Summer 2018

School Psychologists and Suicide Risk Assessment: Role Perception and Competency

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SCHOOL PSYCHOLOGISTS AND SUICIDE RISK ASSESSMENT: ROLE PERCEPTION AND COMPETENCY

A Specialist Project
Presented to
The Faculty of the Department of Psychology
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
Of the Requirements for the Degree
Specialist in Education

By
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August 2018

SCHOOL PSYCHOLOGISTS AND SUICIDE RISK ASSESSMENT: ROLE PERCEPTION AND COMPETENCY

Date Recommended July 6, 2018

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I dedicate this thesis to those who have been affected by the tragedy of suicide. As Victor Hugo writes, “There is suffering in the light; in excess it burns.” My hope is that this research adds to the light of knowledge and awareness of how to better serve those who are suffering internally, and to aid in the comfort of those who have lost someone to death by suicide.

ACKNOWLEDGMENTS

Without the continual support from faculty, family and friends, this project would not have been possible. I would first like to acknowledge Dr. Sarah Ochs, who served as director, for her openness when I was in the first stages of deciding what to research and her constant guidance throughout the process. She has been a continued source for positivity, and has pushed me to new experiences that I would have otherwise not pursued. I would also like to acknowledge Dr. Carl Myers and Dr. Meghan Bankhead for providing encouragement, offering counsel, and challenging me during each step.

I am fortunate to have grown up in a family where independence and perseverance is valued. Without having parents who encouraged me to follow my own path, graduate school would not have been in the cards. Completing a thesis or specialist project can be daunting, and it must be balanced with a little fun. I am thankful to surround myself with individuals who understand this balance and make sure I'm not taking myself too seriously.

Lastly, I would like to acknowledge my husband, Trent. He has been patience when I have lost mine, a level-head when mine is in the clouds, and a constant in a time when nothing else seems to be. No accomplishment is achieved without a little help, and I'm fortunate to have people in my corner who help my dreams come to fruition.

CONTENTS

LIST OF TABLES

SCHOOL PSYCHOLOGISTS AND SUICIDE RISK ASSESSMENT: ROLE PERCEPTION AND COMPETENCY

Kristen Herner Erps August 2018 55 Pages

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As the second leading cause of death for adolescents, suicide has become one of the biggest concerns for school personnel. School psychologists are often expected to be the most competent and able to lead in suicide prevention efforts, however, studies have shown a lack of preparedness in crisis intervention and, more specifically, suicide risk assessment. This study surveyed practicing school psychologists (N = 92) to explore their perception of both their role and competency in suicide risk assessment. While school psychologists reported having varying roles within their district related to suicide risk assessment, the majority endorsed having a role at the tertiary level (i.e., intervening with a student identified as needing help). Participants indicated lacking both graduate training and competency in this area. Significant interactions were found between perceptions of role and competency and primary school setting, state employed, and previous training or exposure. Limitations and future directions are discussed.

Introduction

Defining Suicide

Suicide is defined by the National Institute of Mental Health (NIMH) as "death caused by self-directed injurious behavior with intent to die as a result of the behavior" (2017). Suicide can affect all ages, genders, and ethnicities, and there is no lone cause. Rather, there are several factors that may put someone more at-risk for attempting suicide, such as mental health disorders (e.g., depression, bipolar disorder), family history of violence or suicide, and access to weapons, among many others. Although suicide is a complex tragedy, it is also a preventable death, especially if those close to the individual are aware of its warning signs (NIMH, 2017).

Suicide rates have continued to increase over the past 15 years, with young adults and adolescents considered high risk. For this group (15-34), suicide is currently the second leading cause of death, and the tenth leading cause of death overall (NIMH, 2017). Suicide affects all genders and ages, but children as young as 10-14 have experienced some of the greatest percentage increases in suicide in the last twenty years. Suicide rates for girls between the ages of 10-14 showed a 200% increase, which is the highest of all age groups (Curtin, Warner, & Hedegaard, 2016). When comparing suicide rates between gender, males have higher suicide completion rates than females, while females have a higher rate of attempts. This difference can be attributed to the method of suicide: males often use more lethal methods (e.g., firearms), while females tend to use less lethal methods (e.g., poisoning; NIMH, 2017). The following literature addresses suicide, possible antecedents, and methods of prevention and intervention pertaining to individuals under the age of 18 (i.e., children and adolescents).

Antecedents of Suicide

There are numerous potential antecedents to death by suicide, and they vary based on culture, race, or gender. Suicide is often viewed as being influenced by an individual's mental health state, as well as the environment that he or she is in. According to the American Foundation for Suicide Prevention (AFSP), depression is the most common risk factor for suicide, but it is often left untreated (2016), particularly in youth. While suicide is the intentional act of taking one's life, there are certain problems that, when present, may precede it. These problems can appear at every ecological level, and include individual, relationship and school problems (Holland, Vivolo-Kantor, Logan, & Leemis, 2017). At the individual-level, antecedents could include things such as mental health issues, substance abuse, or alcohol abuse. At the relationship-level, problems may include arguments with peers or significant others, or familial discord. Finally, at the school-level, problems may expand past academic concerns and include negative peer encounters, such as bullying or teasing. With the array of potential antecedents present, it is essential that youth-serving professionals remain vigilant to these events, circumstances, and environments.

Youth Suicide

As children age into adolescence (i.e., nearing 15 years) and out of their prepubescent stage, there is an increase in both suicide ideation and attempts (NIMH, 2017). Suicide ideation may be defined as simply having thoughts of taking one's own life, and often does not precede actions of self-harm or suicide attempt. However, it is at this age that adolescents reach the pinnacle of suicide risk, as it becomes the second leading cause of death (Young, Sweeting, & Ellaway, 2011). During adolescence, youth

often begin to experience significant life transitions (e.g., puberty, high school, relationships), and may gain more awareness of life's stressors as they take on new responsibilities, increase self-awareness, and question meaning and elements of their environment. At this age, adolescents may also be forming their gender identity or sexual orientation. For lesbian, gay, bisexual or transgender (LGBT) adolescents, there is a higher risk for mental health problems and suicide attempts. Compared to heterosexual, cisgender adolescents, lesbian, gay, or bisexual youth are five times more likely to attempt suicide (Centers for Disease Control and Prevention [CDC], 2016), and in a survey of transgender adults, 92% reported at least one suicide attempt before the age of 25 (James et al., 2016). LGBT adolescents are often exposed to more risk factors—such as bullying, ostracism, physical assault, or familial discord—that may influence suicide ideation and attempt (CDC, 2017).

When examining child and adolescent suicide, it is imperative to acknowledge that one's understanding of death is often influenced by media exposure or parental belief systems. Initially, children understand death as being reversible, and neither inevitable nor universal (Orbach, Gross, Glaubman, & Berman, 1986). Although most children grow out of this understanding of death by age 12, over 80% of children continue to believe that death can be avoided or delayed, if one lives a cautious, healthy life (Mishara, 2003). For many, death is often explained with a euphemism, such as the recently deceased are in a "better place." For some children, that "better place" may be interpreted literally, such as the fair or the ice cream shop down the street, and without direct explanation of the finality of death, suicide may be understood as a desirable resolution. Just as many parents will avoid discussing death with their children,

explaining suicide becomes even more taboo, and, unless there is a death by suicide in the family, understanding of this concept will likely be taught by older children or media outlets (Mishara, 2003).

