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ORIGINAL PAPER

The Role of Teachers in School-Based Suicide Prevention: A Qualitative Study of School Staff Perspectives

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Abstract In response to concerns over youth suicide, there has been an increase in school-based suicide prevention programs. However, we know little about teacher perspectives on school-based suicide prevention and mental health programs. This study examined teacher roles in the implementation of a district-wide suicide prevention program through focus groups and interviews with middle school teachers, administrators, and other school personnel. Study results highlighted teachers' critical role in detecting students at risk for suicide. Factors that appeared to facilitate teacher participation in the suicide prevention program included well-defined crisis policies and procedures, communication of these procedures, collaboration across staff, and the presence of on-campus mental health resources. Participants identified a need for direct teacher training on risk factors for suicide, crisis response, and classroom management. Other strategies for improving suicide prevention efforts included in-school trainings on mental health resources and procedures, regular updates to these trainings, and greater visibility of mental health staff.

Keywords Suicide prevention · School mental health · Teachers

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In the report, "Reducing Suicide: A National Imperative," the Institute of Medicine identifies suicide prevention as a national public health concern (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). There has been a nearly 200% increase in the rate of suicide attempts among 11–14 year olds between 1980 and 1999 (U.S. Public Health Service, 1999), with suicide the third leading cause of death in youth ages 10–24 years old (Centers for Disease Control and Prevention, 2009). Results from the 2007 youth risk behavior surveillance survey (YRBS) indicate that: (1) 15% of students had seriously considered attempting suicide during the 12 months leading up to the survey, (2) 11% of students had made a plan about how they would attempt suicide, and (3) 7% of students had attempted suicide one or more times in the year before the survey (Eaton et al., 2008). These statistics highlight the high likelihood that teachers, school staff, and students will come into contact with or be impacted by students at risk for suicide. Further, students at risk for suicide and related

mental health problems are also at risk for poor academic performance (Masten & Curtis, 2000).

Despite these concerns, students rarely receive needed mental health services (Kataoka, Zhang, & Wells, 2002). Recommendations from the YRBS report coupled with those outlined in the President's New Freedom Commission on Mental Health call on schools to play a more central role in the identification and treatment of students in need of mental health care (Eaton et al., 2008; U.S. Department of Health and Human Services, 2003). In fact, 70–80% of children who receive any mental health services receive that care in schools (Burns et al., 1995). Teachers and other school staff play an important role in providing informal support to students and in connecting them with mental health services and other resources at the school. One type of mental health service that has been widely disseminated in schools is suicide prevention programs (Brener, Martindale, & Weist, 2001; Small et al., 1995). However, like other types of school-based mental health programs, we have limited understanding of the effectiveness and real-world implementation of these programs (Hoagwood et al., 2007; Rones & Hoagwood, 2000) and the role of teachers in these programs. The current study aimed to explore the implementation of a district-wide suicide prevention program.

Suicide prevention programs use a variety of approaches, including curricular methods that provide information to (Kalafat & Elias, 1994; Shaffer, Garland, Vieland, Underwood, & Busner, 1991), screenings to identify at-risk students for suicide (Shaffer et al., 2004), and gatekeeper models that train school staff in detection and referral (Centers for Disease Control and Prevention, 1994; King & Smith, 2000). Despite the growth in suicide prevention programs in schools, the actual implementation of suicide prevention programs by school staff has not been adequately investigated. This is particularly relevant to the "gatekeeper" model which seeks to: (1) improve detection of students at high risk for suicide by educating school staff, and (2) facilitate referrals for services by engaging students' social support networks (Centers for Disease Control and Prevention, 1994). In this model, "engaging" refers to the process of connecting students with supportive adults and providing students and their families with appropriate mental health referrals.

Prior studies have found that school staff (including superintendents, principals, and school psychologists) are receptive to gatekeeper suicide prevention programs at their schools, and generally prefer them to school-wide screenings (Eckert, Miller, DuPaul, & Riley–Tillman, 2003; Miller, Eckert, DuPaul, & White, 1999; Scherff, Eckert, & Miller, 2005). Furthermore, gatekeeper training programs have been shown to effectively improve staff awareness of suicide warning signs, knowledge of the resources available to treat suicidal students, and referral practices (Gould, Greenberg, Velting, & Shaffer, 2003; King & Smith, 2000). However, evidence is mixed related to how these kinds of suicide prevention programs impact school staff ability to prevent potential suicides. Studies of the gatekeeper model have shown positive impacts on school staff knowledge and self-reported confidence related to working with students at risk for suicide, but have shown a less significant impact on the actual identification and engagement of students at risk for suicide (Reis & Cornell, 2008; Wyman et al., 2008).

The attitudes of frontline school staff (i.e., teachers, counselors, nurses, social workers, and administrators) toward suicide prevention programs are important in developing a richer understanding of how to effectively implement these programs across a school district. The pivotal role of teachers in the implementation of the gatekeeper model is particularly important to explore, given that teachers spend more time with students than any other school staff. They are uniquely positioned to detect students at risk for suicide, yet little is known about their perspectives regarding the implementation of the gatekeeper model, the assumption of an enhanced "gatekeeper" role, or their own ability to accurately identify, approach, and refer at-risk students. This issue is of particular interest in middle schools, given the drastic change from the student–teacher relationship in elementary school, where students stay with one teacher for the entire school day. In middle school, students typically rotate classes throughout the day, giving each teacher only a brief window in which to observe individual student behavior. In addition, middle school is well recognized as a vulnerable time for the onset of mental health and academic difficulties (Barber & Olsen, 2004; Eccles et al., 1993; Roeser, Eccles, & Sameroff, 1998). Students in this age group have similar and, in some contexts, higher rates of suicidal ideation to high school students (Centers for Disease Control and Prevention, 2007; Eaton et al., 2008), making it especially critical that middle school teachers are prepared with clear and accurate ways to identify risk for suicide.

