



School-Based Suicide Prevention Programs

A Resource Guide

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INTRODUCTION

In 2017, 34.6 percent of Nevada high school-aged youth reported feeling sad or hopeless every day for 2 or more weeks and just over 16 percent (16.6%) considered suicide (Lensch et al., 2018). More than 8 percent (8.5%) of Nevada youth actually attempted suicide (Lensch et al., 2018). In Clark County, home to the country's 5th largest school district, 34.4 percent of high school-aged youth indicated that they felt sad or hopeless every day, 15.9 percent seriously considered suicide, and 8.2 percent of youth attempted suicide (Lensch et al., 2018). These numbers are similar to those Nye County, a mostly rural county in Southern Nevada, showing a pervasive need to address suicide among youth throughout the region. Since 50 percent of all lifetime cases of mental illness begin by age 14 (75% by age 24), and 90 percent of individuals who died by suicide had an underlying mental illness, it is important to begin to address mental illness and suicide prevention early in the lifespan (Kessler, 2005).

It is also crucial to dispel myths about teaching suicide prevention in schools. Research on school-based programs have shown that teaching youth about the warning signs of suicide *does not* lead to unintended negative side effects, such as making them depressed or encouraging thoughts of suicide (Rudd et al., 2006; Van Order et al., 2006). Using suicide prevention programs that teach awareness, intervention, problem-solving, and coping skills also help to reinforce protective factors while reducing risk factors for suicide (Miller, Eckert, & Mazza, 2009). With so many benefits, and little to no negative effects, school-based suicide prevention programs are an ideal way to strengthen student mental health.

The purpose of this Resource Guide is to provide an overview of current research on school-based suicide prevention programs and create a helpful tool for decision makers to learn about which program may be the best fit with their needs. Programs in this guide were identified through several methods. Seven programs (CARE, CAST, Lifelines, LEADS, Reconnecting Youth, Sources of Strength, and YAM) were identified through comprehensive literature reviews of the SOS Program and related research on the implementation of suicide prevention programs in schools. The majority of the programs in this guide were only included if they were evaluated through best research practices and had peer-reviewed publications. The most rigorous research methods would include randomized controlled experiments as these methods best account for internal and external validity, however these methods are expensive and difficult to conduct in natural settings. Therefore, other research designs were considered when evaluating program. Even when the most rigorous experimental designs determine a program is effective, it is important to take other factors into consideration when determining if a program is appropriate for the intended population for instance the representativeness of the research sample to the target population, the ability to replicate the implementation methods in a natural setting, and any need for cultural adaptations for the target population (APA Presidential Task Force, 2006).

In addition to the research based programs included in this guide, two additional programs (The Jason Foundation and The Trevor Foundation) were identified by school staff in Nevada as materials they currently use or would recommend to teach about suicide prevention in their school. For this reason, these programs were included with the original eight to be able to compare the program design, content, and evaluation outcomes. Detailed descriptions of each of these programs is provided, including the number and length of lessons, curriculum content and a summary of evaluation outcomes. Additionally, this Guide provides a Comparison Chart on page 25 as an easy tool for quickly reviewing important program attributes and how each program described in this guide compares to the others.

Research Summary on School-Based Suicide Prevention Programs

School-based suicide prevention programs proliferated during the 1980s and 1990s to combat the significantly rising suicide rates of adolescents and young adults (Surgenor, Quinn, & Hughes, 2016). School-based programs are ideal for addressing suicide and suicide attempts in adolescence since most children and adolescents attend school (Surgenor et al., 2016; Wasserman et al., 2015) and that peak depressive symptoms occur primarily during adolescence (Kwong et al., 2019). Schools are one of the three primary settings where children with mental health needs are identified (Carnevale, 2012).

Many school-based suicide prevention programs are universal prevention programs – programs which do not target individuals already identified with depression, a history of suicide attempts, or suicide ideation. These programs usually aim to help students self-identify a need for mental health care and reach out for help as well as increase the knowledge

of their peers (Carnevale, 2012). Universal prevention programs are just one type of school-based suicide prevention programs. Others include indicated, selective, and gatekeeper programs. Indicated programs target individuals who are identified as having depression or are suicidal (Carneval, 2012). Selective school-based programs identify students who are at-risk of developing depression or suicidality and direct interventions towards prevention the development of depression and suicidality (Carneval, 2012). Gatekeeper programs are aimed at helping adults identify the signs of suicide and depression in the youth with whom they have frequent contact, and teaching them how to respond to those youth and encourage help-seeking behavior.

When deciding what type of program works best for a school, it is important to note what research has shown to be effective, or not effective, in a school-based suicide prevention program and how feasible the program is to implement into a school-based setting (APA Presidential Task Force, 2006). Effective programs are those which have been shown, through observation and experimentation, to be the cause of the intended positive health, knowledge, or behavioral outcomes (APA Presidential Task Force, 2006). Feasibility in school based suicide prevention curricula includes the cost of implementation, the time and amount of training needed for implementation, and how beneficial the program is for students. Since the 1990's, certain suicide prevention curricula in schools have been shown to be effective in:

- Increasing knowledge about suicidal behavior (Mazza, 1997)
- Increasing the number of referrals to school mental health professionals (Miller & DuPaul, 1996)
- Change student attitudes about suicide (Kalafat, 2003).
- Decrease suicide ideation and suicide attempts (Aseltine, Schilling, & Glanovsky, 2007).