In recent years, suicide has not only gained publicity, but has often been sensationalized and romanticized. From video games that depict death as nonpermanent, to popular television shows seemingly glamorizing the act of suicide (e.g., *13 Reasons Why, Suicide Squad*), many children and adolescents gain their first exposure to suicide from these sources (Mishara, 2003). In many shows and video games, death, and more specifically suicide, are nonpermanent. For example, a character may die by suicide in one episode, but in the next may be portrayed as alive and well. Similarly, in many popular video games, such as *Mario Kart*, *Fortnite,* or the *Halo* series, characters are able to quickly come back to life after death by suicide. Research has continued to show that violent media exposure is positively correlated with aggression and risk-taking behaviors in adolescents (Rydell, 2016). However, the impact of exposure to violence in the form of suicide remains unknown.

Suicide in the Schools

Given the amount of time youth spend in schools, school systems and educational personnel are particularly well positioned to address suicide with children and adolescents. As children age into adolescence, the taboo subject of suicide is often addressed in school, either through school-wide education, peer conversation, or direct, personal experience. According to survey data from the CDC (2013), more than one in six high school students had seriously considered attempting suicide, and one in 12 reported attempting death by suicide. These statistics, along with the rise of suicide as

the second leading cause of death for ages 15-34, have put pressure on schools to improve their suicide prevention, intervention and postvention services. To address this pressure, all states have made some degree of suicide training or awareness available for students and/or staff. While only ten states have adopted statewide mandates requiring annual suicide education for school personnel, others have either non-annual or unique suicide prevention statues in place (AFSP, 2016).

Policies for suicide education have been enacted largely due to approaching suicide as a preventable death, with 90% of adolescent suicide attempt attributed to mental health disorders that were left untreated (AFSP, 2016). The average student spends approximately 1,200 hours in school each year (NCES, 2008). Therefore, educators and other school personnel who interact with students daily have a unique responsibility to be aware of, and recognize, signs of suicide. In school districts where suicide risk assessment and intervention procedures have been implemented and examined, there appears to be a decrease in suicide completion (Crepeau-Hobson, 2013). In the previously mentioned study, Crepeau-Hobson (2013) examined three school districts, all of which had suicide risk assessment procedures in place. For students who displayed suicidal intent or were identified as at-risk, they were provided a suicide risk assessment to determine the threat level. Across the districts and over three academic years, there were ten suicides and nearly 3,500 suicide risk assessments administered. However, of the suicides, none were completed by students who had undergone a suicide risk assessment (Crepeau-Hobson, 2013). Although suicides can still occur within districts where prevention and intervention procedures are in place, studies such as Crepeau-Hobson (2013) support the notion that suicide is preventable and that having

standardized procedures for identifying those at-risk may reduce the number of completed suicides.

According to the AFSP (2016), schools have two key tasks in preventing suicide in adolescents: *recognizing* those at-risk and *referring* those at-risk to appropriate mental health providers. The ability to recognize those at-risk comes from suicide education or training, and, as mentioned previously, many states have made, or are in the process of making, this education available for school personnel.

Ethical and Legal Considerations

For school personnel, there is both a legal and an ethical responsibility to actively engage in suicide prevention efforts. From a legal perspective, school personnel can be held liable if they fail to warn or protect those that they reasonably expect may be at harm, especially in cases of "negligence or foreseeability" (Miller, 2014). Though it is interpreted differently across states, the case of *Tarasoff V. Regents of the University of California* (1976) established that mental health practitioners have a duty to breach confidentiality in order to warn or protect those from possible harm. For schools, this is translated to mean that in the case of suicide, there is a legal responsibility for school personnel to share confidential information in order to ensure the student's safety (Miller, 2014). According to Jacob, Decker, and Hartshorne (2011), the presence of these liability court cases "suggest that schools should develop clear suicide prevention policies and procedures that include notifying parents and should ensure adequate staff orientation to district policy and procedures" (p. 174).

Although school personnel and youth-serving practitioners have a legal duty to protect students from threats of harm and warn others, there is a higher set of

expectations they follow: ethical duties. According to the American Psychological Association (APA), if an ethical code "establishes a higher standard of conduct than is required by law, psychologists must meet that higher ethical standard" (2016). Although APA is the largest professional organization of psychologists in the United States, few school personnel would be obligated to follow the standards set forth by APA. However, other organizations have similar ethical codes, including the National Education Association (NEA) and the National Association of School Psychologists (NASP). According to NASP, if their *Principles for Professional Ethics* require a higher standard of behavior, "school psychologists are expected to adhere to the *Principles*" (NASP, 2010). That is, school personnel are responsible for acting ethically, and, many times, their ethical duty surpasses the expected legal response.

Screening

One way to increase engagement in suicide prevention efforts is through the implementation of screening procedures. In schools, students are regularly screened for academic, behavioral, and social emotional concerns. This mechanism is a way to identify students who are at-risk for developing future problems. The Garrett Lee Smith Memorial Act, which Congress signed into law in 2004, pressed schools to incorporate suicide-screening programs as part of early intervention and prevention service (108th Amendment). This method of screening is specifically designed to identify students who may be at-risk for suicide, usually by evaluating self-report survey responses. At the same time, it aims to reduce the possibility of false negatives (i.e., failure to identify students who are, in fact, at-risk) and false positives (i.e., incorrectly identifying students as at-risk) (Peña & Caine, 2006).

With regard to universal screening for suicide prevention, schools may face several ethical and legal challenges. These issues can include parents' rights to examine survey measures and remove their children if they desire, to ensure that the measures are valid, and to ensure follow-up is provided for those identified as at-risk (Miller, 2014). Additionally, school personnel are expected to only practice at their level of competency, and to engage in educational opportunities to improve the areas they are lacking (Miller, 2014). As a result, school-based mental health practitioners (e.g., counselors, school psychologists, social workers), are often expected to lead the development and implementation of suicide prevention efforts for other school personnel (e.g., teachers, custodians, administrators) who may be less competent in the area.

Suicide prevention efforts in schools can take many forms, and there is not one pervasive method of screening for at-risk students. School prevention efforts may involve educating students on suicide and warning signs, providing a school-wide survey for students to complete, or may be a combination of both. Although curriculum-based programs for students have been among the most studied prevention method, in-service training for staff has also been shown to have a positive impact on students' suicidal behavior (Zenere & Lazarus, 1997). Similar to curriculum-based training for students, staff in-service training aims to increase awareness and recognition of signs of suicide, as well as provide information on external resources if a referral is needed (Garland & Zigler, 1993). In-service training encourages school personnel to become more observant of suicidality, understanding that it may be expressed artistically, such

as through writing or art, or may be evident in students' play (Valente, 1987) and then take appropriate action through intervention or referral.

Other than curriculum-based and in-service training to heighten suicide awareness of school staff, another method of suicide prevention that has gained publicity is Reynolds's (1991) two-stage model for identifying adolescent students at-risk for suicide. Within this model, there is first a universal, self-report screening for suicide risk, followed by a more formal interview of those students who self-identified as high risk (Reynolds, 1991).

