GUIDELINES FOR SCHOOL BASED SUICIDE PREVENTION PROGRAMS

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CONCEPTUAL BASIS FOR PREVENTION APPROACHES

What is the purpose of a conceptual basis, or, can't we just cut to the nuts and bolts of implementing a program?

A clear conceptual basis gives us the rationale for choosing a particular prevention strategy for a particular problem, with a particular population, in a particular setting. Why are we choosing this approach over a variety of other possible ones? What exactly are we trying to accomplish? How does this approach achieve the desired outcome?

Kurt Lewin said, "there is nothing as practical as a good theory". The main practical reason for a conceptual basis is that when a program is implemented in a school, or any other setting, it undergoes changes in order to be adapted to a given context. The conceptual basis is a gauge that allows us to decide whether a change is a useful adaptation or a compromise of an important core or active ingredient of the program.

Suicide prevention is competing for time and resources with many other initiatives in schools. We must have confidence in both the efficacy and efficiency of any program that we propose. While schools adopt many programs on the basis of packaging, programs generally are not retained in the absence of results. A sound conceptual grounding is necessary for achieving consistent results and makes it easier to update the program in light of experience and empirical findings.

Part of the effort to build the conceptual base for prevention in general has resulted in typology intended to clarify prevention methodology (Institute of Medicine,1994) which included:

1. *Universal* interventions, which are directed at an entire population rather than selected subpopulations or individuals. Such interventions may include efforts to enhance the supportiveness of populations such as their ability and inclination to provide a helpful initial response to a troubled youth; or, they may include teaching generic coping skills to an entire population; or, they may seek to enhance the sense of connection and participation among members of an organization or community.
2. *Selective* interventions, which are targeted to subpopulations that are characterized by shared exposure to some epidemiologically determined risk factor(s). For example,

students at critical transitional periods, such has entering middle school or high school, can be at greater risk for a variety of adjustment and/or academic problems.

3. *Indicated* interventions are targeted to specific individuals who are already preclinical levels of a disorder and who have been identified through screening procedures. For example, students who self identify or are identified by others as having suicidal thoughts or plans are referred for an appropriate treatment.

There is still confusion about these terms and approaches. For example, universal programs have been criticized as being inefficient because they focus on large numbers of students when only a small percentage would be at risk for suicidal behavior (Shaffer, Garland, Gould, Fisher, & Trautman,1988). Such criticisms clearly display a lack of understanding of universal approaches, (or of the traditional category of primary prevention), which, by definition, are aimed at populations not evidencing conditions one wishes to prevent. In practical terms, it is important to identify which prevention approaches are most likely to be maintained in schools.

Universal Suicide Prevention Approaches

The goal of universal approaches is *to raise the overall supportiveness and responsiveness of the at risk youths' environment.* This approach is preferable when the causes of a risk behavior are not yet clear or easily attenuated. Many factors have been proposed to contribute to youth suicide. The best current risk factors produce high false positives, thus universal approaches that help school personnel to identify and get help for at risk youth represent an efficient approach.

The role of the school is seen as critical, but limited. All schools are not assumed to possess the resources to treat suicidal or emotionally disturbed students. They *can* enhance their capacity to identify and get help for these students as part of their mandate to socialize and protect their students.

Following are empirical bases for the universal program that includes classes for students:

- Most suicidal youths confide their concerns more often to peers than adults.
- Disturbed youth (e.g. depressed, substance abusers) prefer peer supports over adults more than their non disturbed peers.

- Some adolescents, particularly some males, do not respond to troubled peers in empathic or helpful ways.
- As few as 25% of peer confidants tell an adult about their troubled or suicidal peer.
- School personnel are consistently among the *last* choices of adolescents for discussing personal concerns.
- Consistent reasons cited by students for reluctance to confide in adults in their schools include: confidentiality is not respected, and school schedules and conflicting adult roles (i.e. evaluative and disciplinary) prevent students from getting to know adults well enough to confide in them.
- The inaccessibility of, and reluctance of adolescents to seek out helpful adults is considered to be a *risk factor* that contributes to destructive outcomes associated with a variety adolescent risk behaviors.
- Conversely**,** research has shown that contact with helpful adults may be considered a *protective factor* for a variety of troubled youth.
- There is also evidence that *provision* of help by youths may be beneficial to them: participation in helping interactions can shape prosocial behaviors and reduce problematic behavior; and is related to indices of social competencies that can carry over to other challenging situations.

