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School-wide Staff and Faculty Training in Suicide Risk Awareness: Successes and Challenges

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Abstract

Problem—Rates of youth suicide and suicidal behavior remain high despite prevention efforts. Training high school personnel as gatekeepers is an important strategy.

Methods—Training was implemented in a school district's 5 high schools. Surveys were conducted before and after training sessions, which targeted all adults working at the high school. Two-hundred thirty-seven individuals completed the pretest and/or posttest.

Findings—Participants reported gains in knowledge, confidence, and feelings of competence in recognizing, approaching, and connecting distressed youth to school-based resources. Training was well-received.

Conclusion—Training is acceptable and appropriate for school personnel. Increasing the number of school personnel who participate in the training is challenging.

Keywords

adolescent; high school; school personnel; suicide prevention

Introduction

Rates of suicide and suicidal behavior among adolescents remain unacceptably high despite the considerable progress made in youth suicide prevention programming. Although a number of prevention programs exist (Suicide Prevention Resource Center, 2012), each year, approximately 4400 young people between the ages of 10 and 24 die by suicide (Centers for Disease Control and Prevention, 2012), and many times that number attempt or seriously consider suicide. Studies have demonstrated that youth respond well to interventions that target their suicide risk behaviors (Gould, Greenberg, Velting, & Shaffer, 2003; Hooven, Herting, & Snedker, 2010; Hooven, Walsh, Pike, & Herting, 2012; Wyman, et al., 2010), yet the places where many adolescents congregate, in particular, high schools, often do not offer or are unable to sustain suicide prevention programs. In general, school personnel who interact daily with students, such as administrators, teachers, cafeteria

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workers and custodians are not included or trained in suicide prevention activities. In some schools even counselors have limited training about youth suicide. One reason is that school-based suicide prevention often relies upon outside expertise and support, typically from clinicians and researchers who are not formally affiliated with the schools. This means that there is less reliance upon the expertise and experience of those in daily contact with youth at schools, and little support for the participation of school personnel in prevention efforts. In any high school it is the school staff and faculty members who are in a pivotal position to notice youth distress. Knowledge of the signs of emotional distress, and how to respond, is consistent with the roles of school staff and faculty, as well as with their ongoing access to youth. However, establishing such suicide prevention programs in schools requires careful consideration of all roles within a school system, how they will interact with each other, and the day-to-day realities of working in busy schools.

Background

Increasingly, schools have been required to address the mental health needs of students, including prevention of youth suicide (Centers for Disease Control, 2000; New Freedom Commission on Mental Health, 2003). A compelling reason for inclusion of school personnel in suicide prevention efforts is that many behaviors associated with youth suicidality are behaviors that school personnel manage regularly, including school difficulties, depression, anxiety, substance use, and disruptive behaviors (Esposito & Clum, 2002; Perkins & Hartless, 2002; Reynolds & Mazza, 1999),as well as fights, bullying, teasing, suspensions and expulsions (Smith et al., 2008; Vajani, Annest, Crosby, Alexander, & Millet, 2010). In addition, interpersonal conflict with parents, conflicts and/or break-ups in romantic relationships, and legal/disciplinary problems are often identified as precipitants of suicidal behaviors (Moskos, Olsen, Halbern, Keller, & Gray, 2005). Although these events usually happen outside of school, the effects of such events have the potential of being observed by or brought to the attention of school personnel, who therefore are in a position to help prevent adolescent suicide.

This is particularly important because suicidal youth are reluctant to initiate seeking help (Burns & Patton, 2000; Carlton & Deane, 2000), leaving it to those they interact with to notice and respond to their distress. High school students in general tend to lack awareness of available resources and fail to utilize traditional sources of help. For example, in a psychological autopsy study of 49 youth ages 13–21 (Moskos et al., 2005), two-thirds of the parents interviewed reported that their deceased child perceived seeking help as a sign of weakness or failure. When treatment is available or arranged, young people do not regularly attend treatment, and low adherence rates are common among adolescents who attempt suicide (King et al., 1995; Stewart, Manion, Simon, & Cloutier, 2001), arguing for easily accessible services tailored to their needs. Given high school students' vulnerability and reticence to seek help or follow through with treatment recommendations, school-based programs that invite and promote help seeking and access to support resources are a necessary and appropriate response to the challenge of youth suicide prevention.