Curriculum-based, in-service and universal screening have been among the most commonly used methods for suicide prevention. In a study examining these three methods, schools psychologists rated the acceptability and level of intrusiveness of each (Eckert, Miller, DuPaul, & Riley-Tillman, 2003). Findings revealed that school psychologists rated school-wide screening as the least acceptable and most intrusive method of suicide prevention, with curriculum-based and in-service training significantly more acceptable and less intrusive. Despite the low acceptability of the universal screening by these professionals, other studies have shown universal screening to be very effective for identifying students at-risk (Shaffer & Craft, 1999). The disparity of results from the acceptability study compared to its reported effectiveness demonstrate the need of increased education and guidance on suicide prevention methods for school personnel, specficially school psychologists.

Screening Measures

One screening method that is used within schools is the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011). The C-SSRS is a universal screener

that provides information on suicide ideation, suicide attempts, emotional concerns (e.g., sadness, social withdrawal), and gives students an opportunity to ask for help or follow-up. One study compared C-SSRS's identification of students at-risk for suicidal or emotional problems with school and clinical professionals' opinions (Scott et al., 2009). This study screened 1,729 students from seven high schools in the New York metropolitan using the C-SSRS. After the screening, clinical and school professionals used the Diagnostic Interview Schedule for Children (DISC; Shaffer, Fisher, Lucas, Dulcan , & Schwab-Stone, 2000) to assess whether there was any emotional concerns for all students. Scott et al. (2009) found that screening accurately identified 62.7% of students with significant mental health concerns, while school professionals accurately identified 36.5% of students.. The results of this study acknowledge that screeners, such as the C-SSRS, can be both effective and accurate identifiers of students with mental health conerns unidentified by school professionals.

Another pervasive screening tool is Signs of Suicide (SOS). Unlike the C-SSRS and the SRS previously mentioned, SOS combines both gatekeeper training and universal screening, and has been the only program that has demonstrated a significant impact on suicide attempts post-implementation (Aseltine & DeMartino, 2004). Before conducting universal screening, students are taught to recognize different signs of suicide and memorize the acronym ACT: "acknowledge, care, tell." One study looked at the effectiveness of SOS in reducing suicidal behavior. With a sample of 2,100 students across five high schools, this study found significantly lower rates of suicide attempts post-implementation and higher rates of knowledge related to suicide and depression (Aseltine & DeMartino, 2004).

Although screeners such as the C-SSRS and SOS are readily available, there is a need to address the low acceptability of universal screening mesaures and the lack of perceived feasibility to implement them within schools. With many suicide screeners, there are often an alarming number of students identified as at-risk students, as these tests tend to over-identify false positives based on the severity of a suicidal threat. In a study that had school personnel screen 1,310 students in ten high schools using the Suicide Risk Screen (SRS), 29% of students were rated as at-risk (Hallfors, Brodish, Khatapoush, Sanchez, Cho, & Steckler, 2006). As a result of this high percentage, the study was discontinued after two semesters. School personnel commented that they are already overloaded with students and that an implementation of universal screening and follow-up would be unrealistic with that many students.

To address the lack of feasibility, one program, TeenScreen, uses a multi-stage screening process that focuses on connecting at-risk students to external resources (Torcasso & Hilt, 2016). Unlike the suicide screeners aforementioned, TeenScreen utlizes professionals from outside the school (e.g., clinicians, consultants, case managers) and requires active parental consent and student assent. Unlike passive consent, which assumes consent unless a parent opts out, active consent requires not only families to turn in a signed form, but also student agreement. After students are screened initially, they all go on to a second-stage, whether it be a debriefing session or follow-up interview, and students who are determined to be at-risk are then provided a referral packet that gives families outside resources and highlights next steps (Torcasso & Hilt, 2016).

In a study that looked at the effectiveness of TeenScreen on reducing suicidal behaviors for ninth grade students, Torcasso and Hilt (2016) found that post-intervention, there was a decrease in suicidal ideation and attempts, and, for students who were screened positive for suicidal risk, there was an increase in follow-up with outside mental health services. TeenScreen's utilization of external resources has the potential to alleviate the burden of universal screening for suicide risk within schools, while strengthening the feasibility of its implementation.

The Role of School Psychologists in Suicide Risk Assessment

While all school personnel may have a duty to aid in suicide prevention efforts, school psychologists' competency in mental health promotion makes them uniquely positioned for the role of leading suicide prevention efforts. Consistent with other multi-tiered systems of service delivery, school psychologists' roles in suicide prevention can be arranged into three tiers of increasing intensity: universal, targeted, and tertiary (Miller, Eckert, & Mazza, 2009).

At this first level, or tier, school psychologists may aid in the universal screening for suicide risk. This tier includes in-service trainings, curriculum-based suicide education, and school-wide screenings. At the second tier, school psychologists' roles become more targeted with prevention focusing on students who have been identified as at-risk, likely from the universal measures of screening and education, or by teacher report or observation. School psychologists may then incorporate more comprehensive suicide risk assessments and follow-up with those students (Miller et al., 2009; Reynolds, 1991). At the third, or tertiary, tier, school psychologists' role becomes centered on students who have been identified as suicidal, either from suicidal intent,

ideation, or history. School psychologists' role at this level involves collaboration with parents and outside professionals to find treatment for the student and minimize threat of harm (Miller et al., 2009). In some cases, however, school psychologists do not have the available time or resources to intervene with identified students. As a result, schools may need to engage with community mental health agencies to counter that disparity and meet the mental health needs of identified students (Gutierrez, Watkins, & Collura, 2004).

Although several domains of practice identified by the National Association of School Psychologists (NASP, 2010) include the promotion of mental health (e.g., Domains 1, 2, 4, 6), many professionals feel inadequately prepared to prevent or intervene in a crisis (e.g., suicide) (Allen et al., 2002). In a survey of 276 nationally certified school psychologists, Allen et al. (2002) gathered information pertaining to practitioners' graduate preparation, continued education and current role in addressing school crises. Of the total respondents, only 37% reported that they received crisis intervention training in their graduate program or practica experiences, and 58% reported feeling ill-prepared to intervene in a crisis. However, graduates of school psychology programs after 1993 indicated better preparedness and training in crisis intervention when compared to professionals who graduated prior to 1980 (Allen et al., 2002).

Despite an improvement of training in this area, there appears to be a gap in graduate education. To better understand this gap, and to ascertain graduate program directors' perceptions of their program's training in suicide risk assessment, Liebling-Boccio and Jennings (2013) conducted a survey of 75 directors from NASP-approved

programs. Results indicate that suicide training was reported as very important, and that program graduates, albeit specialist- or doctoral-level, would graduate with a competency in this area. Program directors also reported that suicide risk assessment was addressed in multiple classes throughout the program. However, gaps in education of this area were also examined, and education of quantitative suicide risk assessment measures, universal prevention methods, direct intervention with suicidal adolescents, and postvention procedures were all lacking (Liebling-Boccio & Jennings, 2013). Although Liebling-Boccio and Jennings (2013) provide some insight into graduate preparation, there is a scarcity of studies that have examined the experience or preparation from the perspective of graduate students since Allen et al. in 2002.

