles, such

<table>
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<tr>
<th>TABLE 2. Participants’ Satisfaction Ratings of CSSS Workshop % (n)</th>
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<tbody>
<tr>
<td><strong>Item</strong></td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>The content of this workshop was relevant to my job.</td>
</tr>
<tr>
<td>I learned a lot from this workshop.</td>
</tr>
<tr>
<td>I found this workshop useful.</td>
</tr>
<tr>
<td>I would recommend this workshop to others.</td>
</tr>
<tr>
<td>A follow-up consultation would help in furthering suicide prevention efforts in my school.</td>
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</table>
as the hectic schedules of school personnel and the stigma attached to discussing suicide, continue to present a challenge to schools interested in embracing best practices related to suicide prevention, response, and postvention.

Discussion

The Creating Suicide Safety in Schools workshop was developed with input from school leaders and is grounded solidly in public health prevention models which are familiar to schools including multi-tiered systems, risk-resilience, and social ecology. The CSSS has been provided to over 1,000 school and community participants representing over 300 schools in New York, Florida and Arkansas. Early evaluation efforts in New York State demonstrate improvements in attitudes, knowledge, support and empowerment at completion of the workshop.

Few other school-based suicide prevention programs utilize multi-tiered systems. Rather, selective school-based suicide prevention programs specifically take Tier 2 approaches by targeting individuals at risk. These focus on general suicide awareness, and the training of school personnel to become gatekeepers who can recognize students at risk, and then intervene and connect them with professional services. These include gatekeeper training programs such as Question Persuade Refer (QPR) (Quintet, 1995), “Making Educators Partners in Teen Suicide Prevention” (Underwood, 2015), and Kognito’s “At Risk series” (Albright & Goldman, 2011). Other Tier 2 programs that target student presentations and promote screening include “Signs of Suicide” (Jacobs, 2007) and “Lifelines” (Underwood & Kalafat, 2009). However, such single strategy programs, focused on identifying students at risk, are not sufficient to bring down youth suicide rates.

Universal interventions (Tier 1), focusing on improving the awareness, coping skills, and connectedness of an entire school’s population, seem to be most promising. A multi-centered randomized controlled trial in Europe, the Youth Aware of Mental Health Program (YAM), was more effective in reducing suicide attempts and severe suicidal ideation in adolescents than the QPR gatekeeper training for staff (Wasserman et al., 2015). Another randomized controlled study (Wyman et al., 2010) found improvements in adaptive norms regarding suicide, connectedness to adults, and school engagement in high school students participating in the Sources of Strength Program over those in the control group.

In taking a multi-tiered approach to school suicide prevention, the CSSS recognizes the value of blending the above mentioned universal approaches that promote social and emotional wellness among all students, with more selective (Tier 2) gatekeeper and screening programs, along with awareness of resources for individual intervention (Tier 3). These include The Safety Planning Intervention (Stanley & Brown, 2012), and Applied Suicide Intervention Skills, which have been used alongside CSSS. Thus, CSSS does not replace the need for other programming; rather, the CSSS framework guides and empowers school leaders to evaluate and choose suicide prevention tools and training that fit the particular culture, readiness, and resources available to their school.

School suicide prevention begins with school leaders and champions of prevention assessing existing assets and resources, followed by an understanding

### TABLE 3. Barriers to Implementing School-Based Suicide Prevention and Suicide Safety Efforts at Follow-Up (N = 19)

<table>
<thead>
<tr>
<th>Barrier</th>
<th>% (n)</th>
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<tbody>
<tr>
<td>Not enough time</td>
<td>78.6 (11)</td>
</tr>
<tr>
<td>Stigma surrounding talking about suicide</td>
<td>35.7 (5)</td>
</tr>
<tr>
<td>School staff’s lack of confidence in the potential effectiveness of these efforts</td>
<td>21.4 (3)</td>
</tr>
<tr>
<td>Community resources/agencies are not responsive to school’s needs</td>
<td>21.4 (3)</td>
</tr>
<tr>
<td>Inadequate funds</td>
<td>14.3 (2)</td>
</tr>
<tr>
<td>Insufficient support from administrators</td>
<td>14.3 (2)</td>
</tr>
<tr>
<td>Insufficient parental support</td>
<td>14.3 (2)</td>
</tr>
<tr>
<td>School staff’s lack of knowledge/guidance as to how to proceed</td>
<td>14.3 (2)</td>
</tr>
<tr>
<td>Poor communication with community resources/agencies</td>
<td>14.3 (2)</td>
</tr>
<tr>
<td>Staff members have difficulty working as a team</td>
<td>7.1 (1)</td>
</tr>
<tr>
<td>Insufficient referral resources in the community</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>
that just as the risk and protective factors for suicide are numerous and dynamic, so are the interventions to create suicide safety. The CSSS training provides a comprehensive model for incorporating indicated, selective, and universal approaches to guide and support school public health suicide prevention efforts.

Levert: 08.03.17 – Revidert: 12.06.17 – Godkjent: 13.06.17

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Website: http://www.who.int/gho/mental_health/suicide_rates/en/


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suicidologi nr 2/2017 25