School personnel are aware of the important role they play in young people's lives, and view suicide prevention as important and a part of their jobs (King, Price, Tellijohann, & Wahl, 1999), but often feel unprepared or uncomfortable responding to warning signs or suicidal behaviors. Suicidal behaviors are a particularly difficult topic for many people; there are concerns about what to say or not say, fear of doing harm, fear that the young person will respond in the affirmative when asked about suicidal thoughts or behavior, fear that the staff member will be left alone to manage a suicidal young person, and general concerns about available resources for referrals. Such concerns are not unanticipated as there are known deficits in suicide intervention training for teachers (Evans, 1999; Westefeld, Kettmann,

Lovno, & Hey, 2007), school counselors (King & Smith, 2000) and psychologists (Debski, Dubord Spadafore, Jacob, Poole, & Hixson, 2007). Teachers and other school staff members are often unprepared to respond effectively when a student presents as being at risk for suicide (Brown, Wyman, Guo, & Pena, 2006; Staal, 2001). While some faculty and staff members gain skills and knowledge through school trainings, such trainings are not consistently offered (King et al., 1999), or if they are offered, offered often only to select school personnel. The danger in these situations is that, instead of being everyone's job, youth suicide prevention often becomes the job of a select few, some of whom are assigned to multiple schools and are, therefore, not present every day at a single school.

Schools for the most part have welcomed and actively participated in suicide prevention programs that have been offered by universities and community agencies (e.g., Hooven, Walsh, Willgerodt, Salazar, 2011; Walker, Ashby, Hoskins, & Greene, 2009); these partnerships combine the advantages of the daily monitoring that is offered by school personnel with the support and expertise of external clinical resources. These programs are typically sustained throughout the duration of a funded program or research study, but unfortunately tend to wane after a few years as support is withdrawn, or when a study is complete. The termination of such supplementary programs may mean that schools no longer feel that they have the expertise, staffing or resources to serve suicidal youth.

An important direction for youth suicide prevention is partnering with high schools in order to increase the reach and effectiveness of suicide risk screening and intervention. This often means increasing the ability of school personnel to identify and intervene with distressed youth, and involves promoting suicide prevention as an expected component of high school student services programs. High school environments are well-suited to implementing suicide prevention programs, as they provide an important context for young people's lives and a venue for reaching young people and the adults who interact with them. As such, school faculty and staff members are important gatekeepers—individuals who are in daily contact with young people and who can recognize and refer someone who is at risk for suicide (Tompkins, Witt, & Abraibesh, 2010). The efficacious prevention programs that exist -- for the most part-- have not been translated adequately from research to the actualities of high school settings. For instance, high turnover rates typical among school personnel, and cutbacks that fall disproportionately on the student service sector, may mean instituting comprehensive school-wide training in suicide prevention in order to share the expertise and the burdens among staff and faculty, and to support school-wide staff and faculty involvement with at-risk youth.

For school-based prevention to succeed, however, those who introduce programs must attend to the capacity of the school system to implement and maintain programming, which means identifying the barriers to adding these programs to school services. School personnel typically have designated areas of responsibility, and if new tasks are added, ongoing tasks must be adjusted. Some tasks may be perceived as more in alignment with certain staff or faculty members' roles than with others'. Programs involving school personnel are useful and sustainable when they can be incorporated into the school setting and hierarchy. To do this, programs must take into account how faculty and staff members understand their roles, directly address practical and perceived barriers to the use of skills taught, promote the importance of skills for personnel at all levels of the school hierarchy, and demonstrate that the program makes a difference in how personnel enact the training in the context of their jobs, as well as the obvious goal of making a difference in terms of helping students.

School-wide gatekeeper training is a systematic approach to embedding suicide prevention in schools, and to utilizing the expertise of all school faculty and staff members to maximize prevention effects. Gatekeeper training is designed to increase support for youth by creating

an infrastructure of caring adults who are comfortable and able to talk with teens about suicide (Bond, Glover, Godfrey, Butler, & Patton, 2001; US Department of Health and Human Services, 2001). A compelling question is how to implement programs that increase staff and faculty awareness and response within school systems, and how to do so in ways that can be sustained across time.

Toward that end, a 90-minute gatekeeper training was developed. The training was designed to be appropriate for all school personnel, including counselors, teachers, school resource (police) officers, custodial and cafeteria staff members, and was crafted to be responsive to reported barriers, such as discomfort with suicide, failure to perceive its relevance to one's school role, and fears of revealing lack of skill in dealing with suicidal youth. In addition, the pragmatics of the individual and school situations were considered. For example, programs were offered at flexible times, provided information specific to the school and district-level support, were tailored to individual styles, and focused on increasing networks within the schools.