Graduate preparedness can also depend on level of training. One study that looked at school psychologists' perceived preparedness in prevention and postvention activities found that docotoral-trained practitioners reported greater levels of preparedness when intervening with suicidal situations (Debski, Spadafore, Jacob, Poole, & Hixson, 2007). Additionally, Debski et al. (2007), reported that although school psychologists tended to report moderate understanding of suicidal warning signs and how to respond to them, there was a lack of knowledge related to postvention activities (e.g., preventing contagion).

With the exception of the aforementioned studies examining graduate preparation, there is a lack of literature exploring the role of practicing school psychologists in the assessment of suicide risk, and a need for its expansion.

Purpose of the Present Study

As the second leading cause of death for adolescents, suicide has become one of the biggest concerns for school personnel (NIMH, 2017). Under the notion that suicide is preventable, schools have both an ethical and legal responsibility to engage in some sort of preventive measure, which can include universal education, risk assessment and/or staff in-service. School psychologists' role within the education system is, although comprehensive, one that is rooted in preventing and improving student mental health and overall well-being. As a result, these professionals are often expected to be the most competent and able to lead in suicide prevention efforts including assessing risk. Often, their role can be broken into three levels: universal (e.g., school-wide screening and education), secondary (e.g., more intensive intervention with at-risk students), or tertiary (e.g., collaborating with parents and outside professionals) (Miller et al., 2009). However, studies have shown a lack of preparedness in crisis intervention and, more specifically, suicide risk assessment (e.g., Liebling-Boccio & Jennings, 2013). Suicide in youth remains a significant concern yet we have very little research that directly explores the perceptions of those commonly involved in suicide prevention and risk screening.

This study aimed to survey practicing school psychologists to explore their perception of their role and competency in suicide risk assessment. Specifically, this study explored the following three research questions:

1. What are school psychologists' perceived and reported roles in suicide risk assessment? It was expected that school psychologists would report variable perceptions of their role in suicide risk assessment.

2. What are school psychologists' perceptions of their competency in recognizing, identifying, and intervening with students at-risk for suicidal behavior? It was expected that school psychologists would report low levels of competency
3. Is there a significant difference in overall role or competency by years of experience, primary school setting, number of campuses served, degree type, graduate training, exposure to suicide risk assessment, presence of a state-wide mandate for education or assessment, presence of a crisis response team, or state of practice? It was expected that all differences would be significant with the exception of state of practice for role, and number of campuses served, primary school setting, state of practice, or presence of a crisis response team for competency.

Method

Participants

Participants were recruited primarily through school psychology social media sites. Although 162 individuals started the survey, only the 92 participants who completed the entire survey were included in the analyses. Participants were only included in the data analysis if they are currently practicing, or have practiced, within the school setting. Table 1 contains participant demographic information.

Table 1

Participant Demographics

	N	%
Age		
18-24	4	4.3
25-34	47	51.1
35-44	24	26.1
45-54	11	12
55-64	4	4.3
65-74	1	1.1
75+	1	1.1
Gender		
Male	7	7.6
Female	84	91.3
Non-Binary/ Third Gender	1	1.1
Degree Level		
Masters	28	30.4
Specialist	45	48.9
Doctoral	18	19.6
Baccalaureate	1	1.1
Total N	92	

Measures

This study utilized survey research methods to obtain responses from practicing school psychologists. The survey was researcher-created using the Qualtrics survey system, and guided by the researcher's questions of interest (i.e., perceived role and competency) to identify gaps in the literature. The survey began with an informed consent page, which described the voluntary nature of the study as well as its foreseeable risks and benefits. This was followed by a page highlighting the purpose of the survey and definitions of key words. The first set of questions gathered demographic information. The survey then included questions related to school setting and graduate training of suicide risk assessment. To assess perception of role and competency, 28 Likert questions were included. Four questions asked school psychologists to rate their levels of confidence in their knowledge of suicide, and their comfort when identifying or intervening with a student who is suicidal. The seven-point Likert scale ranged from Strongly Disagree (0) to Strongly Agree (6). These questions were specific to school psychologists' role(s), perception of their competency, and comfort level related to suicide and crisis intervention. Two open-ended questions were included at the end to allow for additional input and were analyzed for themes. A copy of the survey items can be found in Appendix A.

Procedures

This study was an exploratory study, which surveyed practicing school psychologists about their role in suicide risk assessment. As a result, participants were recruited through several means. This study used a snowball method of data collection, allowing school psychologists to share the survey with fellow colleagues to expand the

number of respondents. The survey was posted on school psychology Facebook pages, as permissible. The survey remained open from April 10th, 2018 through May 1st, 2018 and three reminders were posted. No identifying information was collected. Data collection commenced following approval from Western Kentucky University's Institutional Review Board, which can be found in Appendix B.

Data Analysis

Data were analyzed using the statistical software SPSS. Descriptive statistics are reported for school psychologists' overall perceived competency, roles in suicide risk assessment, degree type, years practicing, school setting (i.e., number of campuses served, primary school setting, presence of a crisis response team), graduate training, exposure to suicide risk assessment, state of practice, and presence of state-wide mandates for education and screening. Independent variables include years practicing, primary school setting, number of campuses served, degree type, graduate training, exposure to suicide risk assessment, presence of statewide mandates, presence of crisis response team, and state of practice. Dependent variables included perceived roles and perceived competency. There were 17 questions looking at role, and 12 questions looking at competency. Role and competency items were summed and the total score was used as a continuous dependent variable. Statistical analyses included a test of means difference. A multivariate analysis of variance (MANOVA) was used to test for group differences.

Results

The following section includes a summary of data to address the proposed research questions. This includes school psychologists' role and perceived competency in preventing and intervening with suicidal students. It also includes a description of different variables that may impact school psychologists' role and competency.

Survey Questions

The survey questions were intended to explore demographic characteristics that may impact school psychologists' role and competency related to suicide risk assessment. The majority of participants (87%) reported practicing as school psychologists for three years or less. Based on this, most respondents are at the beginning of their career, with 51.1% between the ages of 25-34. The majority of the sample was primarily employed in a public elementary (64.1%), followed by public middle school (19.6%) and public high school (12%) and 86.5% served three campuses or less.

Survey questions also asked about the presence of crisis response teams and universal screening within participants' primary school settings. Of note, a quarter of participants do not have an established crisis response team on their campus, and an additional 7.6% are unsure if a team exists. Very few schools universally screen for risk (9.8%), but 54.3% do provide universal education about suicide, with once a year being most common (78.6%). Although many states have a mandate requiring suicide education or screening, the majority reported being unsure for their state (73.9% unsure about screening; 79.3% unsure about education).

The majority of school psychologists (45.7%) reported that they had received some sort of graduate training in suicide risk assessment, while 41.3% reported that they had not. More specifically, 58.7% reported not being exposed to suicide risk assessment during practicum; however, for internship, the majority (64.1%) reported that they had been exposed to some type of suicide risk assessment.

