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SCHOOL-BASED SUICIDE PREVENTION AND POSTVENTION: SCHOOL PSYCHOLOGISTS' KNOWLEDGE OF ETHICS, LAWS, AND BEST PRACTICES

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SCHOOL-BASED SUICIDE PREVENTION AND POSTVENTION: SCHOOL PSYCHOLOGISTS' KNOWLEDGE OF ETHICS, LAWS, AND BEST PRACTICES

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ABSTRACT

SCHOOL-BASED SUICIDE PREVENTION AND POSTVENTION: SCHOOL PSYCHOLOGISTS' KNOWLEDGE OF ETHICS, LAWS, AND BEST PRACTICES

Veronica Lynn Milito

Suicide is preventable, however suicide rates among children and adolescents are continuing to rise (Curtin & Heron, 2019). As such it is imperative that school psychologists who have an opportunity to impact the incidence of suicidal behaviors amongst students are properly trained in suicide prevention, postvention, laws, and ethics (Miller, 2014). However, there is little known about the efficacy of certain training approaches in suicide for school psychologists that may overcome barriers to implementation such as cost and time consumption (Dunn et al., 2013; Robinson et al., 2013). The present study sought to create a measure encompassing school psychologists' objective knowledge of suicide prevention/postvention best practices, laws, and ethics and their accuracy in implementing best practices, and sought to utilize this measure to evaluate the efficacy of a one-session, virtual, expert-led workshop. The knowledge segment comprised true/false questions regarding suicide prevention, postvention, laws and ethics. The accuracy portion encompassed hypothetical prevention and postvention situations with relevant evidence-based or nonevidence-based practices that were rated by likelihood of implementation on a 5-point scale. Upon review from experts in child/adolescent suicide and piloting of this measure with school psychologists, 50 practicing school psychologists completed the knowledge measure and vignettes before,

one week after, and four weeks after attending a workshop. Their ages ranged from 26-65 with majority of participants being White women who work primarily in a public school setting. Knowledge measure and vignette scores significantly increased from pre-test to post-test time point and were maintained from post-test to follow up. Overall, this study highlights the efficacy of one session, virtual, expert-led workshops in increasing knowledge and application of knowledge. Past knowledge was found to be predictive of knowledge retention upon attending the workshop. Taken together these findings suggest that this format of training can be utilized for school psychologists in the field to remain current on best practices and follow up on prior knowledge to facilitate knowledge retention. As this training was only one hour and delivered in a virtual format, training in suicide can be more approachable and accessible to school psychologists. Other implications for practice and future research are discussed.

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Chapter I

Introduction

Statement of the Problem

For children and adolescents aged 10-24, suicide is the second leading cause of death and the number of suicides occurring within this age range has increased 57.4% from 2007-2018 (Curtin & Heron, 2019; Curtin, 2020). In 2017 alone, 6,774 school aged children died from suicide, also labeled as intentional self-harm, in the United States (Heron, 2019). During 2020, emergency department visits for adolescents making suspected suicide attempts also increased (Yard et al., 2021). In addition, according to the Youth Risk Behavior Surveillance System (YRBSS) conducted by the Center for Disease Control (CDC), 18.8% of high school students seriously considered attempting suicide at some point during the 12 months before taking the survey, 8.9% of high school students had a suicide attempt, and 15.7% of high school students made a suicide plan (Ivey-Stephenson et al., 2020). Suicidal behavior has also increased amongst elementary school-aged children; however, suicide in this population is still not widely studied (Sheftall, 2016). While students between the ages of 5 and 11 years old have a suicide rate of .17 per 100,000 people, which is less than the suicide rate for students ages 12-17 (5.18 per 100,000 people), suicide is still one of the leading causes of death for students ages 5 to 11 after accidents and cancer (Kochanek et al., 2019; Sheftall, 2016). This is a significant problem in the United States, especially for people who are in an age range in which their time is primarily spent in school.

