

The Current Utilization of Suicide Prevention, Intervention, and Postvention in Idaho Junior High and High Schools

SCHOOL COUNSELOR SURVEY

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Identified Problem and Statistics

From the east coast to the west, the number of people dying at their own hand is rising at consistently alarming rates. Recent national figures released by the Center for Disease Control (2008) indicate suicide to be the third leading cause of death in young people between the ages of 15 and 24, preceded only by accidents and homicide. By definition, suicide is the “fatal self-inflicted destructive act with explicit or inferred intent to die” (American Association of Suicidology, 2008). With that definition in mind, percentages translated into numbers would equate to approximately one young person between the ages of 10 and 24 completing suicide every hour and 57 minutes between January and December of 2005 (Center for Disease Control, 2008).

Bringing the numbers closer to home, Idaho rates of suicide have consistently surpassed those of the rest of the nation, ranking above 43 other states in 2006 (Suicide Prevention Action Network of Idaho Fact Sheet, February 2008). According to reports by SPAN Idaho (Suicide Prevention Action Network of Idaho), the states suicide rates spiked in 2004 leaving 239 people dead by self-inflicted means. At a glance, the statistics provided are just numbers, but for those who have experienced the unnecessary and tragic loss of a loved one to suicide, each statistic is a sibling, a parent, a spouse, or someone’s child. And for every person who completes a suicide, there are said to be approximately six to 24 survivors; survivors are defined as “those who have lost a family member or friend to suicide” (Pompili, Lester, De Pisa, Del Casale, Tatarelli, & Girardi, 2008). With that many people being touched by suicide it is not surprising that research and suicide prevention measures are widespread with the aim to both understand and address this growing epidemic. Researchers, mental health providers, medical personnel, policy makers, and survivors alike are seeking answers as to what is actually going on and what we can do to stop it?

Statement of the Problem

Developed in 1996 in response to the suicidal death of their 34 year-old physician daughter, SPAN USA was Jerry and Elsie Weyrauch’s way to create an avenue for survivors of suicide to “transform their grief into positive action to prevent future tragedies” (Brochure published by: Depression and Bipolar Support Alliance (DBSA) and SPAN USA). Modeled after SPAN USA, SPAN Idaho began in 2002 with goals that included increasing community awareness and advancing measures designed to prevent suicide. For such awareness and advancement to take place there exists a need to build political

will and funding, which can be accomplished only through effective research.

According to Kim Kane of SPAN Idaho, the newness of this organization leaves almost all areas of interest unexplored (personal communication, 2008). While SPAN Idaho has been instrumental in developing and distributing a Suicide Prevention Toolkit (Idaho Youth Suicide Prevention Intervention Project, 2007), little information has been gathered on prevention measures currently offered to adolescents identified as being at greatest risk. That being said, this study focused its research on Idaho’s Junior High and High Schools. It’s purpose is to provide SPAN Idaho with necessary data to: 1) identify sources of prevention and assessment training received by school counselors, 2) measure school counselor preparedness in suicide intervention, 3) identify the tools that are being used as suicide assessments, 4) measure counselor preparedness in postvention (i.e. assisting surviving students following the completion of a suicide), 5) identify if schools/districts have existing prevention plans, and 6) identify if school counselors are experiencing suicidal student referrals. The information gained from this research will aid in the identification of strengths and weaknesses of Idaho’s school counselors in the areas of training and preparedness or comfort, specific to suicide assessment; intervention; and postvention; and to ultimately provide SPAN Idaho with the information necessary to request additional financial resources. Researchers also hope to gather necessary information that will provide SPAN Idaho a place to start its suicide prevention efforts across the state, and specifically with the identified highest risk/rural population. From a personal perspective, the researcher’s goal is to assist in lowering the incidents of future suicides thereby shielding families and loved ones from the pain and heartache experienced as the result of suicide.

Definition of Terms

Suicidality.

Throughout this document, the terms suicidality and suicidal ideation may be used interchangeably with the intent of referring to a range from mild thoughts about death to serious and specific plans to take one’s own life (Pinto, McCoy, & Whisman, 1997). While it is purported that the presence of suicidal ideations do not guarantee future attempts to take one’s life, it is identified as a risk factor that is strongly associated with likelihood of attempts (Pinto, McCoy, & Whisman, 1997).

Prevention.

As defined by Leenaars and Wenckstern (1999, p. 133), prevention refers to “good mental hygiene in general”. More specifically, suicide prevention means education that provides strategies that lessen the conditions that may lead to suicide. In school settings, young people, as well as the people who are responsible for providing them with good mental hygiene, must be educated on facts, myths, and ways to identify risk factors present in themselves and those around them. As Leenaars and Wenckstern (p. 133) explain, suicide prevention is enormously complicated and multidimensional.

Intervention.

Leenaars and Wenckstern (1999, p. 133) define intervention as a form of secondary prevention. By that definition intervention may look many different ways; it might refer to the way a person reacts to a suicidal crisis, or in the case of a school setting, an intervention may refer to how effectively a person is assessed for risk of suicide. An intervention may take place when a student presents with suicidal ideations, or it might occur when a student reports another student’s plan to take their own life. All of the above scenarios accurately describe an intervention according to the definition.