School Psychologists' Perceived Role(s) in Suicide Risk Assessment

When looking at the mean response to role statements that range from *Strongly Disagree* (0) to *Strongly Agree* (6), school psychologists responded neutrally (M = 3.00, SD = .78). This neutral rating is in concurrence with the hypothesis, indicating that school psychologists' role varies related to suicide risk assessment. Questions were broken down into different types of roles (e.g., universal, secondary, tertiary, postvention) and participants were asked to endorse not only what their role looks like, but also what they perceive most school psychologists' role looks like. Percentages, means and standard deviations for these Likert questions are provided in Table 2.

School psychologists' roles can be broken down into the levels of universal, secondary, tertiary and postvention. When asked whether their role was at the universal level for suicide risk assessment (i.e., developing or implementing school-wide suicide prevention programs), most respondents (79.3%) indicated some form of disagreement (M = 1.47, SD = 1.63). However, when the same question was asked about *most* school psychologists, participants responded closer to neutral, but, on average, continued to disagree (M = 2.13, SD = 1.63). Similarly, respondents were asked if they had a role in the secondary level of suicide risk assessment (i.e., targeting students who may be at-risk). On average, responses were neutral but leaned slightly on the side of agreement

(*M* = 3.20, *SD* = 1.91); and, when asked if *most* school psychologists' have a role at the secondary level, there was slightly stronger agreement (*M* = 3.55, *SD* = 1.65).

While school psychologists disagreed with having a role at the universal level, and rated their role at the secondary level as neutral, respondents indicated strongest agreement with having a role at the tertiary level (i.e., focusing on youth who have been identified as needing intervention). With this question, school psychologists, on average, endorsed that their primary role was at the tertiary level (*M* = 4.00, *SD* = 1.99), and that most school psychologists' primary role was also at this level (*M* = 3.99, *SD* = 1.52). Finally, with regard to postvention (i.e., helping survivors or those affected to cope), responses were neutral on average with regard to both their personal role (*M* = 3.08, *SD* = 1.90), and expectation for most school psychologists (*M* = 3.58, *SD* = 1.66).

Table 2

School Psychologists' Role in Suicide Risk Assessment (N = 92)

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree	*M (SD)*
My role in suicide risk assessment is primarily at the universal level (i.e., developing or implementing school-wide suicide prevention programs).							
32.6	33.7	13	8.7	2.2	6.5	3.3	1.47 (1.63)
Most School Psychologists' role in suicide risk assessment is primarily at the universal level.							
14.1	31.5	13	26.1	2.2	9.8	3.3	2.13 (1.63)
My role in suicide risk assessment is primarily at the secondary, more intensive level (i.e., targeting students who may be at-risk).							
10.9	19.6	3.3	10.9	22.8	26.1	6.5	3.20 (1.91)
Most School Psychologists' role in suicide risk assessment is primarily at the secondary, more intensive level.							
3.3	16.3	3.3	21.7	15.2	34.8	5.4	3.55 (1.65)
My role in suicide risk assessment is primarily at the tertiary level (i.e., focusing on youth who have been identified as needing intervention).							
8.7	8.7	7.6	7.6	10.9	29.3	27.2	4.00 (1.99)
Most School Psychologists' role in suicide risk assessment is primarily at the tertiary level.							
2.2	6.5	4.3	23.9	19.6	27.2	16.3	3.99 (1.52)
My role in suicide risk assessment involves postvention (i.e., helping survivors or those affected to cope).							
13	15.2	9.8	8.7	27.2	18.5	7.6	3.08 (1.90)
Most School Psychologists' role in suicide risk assessment involves postvention.							
5.4	10.9	6.5	20.7	17.4	32.6	6.5	3.58 (1.66)

Note: Numbers are percentages of responses across each Likert Scale item.

School Psychologists' Perceived Competency in Suicide Risk Assessment

When looking at the mean response to competency statements that range from *Strongly Disagree* (0) to *Strongly Agree* (6), school psychologists rated their competency for suicide risk assessment with slight agreement ($M = 4.24$, $SD = .92$). Of the 92 respondents, 37 (40.2%) reported disagreement with overall ratings of competency in suicide risk assessment. The rest of the respondents (59.8%) reported either neutral or slight agreement for feelings of competency with suicide risk assessment. This result supports the hypothesis that respondents would report low levels of competency. Descriptive statistics for overall role and competency can be found below.

Table 3

Descriptive Statistics

	N	M	SD	Max	Max
Role Total	92	51.14	13.23	7	77
Competency Total	92	50.90	11.05	21	72
Total		102.04	20.73	28	139

Comfort and confidence in identifying and intervening with suicidal students. The competency questions were also broken down into participants' feelings of *comfort* and *confidence* with suicide risk assessment, ranging from Strongly Disagree (0) to Strongly Agree (6). Table 4 shows that, as a whole, school psychologists endorsed slight agreement with both confidence in their knowledge, and comfort in identifying and intervening with youth who are suicidal. On average, respondents indicated that they are slightly confident in their knowledge of suicide ($M = 4.05$, $SD = 1.73$*),* and suicide

risk assessment (*M* =3.80, *SD* = 1.71). Likewise, respondents, on average, indicated similar agreement to levels of comfort intervening with *(M* = 3.97, *SD* = 1.78) and identifying (*M* = 3.98, *SD* = 1.58) youth who are suicidal.

Table 4

School Psychologists' Comfort and Confidence with Suicide Prevention Roles: Percentages, Means, and Standard Deviations

Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree	M (SD)
I am *confident* in my knowledge of suicide.							
1.1	14.1	5.4	9.8	19.6	27.2	22.8	4.05 (1.73)
I am *confident* in my knowledge of suicide risk assessment.							
2.2	15.2	5.4	10.9	25	26.1	15.2	3.80 (1.71)
I am *comfortable* intervening with a student who is suicidal.							
5.4	10.9	3.3	8.7	26.1	25	20.7	3.97 (1.78)
I am *comfortable* identifying students who are suicidal.							
0	13	7.6	9.8	21.7	33.7	14.1	3.98 (1.58)

Note: Numbers are percentages of responses across each Likert Scale item.

Open-Ended Questions

Respondents were given the opportunity to provide additional information at the end of the survey in the form of two open-ended questions. Of those who responded, several reported that they either felt unprepared to address suicide in the schools or would like to have more formal training in the area of suicide risk assessment. Other

respondents indicated that the professional who takes the lead in suicide risk assessment varies by perceived risk and age group. More specifically, responses stated that school counselors were the ones more likely to take the lead if the need was greater, while school psychologists more often did the initial risk assessment.

Multivariate Analysis of Variance

To examine the third research question, a MANOVA was conducted to determine if any of the 12 demographic variables on their own or in combination with one another had an effect on the two dependent variables of total perceived role and competency. The 12 independent variables examined were: primary school setting, state employed, gradate training in suicide risk assessment, exposure to suicide risk assessment during practicum or internship, professional development in the last five years, number of years practicing, number of campuses served, degree type, state mandate for universal screening, state mandate for universal education of suicide, and presence of a crisis response team. Based on the MANOVA and using Pillai's Trace, there were six variables that showed a significant interaction with perceived role and competency when summing the two dependent variables. These variables included primary school setting, state employed, graduate training in suicide risk assessment, exposure to suicide risk assessment during both practicum and internship, and professional development within the last five years.