The school-aged population is also at risk for suicide clusters, which are defined as a high number of suicides that occur during a short amount of time after an initial

suicide within a small geographical area (Haw et al., 2013). There are various risk factors that make a person more vulnerable to suicide clusters including being a male, being directly involved with someone else who fell victim to the suicide cluster and being an adolescent or young adult (Haw et al., 2013). Being that schools are tight knit communities of adolescents who are an at-risk group for suicide and suicide clusters, proper prevention and postvention strategies in school as well as knowledge of the laws and ethics for professional practice regarding suicide in schools are necessary to ensure adolescent suicide is less likely to occur. Despite this, school psychologists continue to report a lack of training and inadequate knowledge in the area of suicide prevention, postvention, laws, and ethics (Gerardi, 2018; O'Neill et al., 2020). In addition, suicide trainings are mandated for school personnel in less than half of states in the United States of America (American Foundation for Suicide Prevention, 2018). The present study is the first to create a measure that assesses school psychologists' knowledge of suicide prevention, postvention, laws, and ethics as well as their responses to hypothetical suicide prevention and postvention scenarios. The present study then utilized this measure to determine the effectiveness in increasing school psychologists' knowledge of suicide prevention, postvention, laws, and ethics, and their ability to apply this knowledge upon attending an expert led workshop.

Suicide Among Youth

As discussed in detail above, deaths by suicide have increased for the school-aged population (Curtin & Heron, 2019). Also concerning is the fact that suicidal ideation and attempt are on the rise across all age groups (Kann et al., 2018). Because of this, it is important to be aware of who is thinking about, attempting, and completing suicide. For

example, while females have more suicide attempts and more frequent suicidal ideation, males complete suicide more often (Heron, 2019). A reason for this is because males tend to choose to complete suicide in more lethal ways such as hanging or through the use of a firearm, whereas females typically think more about the aftermath of suicide and who would find them upon completion (Callanan & Davis, 2012). This corresponds with the fact that the most prevalent ways adolescents 5-24 passed away from suicide in the United States is through the use of firearms or by hanging (Kochanek et al., 2019).

Amongst the school-aged population, there are adolescents who are at greater risk for completing suicide. For example, adolescents in the LGBTQ community are at greater risk for suicidal ideation than cisgender heterosexual students, as supported by the finding that 47.7% of gay, lesbian, and bisexual high school students and 31.8% of high school students unsure of their sexual identity seriously contemplated suicide as compared to 13.3% of heterosexual students (Kann et al., 2018; Shain, 2016). Other risk factors include previous suicide attempts, mental health problems, engagement in non-suicidal self-injurious behaviors, difficulties in school, experiencing bullying, and experiencing social isolation (Shain, 2016). In addition, ethnic minorities are at an increased risk for suicide attempts and even ethnic minorities who are also lesbian, gay or bisexual are more at risk for suicide attempts than a White lesbian, gay, or bisexual youth (Lytle et al., 2014). This is supported by the 2019 YBRSS in which more Black and Hispanic students reported attempting suicide than White students (Ivey-Stephenson et al., 2020). As this is a relevant concern for school-aged children, legally and ethically it is the responsibility of faculty and staff in schools to recognize signs of suicide and to respond to these signs (Miller, 2014).

Legal and Ethical Obligations Amongst School Staff

As stated, school psychologists and other school staff are legally and ethically obligated to protect students from foreseeable risk of harm which arguably includes harm to oneself (Miller, 2014, National Association of School Psychologists, 2020). According to the No Child Left Behind Act of 2001, originally enacted by the Bush administration, and the Federal Emergency Management Agency (FEMA) all schools in the United States must have a crisis or safety plan to take action and maintain order when crises occur such as a natural disaster or a student dying by suicide (2009; 2011). While this is true, school-based programs specific to suicide prevention and postvention are not legally required by the federal government (Miller, 2014). By federal law, school personnel are also required to document each step they take in any intervention process for suicide and must maintain confidentiality unless the student is a danger to themselves or others or they are in danger (Miller, 2014; National Association of School Psychologists, 2015). Based upon *Tarasoff v. Regents of the University of California*, school personnel have to share confidential information in the event that a student is in danger as is the case when a student is exhibiting suicidal ideation or behavior, known as the duty to warn (1974). This is important to know as school personnel including school psychologists, mental health professionals or the school itself may be liable if they do not properly act on a foreseeable suicide, meaning a reasonable risk assessment must occur and action must be taken if it is determined there is risk (*Armijo v. Wagon Mound Public Schools,* 1998*; Wyke v. Polk County School Board*, 1995).