Research suggests that teachers may face challenges in filling the "gatekeeper" role, possibly due to inadequate training and preparation (King, Price, Telijohann, & Wahl, 1999a, b; Scouller & Smith, 2002). A nationwide survey of high school teachers found that teachers are generally knowledgeable about warning signs and risk factors for suicide and that they believe it is their role to detect students at risk for suicide (King et al., 1999a). Only 9% of teachers, however, reported they had the skills to accurately detect a student at risk for suicide (King et al., 1999b). When asked directly about addressing the mental health needs of their students, teachers expressed a willingness to take on an enhanced role, but felt they lacked the skills to successfully address potential suicidality (Rothi, Leavey, & Best, 2008). Gatekeeper training programs appear to impact teacher

attitudes, knowledge, and ability to identify potentially suicidal students. However, these studies also suggest that among teachers with a baseline difficulty engaging at-risk students, there is little improvement in their ability to provide support, and link students with school mental health staff who can then provide appropriate referrals and support (Reis & Cornell, 2008; Wyman et al., 2008).

The current study used qualitative methods to explore school staff (i.e., teachers, counselors, nurses, social workers, and administrators) perspectives on the implementation of a gatekeeper suicide prevention program in a large, urban school district. Of particular interest was the role of teachers at different stages of the gatekeeper model of suicide prevention (detection, referral, engagement in services), and barriers or facilitating factors for implementation of the program.

Method

Youth Suicide Prevention Program

The current study took place in one of the nation's largest school districts with almost 900 schools serving approximately 688,000 students, many of whom are of low-income (77% qualify for free or reduced cost lunch) and/or ethnic minorities (about 73% Latino, 11% Black, 6% Asian/Pacific Islander).

This district's youth suicide prevention program (YSPP) is among the first school-based programs in the United States consistent with the School Gatekeeper Training Model (Centers for Disease Control and Prevention, 1994). The two primary components of the YSPP are: (1) training of school personnel (e.g., gatekeepers) to increase knowledge, change attitudes, and develop skills in detecting students potentially at risk for suicide and referring them for crisis intervention, and (2) "crisis intervention," in which the trained school staff members engage suicidal students' support networks and refer them for counseling or treatment. School staff use criteria outlined in the YSPP district-wide training for identifying students at risk for suicide, which includes those students with sudden worsening of mood and behavior or suicidal ideation. However, peers, parents, or the at-risk students themselves can also make referrals.

Once a student is referred, a trained school staff member determines whether there is a need for crisis intervention (through the assessment of warning signs, a plan or intent for self-harm, the existence of a support network, and a history of psychiatric illness). The crisis intervention itself consists of: (1) providing immediate support to the suicidal student, (2) contacting parents and engaging the student's social support network, and (3) providing appropriate referrals and facilitating entry into treatment (e.g., counseling in the community, on campus, or in a hospital setting). If suicidal risk is determined, the mandatory suicide risk assessment form (which includes information about the referral source, reason for referral, and actions taken during the crisis intervention) is sent to the district's central office.

Annually, the district's Director of Suicide Prevention Services provides a 90-min annual training on the above components of YSPP to multidisciplinary school crisis team members. Each school is required to have at least one crisis team member attend this training, which provides specific guidelines for assessment of suicide risk and interventions (e.g., providing appropriate support, resources, and referrals to students and families). This information can then be shared with other school staff. Materials from this training include handouts for youth, parents, and school staff that address suicide risk among youth, warning signs, and specific actions to take when there is a concern. Individual schools can request additional staff training at their discretion. There are no specific YSPP fidelity-monitoring procedures.

Participants

Five focus groups and ten individual administrator interviews were conducted across five different schools. Participants were recruited through referral by a key contact person at the school (either a school social worker or administrator). Participants were also recruited via announcements made at faculty meetings or via flyers in faculty mailboxes. Efforts were made to include the administrator who oversees counseling at each school. Overall, there were 45 participants (19 males, 26 females) including 10 administrators (22.2%), 7 counselors or mental health staff (15.6%), 2 nurses (4.4%), and 26 teachers (57.8%). About 56% ($n = 25$) of the participants were White, 22% ($n = 10$) were Latino, 7% ($n = 3$) were African American, and the remaining seven (15%) were Native American, Asian American, or of another or mixed ethnicity. On average, participants had worked in schools for 14 years (SD = 11.32) and at their current schools for 6.4 years (SD = 5.5). Twelve (26.7%) participants had bachelors degrees, 30 (66.7%) had masters degrees, and 3 (6.7%) had doctorates. These demographic characteristics mirror those of school staff working in the broader Los Angeles Unified School District (LAUSD), although our sample included a higher proportion of boys (42.2% vs. 19.8% district-wide), a lower proportion of African Americans (7% vs. 15% district-wide), and a greater proportion of staff with masters and doctoral degrees (66.7% vs. 46.6% district-wide for masters degrees; 6.7% vs. 3.6% for doctorates). The difference in educational background may reflect the inclusion of a higher proportion of administrators, school mental health professionals, and counselors in this sample (RAND California, 2010).

Schools were sampled based on their level of YSPP implementation, defined as the annual number of mandatory suicide risk assessment forms completed per enrolled student at the school. The district requires that this assessment form is completed for all students at-risk for suicide that come to the attention of the school. This form serves as an incident report as well as the documentation of specific actions taken by the school. All district middle schools were categorized as having high, middle, or low levels of YSPP implementation (in the top quartile, middle two quartiles, or bottom quartile, respectively). Schools were then randomly sampled from the high and low implementation groups. Of the six schools initially approached, one school did not respond to study staff or school district partners. The five schools that did participate varied in size, test performance, and attendance, reflecting the variability across the school district (See Table 1). They all had over 99% ethnic minority students, with the majority being of Latino decent, a characteristic of the school district. Average class size ranged from 28 to 32 students per class, and the percentage of English language learners ranged from 33 to 56% per school. The rate of completion of mandatory suicide risk assessment forms per capita in each of the three low implementation schools was 0.001; rates of completion per capita were 0.013 and 0.015, respectively, for the two schools in the high implementation group (range across all five schools: 1–39). The non-participating school was not notably different on any of these demographic indicators.