Differences in role perception. Participants differed significantly in their role in suicide risk assessment based on their primary school setting, $F(4,87) = 3.35$, $p = .013$, level of graduate training, $F(2,89) = 4.61$, $p = .012$, exposure during internship, $F(2,89) = 7.57$, $p = .001$, and participation in professional development, $F(2,89) = 6.33$, $p =$

.003. Nonsignificant interactions were found for role perception and state employed, exposure during practicum, number of years practicing, number of campuses served, degree type, state mandate, and presence of a crisis response team. Results deviated from the hypothesis, which expected that state employed would be the only nonsignificant interaction.

Differences in Competency. Participants significantly differed in their perceived competency based on their primary school setting, $F(4.87) = 2.56$, $p = .04$, level of graduate training, $F(2,89) = 3.87$, $p = .024$, exposure during practicum, $F(2, 89) = 9.61$, $p < .001$, exposure during internship, $F(2,89) = 8.08$, $p = .001$, participation in professional development, $F(2,89) = 13.30$, $p < .001$, and the presence of a crisis response team, $F(2,89) = 3.39$, $p = .038$. Nonsignificant interactions were found for perception of competency and state employed, number of years practicing, number of campuses served, degree type, and state mandate. Results deviated from the hypothesis, which expected that the number of campuses served, primary school setting, state employed, and presence of a crisis team would all be nonsignificant interactions.

Discussion

School psychologists' role within the education system is rooted in improving student mental health and overall well-being. As such, these professionals are often expected to be competent and able to lead in suicide prevention efforts including assessing for risk. However, studies have shown a lack of preparedness in suicide risk assessment (Allen et al., 2002) as well as varying roles within their district (Miller et al., 2009). This study sought to corroborate results with previous studies regarding training

and competency related to suicide risk assessment, as well as get a better glimpse of school psychologists' roles related to suicide risk assessment within their district.

Based on the demographic information gathered from this study, most respondents were early in their career and primarily worked in public elementary schools. This information is important when considering results, as involvement in suicide risk assessment for elementary students is very different than for middle and high school students. A quarter of respondents indicated that their school does not have a crisis response team, and the majority responded that they did not universally screen or provide universal education for suicide within their schools. Although these high responses may result from the majority of participants working in elementary settings, it is alarming when considering the rising number of suicide rates for prepubescent children (Curtin et al., 2006). Results from this study aligned with previous literature related to graduate training. For example, this study found that only 45.7% reported receiving some type of graduate training in suicide risk assessment, and previous literature reported 37% receiving graduate training (Allen et al., 2002). More specifically, this study expanded graduate training into practicum and internship, and found that over a quarter lacked any exposure to suicide risk assessment prior to working independently as a school psychologist. These results indicate that there continues to be a lack of graduate training in suicide risk assessment, and many of these professionals—who are expected to be competent in this area—are going into their independent work without any formal preparation in this area. Likewise, open-ended responses indicated that many school psychologists feel unprepared to address suicide in the schools and would like to have more formal training.

With regard to school psychologists' role in suicide risk assessment, results from this study varied. Participants were asked to endorse their role at different levels (e.g., universal). However, the majority of respondents indicated the greatest endorsement of having a role at the tertiary level (i.e., focusing on youth who have been identified as needing an intervention), and the greatest disagreement with having a role at the universal level (i.e., developing or implementing school-wide interventions). These results indicate that, for school psychologists in elementary schools, they are mainly intervening with students only when a student has been identified as needing help, and are less involved with prevention.

Participants in this study reported varying levels of competency for suicide risk assessment. A slight majority reported neutral or slight agreement when asked to endorse competency, while the rest (40.2%) reported disagreement with ratings of competency. Additionally, when looking at perceived comfort intervening and confidence with knowledge of suicide, respondents on average reported only slight agreement. These results indicate that most respondents report lacking competency in the area of suicide risk assessment, which should be taken into consideration when making sure that professionals do not work outside their level of competency, even if their role is to promote mental health well-being within the school.

Results of the MANOVA demonstrated that role perception significantly differed based on four of the twelve independent variables and perceived competency significantly differed for six of the twelve independent variables. This suggests that some independent variables affected each dependent variable differently. Some variables may not have had a significant difference on the role of a school psychologist,

because it may be out of the individual's control (e.g., exposure during practicum). However, more variables may lead to greater competency (regardless of role). For instance, participants who were exposed to suicide risk assessment during practicum differed significantly in their perceived competency, but not in their role. However, being exposed to suicide risk assessment during internship yielded significant differences in both role and competency perception. This finding likely highlights the more expansive, independent role that an intern has when compared to a practicum student. Finally, results indicated that individuals with a crisis response team on campus significantly differed in their perceived competency. Having a crisis response team may encourage more training in the area of suicide risk assessment, which in turn may increase the competency levels. Results suggest that there may be certain variables within our control as a field (e.g., professional development) that can change, or increase, a school psychologist's level of competency related to suicide risk assessment.

Implications for Research and Practice

This study has implications for both research and practice. As the second leading cause of death for adolescents, suicide has become one of the biggest concerns for school personnel. Under the notion that suicide is preventable, schools have both an ethical and legal responsibility to engage in some sort of preventive measure. Despite the significant problem of suicide in a school-aged population, we continue to have limited studies examining the role of school psychologists in prevention and intervention. These professionals are expected to have a role rooted in mental health and promotion of overall well-being, as well as be the most competent and able to lead in suicide prevention efforts. However, studies, including this one, have shown a lack of

preparedness in crisis intervention and, more specifically, suicide risk assessment. This study contributes to closing the literature gaps and provides one estimate of perceptions and practices related to suicide risk assessment.

Results of this study have the potential to inform policies and practices around suicide risk assessment. Although school psychologists are seen as mental health professionals within school districts, many are leaving graduate training feeling inadequately prepared for having a role in suicide risk assessment (Liebling-Boccio & Jennings, 2013). This study found similar results, reporting a lack of preparedness in graduate coursework and exposure prior to working independently. Furthermore, because this study's sample was primarily young professionals, results indicate that the lack of preparation continues to be problematic for current graduate students, despite past research indicating the need for change. Both graduate training and internship placements can be encouraged to provide these learning opportunities for new professionals. As the leading mental health professionals within schools, this should raise concern, and should encourage graduate programs to incorporate greater suicide risk assessment preparation into their curriculum and districts to provide more professional development for suicide where it's lacking.

Limitations and Future Directions

This study inevitably has limitations. First, the survey was researcher created and no reliability and validity data were collected. However, this survey was not intended to function as a measure (e.g., measure of knowledge) but rather a tool to gather a wide range of data from a desired sample (i.e., practicing school psychologists). Another limitation was the method of collecting survey data. Because participants were recruited

primarily through social media, most respondents were limited to those who are active on these group pages. Additionally, as mentioned previously, the survey completion rate was low when compared to the total number of individuals who opened and/or began the survey (approximately 57%). This response rate may result from using social media, as many who started it may not have realized it was exclusively for school psychologists.

This method of data collection may lack generalizability to all school psychologists, as both the snowball and convenience method of data collection may have contributed to more respondents from fewer geographical locations, as well as a younger sample. Participants represented 28 different states and all regions, but the majority ($N = 15$) practiced in Kentucky and worked primarily in public elementary. Having a sample of primarily elementary workers likely limited the scope of reported roles, as most suicide risk assessment does not become prevalent until either middle school or high school.