Each individual state also has their own suicide prevention plans and state-level legislation. For example, in New York and Texas' Suicide Prevention Plans, there is a

focus on creating strong community-based programs to advocate for suicide prevention in schools and training of school staff on early identification of suicidal behaviors (OMH Suicide Prevention Office, 2016; Texas Suicide Prevention Council, 2018). Both take the approach that suicide prevention should be targeted across the lifespan. In addition to suicide prevention plans, twenty-one states have enacted the Jason Flatt Act (JFA) which requires all educators in that state to complete two hours of annual training in suicide awareness in order to maintain their certification (The Jason Flatt Act, 2007). An additional nine states plus Washington D.C. require personnel to complete suicide prevention training, however it is not specified that the training is mandated annually (American Foundation for Suicide Prevention, 2018). Fifteen states have laws in place that encourage training, which can mean personnel have the option to take this training as professional development or training must be accessible to educators, however the educator is not required by law to take it. Finally, eighteen states along with Washington D.C. require by law that each school has suicide prevention, postvention, and intervention policies in place, while seven additional states encourage these policies, but do not require them by law (American Foundation for Suicide Prevention, 2018).

In addition to legal obligations, there are professional ethical obligations school psychologists and school personnel must abide by (Miller, 2014). Ethical principles are often considered to be of an even higher standing than the standards set by the law, meaning just meeting the requirements of the law is often not enough to give proper and ethical care (American Psychological Association, 2017). Various school professionals have their own codes of ethics they are obligated to abide by including educators, school counselors, and school psychologists (American School Counselor Association, 2016;

National Association of School Psychologists, 2020; National Education Association, 1975). The balance between meeting legal requirements and upholding ethical standards can become complex when it comes to suicide prevention practices such as widespread screening (Miller, 2014). While school psychologists may want to uphold best practices by implementing a school-wide screening for suicide to determine students at risk, parents must be notified of this screening and are able to remove their child from participating in the screening (National Association of School Psychologists, 2020). In addition, while school psychologists have to seek parental consent before taking part in any assessment or therapeutic intervention with the student, ethically the school psychologist is able to provide assistance to the student without parental consent if the school psychologist believes the student is a danger to others or themselves (National Association of School Psychologists, 2020).

Similarly, while school psychologists are ethically required to implement evidence-based practices for students' mental health needs, school-based suicide prevention and postvention programs are suggested, but not legally required in some states, as stated previously, despite the emerging evidence that these programs are effective (American Foundation for Suicide Prevention, 2018; National Association of School Psychologists, 2020; Robinson et al., 2013). It is also the ethical responsibility of the school psychologist to ensure that all students regardless of any characteristics have an equal opportunity to benefit from these evidence-based school programs (National Association of School Psychologists, 2020). In addition, it is the ethical responsibility of the school psychologist to ensure the safety and wellbeing of students by recognizing a student's suicidal behavior, while also practicing within their competence (National

Association of School Psychologists, 2020). This means a school psychologist should understand the limitations of their training and receive assistance from others with more expertise in the area they lack training or continue to pursue professional development in these areas. For example, if ongoing training in suicide prevention and postvention is not required by law, it is still the ethical responsibility of the school psychologist to recognize suicidal behaviors, so it is their responsibility to seek out this knowledge elsewhere (National Association of School Psychologists, 2020; National Association of School Psychologists, 2015). Emerging data on suicide rates and suicidal behavior among youth along with the laws specific to each state and ethical obligations of school personnel can also influence the crisis intervention plan each school chooses to put in place.