With regard to the programs included in this resource guide, each program shows effectiveness at impacting different things. The Signs of Suicide (SOS) and Youth Aware of Mental Health (YAM) programs both have evidence of significantly reducing suicide attempts, while SOS, YAM, and Care, Assess, Respond, Empower (CARE) are all effective at significantly reducing suicide ideation (Aseltine et al., 2007; Hooven et al., 2010; Schilling et al., 2014; Schilling et al., 2016; Thompson & Eggert, 1999; Wasserman et al., 2015; Wasserman et al., 2018). Coping and Support Training (CAST), YAM, and CARE are also effective at significantly reducing the risk factors that can lead to depression, suicide attempts, and suicide ideation (Egger et al., 2002; Hooven et al., 2010; Thompson & Eggert, 2010; Wasserman et al., 2015; Wasserman et al., 2018). LEADS: For Youth, and the Jason Foundation programs are all effective at increasing knowledge of the signs of suicide and depression in youth (Labouliere et al., 2015; Leite et al., 2011; Wasserman, et al., 2015). Sources of Strength significantly increases help-seeking behavior and peer support (Pickering et al., 2018; Wyman et al., 2010). Source of Strength, along with CARE, CAST, and Reconnecting Youth (RY) are all effective at significantly increasing protective factors against depression and suicidality (Eggert et al., 2002; Pickering et al., 2018; Thompson et la., 2000; Wasserman et al., 2015; Wyman et al., 2010). Please refer to the detailed description in the program regarding each program for a more detailed explanation of the research methods and results.

Additional Types of School-Based Programs that Improve Mental Health

In addition to the types of programs mentioned above, there are various other types of programs that can help to mitigate risk factors and enhance protective factors for suicidal behaviors and ideation among youth. Many social emotional learning (SEL) programs have the ability to be customized to fit the unique needs of each school, while helping students to learn information and skills to enhance their long term resilience and help them reduce or avoid risk factors for suicide like engaging in high-risk behaviors (Zins, Elias, & Greenberg, 2003). Additionally, positive behavior interventions and supports (PBIS) have been shown significantly improve school climate through reductions in office discipline, bullying perpetration, and peer rejection by implementing sustainable changes in disciplinary practices and focus on promoting positive behaviors rather than penalizing negative ones (Bradshaw, 2013). While there are many other types of programs that can address risk and protective factors for suicide in a school-based setting – without the primary focus of suicide prevention - SEL and PBIS are two of the most commonly used and evaluated types of programs, which is why they are highlighted below.

Social Emotional Learning (SEL).

Risk factors for suicide exist on many levels of the social ecology, which can be addressed by multifaceted social emotional learning programs. Research has shown that SEL programs are effective in preventing bullying behavior and victimization (Fox & Boulton, 2003), as well as enhancing skills for emotional regulation which may help prevent aggressive and

oppositional behavior (Taylor, Eddy, & Biglan, 1999). According to a 2005 survey replicating the National Comorbidity Survey, more than half of all diagnosable mental illnesses begin prior to the age of 14, indicating that early intervention focusing on protective factors could be beneficial to overall mental health (Kessler et al, 2005). Additionally, SEL programs can help to increase and strengthen protective factors that, in the long term, can work towards the prevention of suicide (Alperstein & Raman, 2003; SPRC, 2012; Wyman, 2014). Modifying upstream risk factors, such as previous suicide attempts and/or self-harm, and protective factors known to affect suicidal thought and behavior can help to reduce the risk of suicide along with related mental health and substance abuse problems later on, as well as promote the general health of a broader population (Wyman, 2014). Many school-based SEL programs aim to achieve this by focusing curricula and activities on strengthening the self-regulation of emotions and behavior in children.

Positive Behavioral Interventions & Supports (PBIS).

Universal prevention programs can take many forms, including policies for addressing student conduct and disciplinary practices that can be implemented at the school-wide, classroom, or targeted group level (Leaf & Keys, 2005). This multi-tiered model allows PBIS to address the behavioral, academic, and environmental contexts in which behavioral problems manifest and establishes school-wide expectations and reward systems for students (Bradshaw, 2013). When these expectations are consistently taught, research has shown that successful implementation of PBIS can reduce problem behaviors in students and change aspects of the classroom and/or school environment to help them be safer, more organized, and more productive (McIntosh & Miller, 2014).

Choosing a School-Based Suicide Prevention Program

When choosing which suicide prevention program to implement in a school, it is imperative that the unique needs of the students that live and learn *within each school's community* are considered when selecting a program. What works in one school, may or may not work in another school with a makeup of the student body. The next section of this Resource Guide will provide detailed descriptions - including the number and length of program lessons, the target audience for the program, content discussed in the program, and a brief summary of the evaluation research conducted to date - for each of the following programs:

- Care, Assess, Respond, Empower (CARE)
- Coping and Support Training (CAST)
- LEADS: For Youth
- Lifelines
- Reconnecting Youth
- Signs of Suicide (SOS)
- Sources of Strength
- The Jason Foundation
- The Trevor Project
- Youth Aware of Mental Health (YAM)

DETAILED DESCRIPTIONS OF SELECT SCHOOL-BASED SUICIDE PREVENTION PROGRAMS

Care, Assess, Respond, Empower (CARE)

Designed for Ages/Grade Levels: 14 – 19 years

Lesson Length: 3 ½ - 4 hours

Schedule of Lessons: 1 ½ - 2 hour suicide assessment (Measure of Adolescent Potential for Suicide (MAPS)); 2 hour motivational counseling session

Total Number of Lessons: 1

Program Description:

The CARE program is a brief assessment and crisis intervention for youth identified as at risk for suicide. It is designed to connect at-risk youth with a trusted person from their social lives or school. Parents are involved early, and learn how to provide support and understanding during the assessment process. The goal is to reduce suicide-risk behaviors by introducing youth to an alternative perspective on their situation.

Program Materials:

- MAPS Evaluation*

Note: * Indicates program materials required for implementation.

Evaluation Summary:

Hooven and colleagues (2010) assessed the long term effects of the CARE intervention for youth who were identified as at risk for suicide. Teens who screened as at-risk for suicide were recruited into the CARE program from one of twenty high schools in the Pacific Northwest. A total of 615 youth were identified as at risk for suicide from 2000 youth who were screened from 20 high schools in the Pacific Northwest of the United States. Teens at risk were identified using the High School Questionnaire: Profile of Experiences (HSQ), which included a suicide-risk screen (SRS). Once identified, teens were assigned to either the Parent version of the CARE program, the youth version of the CARE program, a combination of parent and youth version, or a minimal intervention protocol. All programs used in this study demonstrated significant reduction in risk factors and increases in protective factors after participation in the program and at the 9-month follow-up ($p < .05$). The model of CARE that included the youth and parent components show significantly better outcomes compared to the other groups. These results held fairly consistent during a 6 year follow up demonstrating the continued reduction in risk factors for the participants, especially for those that receive the parent and youth intervention.