Procedures

The majority of administrators were interviewed individually by telephone by a member of the research staff; one administrator was interviewed in person. All focus groups with school staff were conducted at the school site by two

Table 1 School demographics

	School 1	School 2	School 3	School 4[a]	School 5
School size	1,939	2,227	3,249	1,005	1,830
Racial/ethnic profile of students					
Hispanic	65.7% (1274)	93.2% (2075)	95.3% (3097)	97.3% (983)	75.0% (1373)
Black	33.9% (658)	0.9% (20)	1.4% (47)	0.2% (2)	23.6% (432)
Asian	0.0% (0)	4.8% (107)	2.6% (86)	0.3% (3)	0.7% (12)
Filipino	0.0% (0)	0.4% (10)	0.4% (14)	0.3% (3)	0.2% (4)
Alaskan	0.2% (3)	0.4% (8)	0.1% (3)	1.2% (12)	0.1% (1)
White	0.2% (3)	0.2% (5)	0.1% (2)	0.2% (2)	0.4% (7)
Pacific Islander	0.1% (1)	0.1% (2)	0.0% (0)	0.0% (0)	0.1% (1)
Average class size					
English	27	27	27	N/A[b]	29
Math	32	31	29	N/A[b]	30
Science	32	31	31	N/A[b]	30
Social Science	31	32	32	N/A[b]	30
California standards test (Percent Proficient & Advanced)					
English language arts	9.20%	20.70%	15.50%	14.80%	14.90%
Mathematics	7.10%	18.80%	17.90%	31.70%	12.20%
English language learners	42.6% (803)	33.3% (742)	53.6% (1740)	56.4% (567)	43.8% (802)
Student attendance					
Stability rate	73.46%	86.43%	85.81%	78.51%	84.42%
Transiency rate	45.92%	22.64%	25.45%	38.11%	30.00%
Actual attendance rate	89.26%	94.08%	95.64%	95.12%	92.67%
Suspension rate	36.00%	27.30%	39.10%	4.90%	26.00%
Certified teachers	73	113	113	38	89
Teachers without certification	28	18	13	0	23

Data based on 2005–2006 school year

[a] School 4 is a K-8 school. Separate data on grades 6–8 was not available

[b] Class size for grades 6–8 was not available for school 4

researchers, who alternately served as interviewer and note-taker. Participants were read a consent script and verbally consented to participate before the interview or focus group began. Interviews and focus groups were tape-recorded and transcribed. Transcripts were reviewed by the interviewer and revised if necessary.

The semi-structured interview and focus group protocols were organized around the following overarching areas: (1) detection of students at-risk for suicide, (2) crisis intervention, (3) post-crisis response, (4) training related to suicide (prior training, current needs), (5) quality improvements at the school and district levels targeting each phase of the program, and (6) unique middle school needs. Within each of the broad topic areas were specific prompts designed to elicit case examples, specific protocols/procedures, descriptions of the roles of different school staff members, factors that made their own roles easier or harder, explanations of the school's communication and collaborative processes, relevant resources (on- and off-campus), and suggested improvements. Participants were also given the opportunity to address any issues that they felt were important that had not been asked directly. The questions were formatted to allow school staff to discuss their personal views on at-risk students, to describe school protocols related to each stage of suicide prevention (i.e., detection of students at risk for suicide, crisis intervention, and post-crisis response), and to suggest improvements without specific knowledge of YSPP. However, there was one question pertaining to whether or not they had received training from the school district in suicide prevention (see Appendix for the focus group interview guide). Individual interviews lasted on average 30 min; focus groups lasted about an hour. Participants received $40 compensation for participating in the study. The RAND and UCLA Institutional Review Boards and the school district research review committee approved all study procedures.

Data Analysis

Transcripts were preliminarily coded in the major domains using qualitative data analysis software (Muhr, 1998) and the techniques described by Morgan and Krueger (1997). First, two of the authors serving as primary coders (EN, VC) reviewed the range of answers for each question and conducted open coding of the participants' responses guided by the key domains addressed in the interview questions. This included review of all five focus groups and about half of the administrator interviews. The research team (EN, VC, SK) then jointly generated a list of codes that corresponded to interview topics, as well as additional codes that emerged from the transcripts. Through this process, teachers' unique role in the detection of at-risk students emerged as a central area of importance; subsequent coding focused on capturing teachers' roles during the key phases of YSPP implementation (e.g., detection, referral) both from the perspective of teachers as well as the perspective of other staff members (e.g., social workers, nurses, administrators). Next, using this working code list, the coders conducted independent coding of half of the focus groups and administrator interviews, then met with the research team to discuss expanding, collapsing, or eliminating codes until there was a refined list of mutually agreed upon codes. Once the final code list was agreed upon, all transcripts were reviewed by the research team until consensus was reached on all the codes.

Results

Four primary themes emerged regarding teacher roles and staff perspectives on school-based suicide prevention: (1) detection of students at risk for suicide, (2) communication and referral procedures, (3) post-crisis issues, and (4) training. The subthemes reported below were discussed in all, or the majority of, the transcripts, with participants expressing general agreement with their content. We have also included additional themes that were particularly illuminating with respect to teachers' experience of the YSPP implementation are also included. Themes are presented below in order of salience (determined by the order in which the topic arose during discussion, the depth/extent of each topic's discussion, and participant agreement on its importance or relevance). There were no substantial differences between the high and low implementation schools regarding in the presence of certain themes, or in the extent to which each theme was discussed. Results are presented across all schools.

Detection

Across all of the administrator interviews and focus groups, teachers were perceived to have the most consistent contact with students and were identified across all schools as typically the first school staff member to become aware that a student may be at risk for suicide. Teachers identified student risk for suicide either through direct observation or self-report from students.