School-Based Crisis Intervention Plans

Crises are emergency situations that can be traumatic and have potential to harm children physically or mentally (National Education Association, 2018). A school crisis is often unexpected and can create chaos in schools if a plan is not in place for how to deal with the situation in a safe and effective manner. This can include situations such as natural disasters, school shootings, or suicide. As outlined by Kerr and King (2018), the main goal of a crisis intervention plan is to ensure the safety and wellbeing of the children. In order to do so, by federal law schools must arrange a crisis team to create plans for possible situations and carry these plans out in the event that a crisis does occur (Federal Emergency Management Agency, 2009; No Child Left Behind Act of 2001, 2011). These plans are often based on a theoretical model and include protocols that outline how to both prevent an emergency situation, and how to handle postvention when emergency situations do happen both at school and outside of school (Kerr & King,

2018). Various models have been integrated into different schools and will be briefly outlined below.

According to a broad model outlined by the United States Department of Education's Presidential Policy Directive, there are six steps for planning for emergency situations in schools. These steps include forming a team, identifying and understanding different situations that can arise, determining goals, developing a plan, preparing/reviewing this plan, and finally implementing and maintaining the plan (Duncan, et al., 2013). In addition, in this model there are five mission areas including prevention, protection, mitigation, response, and recovery. Within the various types of emergencies schools have to plan for, suicide is categorized as an adversarial, incidental or human-caused crisis and while it obviously causes physical harm to the child who attempts or commits suicide, other children can be mentally and emotionally harmed as an effect as well (Duncan, et al., 2013).

The National Association of School Psychologists (NASP) proposed a conceptual framework for carrying out crisis prevention and intervention called the PREPaRE curriculum that incorporates the five mission areas outlined by the United States Department of Education as discussed above (Brock, et al., 2016). This model establishes a crisis team that is involved in the hierarchical activities: preventing trauma, reaffirming health and safety, evaluating risk, providing interventions, responding to psychological needs, and examining the crisis prevention and intervention effectiveness. This curriculum is one of the first nationally available programs in the United States to train school professionals on what is necessary to prevent crises from happening and intervene when they do (Brock et al., 2016).

Embedded in many of these theoretical models, including NASP's PREPaRE model, is a three level multitiered system of supports (MTSS) as outlined by Caplan (1964). The three tiers Caplan lays out are primary prevention, secondary intervention, and tertiary intervention (1964). These tiers can also be viewed as a pyramid, in which the first tier, primary prevention is the base meaning it is provided to all children. The goal of primary prevention is to prepare for emergency situations before they happen. An example of a primary prevention would be having a suicide prevention program in place schoolwide that encourages faculty to identify students at risk for suicide and facilitate them getting help (Kerr & King, 2018). The second tier is in the middle of the pyramid, as these supports are only provided to the students who were moderately to severely impacted by the traumatic event that occurred (Brock et. al., 2016). These secondary interventions typically occur during or after a crisis happens to try to mitigate the effects of the crisis (Kerr & King, 2018). An example of a secondary intervention would be using a classroom-based intervention to address the traumatic event. Finally, at the top of the pyramid is tier three or as Caplan refers to it, tertiary intervention (1964). This is at the top because these are typically the interventions that are provided to the smallest subset of students who were severely impacted by the traumatic event that occurred (Brock et al., 2016). An example of a tertiary intervention would be one-on-one counseling or monitoring of a student after the traumatic event occurs. If a student was found to be at high risk for suicide, this student would be considered part of the tertiary level and the primary goal would be to provide necessary levels of support to keep the student safe such as individual psychotherapy and referrals outside of school (Miller, 2014).