Many are under the false impression that depression must be present in order for a person to seriously consider suicide (Medical News Today, 2008). However, according to research done by Pfeiffer and Shaffer (2001), adolescent suicides often times follow other psychosocial stressors such as a recent loss, rejection, or academic crisis; these are feeling and events that would be screened for by conducting a proper suicidal risk assessment. Leenaars and Wenckstern also point out that effective suicide intervention in schools requires community involvement. Therefore education within the schools vicariously extends into the community (p. 133); a concept further supported by Hirsch’s research on rural suicides (2006, p. 192).

Postvention.

A term coined by Shneidman in 1985 (Leenaars & Wenckstern, 1999), postvention refers to intervention and services offered *after* a traumatic event, such as a suicide. In the event of an adolescent’s exposure to a suicide, postvention is designed to intervene on another potential incident of suicide by the surviving adolescent, as well as to provide grief resolution (Debski et al., 2007). Despite fearful myths to the contrary, postvention techniques, which include talking about the suicide with caring and supportive professionals have been shown

to improve the mental health skills of those whom have been traumatized by the suicidal death of someone they know and/or care about (Leenaars & Wenckstern, 1999). In fact, to not do so can lead to what Freud and others described as re-traumatizing or experiencing the traumatic event again and again. In addition, symptoms of depression may arise that include isolation, survivor’s guilt, and sleep disturbance, just to name a few. Postvention techniques, properly executed by fully trained staff, can be effective in identifying presenting symptoms, can provide relief to those who are suffering from the loss, and may intervene on others who are contemplating or glorifying the act of suicide themselves. What postvention is not is a replacement for grief counseling. It does not look the same for everyone nor is it a trigger for suicidality (Leenaars & Wenckstern, 1999).

As stated in the introduction, Idaho differs greatly from the majority of the nation with regard to suicide rates. While the reason for such a drastic difference is not fully understood, recent research on suicide rates in rural areas has provided information that indicates the presence of certain risk factors in rural communities that do not exist in urban communities. Rural communities or states, such as Idaho have been defined as areas having a decreased population over a vast amount of geographic area (Hirsch, 2006). Hirsch's research (2006) proposes that cultural characteristics in rural areas may propose additional internal and external risk factors (p. 192) that contribute to already identified risks such as substance abuse, (Mino, Bousquet & Broers, 1999) and psychiatric disorders that include depression and other mood disorders (Medical News Today, 2008). Hirsch identifies these additional risk factors as geographic isolation, economic and political factors, rural ideology, and interpersonal isolation (p. 192). While all of these risks may be equally important, three specific threats will be defined and discussed at this time in an effort to provide further justification for focusing on the school setting as an important resource for suicide prevention. The three focus areas are *rural ideology, geographic isolation, and economic distress*.

Rural ideals often refer to such things as strong work ethic, religiosity and family values, as well as independence and self-sufficiency (Hirsch, 2006). However, in this particular perspective, rural ideology also refers to the propensity to negatively stigmatize mental health disorders (Hirsch, 2006) such as major depression and anxiety disorders, both of which have been strongly correlated to suicidal tendencies among adolescents (Debski, Spadafore, Jacob, Poole, & Hixson, 2007). Such ideologies often result in under utilization of counseling or other mental health resources, even if they are available in the community (Hirsch, 2006).

While it is common for people in rural communities to more readily utilize physicians or religious leaders to combat mental distress, the remaining two cultural characteristics, *geographic isolation* and *economic distress*, create even more barriers to the utilization of mental health support services. *Geographic isolation* refers to small communities that are sparsely populated and geographically spread out, thereby lacking community-based supports, professional resources and emotional and social supports (Hirsch, 2006).

Geographic isolation coupled with *economic distress*, often present in rural communities, can result in limited personal and community resources (Hirsch, 2006). Not only is it less feasible to delegate the family finances for such services, limited state and

federal funding of community based mental health agencies also leads to shortages of professional services (Hirsch, 2006). Little access to mental health services and limited willingness to utilize them confirm the reality that health care systems alone cannot be relied upon to meet the needs of adolescents at risk of suicide (Leenaars & Wendckstern, 1999). An assumption could then be made that schools may be a reasonable resource for suicide prevention in rural areas.

Hypothesis

Research shows that well meaning, yet untrained school professionals can actually worsen an already fragile situation, leading to hindered emotional development and increased potential for suicide (Leenaars & Wenckstern, 1999). That being said, it is important to not only identify *what* school personnel are currently offering students with regard to suicide prevention or support, but of equal importance is to identify the extent of counselor's training and level of comfort with the information they are currently presenting to the students. According to a 2002 survey completed by nationally certified school psychologists regarding the level of crisis intervention training and knowledge provided to them during their university coursework, only 37% reported completion of the type of coursework needed to deal with the crisis circumstances they had experienced in their jobs (Debski et al, 2007). Additionally, of that 37%, most (58%) reported being only minimally prepared by the coursework to handle any crisis related to suicide.

Due to the high incidents of suicidality in school settings, the study concluded that school psychologists need to be knowledgeable of the risk factors, assessment measures for risk, warning signs, as well as the appropriate postvention techniques frequently needed in school settings (Debski et al, 2007). Debski et al, support Leenaars and Wenckstern's statement that state suicide intervention, without appropriate and effective training of staff, can prove to be counterproductive at least, and at most may lead to the very result they intend to avoid. It is hypothesized that school districts with the highest levels of suicide completion are school districts with professionals having the least level of training or comfort in suicide prevention, intervention, and postvention measures.