Limitations:

- No control group with which to compare data due to protocol and ethical considerations for students who show suicide risk. (Hooven et al., 2010)
- A brief parent version of the CARE program, including a 2-hour home visit, was offered to families of youth participating in this study. The greatest positive effects measured were for those where both the teen and parent received an intervention. (Hooven et al., 2010)
- Almost 70% of the sample population studied was comprised of Caucasian students (Hooven et al., 2010). Future studies should explore the effectiveness of this program among a more racially diverse sample of youth.

References:

Hooven, C., Herting, J. R., Snedker, K. A. (2010). Long-Term Outcomes for the Promoting CARE Suicide Prevention Program. *American Journal of Health Behavior*, 34(6), 721 – 736.

Coping and Support Training (CAST)

Designed for Ages/Grade Levels: 6 - 12

Lesson Length: 55 minutes

Schedule of Lessons: Twice per week

- | | |
|--|--|
| 1) Welcome & Orientation | 7) Anger Management #2 |
| 2) Group Support & Self-Esteem | 8) Drug Use Control – Making Healthy Decisions |
| 3) Setting & Monitoring Goals | 9) School Smarts |
| 4) Building Self-Esteem, Beating the Blues | 10) Preventing Slips & Relapses |
| 5) Decision Making – Taking STEPS | 11) Recognizing Progress & Staying on Track |
| 6) Anger Management #1 | 12) Celebrating Graduation |

Total Number of Lessons: 12

Program Description:

The CAST (Coping and Support Training) Program is twelve, 55-minute sessions designed for at-risk youth to improve moods, decrease drug use, and improve school smarts. Each group consists of 6 – 8 students who are invited to participate. Each session focuses on key concepts, skills, objectives, an implementation plan, and additional help applying newly acquired skills for mood management, controlling drug-use, and improving school performance. The program can also be delivered to a universal population.

Program Materials:

- Curriculum Kit* which includes:
 - 157 page CAST Leader Guide
 - 102 page Student Notebook
 - 12 “What’s Happening” Agenda posters (1 for each session)
 - 67 posters to use as teaching aids
 - “Saying No” cards (for session 8)
 - “Special Instructions” for users

Note: * Indicates program material required for implementation

Evaluation Summary:

Eggert and colleagues (2002) evaluated the CAST program by randomly assigning 341 participants in grades 9 through 12 who were at risk of dropping out of school into one of three interventions: CAST (n=103), CARE (n=117), and a “usual care” model (n=121) which included a validated assessment interview, Beck’s Suicide Ideation and Intent Scales. Participants responded to a baseline questionnaire – the High School Questionnaire (HSQ), which contained the Suicide Risk Screen. Each group repeated the HSQ questionnaire two additional times: 4 weeks after baseline (after the initial CARE intervention and “usual care” control were completed) and 10 weeks from baseline (after the CAST training was completed). All three groups showed significant reductions in suicide risk behaviors, anxiety, depression, and drug and alcohol use ($p < .05$). However, CAST assigned youth had the greatest reduction in depression and maintained the lowest mean frequency in depression at the 10 week test period (approximate score of 2 on a 7-point Likert-scale) compared with those who received CARE (≈ 2.1) and those receiving usual care (≈ 2.4). However, for these students, this was directly after program implementation ended. Students in all three groups saw a decrease in the number of suicide attempts from baseline to the first posttest at four weeks, with those in the CAST group dropping from an initial mean frequency of ≈ 0.19 to ≈ 0.07 . However, by the second posttest assessment at 10 weeks, all three groups reported similar numbers, yielding a mean frequency across all groups of ≈ 0.12 .

Limitations:

- Does not test long-term retention of results.
- Does not include a no-intervention control group due to ethical considerations.
- Study does not determine what predicts successful outcomes or for which groups the program works best.

References:

Eggert, L. L., Thompson, E. A., Randell, B. P., & Pike, K. C. (2002). Preliminary effects of brief school-based prevention approaches for reducing youth suicide: Risk behaviors, depression, and drug involvement. *Journal of Child and Adolescent Psychiatric Nursing, 15*(2), 48-64.

LEADS: For Youth

Designed for Ages/Grade Levels: 9 - 12

Lesson Length: 3-hours

Schedule of Lessons: 1-hr a day for three days

Total Number of Lessons: 3

Program Description:

LEADS: For Youth is a suicide prevention curriculum for high school students. The program is designed to increase knowledge about depression and suicide, change perceptions about depression and suicide, and increase knowledge of suicide prevention resources. It's also designed to encourage help-seeking behaviors. The program focuses on symptoms of depression and the link between depression and suicide, as well as some of the risk and protective factors associated with suicide. Finally, the program addresses how to identify the warning signs of suicide, how to seek help, and school and community resources for suicide prevention.

The program is implemented for one hour per day for three days. Each lesson includes a lecture, group and individual activities, small-group discussions, as well as activities and homework. Homework activities are primarily technology based, and include blogs, emails, and instant messaging activities designed to resonate with today's youth.

Program Materials:

- Curriculum and Teacher's Guide*
- Implementation Checklist
- Teacher Survey
- Welcome Letter

Note: * Indicates Program material that is necessary for implementation.