Amongst all of the aforementioned models, a multidisciplinary team involving mental health professionals or school psychologists are required to create and implement the crisis intervention plan (Brock et al., 2016; Caplan, 1964; Duncan et al., 2013). Each member of the team should have a clear role and be aware of their responsibilities when it comes to developing and carrying out crisis intervention plans (National Association of School Psychologists, 2015). As it pertains specifically to suicide, the school psychologist in the crisis team should be considered a "designated reporter" and all faculty and staff should report to them any concerns about potentially suicidal students. In addition, best practice would be for school psychologists or mental health professionals to help facilitate schoolwide education regarding general knowledge of youth suicide and risk factors to look out for when it comes to preventing suicide from occurring, also known as gatekeeper training (Robinson et al., 2013). Part of the crisis plan should also entail creating postvention procedures for after a student commits suicide to support those affected by the student's suicide and to prevent contagion effects (Miller and Mazza, 2013). As it is the school psychologist's job to act on reports of suicidal students and facilitate suicide prevention and postvention plans depending on the crisis intervention model the school has in place, it is important the school psychologist is knowledgeable about suicide prevention and postvention best practices and the specific laws and ethics that pertain to suicide in schools in order to make proper clinical decisions.

The Role Knowledge Plays in Clinical Decision Making

For fields in which research and new information are constantly emerging, such as the medical and psychological science fields, it is important to stay aware of new

findings in order to make decisions based on the most current knowledge (Hunink et al., 2014). In the medical field, a large amount of knowledge from years of training needs to be accessed on a daily basis to ensure the proper diagnosis and care for patients (Hunink et al., 2014). This is similar to the psychology field. Specifically, in the child and adolescent suicide field, it is vital school psychologists are adequately knowledgeable about suicide prevention and postvention in order to competently implement procedures in these areas (Gerardi, 2018; Wilkins et al., 2013). For example, Gerardi (2018) discussed how it is important for clinicians to be knowledgeable about the procedures for risk assessing clients and managing suicidal behavior in order to properly carry out a suicide risk assessment. Interestingly, however, she found that reported confidence in being able to implement these procedures did not correlate with actual knowledge about the risk assessment procedures, meaning while perceived knowledge may make the clinician more confident in their ability to carry out the necessary suicide intervention procedures, in actuality they may not be as knowledgeable as they perceive themselves to be (Gerardi, 2018). This confidence due to perceived knowledge may cause a clinician to decide they do not need continuing education even though they may actually have a gap in their knowledge. On the other hand, if the clinician is objectively knowledgeable in the area of suicide prevention and postvention but has never implemented these practices in vivo and does not perceive their knowledge to be as adequate, they make lack confidence in their ability to carry out a risk assessment (Gerardi, 2018). As such, while objective knowledge is important, it is also important that psychologists perceive they have this knowledge to have the confidence necessary to make effective clinical decisions during suicide prevention and postvention (Erps et al., 2020).

While ideally once knowledge is acquired, whether through graduate training or continued education, that knowledge is then incorporated into and impacts the decisions clinicians make in clinical practice, oftentimes turning knowledge into action is not straightforward. Across various fields, there has been a gap between what someone in the field learns and their incorporation of that knowledge into practice, called the knowledge-action gap (Khan et al., 2013; MacDonald & Frank, 2016; Wilkins et al., 2013). Instances of this have been seen in the medical field in which nurses who are taught to keep up with new research and to integrate these findings into their practice with patients, often do not integrate these findings in practice despite having the new research findings available to them (Côté et al., 2012).

The knowledge-action gap occurs specifically with suicide prevention and postvention information as well (Wilkins et al., 2013). While research in the suicide prevention and postvention areas continue to emerge, psychologists still do not always apply these new findings to clinical decision-making in their practice (Wilkins et al., 2013). For example, despite the fact that research has continued to emerge against the use of permanent memorials within schools and hanging up pictures of the suicide victim, these practices still occur across schools in the United States (American Foundation for Suicide Prevention et al., 2018; O'Neill et al., 2020). Having knowledge is critical because without it, clinicians would not know how to properly respond during crisis situations, how to risk assess when a student expresses suicidal thoughts, or how to limit contagion effects when a student does die by suicide (Boccio, 2018; Gerardi, 2018; O'Neill et al., 2020). However, obtaining knowledge in a way that may not be as effective, such as only independently studying, may contribute to the knowledge-action

gap (Wilkins et al., 2013). This is why it is also important during training to obtain what is referred to as actionable knowledge or knowledge that can be readily incorporated into clinical decision-making (Wilkins et al., 2013). In order to have and maintain a current actionable knowledge base in suicide prevention and postvention laws, ethics, and best practices, it is important to have adequate and effective training that allows for the acquiring of actionable knowledge in both graduate school and through continued education.