Direct Observation

Across all focus groups and interviews, there was agreement that direct observation by teachers serves as the primary means by which students who might be at risk for suicide were are identified. Social workers and administrators noted that teachers were able to offer important

information that may be difficult for others to obtain. Teachers largely relied upon changes in behavior or mood as key indicators of problems. One teacher stated, "*You see their mood every day, so you can see if their mood changes.*" Teachers also reported that observing peer interactions, including the interactions during classroom group work, helped to detect students who were struggling. Many teachers indicated that they consulted with other teachers on student behaviors to determine whether there was cause for concern, *"I always ask teachers, 'Oh, how is so-and-so doing in your class? He's doing this in my class; do you have that same kind of behavior going on there?'"*

In addition to observed changes or behavioral indicators, teachers in each of the focus groups identified a number of subgroups whom they felt were at risk for suicidal behavior. These included the "Goth" group (e.g., students who dress in black, involve themselves in counterculture), students who are cutting or otherwise physically hurting themselves (e.g., have been observed with cigarette burns), students who exhibit disciplinary problems, students without friends, students in special education, and LGBT (lesbian, gay, bisexual, transgender) students. With regard to students identified with countercultural groups, one teacher commented, *"Sometimes it is just an expression of teenage rebellion, but very often there is a comment behind it. I always like to talk to those children in more depth to find out where this need to express themselves in this dark way comes from and very often there is something there that's depressed.*"

Student Self-Report

Another common method discussed in the majority of focus groups and administrator interviews was that teachers commonly detected at-risk students through self-report. Respondents characterized this method of detection as arising primarily from student writing (most often in English class) and art. An administrator noted, *"Many of our teachers have [students keep] daily journals. It's not a graded activity but it's a way to get them to write, to express feelings. And the teachers will read them, they'll comment, they'll give suggestions. And they know their kids pretty well."* Another teacher indicated that showing an interest in students' personal lives can sometimes lead students to verbally report on emotional issues.

Communication and Referral Processes

Across schools, the perceived effectiveness of the referral process appeared to be closely connected to strong communication and a sense of collaboration among teachers and other staff. Although administrators and staff typically described a formal referral process at their school, teachers across all of the focus groups also seemed to rely heavily on informal networks to seek support for potentially suicidal students.

For example, some respondents described formal bi-weekly meetings to manage the needs of students with academic, social, or mental health problems. An administrator from one school described a "Resource Coordinating Team," through which counselors and team teachers met every 2 weeks and discussed ways to identify and follow-up with students with academic, social, and mental health problems. A counselor described this regular bi-weekly meeting: "*This meeting is comprised of all our counselors, our dean, our nurse, administrators, and outside community agencies that the district has used… All these things we use that the parents can tap into, resources that are free to them, and that help students in need.*" In another school, a teacher described a clear protocol: *"If you identify the student as being potentially at risk for suicide, you would make a referral to the counselor, and that counselor should bring that information to a COST meeting [Coordination of Services Team, a school-based case review system], and present it. The COST meeting includes counselors, deans, psychiatric social workers, the family center personnel, and outside agencies."* A third school coordinated similar procedures through their "Healthy Start" program. While there was usually at least one administrator, teacher, or social worker at each of the schools who was able to describe these procedures, the majority of focus group participants were not aware of formal referral processes at their school.

In addition to these formal mechanisms, teachers at each school reported referring students to whichever staff members they knew best and appeared to be more likely to refer if they had pre-existing relationships with counselors. A social worker commented, "*Sometimes teachers go to who they're comfortable speaking to. There are some new teachers here that don't know where we are, for example. So maybe they'll talk to their assistant Principal or their direct supervisor [instead of us].*"

Teachers in each of the focus groups reported a desire for better communication with administrators or counselors about mental health issues. Some of these teachers appeared most comfortable turning to each other for support on mental health concerns and often did not reach out to other professionals on campus. One teacher noted, *"I have some really supportive teachers who work on the same floor as me, so I'm really lucky that way…unless you're reaching out, I don't think anyone's reaching in."* Although they were not directly asked about it, a few teachers in one focus group explicitly discussed a concern with being perceived as incompetent if they asked for help regarding students' mental health needs. These teachers

indicated that this was a reflection of the fact that their school had such limited resources. They were told to only refer in the event of a danger to self or others, and felt that they were expected to solve problem on their own to address students' needs.

Facilitators of Communication and Collaboration

In addition to a clear communication or referral structure and staff awareness of such processes, some administrators emphasized the importance of a "*culture of safety.*" Aspects of the cultivation of such a culture included increasing the visibility of mental health resources, encouraging referrals (despite the increased likelihood of false positives), and developing teacher–counselor relationships so students feel safe speaking to any adults at the school. In discussing referrals, an administrator explained, *"Not to be weird about it, but we tell the teachers, 'If you think of recommending, it's not a dumb thing to do, do it!' We don't want them to say, 'I thought the kid was going to be okay.'"*

Increased visibility of mental health resources was perceived to facilitate the development of teacher–counselor relationships. For example, teachers in the school with a "Healthy Start" program reported that counselors consulted with them about specific students and would provide classroom observations of students. In the other schools, a few of the teachers noted that counselors were present at staff development sessions, in the cafeteria, or on the playground. A teacher commented, "*We know where they're at. We always pass by their place."* One social worker explained how this relationship building can occur in the context of classroom observations: *"You pick up on what some of [the students'] typical behaviors are in the classroom that way. And the teacher sees who you are, so this way if they ever need you, they at least have a general idea of who you are."*

Post-Crisis Phase

Even when teachers have made referrals for students at risk for suicide, teachers across each of the focus groups described a lack of follow-up after the referral, which they attributed to confidentiality procedures. Teachers and staff identified both challenges and benefits to these procedures, as well as specific strategies that could be used to involve teachers. Many teachers reported that lack of feedback left them unable to effectively attend to students' mental health needs once they returned to class. As one teacher expressed, it is *"frustrating to not be able to help them! I mean, you go home and you wonder…what?"* Furthermore, questions of confidentiality raised barriers to staff collaboration. One teacher noted that this lack of communication post-crisis prevents teachers from learning from these situations. For example, a teacher explained that *"…because of confidentiality rules that are in place, we wouldn't know about other situations… That what happens up front, the back people don't know, and so forth"*

However, other school staff (social workers, administrators) talked about the necessity of confidentiality procedures both for students' "best interest" and to enhance the detection of students with mental health issues more generally. A counselor noted, *"[sharing treatment information] would not be appropriate … they may tell the student, 'Oh you just came back from the hospital,' in front of the other students. You just have to make sure that the teachers understand the sensitivity behind that."* An administrator described the importance of confidentiality by saying, *"The only thing that works for us, basically, is confidentiality. The kids know that we are not going to 'spread their business,' as the kids put it, in the street. And that whatever they say, unless necessary for their own protection, will not be discussed."*