Evaluation Summary:

Researchers from Wilder Research (Leite et al., 2011) evaluated the LEADS curriculum using a non-random quasi-experimental design, with youth from 14 high schools in Minnesota. Nine schools were assigned to the treatment group and were provided the LEADS curriculum, while the remaining five schools were assigned to the control group and received a brief presentation on suicide prevention. Students in all schools were administered pre and post curriculum surveys, as well as a three month post-test, however one control school was removed from analysis due to the occurrence of two suicide incidents during data collection. Data analysis included 361 pre and post surveys from the control group and 369 pre and post surveys from the treatment group. Survey results showed that a majority of students already had knowledge about depression and suicide before beginning the LEADS curriculum (70% at pretest) however posttest scores showed mastery of this knowledge among virtually all students who had received the program (98% posttest). The evaluation also found that significantly more youth were able to identify frequent headaches and stomach aches and trouble concentrating as symptoms of depression (43% at pretest vs. 67% at posttest). At posttest, increases were seen in the number of youth that reported being willing to engage in some help-seeking behaviors, like calling a suicide helpline (59% pretest vs. 72% posttest) or searching for resources on the internet (82% pretest vs 92% posttest). These improvements were still present among students in the treatment group at three months after participating in the program, and even more students were able to identify suicide prevention resources at 3 months post implementation (81%) than immediately following participation in the curriculum (75%). In comparison with the control group, students who participated in the LEADS program (76%) were more likely to be able to identify at least five suicide prevention resources than those in the control group (62%). Also, students who received the program showed higher levels of knowledge about depression and suicide at posttest (92%) than those in the control group (86%), and were *more* like to agree that depression is a medical illness (76% vs. 61%).

A process evaluation was also conducted to assess the experience of program implementation among 15 classrooms at four schools. Seven of the teachers observed during this process completed surveys meant to capture their opinions of the curriculum. All teachers who completed the survey provided positive feedback about the LEADS curriculum and reported overall satisfaction with the program including that it was:

- Appropriate for high school youth,
- Easy for students to understand, and
- Taught youth interesting information that was new to them and prompted relevant questions.

Though all teachers reported feeling prepared to teach the curriculum and answer questions, only five of the seven teachers felt *comfortable* teaching it. However, all teachers reported they would recommend the program to other teachers and would use LEADS again.

Limitations:

- Does not test long-term retention of results.
- Difficulty determining whether program was implemented consistently between classrooms.
- The majority of youth included in this study identified as Caucasian and were between 15 and 16 years old (Leite et al., 2011). Future studies should explore the effects of this program with a more diverse sample of youth.

References:

Leite, A., Idzelis, M., Reidenberg, D., Roggenbaum, S., & LeBlanc, A. (2011). Linking Education and Awareness of Depression and Suicide (LEADS): An Evaluation of a School-Based Suicide Prevention Curriculum for High School Youth. St. Paul, MN: Wilder Research.

Lifelines

Designed for Ages/Grade Levels: Grades 5 - 12

Lesson Length: 45 – 90 minutes

Total Number of Lessons: 4 for grades 5 – 10; 2 for grades 11 - 12

Schedule of Lessons:

Grades 5 and 6

- Session 1: Suicide Isn't Silly
- Session 2: Friends Help Friends
- Session 3: Asking for Help Takes Courage
- Session 4: Practicing What We've Learned

Grades 7-10

- Session 1: When Is a Friend in Trouble?
- Session 2: How Do I Help a Friend?
- Session 3: Where Can I Go to Get Help?
- Session 4: How Can I Use What I've Learned?

Grades 11 and 12

- Session 1: Do You Need a Crystal Ball to See the Future?
- Session 2: How to Get from Here to There

Program Description:

The Lifelines program is a “whole-school” program educating administrators, faculty, staff, parents, and students. It was designed to fit into current health class programming and lesson plans. The program consists of three parts: prevention, intervention, and postvention. The prevention portion of the program includes role-playing activities for students to learn how to interact with a suicidal peer, 9 video segments that depict real-world situations, and interviews with recent high school graduates. There are also two video segments that are adult-specific and provide training on suicide prevention skills for adults.

The intervention segment teaches adults how to prepare and respond to threats and signs of suicide and how to intervene with a student who may be suicidal. The postvention segment prepares schools in how to respond to a suicide or any traumatic death in the school population. Each portion of the curriculum comes with a manual, and a USB drive. The intervention and prevention portion also come with video components on DVD.

Program Materials:

- Teacher's Manual*
- DVD*
- USB*

Note: * Indicates program materials required for implementation.

Evaluation Summary:

In order to assess the efficacy of the Lifelines program, 109 students from one northeastern middle school in the United States were divided into a control and treatment group (Kalafat & Gagliano, 1996). The treatment group consisted of 52 students who received the Lifelines lessons over a five day period. All students were asked to complete a pretest during the week prior to program implementation, and a posttest 2.5 weeks after the last session of Lifelines lessons. On these assessments, students were provided with two vignettes in which they were asked to write out how they would respond to the situation in question as well as how they think others would respond. The first vignette showed a student who was less ambiguous about their suicidality; the student in the vignette indicated that sometimes they think about killing themselves. The second vignette showed a more ambiguous situation, where the student writes vaguely about their thoughts of suicide. Vignettes were developed by the research team in collaboration with two experienced health teachers from a different suburban high school and focus tested with approximately 30 peer counselors from that school. Responses to these vignettes were categorized by raters as one of three options: 1) Tell (a trusted adult), 2) Talk (to the peer to dissuade the attempt or talk about the situation with peers), or 3) Do nothing (ignore or not take the situation seriously).

Students who received the Lifelines program and viewed the vignette in which a student clearly presented signs of distress were statistically significantly more likely to tell a trusted adult if a friend showed signs of suicide (40.4%, $p < .001$) than those in the control group (1.8%). This also held true for the second vignette in which the warning signs of suicide ideation

were intentionally vaguer. Those who participated in Lifelines were more likely to say they would tell an adult about the situation (28.8%) than those in the control group (0.0%).

Limitations:

- Post-test only design causes challenges in determining changes in knowledge.
- Does not examine changes in participant risk of suicide.
- Participants in this evaluation were selected from a completely homogenous sample of Caucasian, middle-income students living in a suburban area (Kalafat & Gagliano, 1996). A more racially, geographically, and socio-economically diverse sample of youth should be considered for future evaluations of this program to determine whether its effectiveness can be measured across populations.