The Impact of Training on Knowledge

The way in which training is delivered, the type of experience the trainee is offered during training, and how often training occurs all impact the knowledge that is acquired on the part of the trainee (Dolan & Collins, 2015; Dunn et al., 2013; Valenstein-Mah et al., 2020). In general, active learning is more effective than sitting and listening to a lecture (Dolan & Collins, 2015). Memorizing facts from articles or books does not help trainees fully grasp concepts. Instead, posing open-ended questions and allowing trainees to speak and collaborate with each other to solve these problems requires higher-level thinking and engages trainees in a way that makes learning more effective (Dolan & Collins, 2015; Martin et al., 2013). According to Martin and colleagues, (2013) there are three types of learning modalities, one being learning through doing which has been suggested to be advantageous and widely used across several types of training. Having direct field experience for example, working directly with suicidal clients, results in more knowledge and confidence in that area (Jahn et al., 2016). In terms of knowledge retention, Dunn and colleagues (2013) discussed that long-term knowledge retention is better when information is learned in multiple spaced out sessions overtime rather than

learning all of the information in one session and not repeating the information taught or reinforcing that knowledge with other future sessions. One-time training may be reinforced, however, by the trainee's perceived knowledge being more than their actual knowledge after one training session (Gerardi, 2018). If after one session someone perceives they have adequate knowledge in an area, they may be less likely to seek continued education in that area.

In the psychotherapy field, mental health professionals are trained in how to administer evidence-based psychotherapies (EBP), however different training methods are especially important as the method of training influences the amount of knowledge the mental health professional has in that specific EBP and influences client outcomes (Valenstein-Mah et al., 2020). Within the review of EBP training studies conducted by Valenstein-Mah and colleagues (2020), overall expert-led workshops that are in-person were more effective at improving mental health professionals' competence in that area than self-guided training. This corresponds to MacDonald and Frank's (2016) discussion that only self-guided studying such as reading research articles is not as effective of a learning method as workshops because the findings in research studies do not always apply to individual clients seen in the field. Live workshops that allow for discussion with the presenter such as the workshop utilized in the present study delivered by Dr. Scott Poland, are more effective in conveying information and helping mental health professionals maintain this knowledge than independent learning (MacDonald & Frank, 2016; Valenstein-Mah et al., 2020).

Similarly to the psychotherapy field, in the suicide prevention and postvention field specifically, the way in which mental health professionals are trained also effects

how much information from the training is retained (Wilkins et al., 2013). Suldo and colleagues (2010) created an effective workshop that trains school psychologists on suicide prevention, intervention, postvention and legal and ethical issues. In order for this workshop to be effective, Suldo and colleagues (2010) incorporated many of the best training practices stated above such as making the workshop interactive by using handouts and challenging the school psychologists to collaborate and problem-solve resolutions for difficult suicide case vignettes. In addition, the school psychologists who attended were given a handbook to take home and refer back to. Each of these practices were incorporated into the workshop in order to better allow the knowledge they gained to be incorporated into the school psychologists' everyday practice (Suldo et al., 2010). The current study builds upon this research by adding a component in which participants had to respond to knowledge questions and case vignettes again four weeks after the training to determine if school psychologists' knowledge and accuracy for implementing what was learned is maintained.