Therefore, the overall goals of the universal program are to increase the likelihood that school gatekeepers (administrators, faculty, and staff) and peers who come into contact with at-risk youth can more readily identify them, provide an appropriate initial response to them, will know how to obtain help for them, and are consistently inclined to take such action.

Protective Factors & Wellness Promotion

It should be noted within the context of universal prevention programs that research on resilient youth (those who fail to evidence risk behaviors such as poor social and school performance in spite of coming from difficult environments) and protective factors has identified characteristics of youth and their environments that can attenuate the likelihood that they will engage in a variety of risk behaviors such as delinquency, substance abuse, and suicidal thoughts. Some longitudinal research indicates that the presence of protective factors

may have a stronger influence on the likelihood that risk behaviors will occur than the presence of risk factors.

These protective factors include personal characteristics such as social problem solving competencies; and, environmental characteristics such as contact with a caring adult and a school climate that promotes students' involvement, contribution, and sense of connection with their school. Thus, there is evidence that universal, empirically grounded, multigrade school programs that teach problem solving, decision making, and other competencies may attenuate the likelihood of a variety of risk behaviors. The multiple impacts of such programs makes them more efficient than categorical programs, and thus appealing to educators.

Programs that increase the opportunities for students to participate in and contribute to their schools, as well as opportunities for outside of class interactions among students and adults in their school are also potentially powerful preventive interventions.

One caveat concerning resilient youth is in order. Research indicates that youth who come from high risk environments and yet do well in school and peer relations still evidence a greater prevalence of anxiety and depression than peers who do not come from such environments. Anxiety and depression are significant risk factors for suicide, and these internalizing disorders are more likely to go undetected than the externalizing behaviors with which school must contend. Universal screening programs have been proposed for schools, but such programs are beyond the resources of schools and require parental consent. Moreover, students' self reports of suicidality have been shown to change on surveys a few weeks apart, so how often would schools have to conduct screening in order to obtain reliable results? At the very least, all school personnel should be aware of basic signs of depression and anxiety in students.

Selective Suicide Prevention Programs

While subgroups that are at greater risk for suicide will by definition be exposed to universal programs, these programs are aimed more at their peers and may not be of sufficient dosage or focus to affect specific vulnerable subpopulations such as disenfranchised or depressed students.

Some of these students may become known to school officials, particularly if school personnel and parents are educated to identify troubled students before they make overt

statements or attempts. Thus gatekeeper training is a common selective program that has shown promise for increasing identification and referral. There is some evidence that students are more likely to use telephone crisis and referral services because they are anonymous, and don't require fees, transportation, or appointments. Publicizing these services (e.g. through wallet cards continuously available throughout the school) and linking them to established screening teams can facilitate contact with at risk youth. However, these services are still underutilized by males. The literature on *help seeking* provides some guidelines for increasing accessibility of help to students.

Research has identified specific reasons why students do not turn to school based adults for help. Among these are that school schedules preclude outside of class interactions between adults and students through which students gain familiarity and comfort that they feel is necessary for confiding. Also, most adults, including guidance counselors, have disciplinary and evaluative roles that attenuate confiding. The presence of adults who do not have these other functions and are able to take the time to interact and establish credibility with even less outgoing or adjusted students may be the best means of reaching at risk youth. The growing number *school based services* may be able to fill this need.

Indicated Suicide Prevention Programs

The goal of indicated programs is to reduce the incidence of suicidal behaviors among students who already display risk factors or early warning signs associated with suicide such as frequent suicidal thoughts, previous attempts, depression, or substance abuse.

This approach is most feasible for schools when existing school records contain data that can identify potentially at risk students, such as potential dropouts. These students can then be screened for suicidal feelings, plans, or past attempts. Brief programs that reduce risk factors and promote protective factors are then provided to these identified students.