References:

Kalafat, J. & Gagliano, C. (1996). The Use of Simulations to Assess the Impact of an Adolescent Suicide Response Curriculum. *Suicide and Life Threatening Behavior* 26(4), 359 – 364.

Reconnecting Youth

Designed for Ages/Grade Levels: 9 - 12

Lesson Length: 1 class period

Schedule of Lessons: Semester long for-credit class

Total Number of Lessons: 75

Program Description:

The Reconnecting Youth program is designed for high-risk youth to increase student involvement in healthy social activities and increase bonding to the school to help prevent high school dropout and improve school results. To be considered eligible to participate in this program, a youth must meet the following criteria:

Eligibility Group 1 (must meet all 3)

- Behind in credits for their grade level
- In top 25th percentile for absences
- GPA less than 2.3 or a precipitous drop in grades

Eligibility Group 2

- OR
- A prior dropout status
 - Referred by school personnel AND meet 1 or more of the criteria from group 1

Because many high-risk youth experience depression and suicide risk-behaviors, suicide prevention is a major part of the Reconnecting Youth program. The Reconnecting Youth program is not a universal suicide prevention program, and is delivered as a class comprised of 10-12 students who are INVITED to participate because they meet the eligibility criteria.

Program Materials:

- Reconnecting Youth Curriculum*
 - 5 Lesson Plan books: Getting Started, Self-Esteem Management, Decision Making, Personal Control, Interpersonal Communication
- Student Workbook*
- Posters: First 10 Days Agenda, Program Goals, Leader Behavior
- Evaluation Materials

Note: * Indicates program materials that are necessary for implementing the program

Evaluation Summary:

From 1989 to 1993, approximately 1,000 students from five high schools participated in the pilot study of Reconnecting Youth (Eggert et al., 1994). Students were assigned to groups of 10-12, with eight intervention groups meeting per year. Students in both the control group and group that received the program completed the High School Questionnaire (HSQ) three times: pre and post program implementation, and at a five to seven month follow up, usually scheduled at the end of the school semester. The HSQ assessed suicide risk behaviors, including: frequency of suicide thoughts, direct and indirect suicide threat, and suicide attempts. The HSQ also assessed depression, where students were asked to respond on a scale of "never" to "always" on statements such as "I feel depressed" and "nobody cares." To determine the level of risk a student faces in regards to suicide behaviors, the Measure of Adolescent Potential for Suicide (MAPS) Interview was used to assist with establish students' eligibility to participate in the experimental group. Those deemed eligible participated in a Personal Growth Class (PGC) that taught life skills, building self-esteem, self-management, and communication skills over the course of the semester. This initial study found that PCG participants reported increases self-esteem, and perceived school bonding/support from teachers ($p < .02$), while those in the control group showed little to no changes. Program participants also showed a 40% decrease in depression at the 5-month follow up assessment, versus an 8% decrease reported by the control group. PGC students also showed an 18% decrease in stress and 35% decrease in anger by the end of the program.

Another study by the same research team examined a sample of 105 high-risk youth from five high schools to determine if outcomes differed by providing the PGC curriculum for two semesters instead of one (Eggert et al., 2015). Students were assigned to one of three groups: 1) 1-semester PGC with HSQ assessment ($n=36$), 2) 2-semester PGC with HSQ ($n=34$), or 3) HSQ assessment only ($n=35$). Additionally, 202 students determined to be not at-risk for school failure were randomly selected from the same five high schools to be used as a comparison group. Results of this study showed an overall decrease among all three groups in suicide risk behaviors, depression, hopelessness, stress, and anger, while scores for

self-esteem and social support increased for all three groups; all of these changes were significant at $p < .01$. However, only PGC participants saw a significant increase in personal control, suggesting this program substantially influences youths' beliefs about their own ability to cope and problem solve effectively.

Limitations:

- High-risk youth targeted for this program often have co-occurrence of problem behaviors that need to be addressed. (Eggert et al., 1994)
- More recent studies with more diverse populations have not been published to confirm the effectiveness of this program in contemporary populations.

References:

Eggert, L. L., Thompson, E. A., Herting, J. R., & Nicholas, L. J. (1994). Prevention research program: Reconnecting at-risk youth. *Issues in mental health nursing, 15*(2), 107-135.

Eggert, L. L., Thompson, E. A., Herting, J. R., & Nicholas, L. J. (1995). Reducing suicide potential among high-risk youth: Tests of a school-based prevention program. *Suicide and Life-Threatening Behavior, 25*(2), 276-296.

Signs of Suicide (SOS)

Designed for Ages/Grade Levels:

- Middle School Program: Grades 6 – 8
- High School Program: Grades 9 - 12

Lesson Length: 50 minutes

Schedule of Lessons: Once per year. Can be implemented throughout school year; but should not be implemented on Fridays, during the last period of the day, or right before a school break.

Total Number of Lessons: 1

Program Description:

The SOS Program combines two strategies for suicide prevention: curriculum aimed at suicide and depression awareness and screening for depression and risk factors associated with suicide. The curriculum component stresses the fact that suicide is directly related to mental illness, and suicidal behaviors and ideation are not normal reactions to stress or emotional upset. Youth who participate in the program learn to recognize the signs of depression and suicide in themselves and others and how to respond to those signs. The SOS Program uses the acronym ACT to encourage youth to Acknowledge, Care, and Tell a responsible adult. Through the SOS Program, youth learn to acknowledge the signs of suicide and depression that others display, and to take those signs seriously.

Students watch a video with dramatizations of interactions that depict signs of depression and suicidality and then discuss each of the interactions and the recommended ways to respond to people who are showing signs of depression and suicidality. Students then complete the Brief Screen for Adolescent Depression (BSAD), which helps them recognize the signs of depression in themselves. Finally, students complete a student response card, which lets them tell school mental health professionals that they would like to speak to someone about themselves or a friend.