Study Participants and Informed Consent

The participants of the survey consisted of professional school counselors, and social workers that are members of the School Social Work Association of Idaho, who are currently working in Idaho middle school, junior high, or high school setting. There are currently 303 identified junior high schools and high schools in the state of Idaho (State Department of Education). An informed consent letter with a link to the survey was sent via e-mail to all of the Safe and Drug Free School Coordinators in the state. Dispersion of the survey to the school counselors was then left to the discretion of each Safe and Drug Free School Coordinator. Each coordinator oversees a specific region of the state and all of the schools within that region. This list of coordinators was provided to the researchers by Matt McCarter, Head of the Safe and Drug Free Schools Program within the Idaho Department of Education. Researchers were also contacted by the president the School Social Work Association of Idaho (SSWAI), Tod Gunter; and with the permission of the researchers, the survey was dispersed to school social workers that were identified as members of SSWAI. The informed consent letter identified the intent of the survey, “to collect information about training and experiences in the area of adolescent suicide assessment, prevention, intervention and postvention”. Its purpose was identified as: “identifying current practices in these areas and future training needs in the area of adolescent suicide prevention throughout the state”. Participants were not asked to identify themselves by name on the survey, nor were they contacted directly by the researchers; therefore, complete anonymity was assured regarding survey participation. Participants were also informed that participation in the survey was completely voluntary.

(See the informed consent as attachment A)

Instrumentation

The research was conducted in the form of a quantitative descriptive study in which participants were asked to voluntarily participate in an electronically generated Internet questionnaire. The survey design closely followed a survey that was developed and utilized by Susan Jacob, Ph.D., of Michigan University. Susan’s survey, which was used in research conducted in 2007, gathered much of the same information but was specifically dispersed to school psychologists. Having obtained Dr. Jacob’s written permission, researchers adapted the survey to meet the specific needs and characteristics identified for this study’s purpose. Although the current survey was intended to be sent

out as a mailed survey, it was ultimately made accessible to participants as an online survey via the website: www.survs.com.

The survey included the following variables: 1) credentials of professionals, 2) highest level of education obtained, 3) level of preparedness in assessment, prevention, and postvention services, 4) trainings obtained by the professionals, 5) the number of students being served by the professional, 6) the number of years worked in the current professional role, 7) the number of incidents of completed suicides within the school over the past two years, 8) the number of suicide referrals received over the past two years, 9) perceived employment settings (e.g. suburban versus rural), and 10) the age range of the respondents.

(See the survey as attachment B)

On average the survey took 13 minutes for respondents to complete. A total of 109 respondents took the survey, n=109. It has been noted as a limitation that four participants did not recognize pages beyond the first page of the survey; therefore, the total number of participants decreased from n=109 to n=105 at question number 9. This limitation, along with any participants who skipped survey questions, has ultimately led to a completion rate of 96%. Please note that the statistics presented will only be calculated from participants who actually answered the question,

and that statistics will not reflect the input of participants who skipped the question.

The following is a detailed description of each question as it appeared on the survey, as well as univariate results reported statistically. Both percentages and raw scores are provided in a graph below each survey question. Only descriptive information and raw scores are provided for the surveys open-ended questions, percentiles are not

Survey Results

1) What training have you received in assessment of suicide risk (“prevention”)? *(Check all that apply)*

	Percent of Total	Respondents
Graduate level coursework	70%	76
Professional development workshops	79%	86
District in-service	36%	39
Self-study (e.g., read books)	63%	69
Total respondents		109
Respondents who skipped this question		0

2) How well prepared do you perceive yourself to be in handling students who are potentially suicidal (“intervention”)?

	Percent of Total	Respondents
Not at all prepared	2%	2
Somewhat prepared	43%	47
Well prepared	55%	60
Total respondents		109
Respondents who skipped this question		0

3) What training have you received regarding appropriate actions following a completed student suicide (“postvention”)? *(Check all that apply)*

	Percent of Total	Respondents
Graduate level coursework	49%	51
Professional development workshops	66%	69
District in-service	27%	28
Self-study (e.g., read books)	57%	60
Total respondents		105
Respondents who skipped this question		4

4) How well prepared do you perceive yourself to be in providing postvention (i.e., assist following a completed student suicide)?

	Percent of Total	Respondents
Not at all prepared	15%	16
Somewhat prepared	50%	55
Well prepared	35%	38
Total respondents		109
Respondents who skipped this question		0

5) Rank the following areas in order based on your desire for additional training (1 = most, 4 = least).

____Assessment ____Intervention ____Prevention ____Postvention (*Open-ended text*)

**Due to the formatting of the online survey, participant's responses could not be accurately interpreted; therefore results will not be included in the analysis.*

6) Does your school/district have a written plan to reduce the likelihood of student suicide?

	Percent of Total	Respondents
Yes	34%	37
No	26%	28
Not sure	40%	43
Total respondents		108
Respondents who skipped this question		1

7) Whether or not your district has a written plan, which of the following suicide prevention roles do you fill in your job setting?