In this paper we describe the process and outcomes of implementing this gatekeeper training. The purpose of this training was to embed suicide prevention awareness throughout the school system, including awareness of designated resource persons, such as the school nurses, counselors, social workers and psychologists, to whom those on the "front lines" could turn in high-risk situations. Gatekeeper training was one aspect of a multi-level training program designed to increase school- and district-wide capacity to recognize and respond to youth in crisis. In addition to describing the training and its effectiveness, we describe successes and challenges encountered in implementing prevention programs in the school setting, and provide suggestions for maximizing success and overcoming potential challenges.

Methods

In this exploratory study, we worked with district and individual high school personnel to schedule trainings. We used surveys before and after the training to gather information about staff and faculty members' willingness, comfort, and confidence in approaching distressed youth, as well as their experience with at risk youth, and their perception of the relevance of the program to their role.

Procedures

Approval for procedures and instruments was obtained from the University of Washington Institutional Review Board as well as the school district's research division. Inclusion criteria were school district employee status, age 18 or over, and willingness to participate in training evaluation. The only exclusion criterion was unwillingness to complete training evaluation surveys. An e-mail invitation was sent to eligible school personnel by our district liaison describing the training and noting that the training was part of a research project. Training participants were informed about the training location and that they were free to participate in the training without obligation to participate in evaluation of the training (i.e., completing a survey prior to and after the training). With an average of 165 faculty and staff members employed at each school, training was offered to more than 800 individuals. Because listserves were used to invite people to training, the exact number of people who received, and read, the invitation cannot be ascertained. A total of 237 individuals completed the pre-training and/or post-training survey. Demographic characteristics of participants are detailed in the results section and in Table 1.

Measures

Paper and pencil surveys were distributed prior to and at the end of training. Survey items were used in previous studies (Eggert, Karovsky, & Pike, 1999; Randell, 2002) and reflect standard gatekeeper training questions developed by suicide prevention specialists, with the items specific to training evaluation developed for this study. Surveys covered several areas relevant to prevention programming, knowledge about suicide risk factors, and actions taken with at-risk youth. Pretest and posttest questions addressed the importance of school-based prevention (Items listed in Table 2), knowledge of specific programs ("Are you aware of specific programs at your school for students who are exhibiting problem behaviors [e.g., anger control problems, drug use/abuse, suicide-risk behaviors]?") and appropriate actions to be taken with a young person who appears depressed or suicidal. Respondents were asked to use a 0 – 6 scale, or to select or write in the response(s) that corresponded with the actions they would take. Also, respondents used a 0 – 10 scale to rate likelihood, comfort, and confidence in checking in with a distressed youth, where 0 was "not at all" and 10 was "extremely". The post-training survey contained questions about the quality and usefulness of the training. Responses were on a 0 – 6 scale (see Table 4 for items). Items were designed to measure training objectives, as well as satisfaction with the training. While we were interested in single item responses, we also examined reliability for items measuring similar constructs, with Cronbach's alpha ranging from 0.79 to 0.90.

Intervention/Training

Initially, the training was delivered in a 90-minute format, with 10 minutes at the beginning and end of the training for survey completion. Training included an interactive didactic format and slide show addressing the scope of the problem of youth suicide, facts and myths about youth suicide, risk factors, and suicide risk warning signs. Participants were encouraged to reflect on their own experiences with students and discuss how the risk factors and warning signs might manifest in their students. Next, basic suicide prevention helping steps (show you care, ask the question, get/offer help) were discussed and demonstrated. Then participants worked in small groups to personalize the language used in each of these steps, with trainers providing feedback and correction of ideas if needed. Participants practiced the helping steps in groups of 3, with each group member having a turn as the helper, the student, and an observer who gave feedback to the helper on the degree to which the helping steps were followed. Trainers circulated and observed during practice and provided coaching, feedback, and correction if needed. After the practice, the large group came together again for a discussion of resources available in the school if a staff or faculty member was concerned about a student. Whenever possible, school-based counselors, social workers, nurses, and psychologists, as well as at least one district-level service support person, participated in the training; they took a leadership role in order to reinforce (and if necessary, identify) their roles as support resources and to discuss school and district-specific referral procedures.