Future research should expand upon this and similar studies. This study's sample primarily consisted of professionals who are early in their career and working in public elementary. It is imperative for future research to include more seasoned professionals with varying backgrounds and school settings, which can be achieved by using other methods of data collection. These methods could involve contacting district listservs, reaching out to professionals at conferences, or using online databases to contact school psychologists (e.g., NASP member lists). This will allow greater comparison across school settings and may result in differentiation of role perception. However, despite being a younger sample, this research provided unique findings into the change, or lack

of change, in school pscyhologists' graduate preparation and role. While this study was exploratory and looked at many different variables that may impact school psychologists' perceived role and competency in suicide risk assessment, it would be useful to delve deeper into some of the variables that were addressed here. This could include more open-ended questions related to exposure of suicide risk assessment in practicum and internship, as well as an updated study of Allen et al. (2002), looking at graduate training and program director perceptions.

Additionally, this study originally looked at the suicide risk assessment measures (e.g., Signs of Suicide) used across districts. Because respondents in this study reported low levels of screening, results were uninformative. Future research should gather more information related to suicide risk assessment measures, which can serve as an educational aid for districts that are unsure what might be out there. With the notion that suicide is preventable, there are constantly new screeners, interventions, and recommendations for handling this type of crisis situation. Rising suicide rates indicate a need for more studies on this topic; whether that be replicating past studies or developing a novel intervention, it is urgent to increase awareness, while equipping mental health professionals with the tools needed to perform their job with competency and confidence.

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APPENDIX A: SURVEY QUESTIONS

School Psychologists and Suicide Risk Assessment: Role and Competency

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Start of Block: Default Question Block

Q1 **Purpose**

The purpose of this survey is to gather information on School Psychologists' training, role, and perceived competency related to suicide risk assessment within schools.

Q2 **Please keep these definitions in mind while completing this survey**

Suicide prevention: Preventive methods for suicide built into the academic setting, often universal (e.g., questionnaires, curriculum-based programs).

Suicide Screening: Surveys, questionnaires, etc., that are universal in nature and seek to gather information on suicidal ideation, depression, self-harm, and other factors related to suicide.

Suicide Risk Assessment: Broad term pertaining to any measures taken in prevention, intervention, or postvention for suicide. This can be universal (e.g., school-wide screening, in-service trainings), secondary (e.g., targeting at-risk students), or tertiary (e.g., working with identified youth in need of intervention, postvention activities).

End of Block: Default Question Block

Start of Block: Demographics

Q3 What is your age?

- o 18 to 24 (1)
- o 25 to 34 (2)
- o 35 to 44 (3)
- o 45 to 54 (4)
- o 55 to 64 (5)
- o 65 to 74 (6)
- o 75 or older (7)

Q4 What is your gender?

- Male (1)
- Female (2)
- Non-binary/ Third gender (3)
- Prefer to self describe: (4)

_____

Q5 Including your internship year, how many years have you been practicing as a School Psychologist?

- Less than 1 year (1)
- 1-4 years (2)
- 5 - 9 years (3)
- 10-19 years (4)
- 20-24 years (5)
- 25+ years (6)

Q6 What is the highest level of education you have completed or degree you have received?

- Specialist (Ed.S) (1)
- Masters (M.A.; M.S.) (2)
- Doctorate (Ph.D; Psy.D) (3)
- Other (Please Specify) (4)

_____

Q7 When did you complete your graduate coursework in School Psychology?

- Within the last 5 years (1)
- Within the last 6-10 years (2)
- Within the last 11-20 years (3)
- Within the last 21-30 years (4)
- More than 30 years ago (5)

Q8 In which state or U.S. territory do you currently reside?

▼ Alabama (1) ... I do not reside in the United States (56)

Q9 Select all school setting where you practice as a School Psychologist: (Select all that apply)

- Public Elementary (1)
- Private Elementary (2)
- Public High School (3)
- Private High School (4)
- Public Middle School (5)
- Private Middle School (6)
- Preschool (7)
- Other (please specify) (8)
  _____

Q10 In which setting do you spend the majority of your time practicing as a School Psychologist?

- Public Elementary (1)
- Private Elementary (2)
- Public High School (3)
- Private High School (4)
- Public Middle School (5)
- Private Middle School (6)
- Preschool (7)
- Other (please specify) (8)
  _____

Q11 How many school campuses do you currently serve as a School Psychologist?

- 1 (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6+ (6)

End of Block: Demographics

Start of Block: School Information

Q12 *The following questions will be used to better understand your school setting. Answer based on the campus or district where you spend the majority of your time.*

Q13 Does your school have a crisis response team?

- Yes (1)
- No (2)
- Unsure (3)

Q14 Select which individuals are members of the crisis response team:*

- Teacher(s) (1)
- Principal (2)
- Assistant Principal (3)
- Other Administration (4)
- School Psychologist (5)
- School Counselor (6)
- School Social Worker (7)

Q15 Briefly describe your role on the crisis response team.

_____

Q16 Briefly describe what it means for a school to universally screen for suicide.

_____

Q17 Does your school district universally screen for suicide?

- o Yes (1)
- o No (2)
- o Unsure (3)

Q18 How often does your school district universally screen for suicide?

- o More than three times per year (1)
- o Three times per year (2)
- o Once a year (3)
- o Every two years (4)
- o Other: (5) _____

Q19 What grade levels are screened for suicide risk? (Select all that apply)

- o Kindergarten (1)
- o First grade (2)
- o Second Grade (3)
- o Third Grade (4)
- o Fourth Grade (5)
- o Fifth Grade (6)
- o Sixth Grade (7)
- o Seventh Grade (8)
- o Eighth Grade (9)
- o Ninth Grade (10)
- o Tenth Grade (11)
- o Eleventh Grade (12)
- o Twelfth Grade (13)

Q20 What measure does your school district use to screen for suicide risk? (Select all that apply)

- o Safe-T (1)
- o Signs of Suicide (SOS) (2)
- o Applied Suicide Intervention Skills Training (ASIST) (3)
- o Beck BSI (4)
- o Suicide Ideation Questionnaire (SIQ) (5)
- o Columbia-Suicide Severity Rating Scale (C-SSRS) (6)
- o Other (please write) (7) _____

Q21 Does your school district provide universal *education* of suicide for students?

- Yes (1)
- No (2)
- Unsure (3)

Q22 How often does your school district provide universal education of suicide for students?

- More than three times per year (1)
- Three times per year (2)
- Once a year (3)
- Every two years (4)
- Other: (5) _____

Q23 What grade levels are provided suicide education? (Select all that apply)

- Kindergarten (1)
- First grade (2)
- Second Grade (3)
- Third Grade (4)
- Fourth Grade (5)
- Fifth Grade (6)
- Sixth Grade (7)
- Seventh Grade (8)
- Eighth Grade (9)
- Ninth Grade (10)
- Tenth Grade (11)
- Eleventh Grade (12)
- Twelfth Grade (13)

Q24 Briefly describe what suicide education your school district provides to students:

_____

Q25 In your state, are you aware of a mandate that requires school districts to screen for suicide?