(*Check all that apply*)

	Percent of Total	Respondents
Provide training for staff on recognizing suicide warning signs and appropriate actions	56%	60
Plan and/or implement curricular components to teach students healthy problem solving	56%	60
Serve on crisis intervention team	71%	76
Conduct assessment of suicide risk of individual students	79%	84
Coordinate referrals of at risk students and their families to community agencies	88%	94
Provide in-school counseling/support for students identified as potentially suicidal	94%	101
Total respondents		107
Respondents who skipped this question		2

8) Does your school/district have a written plan to respond to a completed student suicide?

	Percent of Total	Respondents
Yes	42%	46
No	18%	20
Not sure	39%	43
Total respondents		109
Respondents who skipped this question		0

9) Whether or not your school/district has a written plan, which of the following suicide postvention roles do you fill in your job setting? (Check all that apply)

	Percent of Total	Respondents
Coordinate the school's post-suicide crisis plan	44%	45
Coordinate school and community support services	44%	45
Provide grief counseling to students	94%	97
Assess suicide risk of other students	85%	88
Help school community understand the grief process	55%	57
Provide de-briefing for staff	67%	69
Respond to inquiries from media	5%	5
Follow the deceased student's class schedule	32%	33
Refer students at risk to community agencies	85%	88
Respond to concerns of parents of other students	93%	96
Total respondents		103
Respondents who skipped this question		2

10) Does your school/district have a written policy allowing students to be seen by the school counselor without parent consent if it is suspected that the student may be suicidal?

	Percent of Total	Respondents
Yes	38%	39
No	17%	18
Not sure	45%	47
Total respondents		104
Respondents who skipped this question		1

11) Have you ever had a student referred to you as potentially suicidal?

	Percent of Total	Respondents
Yes	97%	101
No	3%	3
Total respondents		104
Respondents who skipped this question		1

12) In the past two years, about how many students have been referred to you as potentially suicidal? (Open-ended text)

Of the 103 responding participants that indicated receiving referrals in the last 2 years only three indicated that they had never received a referral for a potentially suicidal student. Four counselors indicated 1 referral, sixteen indicated 2 referrals, ten indicated 3 referrals, twelve indicated 4 referrals, thirty-six indicated 5-10 referrals, seven indicated 11-15 referrals, six indicated 16-20 referrals, and four indicated more than 20 referrals. The counselor who reported the most referrals has had over 50 students referred to him or her as potentially suicidal.

	Percent of Total	Respondents
Total respondents		103
Respondents who skipped this question		2

13) If you have seen one or more students referred as potentially suicidal, please indicate which of the following procedures and instruments you have used to assess suicide risk. (*Check all that apply*)

	Percent of Total	Respondents
Suicidal Ideation Questionnaire (SIQ or SIQ-JR)	13%	12
Student interview	97%	93
Teen Screen	6%	6
Suicide Probability Scale (SPS)	8%	8
Beck Hopelessness Scale	5%	5
Beck Hopelessness Scale for Adolescence	5%	5
Beck Scale of Suicidal Ideations	7%	7
Other, please specify*	29%	28
Total respondents		96
Respondents who skipped this question		9

* *The following are the detailed responses to “Other, please specify” from question #13 and are presented exactly as reported.*

- *Scaling and questions I learned in past. I don't know if they are from a formal assessment.*
- *Other counselor assisted in process*
- *Referred to professional services*
- *Compu 15*
- *Historical information, parent/teacher observations, etc.*
- *SLAP*
- *Suicide Risk Assessment Worksheet*
- *Interview*
- *Suicide Risk Assessment Summary Sheet (from a training)*
- *Individual counseling*
- *Combination of questions; look for unusual marks on their body; empathy*
- *I have other tools / questionnaires which I use*
- *Beck Depression Inventory*
- *Student referral with text evidence*
- *I marked all of them because I use parts of several different assessment tools*
- *Parent and teacher interview*
- *Beck Depression Screen for Adolescents*
- *Boise School District intervention assessment*
- *School district designed questionnaire*
- *Research based suicide risk assessment developed in district*
- *Questionnaire from another book from a training*
- *Beck Depression & general risk questions*
- *Children's Depression Inventory*
- *Use district developed manual and questionnaire and forms for the process*
- *Adolescent and Child Urgent Threat Evaluation*
- *ACUTE*
- *Risk assessment*
- *Parent contact*

14) In the past two years, how many completed student suicides have occurred in your school? (*Open-ended text*)

Of the 102 respondents, 89 indicated no completed suicides, 8 indicated one completed suicide, 4 indicated two completed suicides, and 1 indicated between two and four completed suicides in the past two years.

	Percent of Total	Respondents
Total respondents		102
Respondents who skipped this question		3

15) How many years have you worked as a school counselor? (Open-ended text)

Survey participants varied greatly in their answers regarding lengths of service. Responses ranged from one year to 41 years.

	Percent of Total	Respondents
Total respondents		103
Respondents who skipped this question		2

16) What is the highest degree you have attained?

	Percent of Total	Respondents
Masters	47%	47
Masters plus licensure	51%	51
Doctoral	2%	2
Total respondents		100
Respondents who skipped this question		5

17) Age?

	Percent of Total	Respondents
20-29 years	8%	8
30-39 years	24%	24
40-49 years	21%	21
50-59 years	31%	32
60+ years	17%	17
Total respondents		102
Respondents who skipped this question		3

18) What grades or age groups were included on your caseload in the past two years?