Strategies for Teacher Involvement Post-Crisis

There was a recognition among the non-teaching staff in each of the focus groups of the benefits associated with involving teachers in the post-crisis phase, and several participants described the vital role of teachers following a crisis. A counselor stated, *"I think it's important for the teacher to be aware on a certain level of what's going on with the child because otherwise what happens is, the teacher gets frustrated because maybe they're not doing their work, or they're withdrawn. The teacher's response will totally change toward the child [if the teacher is aware of the situation]. In fact, that helps the child work harder, do better in school. The more knowledge the teacher has, they don't feel that this child is just trying to take advantage or manipulating or misbehaving."* Some counselors reported that they provide teachers with general information through a referral feedback form: *"Usually what I do instead of specifically saying, 'this is what is going on in counseling,' I try to let the teachers know I am seeing the student for something overarching, like anger management or something else."*

Some teachers also reported that they asked students directly, particularly to maintain their relationship with the students. For example, one teacher described her own experience after having made a referral for a student: *"I ask the kid. Just for my own [knowledge]. I need to know if they're okay. There's the connection. I think they need to trust that you did the right thing as well, that you're not going to hurt them. So talking to them, I'll say 'Are you okay? Are you okay with that?'"*

Staff also detailed specific incidents where teachers were included in the post-crisis process. Participants across the focus groups generally agreed that if a child was planning to engage in suicidal behaviors within a particular class (e.g., running across the highway during PE class), that specific teacher would be informed about ways to help keep the child safe. An administrator also described another scenario, *"Sometimes a parent will come in and tell us, 'I want everyone to know to watch her.' And we do. And sometimes I will initiate that; I will ask permission of the parent."* Although these actions appeared to occur less frequently, they highlight ways to collaborate effectively with teachers to provide continuity of care to students.

Training and Support

Participants in each of the focus groups and almost all administrators interviewed were in agreement that teachers needed more training on suicide prevention. Participants discussed both current needs and possible ways to improve training.

Specific Training and Support Needs

A common theme in all the focus groups was teachers' self-reported lack of knowledge about basic "warning signs" for suicide risk and related mental health problems. Some teachers also expressed confusion about how to interpret behaviors such as cutting; they wanted more guidance on when something was *"just a cry for help"* rather than an indicator of suicidality. One teacher commented, "*Well maybe we can train the teachers. Just to show us the signs. Because sometimes we can see something, and someone will just push it off, when it's something more serious."* Repeatedly, school staff (including teachers) reported that some teachers lacked "sensitivity" to the mental health needs of students. Teachers noted that some of their colleagues were not interested in attending to the mental health needs of students because they felt it is beyond the scope of their job, "*You know I am a teacher. That is why I got into this profession. I am going to close my door from 8 to 3. Don't bother me. I know my subject well, and I am going to teach it."*

Many teachers linked this insensitivity to feeling overburdened. Several teachers reported that it is difficult for them to address the mental health needs of students due to both systemic and school priorities related to testing, the sheer volume of work, the demands of the classroom, and the level of community violence and trauma in some communities. One teacher commented, *"With 2,000 kids and 3 counselors and 2 school psychologists, it's just not nearly enough, especially when you consider the environment and the socioeconomic class…that leads to all the problems. By that nature, every teacher becomes a counselor, a parent, a friend. I can't speak for all teachers, but I handle many more problems in my class on my own, than I ever send to the counselor."*

Teachers in most of the focus groups also reported a need for training in classroom strategies, such as behavior modification and crisis management. One teacher stated an interest in "*anything that deals with strategies, classroom strategies. You're in a classroom situation, you're with many students. You have one student who has an issue, what do you do without disrupting the entire educational structure to meet the need of that student? Without drawing attention to that student? Without it becoming a chaotic situation? Those are the kinds of things that we need. What do we do, what do you say? What is the procedure?"*

Strategies to Address Training Needs

Participants also offered several practical suggestions for addressing training needs. Many agreed that training on suicide prevention protocols, especially regarding available resources and follow-up procedures, was warranted. Some participants, particularly administrators, also suggested regular refresher trainings to remind current staff of the procedures and to educate new staff. Teachers also were interested in generally increasing mental health resources at their school. One teacher described how attention to students' mental health needs allows teachers to focus on educating students: *"A student's not going to do any learning if they have other stuff going on. So we can refer them, and get that taken care of. And hopefully they can come back, and be ready to learn, after that."*

In addition to tangible on-campus resources and protocols, teachers suggested regular in-services on suicide risk, handouts for students describing hotlines and websites to access outside of school, and improved communication with counselors and administrators about students' mental health needs. Administrators and mental health staff reported that the school district took responsibility for training administrators and counselors, while the burden of training teachers fell upon each individual school. An administrator explained, *"I think that a lot of times they [the district's suicide prevention staff] expect to give administrators or counselors the information, and hope that it filters down to teachers at the school site. For example, the idea of training of trainers. That doesn't always work, especially in issues where sensitivity is involved. I think there should be more direct training for teachers at the district level for that."*

The school that hosted a "Healthy Start" program appeared to be particularly effective at communicating, working collaboratively, and knowing how to respond to students at risk for suicide; staff reported that "Healthy

Start" personnel lead presentations at the beginning of the school year to educate teachers about the services offered, referral procedures, and detection of students at risk for suicide and other mental health problems. This group was the only one in which the majority of the teachers, prior to these focus groups, reported being aware of the presence of the mental health staff and resources on campus. At a start-of-year presentation and several times throughout the school year, "Healthy Start" personnel provided teachers with materials, such as mental health handbooks and flyers, as a resource for them as well as their students. Perhaps most importantly, "Healthy Start" staff made an effort to form strong relationships with teachers and to promote referrals. Both administrators and teachers at this school reported that the "Healthy Start" program conveyed the message, *"If you're not sure, send them over."* A teacher talked about the usefulness of this onsite program: "*[Having mental health resources] makes things a lot easier. A lot of times we have to deal with parents with academic work and things like that. When it comes to emotional problems, we can only do so much in the classroom. Having a "Healthy Start" program in school, they can really channel it better than we could."*

Discussion

Gatekeeper models for suicide prevention, which involve training school staff to detect at-risk students, have promise in the school setting as they are acceptable to a range of school staff (Eckert et al., 2003; Miller et al. 1999; Scherff et al., 2005). The current study provides insight into the perspectives of teachers and other school staff regarding the implementation of these models, and the specific role teachers play at each stage of suicide prevention (i.e., detection of students at risk for suicide, crisis intervention, and post-crisis response). The findings have implications for implementation of the youth suicide prevention program (YSPP) and similar suicide prevention efforts, as well as for teacher involvement in school-based mental health programs more broadly.