Another form of training that has been supported by research for suicide prevention and postvention is referred to as gatekeeper training (Robinson et al., 2013; Wilkins et al., 2013). Gatekeeper training is an evidence-based training method that works to educate individuals, such as school psychologists on how to accurately identify and refer students who are at risk for suicide (Wilkins et al., 2013). While having this training only one time did not guarantee long term knowledge retention, ongoing training can make a difference in maintaining the knowledge learned from the training and using this knowledge to accurately identify students at risk for suicide (Wilkins et al., 2013). In addition, while it is important for school staff to be aware of local resources for suicide

prevention and postvention, these resources are often forgotten about after the training. While the aforementioned training styles are ideal, even the states that require suicide prevention training in schools, tend to only require one-shot training sessions that range from one to two hours in length and are not necessarily repeated annually (American Foundation for Suicide Prevention, 2018). As such, the current study seeks to incorporate a workshop that is more representative of those commonly used to train practicing school psychologists. Evidence-based training considerations are especially important in the suicide prevention/postvention, laws, and ethics field as school psychologists need to retain this information in order to effectively incorporate it into practice as keeping students safe is their legal and ethical obligation.

Implications for Practice and Future Research

Despite the fact that suicide is preventable, suicide rates for children and adolescents are continuing to rise (Curtin & Heron, 2019; National Association of School Psychologists, 2015). As these individuals primarily spend their time in school, the school community is an integral setting in which to work towards preventing suicide (Miller, 2014). School settings present a unique opportunity to allow for students to have contact with a mental health professional in which they can follow up and monitor the student's care (O'Neill et al., 2020). In order to do so, knowledge of prevention best practices is necessary to allow students to get effective resources; knowledge of postvention best practices is necessary to limit suicide contagion, and knowledge of laws and ethics is necessary to properly deliver the required care (American Foundation for Suicide Prevention et al., 2018; Miller, 2014; National Association of School Psychologists, 2015).

Schools are also legally required to have a crisis intervention plan for various school crises such as suicide and school psychologists are ethically required to implement best practices to protect students in these scenarios; however, based on past studies school psychologists do not feel competently trained in suicide prevention or postvention best practices in schools (Boccio & McDonough, 2018; National Association of School Psychologists, 2020; No Child Left Behind Act, 2011; O'Neill et al., 2020). In addition, while past research has looked at how school psychologists subjectively believe their suicide prevention and postvention training was in terms of adequacy and maintenance of knowledge or objectively measured knowledge of either prevention or postvention best practices, comparatively researchers have not given an objective measure encompassing suicide prevention/postvention best practices, laws, and ethics to determine where school psychologists' competency truly lies in each of these areas upon attending a training and paired this with a measure to look at ability to apply knowledge to practice (Hopple, 2017; Nader, 2013; O'Neill et al., 2020).

Understanding exactly where deficits in training lie is integral in the suicide prevention and postvention field as this can determine if more or different training in the suicide prevention/postvention, laws, and ethics field is necessary during graduate school or if more ongoing professional development in this area should be required. School psychologists can influence the incidence of suicidal behavior amongst students depending upon their implementation of prevention and postvention best practices (Savoie, 2016). Improperly recognizing signs of suicidal ideation and behavior can lead to a student not receiving the resources they need and, in the most extreme case, lead to the death of a student (Robinson et al., 2013). Similarly, not using the correct postvention

practices such as announcing the suicide through an assembly or sensationalizing the suicide by posting pictures of the suicide victim around school may contribute to suicide contagion or an increase in suicides in the community (American Foundation for Suicide Prevention et al., 2018). In these cases, improper practice implementation can potentially contribute to a suicide that could have been prevented (Suldo et al., 2010). In addition, a discrepancy between perceived knowledge and objective knowledge may facilitate the confident administration of practices that are no longer best practice or empirically based (Gerardi, 2018). The current study seeks to objectively determine the efficacy of a commonly used training approach to suicide prevention/postvention best practices, laws, and ethics training through the use of a knowledge measure and theoretical vignettes.

Present Study's Hypotheses

Given that live, expert-led workshops have been shown to lead to an increase in knowledge (Dolan & Collins, 2015; Valenstein-Mah et al., 2020), it is hypothesized that:

1. School psychologists' scores on the knowledge of suicide prevention/postvention best practices, laws, and ethics questionnaire will increase as a function of attending a workshop on suicide violence, laws and ethics in schools for school psychologists and this increase in knowledge will be maintained from post-test to follow up time point.
2. School psychologists' vignette accuracy scores on which practices they are most likely to implement for each vignette will improve as a function of attending a workshop on suicide violence, laws and ethics in schools for school psychologists and this increase in accuracy score will be maintained from post-test to follow up time point.