	Percent of Total	Respondents
6-8th grades - Middle School/Junior High	23%	24
9-12th grade - High School	31%	32
Both	23%	24
Other, please specify	23%	24
Total respondents		104
Respondents who skipped this question		1

** Results indicate this question to be poorly worded as evidenced by the positive responses to the "Other" category, which should have been included in one of the other three choices. It also appears that respondents may have had trouble consistently reporting data due to the different ways school districts divide their students into junior high school versus high school populations; i.e. 9th grade students are sometimes kept in junior high schools while other schools include 9th graders in their high school population.*

19) In the past 2 years, about how much time have you typically spent working DIRECTLY with middle and/or high school students each week?

	Percent of Total	Respondents
None	3%	3
1-4 hours	3%	3
5-10 hours	11%	11
11-20 hours	25%	26
More than 20 hours per week	59%	61
Total respondents		104
Respondents who skipped this question		1

20) About how many students are on your caseload? (*Open-ended text*)

One counselor reported a number as low as 3 students on his or her caseload. This low of a number might lead one to believe that this respondent is a counseling intern. The counselor with the largest caseload indicated approximately 1100 students. What the numbers did indicate was that counselors from both rural populations and larger city type of populations responded.

	Percent of Total	Respondents
Total respondents		103
Respondents who skipped this question		2

21) How many schools do you serve? (*Open-ended text*)

72 respondents indicated serving one school, 17 indicated serving 2 schools, and 14 respondents indicated serving 3 or more schools.

	Percent of Total	Respondents
Total respondents		103
Respondents who skipped this question		2

22) Do you serve a rural population? (*Open-ended text*)

65 respondents indicated that they serve a rural population, and 38 indicated they did not.

** It has been noted by the researchers that counselors who work in some of Idaho’s larger cities may still serve “rural populations”; and that the subjectivity of the question has lead to subjective results.*

	Percent of Total	Respondents
Total respondents		103
Respondents who skipped this question		2

23) Do you believe any of the following limit your ability to be involved in suicide prevention and response? (*Check all that apply*)

	Percent of Total	Respondents
Job description focuses on assessment and prevention only.	20%	9
Suicide intervention and response is the job of others within the school (e.g., school social workers or psychologists).	13%	6
Suicide intervention and response is the job of others outside of the school (e.g., mental health hospitals, psychiatrists).	17%	8
Serve too many schools to be involved in suicide prevention and response.	17%	8
Lack of training.	63%	29
Not interested in this aspect of services.	2%	1
Total respondents		46
Respondents who skipped this question		59

Descriptive Statistics

At the request of the research collaborator, Kim Kane of SPAN Idaho, the central focus of statistical interpretation will be:

- 1) the ‘sources of prevention and assessment training’ received by counselors
- 2) ‘counselor preparedness in suicide intervention’
- 3) ‘tools being used for assessments’
- 4) ‘counselor preparedness in postvention’ i.e. assisting surviving students following the completion of a suicide
- 5) ‘district prevention plans’
- 6) ‘counselors with suicidal student referrals’. Each of these areas will be broken down to provide further clarification and application

Sources of Prevention and Assessment Training.

Survey results indicate that the majority of training received in suicide prevention or assessment is occurring in “professional development workshops” that are neither provided by “graduate level coursework” or “district in-service”. 30% of participating school counselors report that they were not introduced to any form of suicide risk assessment in their graduate program. 63% of participants indicate that they have studied assessments and preventive measures of their own will. Further, respondents indicate that they are least likely to receive preventative training from their employer, the school district.

Assessment Training

	Percent of Total	Respondents
Graduate level coursework	70%	76
Professional development workshops	79%	86
District in-service	36%	39
Self-study (e.g., read books)	63%	69
Total respondents		109
Respondents who skipped this question		0

Counselor Preparedness in Intervention.

45% of counselors responded as feeling less than well prepared to intervene with a potentially suicidal student. Of these participants 45% cited a lack of training as the reason for their lack of preparedness. Further exploration shows that 92% of counselors who reported feeling less than well prepared to intervene had indeed experienced a student referred to them for suicidal ideation. Put into laymen’s terms, when a student comes to a counselor or is referred to a counselor because he or she is feeling suicidal, 45% of all school counselors do not know how to effectively deal with the student.

Counselor Intervention Preparedness

	Percent of Total	Respondents
Not at all prepared	2%	2
Somewhat prepared	43%	47
Well prepared	55%	60
Total respondents		109
Respondents who skipped this question		0

Tools being Used for Assessments.

Survey results report that a majority of school counselors, 97%, have used the ‘student interview’ as a tool for assessing student suicidality. Results also illustrate that there is little to no consistency in the use of formal suicide assessments within Idaho schools; in fact, some participants even indicated using tools not specific to measure suicidality, such as the Beck Depression Inventory.

Assessment Tools

	Percent of Total	Respondents
Suicidal Ideation Questionnaire (SIQ or SIQ-JR)	13%	12
Student interview	97%	93
Teen Screen	6%	6
Suicide Probability Scale (SPS)	8%	8
Beck Hopelessness Scale	5%	5
Beck Hopelessness Scale for Adolescence	5%	5
Beck Scale of Suicidal Ideations	7%	7
Other, please specify	29%	28
Total respondents		96
Respondents who skipped this question		9

Counselor Preparedness in Postvention.