Our goal was to offer the training twice at each of the district's five comprehensive high schools. Despite our focus on faculty and staff working at the high schools, by district-level invitation a number of personnel from a variety of schools and grade levels in the district attended the trainings in the first year. In the second year of training, we focused on individual buildings and worked with building-based staff members to recruit personnel at the school. There were varying degrees of success with this approach, as we detail in the results and discussion sections. When school staff and faculty members were allowed to earn continuing education hours for the training, more staff and faculty members attended.

Analysis plan

Frequencies and percentages were used to describe participants' characteristics as well as their responses to yes/no and questions that involved reporting a specific number. We used paired t-tests to examine changes from the pre-training survey to the post-training survey.

Results

Table 1 contains information about participants. The majority of participants were female and were age 50 or younger. Racial backgrounds reported were diverse, with the largest group (48%) identifying as Caucasian. Sixteen percent reported their ethnic background as Hispanic or Latino. The largest group of participants was classroom teachers (42%), with the next most frequently represented group consisting of professionals responsible for mental health care (nurses, social workers, counselors, psychologists-16%). School administrators and non-educational staff were present less frequently. More than 70% reported working at their school for less than 10 years, while 46% reported working in the school district for 10 years or more.

Of the 220 participants who completed a pretest, 43% ($n = 94$) reported having had contact since the beginning of the school year with a young person who was depressed or suicidal. Of these 94, 80 (85%) reported that they talked with the young person about concerns for the young person's well-being, while an additional 12 (13%) reported that they talked indirectly about their concerns. Fifty (53%) of these individuals reported that they asked the young person if they were considering suicide or harming themselves, and an additional 13 (14%) said that they asked about this indirectly.

Prior to training, participants recognized the importance of prevention programs that address suicide-risk behaviors, anger control problems, violent behavior, and drug use/abuse (Table 2). After training, there were significant increases in the mean values for all four areas of prevention programming.

In terms of attitudes about taking action with a distressed and possibly suicidal person, there were significant increases in mean levels of participants' opinions about the appropriateness of asking directly about suicide thoughts (Table 3). There were also significant increases in mean values of participants' reports of likeliness of asking directly about suicide risk, comfort asking about suicide risk, and confidence in their ability to check in with a young person about how he/she is feeling. In addition, there was a significant increase in the amount that participants agreed that youth suicide is a major issue facing their community.

We also examined the percentage of participants who reported being uncomfortable or comfortable with addressing suicide by dichotomizing the 0–10 scale to indicate those who were less comfortable/neutral, and more comfortable. For appropriateness of asking a young person about suicide risk, 83% were comfortable before training, while 96% were comfortable after training. Likeliness of asking the young person about suicide risk increased from 77% of participants to 96% of participants. Comfort in approaching the young person and checking in about how s/he is feeling increased from 60% of participants pre-training to 90% post-training. Importantly, confidence in ability to check in with the young person increased from 82% to 96%.

Training evaluations were positive (Table 4). Overall satisfaction with the training was high ($M = 5.18$ on a 0–6 scale, $SD = 1.03$), and participants reported that training was highly relevant to their role, that they learned something new and important, and that feedback from trainers was useful. The response to the small-group practice was favorable, though mean values were not as high as other ratings. In terms of what was learned from the

training, scores were positive, with intent to use the training information in their role at school receiving the highest rating ($M = 5.34$, $SD = 0.94$).

Ratings for knowing “how to respond to a distressed youth”, ”room to utilize skills learned in training in their role”, and “confidence that services are available at school to help students” all had mean ratings greater than 5 on the 0–6 scale. The mean rating for ability to recognize signs that a young person is distressed and possibly thinking of suicide was also high ($M = 4.95$, $SD = 1.02$). The area of the evaluation that was least strong was the rating of application of training to students from different cultural backgrounds; attitudes were positive but were closer to neutral than other ratings ($M = 3.79$, SD=1.78).

In summary, training achieved the goals of increasing perceived competencies of school personnel to recognize, approach, and refer youth who might be at risk for suicide. Training was well-received by school personnel, who reported that the training was relevant to their role in the school.