With respect to the detection stage of suicide prevention, our findings suggest that school staff viewed teachers as the frontline in detecting students in crisis or at risk for suicide. Counselors, social workers, and administrators relied on teachers to alert them to concerns about student behavior. When gathering information, teachers depended primarily on direct observation of student behavior (emphasizing behavior and mood changes), self-reports from students, and consultation with colleagues, with special attention and concern toward certain subgroups (e.g., "Goth" students, students in special education, LGBT students). Although our study did not set out to assess teachers' knowledge base, the signs that teachers reported using to determine whether or not a student was at risk for suicide were generally consistent with signs identified in existing literature (King et al., 1999a), despite concerns among teachers and other staff that they need more training in this area. In addition, several teachers reported that when they had a concern, they directly queried the student—a step that is consistent with, and critical to, successful implementation of the gatekeeper model (Wyman et al., 2008). The findings regarding teacher knowledge are intriguing in that they raise questions about the best methods for imparting practical knowledge about suicide risk to teachers in the YSPP and similar gatekeeper programs that expands upon their existing knowledge base. Teachers may benefit from targeted training on individual-level signs of risk and specific actions to take, rather than training on broader epidemiological risk factors and general awareness.

The next stage of suicide prevention involves assessment, referral, and engagement of students and families in supportive services. The role of the "gatekeeper" at this stage is to make the referral to the appropriate staff at the school. This task appeared to be easiest for teachers and other non-mental health staff when the school had a structured referral process and on-site services that are widely known to the staff and can easily be accessed. The process was further enhanced when administrators encouraged referrals, when there was a visible mental health presence on site, and when teachers and counselors interacted regularly. Well-organized and well-communicated suicide prevention protocols have been associated with more effective implementation of school suicide prevention programs in high schools (Stein et al., 2010). In the present study, this perceived connection between structured and clear protocol and enhanced referrals was evident from participants across both low and high implementation schools.

The third major theme in our study related to the teacher's role during the post-crisis period. To our knowledge, there is little research on the collaborative relationship between teachers and counselors or social workers following a crisis. We found that teachers who had made referrals often felt "in the dark" and wanted additional follow-up information. This desire, however, conflicted with the sentiment among many administrators and social workers that confidentiality is an essential element to the success of a school's suicide prevention efforts. As was found in a previous study of a gatekeeper program in a high school setting (Stein et al., 2010), follow-up challenges primarily arose from the limited communication between staff after referrals had been made, which some attributed to confidentiality procedures. Guidelines for school staff that encourage mental health professionals to inform teachers when a referral has been addressed and to provide

specific ways in which the teacher can support a student in the classroom during the post-crisis period may help address teachers' feeling of being "in the dark," even in the absence of specific information about the student's treatment. Further, our findings suggest that some teachers would like to be involved in helping children post-crisis and it may be useful for mental health professionals to discuss with families if partnering with teachers is an option that would benefit their child.

Across these different stages of the crisis intervention, there were a number of process-related and structural factors that appeared to impact implementation of suicide prevention protocols. One such process was the role of communication. It was clear from our interviews that many teachers relied heavily on their informal networks of communication, working with their peers and others that they had a positive experience consulting in the past. In some cases, this method may be an effective way to communicate concerns and obtain supports for students. However, it is concerning that some teachers felt unsupported in asking for help to address students' mental health needs, a finding that may be reflective of findings that teachers, especially new teachers, can feel isolated (Carroll & Fulton, 2004; Schlichte, Yssel, & Merbler, 2005). Moreover, there was a specific concern voiced by a few teachers that the students in their school were so high-need and resources stretched so thin, prevention-focused mental health referrals were actively discouraged, and teachers feared they would be viewed as incompetent if they referred a student. It is unclear how pervasive this sentiment is, and it certainly merits further exploration in larger studies. The experience of these teachers is important insofar as it might reflect the experience of teachers in other high-needs and low resource schools who are not often given voice. The presence of these themes echoes earlier findings suggesting that organizational culture, climate, and structure are critical elements to the successful adoption and implementation of services (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). In a school setting, the support and leadership of administrators has been identified as a critical component of effective school prevention programs by teachers and other school staff across range of social–emotional issues, including suicide prevention (Domitrovich et al., 2008; Rohrbach, D'Onofrio, Backer, & Montgomery, 1996). Although we cannot make direct linkages between effective communication and effective implementation in the current study, the issues raised here provide insight into constructs that might be examined in future research on school mental health and prevention programs with a larger sample of schools.

Across most schools, teachers had limited awareness about their school's crisis and suicide prevention protocols or on-campus mental health resources. In fact, the focus groups themselves seemed to serve as an intervention, with some teachers taking notes about the roles of school clinicians, how to make a referral, and the available resources on their campus. Although the administrators and social workers could describe formal referral processes, teachers often remained unaware of such resources. Previous studies have found that teachers were more likely to refer students for services when on-campus resources were available (Han & Weiss, 2005) and teachers expressed greater self efficacy about approaching students directly when they knew on-campus resources were available (King et al., 1999b). In our study, participants made a strong case for the availability of on-campus mental health resources. The "Healthy Start" program in which social work staff conducted in-services, described referral process, provided informational materials, and had a visible presence was very well received by teachers. However, even in the absence of a stand-alone school mental health program, our findings elucidate several ways in which school administrators, counselors, psychologists, and social workers can work collaboratively to encourage teacher referrals, train teachers about their role in crisis procedures, and promote the use of available resources (both on campus and in the community). This study also highlighted importance of mental health providers "reaching in" to educate teachers and support them more directly in their relationships with students.