When asked how well prepared counselors are to provide postvention services, 16% indicated that they are “not at all prepared”. In all, 65% of participants indicated that they are less than well prepared to provide postvention services. Of the 101 counselors who reported having experience providing postvention services, 65 maintained feeling less than well prepared; statistical reporting maintained consistent at 64%. This indicates that only 1 counselor out of 100 will feel more prepared to provide services the next time a completed student suicide occurs.

Counselor Postvention Preparedness

	Percent of Total	Respondents
Not at all prepared	15%	16
Somewhat prepared	50%	55
Well prepared	35%	38
Total respondents		109
Respondents who skipped this question		0

District prevention plans.

40% of participating counselors reported that they did not know if their school/district had a written suicide prevention plan to assist them in their duties. 26% of counselors reported that their school/district does not have a written plan to reduce the likelihood of student suicide; and 37 participants, or 34%, reported that their school/district does have a written plan. This indicates that a majority of Idaho's school counselors, 66%, are left to their own devices when facing the prevention of a suicide.

District Prevention Plan

	Percent of Total	Respondents
Yes	34%	37
No	26%	28
Not sure	40%	43
Total respondents		108
Respondents who skipped this question		1

Counselors with suicidal student referrals.

97% of counselors indicated that they have had a student referred to them with suicidal risk factors or suicidal ideations, indicating that school counselors throughout the state are expected to have the knowledge and training to provide suicide assessment and intervention services. When asked more specifically about the number of student referrals that they have had over the last two years, the largest percentage being 35%, reported having 5-10 referrals. In fact, most counselors reported receiving multiple referrals.

Suicidal Student Referrals

	Percent of Total	Respondents
Yes	97%	101
No	3%	3
Total respondents		104
Respondents who skipped this question		1

Conclusions

Consistent with the rest of the nation, Idaho is seeking ways to effectively intervene on the tragedy of teenage suicide. With the development of district wide policies, encouragement toward additional training, and increased awareness thanks to the works of SPAN Idaho, the state has begun the process of addressing this ever-growing wave of teenage hopelessness. However, as this study shows, much more remains to be done with regard to counselor training and comfort (preparedness) if they are to be effective in their suicide prevention, intervention, and postvention measures.

Originally, it was hypothesized that school districts with the highest levels of suicide completions are school districts with professionals having the least level of training or comfort in suicide prevention, intervention, and postvention measures. As a result of confidentiality constraints, information specific to individual school districts was unattainable. However, the survey was able to successfully identify the amount of training counselors have received, and revealed the fact that more training is needed. Additionally, the survey indicated that while the majority of counselors feel well prepared to address prevention and intervention, there are still a significant number of counselors who lack training in these areas.

97% of the school counselors throughout the state reported having had experienced a potentially suicidal student. However, as indicated in question #2, “How well prepared do you perceive yourself to be in handling students who are potentially suicidal?” only 55% of counselors indicated feeling “well prepared” to handle a student who may be contemplating suicide. The disparity of these numbers would seem to indicate that professional experience does not necessarily increase preparedness or competency. It appears that lack of confidence in one’s preparedness paired with the lack of consistency in utilizing evidence based assessment tools, may inadvertently lead to school counselors who are missing the signs of a suicidal student.

To clarify, the survey results show that school counselors are using as many as twenty-eight different intervention measures. Seven of the assessment tools are known to be backed by research, while the other tools may or may not be researched and evidence based. In assessing this information, it could be concluded that actions should be taken to make changes to suicide intervention procedures. Perhaps the implementation of a statewide policy, which identifies specific evidence-based assessment and intervention tools, would increase consistency, competency, and confidence for school counselors throughout Idaho. As it stands now, the majority of Idaho counselors either

deny the presence of district wide policy or plans, or they report uncertainty of their existence. The lack of providing school counselors with policies and plans that are consistent throughout the state is yet another identified weakness in their preparedness.

Of further interest is the indication, by 30% of Idaho counselors, that suicide prevention, intervention, and postvention was never addressed or taught in their graduate level education. They did, however, report getting training from workshops and district in-services provided within different school districts. Despite this fact, 45% of counselors surveyed reported the greatest barrier to them feeling both competent and confident is a lack of training, specifically in the area of postvention. That being said, students would be best served by increasing education in suicide prevention to existing school counselors and social workers, and by adding in depth suicide prevention education to graduate level curriculums. Of particular note however, when Idaho statistics were compared to those of the rest of the nation, Idaho far outranked others in graduate level education. Idaho school counselors and social workers reported receiving suicide prevention education 70% of the time, while the rest of the nation reported 37%. What was not clarified within this survey however was whether that graduate level education had been obtained in Idaho graduate level schools. This then would be an area indicating need for further research.

Of most significant interest is the lack of training and preparedness in the area of postvention. 64% of Idaho junior high and high school counselors reported to be ill prepared to deal with the aftermath of a completed student suicide. Of equal concern are the reports of postvention measures that have been utilized by counselors with limited postvention training. This is alarming given the research that indicates more harm than good can be created by professionals who are poorly educated in the task of postvention. It is proposed that no intervention at all is better than postvention measures executed by well meaning, but untrained counselors. While the intentions are noble and the counselors may be skilled and educated in many other areas, if they have not had specific training in how to properly implement postvention skills, Idaho school counselors may in fact be contributing to the high rate of adolescent suicide. Survey results indicate a high need for statewide suicide postvention training.