Discussion

The purpose of this study was to examine the feasibility of implementing school-wide training in order to increase the number of gatekeepers, that is, individuals who can recognize and refer youth who are at risk for suicide. Establishing system-wide awareness and responsiveness increases the likelihood that a young person at risk for suicide will be approached, connected with, and referred for help and support. A critical step in reducing youth suicide and suicidal behaviors is to move beyond having a single responder in a school building. By doing so we extend the reach of suicide programming to those at-risk youth who often are not noticed, and certainly do not bring themselves to the attention of mental health professionals.

Gatekeeper training for school personnel was implemented as part of a developmental grant and was one tier in a multi-tiered approach to increasing high school infrastructure to recognize, refer, and evaluate students who might be at risk for suicide. In this project, we sought to implement school-wide gatekeeper training and to examine the training’s feasibility, acceptability and effectiveness. Each of five high schools scheduled two trainings, and all but one of the trainings was delivered. (One training was cancelled due to low enrollment, and combined with training at another high school.) A range of school staff and faculty members participated in the training. The specific knowledge gain outcomes, and attitude changes, that were targeted in the study were indeed supported: school personnel reported greater confidence, competence, and knowledge about suicide prevention at the end of the training than they had before training. This increases the likelihood that school staff and faculty members will approach, check in with, and connect young people with school-based resources.

The fact that 40% of trainees had been in contact with a suicidal young person in their everyday work prior to the training reinforces the importance of training school personnel to recognize and intervene with at-risk students, and is consistent with reports from studies with other school personnel (Baber & Bean, 2009; Freedenthal & Breslin, 2010). Given that only 25% of the 40% were clinicians (50% were teachers), we have evidence that people in all roles at school will come across, and hopefully recognize, suicide risk in a young person. This argues strongly for the appropriateness and relevance of broadening the range of school personnel who receive suicide prevention training.

Importantly, participants in the training made significant gains in their willingness to intervene with an at-risk student, as well as in their confidence, their comfort, and their feelings of competence in their ability to intervene. For instance, following the training,

mean levels of feeling confident and competent, and intending to intervene with an at-risk young person, increased significantly. Furthermore, percentages of those who felt some degree of comfort and competence in implementing suicide prevention steps also increased from pretest to posttest. These were key aspects of the study, and key achievements for the training, as the literature reports that lack of willingness, confidence and competence are the primary barriers for school personnel who are asked to expand their roles or take on new roles, particularly when their new role departs from their established area of expertise (Ajzen & Fishbein, 2008; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004). We see that at the same time that comfort, competence and confidence increased, participants reported that they were more likely to intervene as well, and saw intervening with a distressed youth as a more appropriate action to take than they had thought before. Systems level change theory has long recognized that a primary barrier to making changes that are required to fulfill goals is that individuals involved do not feel competent to take on new roles (Ajzen & Fishbein, 2008; Greenhalgh et al., 2004). Therefore, training that increases perceived confidence and competence in these new roles is likely to increase the responsiveness to at-risk youth.

An important area that was addressed by the training, and rated on the surveys, was the extent to which participants viewed the prevention of a range of youth mental health issues, including violence, substance abuse and suicide, as a legitimate area of school responsibility. This addresses another area of relevance; that is, beliefs that prevention is or is not relevant to the *jobs* of school personnel (and not just the likelihood that all school personnel will encounter distressed youth) and to schools in general. Believing that mental health is outside the purview of schools, much less their expertise, is an important barrier to program involvement at the district and school administration levels (e.g., Weist et al., 2000). However, training participants endorsed the importance of prevention programs for at-risk students, with generally high baseline beliefs in their importance, and, notably, those beliefs increased significantly by the end of the training. This is promising, because it reinforces the fact that school personnel see suicide prevention as a legitimate component of services that schools provide.

Given the challenges of finding time in a busy school day to attend trainings, and the fact that the actual trainings were after school - added to an already busy school day - we were concerned that participants would not find the trainings acceptable, useful and relevant. Post-program evaluation ratings showed that participants were satisfied with the training, rating it highly for what they learned and its relevance to their school role, and how it was delivered. An area for continued improvement in the training is related to attendees' perceptions of applicability of the training to students of various cultural and ethnic groups, which was rated somewhat lower. In this particular district, staff and faculty members are from a variety of ethnic and cultural backgrounds, as are the students with whom they work, so perhaps this distinction was less salient for this population; on the other hand, interpreting what does and does not apply to students from different cultural backgrounds can be complex. As noted by Sue and colleagues (Sue, Zane, Hall, & Berger, 2009), there is debate about the definition of cultural competency and what this looks like—is it a set of skills that a health professional possesses, or is it specific adaptation of a program to a particular population, or some combination of the two? Plans for future trainings include addressing cross-cultural issues directly, knowing that we often must rely upon our audience as well as their situation to understand what they need or perceive as important for applying new knowledge cross-culturally.