Finally, a number of training needs were identified. Specifically, teachers reported that they lacked practical training in "warning signs," (e.g., distinguishing whether a student was in immediate crisis), as well as in classroom behavior interventions and crisis management. Although our findings suggest that teachers were able to accurately identify some of the signs that a student may be distressed, teachers may benefit from more specific training on risk factors for suicide and related mental health problems, how to respond to distressed students, and when/how to make a referral. Further training in these areas would give teachers tangible tools and serve as critical elements to successful implementation of the gatekeeper model (Han & Weiss, 2005). Further, given that teachers' seemed to have general awareness of risk factors for suicide, it is important that future trainings be paired with broader structural and procedural changes that facilitate clear, collaborative processes for referral and follow-up. Teachers in schools with concrete, well-communicated procedures may feel less overburdened, a concern reported by many teachers. Participants offered a number of concrete suggestions for improving training procedures for the YSPP, including annual refresher trainings, direct training for teachers and frontline staff (rather than administrators), and more information regarding on-campus and outside resources. These suggestions are consistent with research showing

that teachers who took part in in-services reported greater efficacy in being able to address the needs of students at risk for suicide than those who did not 5 months post-training (Reis & Cornell, 2008).

Interestingly, our study failed to observe consistent differences across the implementation groups. There are a number of potential reasons for this, including a limited sample of schools, or the possibility that some schools categorized fewer of their referrals as specifically suicide-related than did other schools (ultimately completing fewer district suicide assessment forms). This pattern, along with other implementation factors, would render the assessment forms a poor measure of implementation (Stein et al., 2010). It is also possible that the protocols and referral procedures described by our participants were well understood by certain individuals, but this knowledge was not consistent school-wide. Nonetheless, it was apparent that there was room for improvement in the use suicide prevention efforts at each of the schools in the study. With respect to the implementation of the YSPP and other gatekeeper models, it is imperative that the protocols and procedures not just be evident to the administration and key personnel at the schools, but that schools distribute and review these procedures for all frontline staff.

There are limitations to the study that are important to consider. This study was focused on the implementation of a gatekeeper suicide prevention program in a large, urban school district with a multiethnic, socioeconomically disadvantaged middle school population. Both the needs of students in this setting and the implementation context may not generalize to other school districts or grade levels. We conducted focus groups with a convenience sample of teachers and school staff; these individuals may not be representative of the general population of school teachers and staff. It is likely that the staff interviewed for the current study were generally more involved in the school and, given the nature of recruitment, more interested in supporting students at risk for suicide. Interviews that delved into the experiences of a broader range of staff may have revealed additional information. Similarly, the perspectives of other stakeholders such as parents and students regarding the implementation of suicide prevention efforts in schools would be useful to examine in future investigations.

Despite these limitations, the present study is one of few to examine teacher perspectives and roles in suicide prevention and school-based mental health promotion. Our findings highlight the important role that teachers play in identifying, referring, and supporting students in crisis or at risk for suicide. We also discovered that teachers are actively interested in further training in suicide risk factors, practical tools for responding to students in need, classroom management, and how to connect students to resources. Suggestions were made for direct training of teachers by the school district, in-service meetings regarding crisis policies and procedures, and regular refresher trainings. Our findings also underscore the value of having on-campus mental health resources and the importance of a collaborative relationship between mental health providers, administrators, and teachers.

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Appendix

Focus Group Guide

Detection

Let's start by talking about the different ways that students at your school are recognized as possibly being at risk for suicide. Briefly, can someone walk me through a specific case? Have others had different experiences?

Prompts:

- How do you draw the line between being not concerned to concerned?
- How do you detect students at risk?
- How could detection be improved? What support would be helpful?
- Do you consult before you refer? If so, with whom? Are these formal or informal mechanisms?
- What kind of information sharing occurs at different stages of the process?
- How are teachers made aware of mental health resources on campus?
- What is the role of teacher, counselors, and administrators in detection?
- How do/not teachers, counselors, administrators work collaboratively?

Crisis Intervention

Once a student at your school is considered at risk for suicide, what happens next? Walk me through the process.

Prompts:

- Protocols/procedures—how do students get evaluated, who does it?
- Documentation—forms, who fills it out. Do you fill out the [required district form]?
- If someone should know about the [required district form] but does not, try to find out why they do not know about it.

- Find out about other forms, where they came from, who has access to them
- Resources/staff/programs in regard to suicide
- Support services—on campus or nearby? What is process to access?
- Parental involvement
- What is the role of teacher, counselors, and administrators in intervention?
- How do/not teachers, counselors, administrators work collaboratively?
- What makes your role in helping a student at risk for suicide easier or harder?
- Are there written guidelines for responding to crisis. If so, where do they come from, who has access to them, how much are they used?

Post-Crisis

What type of follow-up by the school staff typically happens and by whom?

Prompts:

- What would better help you to support students after a suicide-related crisis?
- Parents/outside agencies/hospitals contacted for follow-up information?
- In school follow-up?
- When follow-up occurs, find out how staff makes time.
- Determine whether there are procedures about confidentiality, what school policy dictates.

Training

What type of training have you received regarding students at risk for suicide?

Prompts:

- Training topics (e.g., risk factors, how to detect at risk students, what to do in crisis, how to follow-up)
- Specific training within school on how each staff person should respond?
- District training (e.g., by [the director for suicide prevention])?
- Training for teachers versus counselors versus administrators?

Quality Improvement

Now I would like us to talk about how suicide prevention efforts can be improved both at your school and at the district level.

Let's start with what can be done at the school level. If you were going to try to improve or change what your school does to help students who may be at risk for suicide, what would you do?

Prompts:

- Detection of students at risk?
- Support services during the crisis?
- Post-crisis period?
- Training?
- Personal time and resources, suggested modifications?

Now let's discuss what can be done at the district level. If you were going to try to improve or change what happens district-wide for students who may be at risk for suicide, what would you do?

Prompts:

- Detection of students at risk?
- Support services during the crisis?
- Post-crisis period?
- Training?

Middle versus high School

- Suicide is sometimes considered a topic that high schools are more concerned about than middle schools. Do you think there are differences in how middle versus high schools should respond to students at risk for suicide?
- Do middle schools have unique needs?

References

Barber, B. K., & Olsen, J. A. (2004). Assessing the transitions to middle and high school. *Journal of Adolescent Research, 19*, 3–30.

Brener, N. D., Martindale, J., & Weist, M. D. (2001). Mental health and social services: Results from the school health policies and programs study 2000. *Journal of School Health, 71*, 305–312.