Limitations

As noted earlier in the summary, the hypothesis could not be concluded or supported due to unanticipated confidentiality

constraints. The original hypothesis stated “school districts with the highest levels of suicide completion are school districts with professionals having the least level of training or comfort in suicide prevention, assessment, intervention, and postvention measures.” However, due to guaranteed confidentiality of survey participants, counselors were not asked to identify themselves by school districts, therefore a mistake was made in not rewriting the hypothesis to state “school counselors with the highest level of suicide completion are school counselors who also report having the least level of training or comfort in suicide prevention, assessment, intervention, and postvention measures.” This would have allowed counselors to continue to remain anonymous while still allowing a correlation to be drawn.

An error was concluded to have occurred as a result of confusion on the part of the participants. It was determined that 4 survey participants dropped off following question number 8 on the survey. Perhaps this problem is a result of the survey being in computer format versus pen and pencil format. It is proposed that this situation could also have been eliminated if wording at the end of page one had stated, “please continue to page 2.”

Poor wording within the survey led to a number of errors and limited usefulness of some of the data. For example, it was determined that an error may have occurred in survey question #3, which asks: “What training have you received regarding appropriate actions following a completed student suicide (“postvention”)? The survey writers have determined that it would have been beneficial to have offered a “none” option for respondents. As it was written an assumption was made that all counselors had received at least some sort of training. Of course making any assumption in a survey is an error in research.

Additionally, by writing survey question #14 “In the past two years, how many completed student suicides have occurred in your school?” in an open ended format, a correlate study was unable to be performed. Therefore the section addressing prevention, intervention, and postvention was left inconclusive and unable to be correlated. It would have been better to offer numerical options that identified either specific numbers or a range of options such as 0-2, 3-5, 6-10, etc. This could then have made correlations to other variables a possibility. These problem areas may be something to consider in future research.

Critique of our Research

This has been a learning process from beginning to end. Considering that our survey was unable to collect the proper

data to support or refute our hypothesis, it is fair to say that we made a few mistakes. In the process of writing our survey, we realized that asking the critical question, “Which school district do you work in” would have compromised our participants’ anonymity. In reflection, we were able to realize that if we had kept the school district question but taken out the gender specific question, the age question, and the years of service question, we would have been able to maintain counselor anonymity and still worked under our hypothesis.

Once we received and reviewed that surveys results we were able to identify that some of the questions that we asked were irrelevant to both our research goal and the hypothesis; thus resulting in a survey that was much longer than it needed to be.

On a more positive note, the results of our research will be useful to our collaborator and may have more applications that originally planned, which was to identify the strengths and weaknesses of Idaho’s school counselors in the areas of training and preparedness or comfort, specific to suicide assessment; intervention; and postvention; and to ultimately provide SPAN Idaho with the information necessary to request additional financial resources. For example, the information if shared with graduate and continuing education programs, could result in more comprehensive trainings of school counselors specific to the use of suicide assessment, intervention, and postvention techniques and tools.

Recommendations for Further Research

This study has shown that many counselors feel ill prepared to provide postvention services due to a lack of training. Since research has shown that damage can be created by the use of poor postvention techniques, it would be of interest for future researchers to identify the most effective ways to provide postvention training; be that graduate level coursework, district in-service trainings, self-study or professional workshops.

Further research can also be done to determine how a student interview is actually conducted by counselors. Is the student interview/questioning being based upon evidence-based research; and is an assessment tool being used with students who show at risk factors, but deny suicidal ideation? This information correlated to the comfort level experienced by the counselors during this process, could potentially back our research results, which indicates that experience does not increase comfort and preparedness, but increased training does.

The results of the survey report that counselors are receiving the least amount of training and continuing education from

their employer, the school district. Based upon this revelation, recommendations for further research include exploration into the quality of “district in-service” trainings being offered to school counselors. Additionally noted as a limitation in our research was the non-distinction of whether the “professional development workshops” are actually being provided and/or paid for by school districts. Due to this in-distinction, one might conclude that the school districts are providing the least amount of educational support to their counselors; however, this conclusion cannot be supported by the data as it was reported.

Dissemination

Survey results will be presented to Kim Kane at SPAN Idaho to be used as a basis for further research, as well as to support SPAN Idaho’s goal to increase awareness and to develop ways to decrease the consistently high number of completed suicides in the state.

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THE ATTACHED SURVEY IS BEING ADMINISTERED WITH THE PERMISSION OF THE IDAHO DEPARTMENT OF EDUCATION, SAFE AND DRUG FREE SCHOOLS, NORTHWEST NAZARENE UNIVERSITY, AND IN COLLABORATION WITH SUICIDE PREVENTION ACTION NETWORK OF IDAHO FOR THE PURPOSE OF RESEARCH.

ALL SUBMISSIONS ARE ANONYMOUS. AT NO TIME WILL YOUR NAME BE LINKED TO YOUR SUBMISSION.

IT IS INTENDED ONLY FOR JUNIOR HIGH AND HIGH SCHOOL COUNSELORS WORKING IN IDAHO SCHOOLS.

Dear **Junior High and High School** Counselors,

Do you feel prepared to handle a student who is suicidal? Do you know how to assist staff and other students following a completed student suicide?