While it is clear that many school personnel, regardless of position, will encounter youth in distress, the challenges of implementing full staff and faculty member awareness programs are considerable. Challenges included changing the school culture, setting up procedures for

everyone from gatekeepers to clinicians, the pragmatics of engaging all school personnel through invitations, and facilitating training attendance. A general challenge was working with non-clinicians to trust the system in place (i.e. that someone “had their back”) for helping youth identified as being at risk enough to feel comfortable speaking up with young people.

Achieving the goal of school-wide training means thinking about the within-school barriers that prevent school personnel from interacting with other personnel outside their primary roles, or biases about individuals in certain roles having (or not having) a voice in student welfare. Some personnel, such as teachers, were already involved in multiple after-school trainings and activities, so it was necessary for administrative and district-level decisions to be made in order for them to attend. It was a challenge in this study to make sure that all staff and faculty members in each school received an invitation to the trainings, that they were encouraged and allowed to attend, and that they received release time or continuing education credit for attending.

Several barriers emerged related to implementing the training, and we provide suggestions for both researchers and school districts that might be helpful for future program development and implementation. Our intent was to train personnel working with high school students in all 5 comprehensive high schools in a school district. We learned that many school district personnel are responsible for students at a number of different schools, and that many work with students who are in elementary and middle school as well as working with those in high school. Although trainings took place at each of the comprehensive high schools, attendees were from various schools in the district. While not the original intent of the training, a benefit of this was that skills in recognizing and referring at-risk students were dispersed throughout the district. The largest group of attendees was teachers, which is important and appropriate for suicide prevention. We were less successful in engaging support staff members and ancillary staff members (e.g., cafeteria staff, custodians) in training. These adults also play a critical role in prevention, and are in a position to notice behaviors that are of concern in students. In addition, reaching out to school personnel who did not have a regular meeting venue (such as custodial and lunchroom staff) was complex, despite the fact that we offered to do as many trainings as an individual school desired. Finding a way to communicate directly with these personnel to issue an invitation and plan training at a time that was convenient for them is critical to increasing participation.

We also had a subgroup of the trainees who worked with younger children but reported that the skills learned were relevant even in the elementary school years. Though this was not our intent, given that the training is focused on interventions with adolescents, we contend that all adults can benefit from training, since they are likely to be in contact with adolescents in some aspect of their professional or personal lives. Principles of the training are relevant, regardless of age group—it is important to notice changes in behavior, to check in directly with the person, and to connect the person to help.

A challenge in scheduling trainings was finding a way to fit training into existing meeting structures. Based on feedback, training was reduced to 60 minutes to accommodate time frames available. This involved consolidating the presentation of myths and facts about youth suicide, and reducing the number of steps in the small-group work where participants prepared their scripts for talking with youth. Content of the training was not altered. We also shortened the pre-training and post-training surveys by selecting key items and eliminating less critical items related to training evaluation.

The issue of sustainability of programs is always a concern, and we were able to train 4 district personnel to deliver the training. This allowed the district to continue to train new personnel, and to provide refreshers for those who have been trained. In addition to building the capacity of the district to deliver the training, having individuals who are part of the system conduct the training is likely to increase attendance, and allows for flexibility of scheduling that might not be offered to an outside organization. We remain committed to providing consultation for the district-based trainers.

Limitations

In evaluating the training and response to the training, there are limitations that need to be acknowledged. First, we did not have pretest and post-test surveys on all participants. This was a function of participants arriving late or leaving early. It is also important to note that this study occurred over a three-year period of intense budget cuts and traumatic transition for the school district. There were personnel losses, as well as changes in roles. There were cutbacks in paid training time at the same time that demands for continued training remained stable. Credits were not allowed for post-school trainings but there were no time slots offered to train at existing meetings or in-service days. Therefore, those who chose to attend the training were often already interested in and motivated to learn more about preventing youth suicide. This may have an influence on the positive responses to and knowledge gained during the training. It likely influenced the high baseline values related to the participants' perception of the importance of suicide prevention. Nevertheless, increases in knowledge, comfort and skills were attained by participants.