The SOS Program also contains resources to train school faculty and staff on how to recognize and respond to a student in crisis. These resources include a training video that all school staff should watch in preparation for implementation of the SOS Program, a power point presentation, and a 90-minute online training module for the SOS School Implementation Team. Additional materials are available for school coaches to help support students during school sponsored activities.

Program Materials:

- Teaching Materials: Video* and Discussion Guide*
- Training Materials: Video training guide for school staff*, informational packet about self-harm, 90 minute online training module and interactive course for planning & implementing the SOS program, training check-list, handouts: myths/facts about mental health, risk factors and warning signs, & references sheets for what to do if concerned about a student.
- Screening Materials: Brief Screen for Adolescent Depression (BSAD)* & Student Response Card* (students can ask to talk to a school mental health professional about themselves or a friend)
- Other Materials: ACT Posters, ACT Stickers, Suicide Prevention Lifeline Wallet Cards, Student Newsletters, Parent Newsletters

Note: * Indicates a program material that is mandatory for implementation of the SOS Program with fidelity.

Evaluation Summary

Three evaluations of the SOS program have yielded positive results for program effectiveness. A study published in 2007 examined nine schools in Western Massachusetts in which 4,133 students were assigned to a control or intervention group (Aseltine et al., 2007). Classes included in the intervention group received the SOS program during the experimental period, and all students were asked to complete a brief survey three months after program implementation. These researcher-generated surveys included questions about suicide ideation or attempts (sourced from the CDC Youth Risk Behavior Survey), knowledge and attitudes about depression and suicide, and help-seeking behavior. Post-test questionnaires showed that students who received the SOS Program showed significant lower rates of suicide attempts ($p < .05$). Students also showed significantly improved knowledge ($p < .05$) about depression and the warning signs of suicide. The effect of the program on suicide ideation and help-seeking behavior did not reach statistical significance.

A second evaluation examined the effects of the SOS program among 5th through 8th grade students in eight Connecticut middle schools identified by the Department of Defense as “high military impact schools” (Schilling et al., 2014). Schools were assigned to either be in the intervention or control group, and all students were asked to complete pre and (3 months) post implementation questionnaires. These surveys, developed by the research team, included YRBS questions to assess suicidal ideation and history of attempts, knowledge and attitudes about depression and suicide, and help-seeking behaviors. Results of this evaluation showed that students who participated in the SOS program did show improvements over a 3-month time period. Students with pretest suicidal ideation who received the program were 96% less likely to report suicidal behavior (in the past 3 months) than those in the control group who also presented with pretest ideation. Additionally, SOS participants showed a statistically significant increase in knowledge of depression and suicide ($p < .05$). However, this evaluation also found that SOS participation overall did not significantly affect help seeking from a sibling, parent, or friend after controlling for pretest help-seeking and suicidal ideation.

A more recent study sought to replicate and extend these previous evaluations by examining 1,036 9th grade students in 17 high schools in Connecticut (Shilling, Aseltine, & James, 2016). A pre/post-test randomized control design was used to assess self-reported suicidal ideation, planning, and attempts, as well as knowledge and attitudes about depression and suicide. Researchers used YRBS questions modified to ask about the previous three months were used to measure suicidal ideation and behaviors, while questions modified from instruments previously used to evaluate school-based suicide prevention programs in the 1990’s were used to measure knowledge and attitudes. This study found that students who received the SOS program were 64% less likely to report a suicide attempt in the previous three months than students in the control group. Students in the control group also a large increase in lifetime suicide attempts (9.4% pretest to 14.9% posttest), attributed to attempts made within the previous three months. Additionally, high risk students (those who reported a previous suicide attempt) who participated in SOS saw a 75% reduction in suicide planning compared to high risk students in the control group ($p < 0.071$). Lastly, results did show a statistically significant increase in knowledge of depression and suicide, as well as more adaptive attitudes towards these issues.

Limitations:

- Efficacy of program beyond 3-month follow-up is not validated in peer-reviewed literature.
- Efficacy of program for rural youth is not validated in peer-reviewed literature.

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Sources of Strength

Designed for Ages/Grade Levels: 14 – 18 years

Program Length: 3 – 6 month project per year; multi-year project

Schedule of Lessons: NA

Total Number of Lessons: NA

Program Description:

Sources of Strength is a comprehensive wellness program that focuses on suicide prevention, but also seeks to impact social issues such as violence, bullying, and substance abuse. The program uses peer leaders and adult advisors to positively change the cultures of the school and community around help seeking behavior using Hope, Help, and Strength messaging. The messaging is designed by Sources of Strength, but each peer team chooses messaging that is most appropriate for their school and community. Sources of Strength is typically implemented in middle or high schools, but can also include cultural and faith based settings, and can be implemented in tribal communities.

Peer leaders receive 4 – 6 hours of annual training. The peer leaders work with adult advisors to create messaging campaigns and activities that encourage students and staff to help individuals who may be struggling with mental health issues connect with help and find support. Adult advisors are drawn from school staff, but can also include parents, community members, and young adults. Adult advisors also receive 4 – 6 hours of training annually. In many areas, adult advisors can also undergo train the trainer training, which involves attending a national skills session, co-training and a trainer/mentor relationship, and finally certification.

Program Materials:

- Sources of Strength Training Materials – video*
- Adult Advisor Guides*
- Peer Leader Guides*
- Different materials that peer leaders can distribute to students during events and messaging campaigns

Note: * Indicates program materials required for implementation.

Evaluation Summary:

Two groups of researchers tested peer exposure to the Sources of Strength intervention after one year of implementation. Wyman and colleagues (2010) randomly assigned 18 schools to take part in either the intervention (Sources of Strength) or control (wait list that began the program 5 months later). At schools assigned to the intervention, 453 peer leaders were trained, and 2,675 students were selected as representatives of the 18 schools. Students at schools in both the intervention group and the control group received a baseline survey. Trained peer leaders completed questionnaires about suicide perceptions and norms, social connectedness, and peer leader behaviors. Peer leaders reported that adults at school helped suicidal students ($p < .001$) and rejected codes of silence ($p < .002$). Training also significantly increased help-seeking behavior from adults at the school ($p < .001$) and the number of identified trusted adults ($p < .001$).