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M., et al. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 147–159.

Carroll, T., & Fulton, K. (2004). The true cost of teacher turnover (Electronic Version). *Threshold*, 16–17.

Centers for Disease Control and Prevention. (1994). Programs for the prevention of suicide among adolescents and young adults. *Morbidity and Mortality Weekly, 43*, 1–7.

Centers for Disease Control and Prevention. (2007). *Web-based injury statistics query and reporting system (WISQARS™)*. Atlanta, GA: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention. (2009). Suicide prevention: Youth suicide. Retrieved November 20, 2009, from http://www.cdc.gov/violenceprevention/pub/youth_suicide.html.

Domitrovich, C. E., Bradshaw, C. P., Poduska, J. M., Hoagwood, K., Buckley, J. A., Olin, S., et al. (2008). Maximizing the implementation quality of evidence-based preventive interventions in schools: A conceptual framework. *Advances in School Mental Health Promotion, 1*, 6–28.

Eaton, D. K., Kann, L., Kinchen, S., Shanklin, S., Ross, J., Hawkins, J., et al. (2008). Youth risk behavior surveillance-United States, 2007. *MMWR Surveillance Summaries, 57*, 1–131.

Eccles, J. S., Midgley, C., Wigfield, A., Buchanan, C. M., Rueman, D., Flanagan, C., et al. (1993). The impact of stage-environment fit on young adolescents' experiences in schools and families. *American Psychologist, 48*, 90–101.

Eckert, T. L., Miller, D. N., DuPaul, G. J., & Riley-Tillman, T. C. (2003). Adolescent suicide prevention: School psychologists' acceptability of school-based programs. *School Psychology Review, 32*, 57–77.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa: University of South Florida.

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). *Reducing suicide: A national imperative*. Washington, D.C.: National Academies Press.

Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and prevention interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 386–405.

Han, S. S., & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology, 33*, 665–679.

Hoagwood, K. E., Olin, S. S., Kerker, B. D., Kratochwill, T. R., Crowe, M., & Saka, N. (2007). Empirically based school interventions targeted at academic and mental health functioning. *Journal of Emotional and Behavioral Disorders, 15*, 66–92.

Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. *Suicide and Life-Threatening Behavior, 24*, 224–233.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548–1555.

King, K. A., Price, J. H., Telijohann, S. K., & Wahl, J. (1999a). High school health teachers' knowledge of adolescent suicide. *American Journal of Health Studies, 15*(3), 156–163.

King, K. A., Price, J. H., Telijohann, S. K., & Wahl, J. (1999b). High school health teachers' perceived self-efficacy in identifying students at risk for suicide. *Journal of School Health, 69*(5), 202–207.

King, K. A., & Smith, J. (2000). Project SOAR: A training program to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health, 70*, 402–407.

Masten, A. S., & Curtis, W. J. (2000). Integrating competence and psychopathology: Pathways toward a comprehensive science of adaptation in development. *Development and Psychopathology, 12*(3), 529–550.

Miller, D. N., Eckert, T. L., DuPaul, G. J., & White, G. P. (1999). Adolescent suicide prevention: Acceptability of school-based programs among secondary school principals. *Suicide and Life-Threatening Behavior, 29*, 72–85.

Morgan, D., & Kreuger, R. (1997). *The focus group kit* (Vol. 1–6). Thousand Oaks, CA: Sage Publications.

Muhr, T. (1998). Atlas Ti. Berlin, Germany: Scientific software development.

RAND California. (2010). Teacher demographic statistics. Retrieved 12/06/10, from http://ca.rand.org/stats/education/education.html.

Reis, C., & Cornell, D. (2008). An evaluation of suicide gatekeeper training for school counselors and teachers. *Professional School Counseling, 11*, 386–394.

Roeser, R. W., Eccles, J. S., & Sameroff, A. J. (1998). Academic and emotional functioning in early adolescence: Longitudinal relations, patterns, and prediction by experience in middle school. *Development and Psychopathology, 10*, 321–352.

Rohrbach, L. A., D'Onofrio, C. N., Backer, T. E., & Montgomery, S. B. (1996). Diffusion of school-based substance abuse prevention programs. *American Behavioral Scientist, 39*, 919–934.

Rones, M., & Hoagwood, K. E. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*, 223–241.

Rothi, D. M., Leavey, G., & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education, 24*, 1217–1231.

Scherff, A. R., Eckert, T. L., & Miller, D. N. (2005). Youth suicide prevention: A survey of public school superintendents' acceptability of school-based programs. *Suicide and Life-Threatening Behavior, 35*, 154–169.

Schlichte, J., Yssel, N., & Merbler, J. (2005). Pathways to burnout: Case studies in teacher isolation and alienation. *Preventing School Failure, 50*, 35–40.

Scouller, K. M., & Smith, D. I. (2002). Prevention of youth suicide: How well informed are the potential gatekeepers of adolescents in distress? *Suicide and Life-Threatening Behavior, 32*, 67–79.

Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 588–596.

Shaffer, D., Scott, M., Wilcox, H., Maslow, C., Hicks, R., Lucas, C., et al. (2004). The Columbia Suicide Screen: Validity and reliability of a screen for youth suicide and depression. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 71–79.

Small, M. L., Majer, L. S., Allensworth, D. D., Farquhar, B. K., Kann, L., & Pateman, B. C. (1995). School health services. *Journal of School Health, 65*, 319–326.

Stein, B. D., Kataoka, S. H., Hamilton, A. B., Schultz, D., Ryan, G., Vona, P., et al. (2010). School personnel perspectives of their school's implementation of a school-based suicide prevention program. *Journal of Behavioral Health Services and Research, 37*, 338–349.

U.S. Department of Health and Human Services. (2003). *New freedom commission on mental health: Achieving the promise: Transforming mental health care in America. Final Report.* (No. SMA-03-3832). Rockville, MD: Department of Health and Human Services.

U.S. Public Health Service. (1999). *The surgeon general's call to action to prevent suicide*. Washington, D.C.: Department of Health and Human Services.

Wyman, P. A., Brown, C. H., Inman, J., Cross, J., Schmeelk-Cone, K., Guo, J., et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*, 104–115.