<https://www.survs.com/survey/KMPDPE5MUL> is a brief 23-item survey that aims to collect information regarding counselor training and experiences in the area of adolescent suicide assessment, prevention, intervention, and postvention. Please complete the survey as soon as possible. **All submissions are due by January 15th 2010.** Results of the survey will be shared with SPAN Idaho (Suicide Prevention Action Network of Idaho) for the purpose of identifying current practices and methodologies used, identifying future training needs in the area of adolescent suicide prevention, and securing future funding for SPAN Idaho.

Participation is voluntary and completely anonymous. Refusal to participate will not involve penalty or loss of benefits. You may discontinue participation at any time. The survey will require **less than 10 minutes** to complete. Please answer questions honestly and completely. Your identity will not be linked to your submission at any time.

Results of the collected data will be presented to SPAN Idaho and a body of school counseling graduate students at Northwest Nazarene University in a classroom setting.

Please note that the research being conducted is also being utilized to fulfill graduation requirements for two students enrolled in the Graduate Counseling program at Northwest Nazarene University (faculty supervisor: Dr. Michael Pitts, mapitts@nnu.edu).

We would be happy to answer any questions you might have. Thank you for your assistance.

Sincerely,

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SUICIDE ASSESSMENT, PREVENTION, INTERVENTION AND POSTVENTION IN IDAHO'S JUNIOR HIGHS AND HIGH SCHOOLS

Training in Suicide Prevention, Intervention and Postvention

What training have you received in assessment of suicide risk ("prevention")? *(Check all that apply)*

- Graduate level coursework District in-service
 Professional development workshops Self-study (e.g., read books)

How well prepared do you perceive yourself to be in handling students who are potentially suicidal ("intervention")?

- Not at all prepared Somewhat prepared Well prepared

What training have you received regarding appropriate actions following a completed student suicide ("postvention")? *(Check all that apply)*

- Graduate level coursework District in-service
 Professional development workshops Self-study (e.g., read books)

How well prepared do you perceive yourself to be in providing postvention (i.e., assist following a completed student suicide)?

- Not at all prepared Somewhat prepared Well prepared

Rank the following areas in order based on your desire for additional training (1 = most, 4 = least).

- _____ Assessment _____ Intervention
 _____ Prevention _____ Postvention

Roles in Suicide Prevention and Response

Does your school/district have a written plan to reduce the likelihood of student suicide? Yes No Not Sure

Whether or Not your district has a written plan, which of the following suicide prevention roles do you fill in your job setting? *(Check all that apply)*

- Provide training for staff on recognizing suicide warning signs and appropriate actions
 Plan and/or implement curricular components to teach students healthy problem solving
 Serve on crisis intervention team
 Conduct assessment of suicide risk of individual students
 Coordinate referrals of at risk students and their families to community agencies
 Provide in-school counseling/support for students identified as potentially suicidal

Does your school/district have a written plan to respond to a completed student suicide? Yes No Not Sure

Whether or Not your school/district has a written plan, which of the following suicide postvention roles do you fill in your job setting? *(Check all that apply)*

- Coordinate the school's post-suicide crisis plan Provide de-briefing for staff
 Coordinate school and community support services Respond to inquiries from media
 Provide grief counseling to students Follow the deceased student's class schedule
 Assess suicide risk of other students Refer students at risk to community agencies
 Help school community understand the grief process Respond to concerns of parents of other students

Prevention and Postvention Experiences

Does your school/district have a written policy allowing students to be seen by the school counselor without parent consent if it is suspected that the student may be suicidal? Yes No Not Sure

Have you ever had a student referred to you as potentially suicidal? Yes No

In the past two years, about how many students have been referred to you as potentially suicidal? _____

If you have seen one or more students referred as potentially suicidal, please indicate which of the following procedures and instruments you have used to assess suicide risk. (*Check all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Student interview | <input type="checkbox"/> Beck Hopelessness Scale |
| <input type="checkbox"/> Teen Screen | <input type="checkbox"/> Beck Hopelessness Scale for Adolescence |
| <input type="checkbox"/> Suicide Probability Scale (SPS) | <input type="checkbox"/> Beck Scale of Suicidal Ideations |
| <input type="checkbox"/> Suicidal Ideation Questionnaire (SIQ or SIQ-JR) | <input type="checkbox"/> Other: _____ |

In the past two years, how many completed student suicides have occurred in your school? _____

Background Information

How many years have you worked as a school counselor? _____

What is the highest degree you have attained? Masters Masters plus licensure Doctoral

Age? 22-29 years 30-39 years 40-49 years 50-59 years 60+ years

What grades or age groups were included on your case load in the past two years? (*Check all that apply*)

- 6-8th grades – Middle School/Junior High 9-12th grade – High School Both Other _____

In the past 2 years, about how much time have you typically spent working directly with middle and/or high school students each week? None 1-3 hours 5-10 hours 10-20 hours more than 20 per week

About how many students are on your caseload? _____

How many schools do you serve? _____

Do you serve a rural population? Yes No

Do you believe any of the following limit your ability to be involved in suicide prevention and response? (*Check all that apply*)

- Job description focuses on assessment and prevention only.
- Suicide intervention and response is the job of others within the school (e.g., school social workers or psychologists).
- Suicide intervention and response is the job of others outside of the school (e.g., mental health hospitals, psychiatrists).
- Serve too many schools to be involved in suicide prevention and response.
- Lack of training.
- Not interested in this aspect of services.