More recently, Pickering and colleagues (2018) tested the implementation and dissemination of the Sources of Strength program to 3,730 students over a period of one year at 20 schools where 533 peer leaders were trained. Students took a start of year baseline survey which assessed friendships and relationships with adults at their school as well as suicidal thoughts and behaviors. The students also took an end of year survey, which assessed their exposure to various portions of the intervention such as seeing posters and videos, having contact with peer leaders, and participation in various intervention activities. A chi-square analysis showed that more peer leaders increased school wide exposure ($p < .05$). Multivariate models showed that more peer leaders also increased the number of students who were able to name trusted adults ($p < .001$). The program also increased help-seeking behavior among suicidal youth and increased perceptions of adult support for suicidal youth.

Limitations:

- Extremely variable intervention exposure between schools (Pickering et al., 2018; Wyman et al., 2010).

- Students who reported suicide attempts were less likely to have exposure to the intervention (Pickering et al., 2018).

References:

Pickering, T. A., Wyman, P. A., Schmeelk-Cone, K., Hartley, C., Valente, T. W. ... & LoMurray, M. (2018). Diffusion of a Peer-Led Suicide Prevention Intervention through School-Based Student Peer and Adult Networks. *Frontiers in Psychiatry* 9: 1 – 16.

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The Jason Foundation

Designed for Ages/Grade Levels: Grades 7 – 12+

Lesson Length: 45 minutes

Schedule of Lessons: 5 Day Plan: Lessons A – E; 3 Day Plan: A, C, Combine Lessons D & E

Total Number of Lessons: 3 – 5 (can accommodate block scheduling)

Program Description:

The Jason Foundation Program is a 3 – 5 lesson curriculum designed to teach students how to identify the warning signs of suicide and depression in their friends. The program provides a brief overview of youth suicide statistics, then teaches students how to provide peer support and respond to peers in need. The Choices Video is provided as part of the program. Students watch the video twice, once where students are asked to watch a specific character and discuss their reactions to the material presented. The second time, students are asked to watch the two main characters, and identify the warning signs of suicidal thoughts they see in the video. The program also helps to students identify a trusted adult with whom they could talk to about themselves or a peer. There is also a smart phone app available called “A Friend Asks” which provides at-risk teens and their friends and family information about warning signs, and direct access to skill building tools to help someone in crises, and helplines for people in crisis to contact. Additionally, The Jason Foundation partners with the Rascal Flatts on the B1 awareness campaign. By pledging to be a part of the B1 program, students are pledging to be there for their friends. The program encourages students to be aware of the problem of youth suicide, to be able to identify friends who may be at risk for suicide, and to have a plan to help friends who indicates that they may be at risk for suicide.

Program Materials:

- Choices Video*
- Teacher Manual*
- Powerpoint*
- Teacher Resource Sheet*
- Posters: #IWONTBESILENT, A Friend Asks App, B1, Choices
- Cards: A Friend Asks App, B1 Project Pledge Card
- Brochures: B1 Project, The Jason Foundation, The Jason Foundation’s Online Professional Development

Note: * Indicates a required program component.

Evaluation Summary:

An evaluation of the Jason Foundation Program, conducted by Labouliere and colleagues (2015) used free-recall to evaluate suicide prevention knowledge and compare levels of knowledge after participating in the student gatekeeper training. Free-recall was used to prevent students from correctly guessing the correct answers without having the information needed to assist suicidal peers. Students (n=1,365) participated in the Jason Foundation Program over a period of 3 years. Students took a baseline knowledge survey consisting of four open-ended questions designed by the Jason Foundation before receiving the program, and then took a follow-up survey after the completion of the program. This brief survey asked students to list five or more suicidal warning signs, four or more appropriate responses to suicidal ideation, two appropriate responses if a peer requested that suicidal ideation be kept secret, and two or more resources available to help peers experiencing a crisis. Student knowledge of suicidal behavior and warning signs increased significantly ($p < .0001$) after the program, however there is still room for student knowledge improvement, as average scores increased from 35% to 51% (barely passing) from pretest to post-test.

Additionally, nine focus groups were conducted with a total of 58 students and included youth who had and had not completed the curriculum in each discussion. Groups were one to two hours in length and conducted either in person or over the phone via teleconference. The purpose of these discussions was to assess participants’ knowledge of suicide risk and their opinions on school climate, knowledge of the program, and recommendations for program improvement. A majority of trained students (64.5%) reported that recognition of suicidality in peers remained difficult, despite the overall sentiment that suicide prevention programs for youth are important. There were differences in the number of those who reported feeling scared to talk to a peer having thoughts of suicide, with 7.4% of untrained students feeling unprepared

and 14.8% stating they were unsure of what to say; whereas only 3.7% of trained students identified these tasks as difficult or scary.

Limitations:

- Cannot compare between studies which used force-choice and open-ended questions to determine increase in knowledge.

References:

Labouliere, C. D., Tarquini, S. J., Totura, C. M. W., Kutash, K., & Karver, M. S. (2015). How Much is Learned by Students Participating in Suicide Prevention Gatekeeper Training? *Crisis* 36(4), 274-280.

The Trevor Project

Trevor Lifeguard Workshop

Designed for Ages/Grade Levels: Middle/High School & College Age Youth

Lesson Length: 90 minutes

Schedule of Lessons: NA

Total Number of Lessons: 1 90-minute lesson or 2 45-minute lessons

Program Description:

LGBTQ youth are already a disproportionate risk for suicide. The Trevor Project Lifeguard Workshop for LGBTQ youth and their allies promotes wellness and resiliency for LGBTQ students, and build empathy and support for LGBTQ youth allies. The program focuses on both building protective factors for youth and identifying support networks where youth can turn when they need help for themselves or a friend. The workshop includes three video segments, interspersed between periods of discussion and activities. Video segments include a segment focusing on depression and self-care, another on the warning signs and how to help students struggling.