Conclusion

Study findings reinforce the importance of training individuals in frequent contact with adolescents to recognize when a young person is in distress, check in about risk for suicide, and refer the young person to support resources. School personnel found the training relevant and acceptable, and training increased knowledge, confidence, and feelings of competence. Overcoming barriers to scheduling training and to reaching more school personnel remains a significant challenge for researchers.

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Table 1

Participant Demographics (N = 237)

Gender		
Female	146	(62%)
Male	54	(23%)
Unknown	37	(15%)
Age Range		
18–20 years	1	(<1%)
21–30 years	44	(19%)
31–40 years	37	(16%)
41–50 years	38	(16%)
51–60 years	61	(26%)
61–70 years	17	(7%)
71–80 years	1	(<1%)
Unknown	38	(16%)
Ethnicity		
Hispanic/Latino	39	(16%)
Not Hispanic/Latino	159	(67%)
Unknown	39	(16%)
Race		
Am Indian/Alaska Native	7	(3%)
Asian	16	(7%)
Nat Hawaiian/Pac Island	3	(1%)
Black/African American	19	(8%)
White	114	(48%)
Mixed	9	(4%)
Time Worked in This School		
Less than 2 years	57	(24%)
2–4 years	56	(24%)
5–9 years	51	(22%)
10–14 years	22	(9%)
15 years or more	15	(6%)
Unknown	36	(15%)
Time Worked in This District		
Less than 2 years	31	(13%)
2–4 years	30	(13%)
5–9 years	32	(14%)
10–14 years	48	(20%)
15 years or more	62	(26%)
Unknown	34	(14%)

Other	18	(8%)
Unknown	42	(18%)
Role		
Administrator	1	(<1%)
Teacher	100	(42%)
Nurse/Counselor/Social Worker/Psychologist	38	(16%)
Classroom Aide	15	(6%)
Administrative Support Staff	14	(6%)
Other Educational Support	16	(7%)
Other Staff	9	(4%)
Program Director	2	(1%)
Unknown	36	(15%)

Table 2

	n	Pretest Mean(SD)		Posttest Mean(SD)		t
Importance of prevention program s for students who exhibit…						
Suicide risk behaviors	191	5.69	(0.72)	5.81	(0.57)	3.02**
Anger control problems	188	5.62	(0.76)	5.72	(0.64)	2.35*
Violent behavior	189	5.73	(0.66)	5.83	0.46)	2.76**
Drug use/abuse	188	5.63	(0.81)	5.77	(0.59)	3.65**

Notes: Scale 0–6 (0= not at all, 3 = neutral, 6 = extremely)

* p < .05

** p < .01

Table 3

Changes in Attitudes, Comfort and Confidence about Suicide Prevention

Item	n	Pretest Mean(SD)		Posttest Mean(SD)		t
Appropriateness of asking a young person directly about suicide risk	180	8.06	(2.48)	9.33	(1.38)	7.25**
Likeliness of asking directly if a young person is thinking about suicide	180	7.57	(2.67)	9.06	(1.46)	8.65**
Comfort asking directly if a young person is thinking about suicide	178	7.00	(2.95)	8.45	(1.87)	9.43**
Confidence in ability to check in with a young person about how he/she is feeling	181	7.70	(2.22)	8.97	(1.42)	8.89**

Note: Scale 0–10 (0 = not at all, 5 = neutral, 10 = extremely) –last item (0 = strongly disagree, 5 = neutral, 10 = strongly agree)

** $p < .01$

Table 4

Training Evaluation Results

About the training:	Mean	(SD)
The information in this training was relevant to my role as a school staff member	5.41	(1.03)
I learned something new and important	5.00	(1.39)
The small group practice in how to talk with students was helpful	4.80	(1.26)
What I learned would apply to youth from different cultural backgrounds	3.79	(1.78)
Feedback from leaders was useful	5.25	(1.01)
Overall, I am satisfied with this training	5.18	(1.03)
What was learned about suicide prevention:		
I can recognize signs that a youth is distressed, and possibly thinking of suicide	4.95	(1.02)
I know how to respond when I am concerned about a student	5.28	(0.83)
I intend to use this information in my position at school	5.34	(0.94)
In my role at school there is room to utilize these skills	5.20	(1.10)
I am confident that there are services available if I refer or try to help a student	5.32	(0.95)

Note: Ratings were on a 0–6 scale.