- Yes, there is a state-wide mandate (1)
- No, there is not a state-wide mandate (2)
- I am unsure if there is a mandate (3)

Q26 In your state, are you aware of a mandate that requires school districts to educate students on suicide?

- Yes, there is a state-wide mandate (1)
- No, there is not a state-wide mandate (2)
- I am unsure if there is a mandate (3)

End of Block: School Information

Start of Block: Graduate Training/ PD

Q27 *The following questions will be used to better understand your graduate training related to suicide screening.*

Q28 As a graduate student, did any of your courses cover suicide screening in the schools?

- Yes (1)
- No (2)
- I don't remember (3)

Q29 Provide the name(s) of the course(s):

_____

Q30 During your School Psychology practicum, were you exposed to suicide risk screening or assessment? Exposure may include training, direct experience, discussion with supervisor, review of policies, etc.

- Yes (1)
- No (2)
- I don't remember (3)

Q31 During your School Psychology internship, were you exposed to suicide risk screening or assessment? Exposure may include training, direct experience, discussion with supervisor, review of policies, etc.

- Yes (1)
- No (2)
- I don't remember (3)

End of Block: Graduate Training/ PD

Start of Block: Block 6

Q32 *The following questions will be used to better understand the training and professional development you receive as a practicing school psychologist*

Q33 Within the past five years, did you complete professional development/ continuing education activities related to suicide prevention?

- Yes (1)
- No (2)
- I don't remember (3)

Q34 As a practicing School Psychologist, how often do you receive suicide prevention training?

- More than once a semester (1)
- Every semester (2)
- Once per year (3)
- Every two years (4)
- More than every years (5)
- Never (6)
- Other: (7) _____

End of Block: Block 6

Start of Block: Likert

Q35 **Below is a list of statements dealing with your general feelings about School Psychologists' role in suicide prevention, intervention, and postvention within schools. Please indicate how strongly you agree or disagree with each statement.**

	Strongly Disagree (1)	Disagree (2)	Somewhat Disagree (3)	Neutral (4)	Somewhat Agree (5)	Agree (6)	Strongly Agree (7)
School Psychologists are the most qualified school personnel to intervene with suicidal students. (1)	○	○	○	○	○	○	○
I received adequate training in suicide risk assessment during graduate school. (2)	○	○	○	○	○	○	○
I am confident in my knowledge of suicide. (3)	○	○	○	○	○	○	○
I am confident in my knowledge of suicide risk assessment (4)	○	○	○	○	○	○	○

I am comfortable intervening with a student who is suicidal. (5)	○	○	○	○	○	○	○
I am comfortable identifying students who are suicidal. (6)	○	○	○	○	○	○	○
I am prepared to handle crisis situations. (7)	○	○	○	○	○	○	○
I know the warning signs of suicide (8)	○	○	○	○	○	○	○
I would be able to recognize a student who is displaying suicidal warning signs. (9)	○	○	○	○	○	○	○
I am aware of the community resources available for students who need additional support regarding suicide. (10)	○	○	○	○	○	○	○
I am aware of the contagion effect. (11)	○	○	○	○	○	○	○

School Psychologists should have a role in suicide risk assessment. . (12)	○	○	○	○	○	○	○
I *currently* ha ve a role in suicide risk assessment in my school(s). (13)	○	○	○	○	○	○	○
I would like to have a greater role in suicide risk assessment. (14)	○	○	○	○	○	○	○
My role in suicide risk assessment is *primarily* at the universal level (i.e., developing or implementing school-wide suicide prevention programs). (15)	○	○	○	○	○	○	○
Most School Psychologists' role in suicide risk assessment is *primarily* at the universal level. (16)	○	○	○	○	○	○	○

My role in suicide risk assessment involves designing or delivering curriculum-based or educational programs to increase suicide awareness. (17)	○	○	○	○	○	○	○
Most School Psychologists' role in suicide risk assessment involves designing or delivering curriculum-based or educational programs to increase suicide awareness. (18)	○	○	○	○	○	○	○
My role in suicide risk assessment involves educating school personnel and/ or students on available resources. (19)	○	○	○	○	○	○	○

Most School Psychologists' role in suicide risk assessment involves educating school personnel and/ or students on available resources. (20)	○	○	○	○	○	○	○
My role in suicide risk assessment is *primarily* at the secondary, more intensive level (i.e., targeting students who may be at-risk). (21)	○	○	○	○	○	○	○
Most School Psychologists' role in suicide risk assessment is *primarily* at the secondary, more intensive level. (22)	○	○	○	○	○	○	○
My role in suicide risk assessment involves the identification and direct assessment of youth who are potentially suicidal. (23)	○	○	○	○	○	○	○

Most School Psychologists' role involves the identification and direct assessment of youth who are potentially suicidal. (24)	○	○	○	○	○	○	○
My role in suicide risk assessment is *primarily* at the tertiary level (i.e, focusing on youth who have been identified as needing intervention). (25)	○	○	○	○	○	○	○
Most School Psychologists' role in suicide risk assessment is *primarily* at the tertiary level. (26)	○	○	○	○	○	○	○
My role in suicide risk assessment involves postvention (i.e., helping survivors or those affected to cope). (27)	○	○	○	○	○	○	○

Most School Psychologists' role in suicide risk assessment involves postvention (28)	○	○	○	○	○	○	○

End of Block: Likert

Start of Block: End

Q36 Please provide any additional information about your role or competency in suicidal risk assessment.

_____

Q37 Please share any additional information you would like.

_____

Q38 *Thank you for taking the time to fill out this survey. If you have any questions, feedback, or additional information that you would like to share, please contact me using the following email:*

kristen.herner887@topper.wku.edu

APPENDIX B: IMPLIED CONSENT

IMPLIED CONSENT

Project Title: School Psychologists and Suicide Risk Assessment: Role and Competency
Investigator: Kristen Herner Erps; WKU Department of Psychology
kristen.herner887@topper.wku.edu

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your agreement to participate in this project.
You must be 18 years old or older to participate in this research study.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.
You should keep a copy of this form for your records.

1. **Nature and Purpose of the Project**: The purpose of this survey is to gather information on School Psychologists' training, role, and perceived competency related to suicide risk assessment within schools.

2. **Explanation of Procedures**: You will be asked to complete approximately 30 demographic questions related to your graduate training and school setting, in addition to 28 Likert scale questions exploring your perception of the role and competency of School Psychologists regarding suicide risk assessment. This survey will take approximately 10 minutes to complete.

3. **Discomfort and Risks**: Although there are no foreseen risks present in this study, some participants may experience mild discomfort given the sensitive nature of the topic (i.e., suicide).

4. **Benefits:** This study will contribute to the literature gaps and provide one estimate of perceptions and practices related to suicide risk assessment. This information can guide further research. Second, results of this study have the potential to inform policies and practices around suicide risk assessment

5. **Confidentiality**: No identifying information will be collected with this survey. All data collected will be online using the Qualtrics survey system.

6. **Refusal/Withdrawal:** Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

Your continued cooperation with the following research implies your consent.

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Paul Mooney, Human Protections Administrator
TELEPHONE: (270) 745-2129