Indicated programs require the presence in schools of individuals who are trained to screen students and to provided the indicated programs. School faculty or special services staff such as guidance counselors can be trained to provide the programs, but professionals such as psychologists or social workers would have to conduct the screening. While such professionals are present at least part time in schools, they often don't have the time to take on additional duties. There are a growing number of school-linked services (community

gatekeepers who provide assessment and counseling services on site) and school based service centers or clinics that can house indicated interventions.

Following are empirical bases for indicated prevention programs:

- Risk factors that are associated with suicide have been identified, including prior attempts, depression, anxiety, anger/aggression, substance abuse, low self esteem, poor problem solving, social isolation, feeling disenfranchised with school, and family distress.
- Many of these risk factors are identified by school officials through regular school procedures; and these individuals could be screened for suicidality.
- Potential school dropouts who are consistently identified in schools by declining grades, absences, and behind in credits are at increased risk for suicide.
- Contact with a caring adult and sense of connection/participation in school are strong protective factors for otherwise at risk students.
- At risk youth do not seek help, and usually do not follow through with referrals to community services.
- Brief, accessible (i.e. school based) interventions that address risk factors and enhance support and protective factors can have an impact on suicidality.

Therefore, the overall goals of indicated programs are to identify at risk students, preferably through existing school procedures, and provide them with accessible, brief interventions that include support, skill training, and opportunities to bond with school and maintain contact with a caring adult.

REQUIREMENTS FOR EFFECTIVE PREVENTION PROGRAMS

The following points have been gleaned from the literature on effective prevention, and the implementation and institutionalization of innovations in schools.

- Conceptually & empirically grounded goals and objectives.

  Note: Clear, observable instructional objectives also serve as outcome or dependent program variables.

- Clearly articulated and packaged components.

  Note: Teachers prefer to work with materials that include lesson outlines and plans, detailed instructor guidelines that include typical student responses and how to respond to these, all handouts, and references for additional materials. As they gain experience with the materials, they may adapt them to their students and their own teaching style.

- Appropriate instructional principles.

  Note: these include participatory lessons that acknowledge and relate the material to students' experience; and the use of the demonstration, practice, feedback, practice sequence for teaching skills.

- Comprehensive: address all levels of targeted organization.

  Note: School programs must include consults and training for administration, all faculty & staff, and students.

- Ecological: address the multiple contexts in which participants interact.

  Note: Most school programs involve identification and referral of at risk students. Close working relationships must exist between the school and community gatekeepers and parents. Gatekeepers must be trained to work with suicidal youth; and parents must be informed about school programs and involved in supportive interventions.

- Conform to the context/culture/values of the target population and organization.

  Note: programs must fit into the educational and protective mandate of schools, minimize disruption of school schedules, and minimize demand on other school resources such as personnel, time, space, and materials.

REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION

No matter how well researched, designed, and packaged a program is, if it is not implemented as conceived, it will not have the desired impact. As with effective programs guidelines for effective implementation can be gleaned from the experience and research, including:

- Pilot

  Note: piloting a program reveals the inevitable adaptations that must be made so it can work in different school contexts. Also, pilots show school personnel that you are taking their context and feedback into consideration and help to promote their ownership of the program.

- Packaging

  Note: Programs must fit into the education, socialization, and protection mandates of the school (in that order of emphasis). They must also fit into the schedules and personnel/material resources of the school. If a program is a pull out, costs too much, or requires too much training and time of school staff, it won't be maintained. (One of the reasons that DARE is so widespread, even though controlled studies have failed to demonstrate impact, is that it is vigorously marketed *and* is provided by outsiders rather than school staff (low effort)).

  Be aware that if the program consists of a even a very detailed manual with no on site consultation, there can be considerable slippage in the implementation. That's why you want to avoid conclusions about a programs' efficacy if the implementation hasn't been checked.

- Reconnaissance and relationship development.

  Note: spending time in the school also shows that you take their context and feedback seriously. Schools are inundated with "innovations". They will adapt those that come from a trusted source. You may start by meeting some other felt need of the school before introducing your program.

- Similar models

  Note: school officials are swayed most by endorsements from colleagues in other schools/districts who have used the program.

- Two-sided communication

  Note: provide opportunities for school personnel to voice and discuss concerns about the program. *Elicit* and address concerns.