Program Materials:

- Lifeguard Workshop Video*
- Whiteboard*
- Support Inventory

Note: * Indicates a required program component

Evaluation Summary:

Evaluation work is currently in progress. No results have been published as of 6/1/2019.

Limitations:

Unknown at this time as evaluation is currently in progress.

References:

Unknown at this time as evaluation is currently in progress.

Youth Aware of Mental Health (YAM)

Designed for Ages/Grade Levels: 13 - 17

Lesson Length: 1 Hour

Schedule of Lessons: 5 lessons over 3 weeks

Total Number of Lessons: 5

Program Description:

The Youth Aware of Mental Health program is a universal mental health promotion program. The program provides youth participants with a safe space for discussion, role-play, and reflection. The program promotes increased knowledge about mental health including peer support, stress, crisis, depression, suicide, and help-seeking behaviors. Six themes are the primary focus of the curriculum provided over the five lessons:

- | | |
|----------------------------|--------------------------------------|
| 13) What is mental health? | 16) Depression and suicidal thoughts |
| 14) Self-help advice | 17) Helping a friend in need |
| 15) Stress and crisis | 18) Who can I ask for advice? |

YAM instructors guide youth through the topics of each lesson and the interactive lectures, but allows student voices and experiences to influence the discussion and role-play aspects of the program. This strategy encourages one of YAM's primary goals in empowering students to consider themselves the experts of their own mental health.

Program Materials:

- Program Booklet*
- Class Posters*
- Slides*
- YAM Guide (of local mental health resources)

Note: * Indicates program materials that are necessary for implementation.

Evaluation Summary:

Two studies have examined the effectiveness of the YAM program on reducing the risk of suicide among youth. First, YAM was evaluated as part of the Saving and Empowering Young Lives in Europe (SEYLE) study which took place from 2009 to 2010 and included 11,110 youth from 168 schools across 10 European Union countries (Wasserman et al., 2015). Schools within each country were randomly assigned to receive one of three interventions, including Youth Aware of Mental Health (YAM), or to be in a control group. Forty-eight schools with a total of 2,721 students were assigned to the YAM program. Using the five item Paykel Hierarchical Suicidal Ladder, the SEYLE project found that YAM reduced new cases of suicide attempts 3 months after program implementation (0.9%; OR=0.78) and saw a continued reduction at 12 months (0.7%; OR=0.45) – a significant difference from the control group ($p < .05$). The same study also found that YAM reduced severe suicide ideation after 3 months (1.23%; OR=0.72), with a significant reduction (0.75%; OR=0.5) at 12-month follow-up compared to the control group ($p < .05$).

A recent, qualitative, study examined the experience of 32 students between the ages of 15 and 17 participating in YAM in four European countries (Wasserman et al., 2018). Sixteen students of each gender were randomly selected from the largest YAM schools in each country to participate in semi-structured interviews. Interview questions developed by the members of the research team based on themes covered in the YAM curriculum. During development, a focus group of six students aged 13 to 18 was convened to help improve the interview format and ensure questions were developmentally appropriate. A mental health association game was also used to help break up the flow of the interview and explore meanings that students assigned to the words. An interview guide was also developed to ensure consistency between research team members. Interviews lasted between 90 minutes and 3 hours, were transcribed verbatim, and translated into English for analysis. Results of this study found that:

- Youth found YAM role-plays useful because they were able to use examples from their everyday lives.
- YAM classroom discussions allowed students to learn more about the opinions of their classmates, leading to continued discussions about mental health outside the scope of the program.

- Students identified as “cautious” or “initially hesitant” appreciate that other students could take the lead during discussions and YAM activities, and still felt they benefitted from less active participation in the program.

Limitations:

- Reliance on self-reported data.
- Evaluation outcomes for American youth not yet available (research is current ongoing at Montana State University). Cultural or environmental differences may influence outcomes for youth in the United States.
- Control group exposed to same mental-health information displayed on posters in the classroom as the YAM group. (Wasserman, et al., 2015)

References:

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COMPARISON CHART OF SCHOOL-BASED SUICIDE PREVENTION PROGRAMS

		SOS	YAM	Lifelines	Sources of Strength	LEADS	CARE	CAST	Jason Foundation	Trevor Project	Reconnecting Youth	
Program Design	Grades/Ages Covered	6 th – 12 th	13 - 17	5 th – 12 th	14 - 18	9 th – 12 th	14 – 19	6 th – 12 th	7 th – 12 th +	6 th – 12 th +	9 th – 12 th	
	Type of Program	Universal	✓	✓	✓	✓	✓		✓	✓	✓	
		Gatekeeper	✓									
		At-Risk						✓	✓			✓
	Number of Lessons		1	5	2 - 4	NA	3	1	12	3 – 5	1 - 2	75 (1 semester)
	Length of Each Lesson		50 mins	1 hour	1 class period	NA	1 hr	3 ½ - 4 hrs	55 mins	45 mins	1 90-mins or 2 45-mins	1 class period
	Setting	Individual		✓				✓				
		Classroom	✓		✓		✓		✓	✓		✓
		School-wide				✓						
		Family				✓		✓				
		Community				✓						
Implementer	Teacher	✓	✓	✓	✓	✓		✓	✓		✓	
	Counselor	✓	✓	✓			✓					
	Paid Program Staff		✓	✓								
Training Required		90 mins	5 days	1 day	4 – 6 hours annually	None	Unknown	4 days	2 hrs	20 mins	4 days	
Evidence of Effectiveness	Decreased Suicide Attempts	✓	✓									
	Decreased Suicide Ideation	✓	✓				✓					
	Decreased Risk Factors		✓				✓	✓			✓	
	Increased Knowledge					✓			✓			
	Increased Help-Seeking Behavior				✓							
	Increased Peer Support				✓							
	Increased Protective Factors				✓		✓	✓			✓	

Note: "Evidence of Effectiveness" refers to outcomes that have been proven through a formal evaluation of the program.

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