- Moderate fear arousal

  Note: school officials often hesitate to add more to their ever-expanding programming unless they are aware of negative consequences if they do not have a program or procedure in place (e.g. schools *have* been sued for providing an inadequate response to a suicidal student. Also,suicide is comorbid with other risk behaviors that are more evident to school officials, such as interpersonal violence and dropout).

- WIIFM

  Note: "what's in it for me" must be addressed with school officials. (e.g. it is now recognized that emotional distress, and community and family stressors are barriers to learning; we cannot separate cognitive and emotional functioning. Collaboration with responsive community providers can assist schools in attenuating barriers to learning).

- Plain language

  Note: even experienced consultants cannot recognize all of their profession's jargon. Program materials should be reviewed with school personnel. (e.g. don't use "comorbid").

- Collegial

  Note: beware of "professional preciousness" evidenced by such statements as "you mean you let *coaches* provide the suicide classes?"

- Listen

- Core & adaptable

  Note: guided by your conceptual basis, you must identify core features of your program that cannot be changed, such as minimum dosage (hours); or, media can be updated but not replaced by a lecture. Other features can be changed to fit the context (e.g. replacing a pull out program with an in-class program).

- Train on site providers (using demonstration, practice, feedback)

  Note: turnkey programs that don't require outside personnel are more likely to be adopted and retained in schools. Outside consultants can provide ongoing or occasional follow up.

REQUIREMENTS FOR INSTITUTIONALIZATION (RETENTION OVER TIME) OF PROGRAMS

There is a considerable body of literature (as well as the experience of anyone who has worked with schools, corporations, and other institutions) that shows that few programs last long in a given setting. There are some strategies for increasing the likelihood that a program will be retained or institutionalized in schools. In addition to the variables associated with effective program design and implementation:

- Supportive administration

  Note: program survival requires the principal's support of the particular program, as well as his/her support of the school's responsibility for prevention of risk behaviors and promotion of positive coping behaviors, student responsibility, and other principles contained in the program.

- Identify responsible individual(s).

  Note: there must be an individual or group that assumes formal ownership of and responsibility for providing and sustaining the program. Some successful programs outlive the recollection of their original source or authors.

- Provide ongoing consultation/support.

  If at all possible, this is helpful at least for the first two cycles of program implementation until school personnel not only gain ownership, but also gain familiarity with resource sources on the topic.

- Identify a place in the curriculum or some other formal school structure such as a school based crisis team or youth service center.
- Create policies, procedures, structures to support innovation.
- Easy to administer assessments to check implementation and impact.

  Note: when educators can see results, they are more likely to retain and update the program. Remember, this is where clear, measurable program objectives come into play.

- Educators feel stretched by the program.

  Note: school personnel will remain advocates when they are able to adapt the program based on their experience; enjoy mutual support; can bring to bear other skills/materials from their background; and, in general, experience involvement with the program as providing a useful addition to teaching repertoire.

COMPREHENSIVE SCHOOL BASED SUICIDE PREVENTION PROGRAMS

This document is intended as a set of general guidelines for school based prevention programs and not a of specific programs. However, the basic components of a comprehensive program can be listed. It should also be noted that there are other prevention approaches such as means restriction, media campaigns, community crisis teams, and community gatekeeper training. These are not detailed here as they are not strictly school-based programs, but it is recommended that they be included in any comprehensive community prevention initiative.

Comprehensive programs are multilevel, multicomponent interventions that include the following components, usually implemented in this order:

1. *Administrative consultation* to ensure that policies and procedures for responding to at risk students, attempts, and completions are in place; and to ensure that community linkages exist for close coordination of referrals to, and return of students from, community gatekeepers.
2. *School gatekeeper training* for all faculty and staff (including such staff as bus drivers and cafeteria workers) on the identification of, initial response to, and effective referral of troubled and at risk students. This sometimes includes the establishment of in school crisis response teams made up of faculty, staff, and administrators.
3. *Parent training* covering similar material as the school gatekeeper training, as well as means restriction strategies.
4. *Community gatekeeper training* that incorporates policies and procedures for effective response and coordination with schools and families. This sometimes includes training in the treatment of depressed and suicidal adolescents. Community crisis teams and media campaigns have also been implemented.
5. *Student classes* usually consist of 4 to 5 class periods included in the health curriculum. Classes include a variety of media, and involve students in discussions and roleplays to prepare them to recognize and respond to troubled peers, and to destigmatize seeking adult help.

6. *Postvention interventions* that are provided by external consultants to schools and communities in which a suicide completion or serious attempt has occurred. These interventions consist of standard steps designed to process faculty, student, and community reactions to the event; facilitate grief work; and, prevent imitative acts among identified vulnerable peers.

Such programs should have the following features:

Class Schedules

The curriculum is organized into 45 minute lesson plans which can be incorporated into existing family life, health, or other classes. No time outside of class is required for the students or teachers, and no expansion of already taxed school curricula is necessary. Special group sessions outside of regular classes can be a popular format with students, and may serve to highlight the important nature of this topic. If schools choose to use his format, the material can be arranged accordingly. It should be noted that there is a high correlation between adolescent suicide and other topics that are often part of health classes such as substance abuse and teen pregnancy. Each of these may represent inappropriate solutions to problems that can be addressed within the context of health or family life education.

Educational Focus

Through collaboration with educators, the curriculum should be organized as explicit lesson plans that are hopefully devoid of mental health jargon. In addition, established educational principles should be employed in the lessons including:

- The lessons are problem vs. content-centered in that material is organized around issues that students are currently dealing with such as keeping confidences.
- The lessons include exercises and media that promote participatory learning.
- Each lesson is limited to about three basic points, which is the most that students (teens and adults alike) will retain in a 45 minute period.

Teacher Provided

The lessons should be presented by regular classroom teachers rather than external consultants. This is not only more cost effective, but is consistent with the goal to enhance s*chool-based* student supports. That is, research seems to show that when students have particular concerns, they are more likely to talk about them with an adult who has demonstrated some interest and expertise in that area. Therefore, when regular classroom

teachers cover material on suicide, students may see them as concerned, responsive adults who are available during school hours.

Students have also reported that they are more likely to perceive as helpful, and to turn to, staff and faculty who take the time to interact with them outside of the confines of their office or the classroom. Presenting the curriculum can enhance the credibility of a teacher in this area, but such additional interaction with students may be necessary to increase the likelihood that they will be seen as a resource by students.

Sample Curriculum Outline

Following is a sample lesson plan for the student class component of a universal prevention program. The goal of the lessons is to provide the knowledge, attitudes, and skills involved in responding to and obtaining adult help for troubled peers.

Student Curriculum Instructional Outline

Content	Rationale	Time	Materials
LESSON 1: THE SUICIDAL SITUATION			
Introduction		3’	Instructor Guideline A
1. Exercise: What Would You Do?	Employs experiential technique to introduce the central goal of the curriculum: to prepare students for their intervention role; provides the why for the curriculum that enhances the salience of the rest of the lessons.	20-25’	Instructor Guideline B Handout 1
2. Quiz & Discussion	Relevant information about suicide is presented in participatory manner that highlights for each student what s(he) needs to know.	20-25’	Instructor Guideline C Handout 2, 3
LESSON 2: THE RESPONSE ROLE			
3. Video: Dead Serious	Reviews warning signs and demonstrates appropriate and insufficient responses to troubled peer.	22’	Instructor Guideline D
4. Discussion	Reviews warning signs and allows students to discuss issues/feelings about intervention.	20-25’	Instructor Guideline E Handout 4
LESSON 3: HELPING A TROUBLED FRIEND			
5. Roleplays & Discussion	Provides demonstration and practice of active responses to two troubled peers.	20-25’	Instructor Guideline F (including scripts) Handout 5
6. Where To Go For Help	Reviews in-school and community resources & how these resources will respond to referrals.	20-25’	Instructor Guideline G Handout: Wallet Cards
LESSON 4: THE HELPER ROLE & REVIEW			
7. Discussion: Telling An Adult	Open discussion of the difficulties involved in talking to adults: students will identify privately one adult they can confide in and sign a contract to take action.	25-30’	Instructor Guideline H Handout 6
8. Review	Review of suicide information, resources and student roles. Students sign contract that they will seek help for troubled peer.	10’	

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