As repeated training over time increases knowledge retention and ability to apply that knowledge to action (Dunn et al., 2013; Wilkins et al., 2013), it is hypothesized that:

3. Prior exposure to suicidal youth training, as measured by graduate training (demographic questions 16-19, and 21), post graduate training (demographic question 24) and prior exposure to working with suicidal cases (demographic questions 27-29) will be predictive of
    a. school psychologists' scores on the knowledge of suicide prevention/postvention best practices, laws and ethics questionnaire upon attending a workshop.
    b. school psychologists' scores on the hypothetical vignettes upon attending a workshop.

An effective form of training is learning by exposure to real life cases such as during internship (Martin et al., 2013). In addition, those who have had experience working with suicidal students have reported more knowledge in suicide risk assessment and protective factors than those who have not (Jahn et al., 2016). As such, it is hypothesized that:

4. Exposure to suicidal cases (as measured by questions 27, 28, and 29 on the demographic questionnaire)
    a. will be the best predictor of knowledge and vignette accuracy scores *before* attending the workshop.
    b. will be the best predictor of knowledge and vignette accuracy scores *after* attending the workshop.

During past research mental health professionals' perceived knowledge has been higher than objective knowledge both regarding suicide prevention and postvention best practices and suicide risk assessment (Gerardi, 2018; Suldo et al., 2010). It is therefore hypothesized that:

5. Upon attending a workshop such as the one proposed on best practices, laws and ethics of suicide in schools, perceived knowledge of suicide prevention/postvention best practices, laws, and ethics will better match objective knowledge. More specifically, it is hypothesized that
    a. perceived knowledge will be significantly higher than objective knowledge *before* the workshop.
    b. perceived knowledge will not be significantly higher than objective knowledge *immediately after* attendance of the workshop.
    c. perceived knowledge will not be significantly higher than objective knowledge *four weeks after* attendance of the workshop.

As there is currently more research on suicide prevention interventions and best practices than postvention interventions or best practices (O'Neill et al., 2020), it is hypothesized that:

6. Scores on the prevention section of the knowledge of suicide prevention/postvention best practices, laws, and ethics questionnaire and vignettes will be significantly higher than scores on the postvention section of the questionnaire and vignettes at each time point.

Chapter II

Stage One (Expert Review and Pilot)

The present study was divided into two stages. During the first stage, experts in the area of child and adolescent suicide were recruited to take and review the knowledge of suicide prevention/postvention best practices, laws, and ethics questionnaire as well as the vignettes to determine school psychology accuracy in implementing best practices in suicide prevention and postvention. Practicing school psychologists across the United States were then recruited to pilot the questionnaire and vignettes. During the second stage this questionnaire and the vignettes were used to look at the effectiveness of an online workshop in increasing the participants' knowledge of best practices for prevention, postvention, laws and ethics involved in the area of child and adolescent suicide as well as increasing the participants' accuracy in determining which prevention and postvention practices are best to implement in a given situation. This section will discuss the methods and results for the first stage of the study regarding the expert review and pilot portions.

Materials and Methods

Participants

For stage one of this research, fourteen experts in the field of suicide among children and adolescents, and specifically suicide prevention and postvention best practices, laws and ethics in schools were recruited to review the questionnaire that measures knowledge of suicide ethics, laws, and pre/postvention best practices in schools and the vignettes that measure accuracy in implementing suicide prevention and postvention best practices. These professionals were considered experts if they had five

or more publications in this area, taught in this area, or held a leadership position on an advisory board for this area. Publications in the area of child and adolescent suicide were reviewed and first authors of the publications were contacted via email. In addition, experts were recruited from advisory boards of foundations in this field such as the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center. These experts were recruited by sending a flyer with information regarding the study directly to their email address (Appendix A). 82 experts were reached out to in this manner and 14 experts agreed to participate. Experts were compensated by being entered into a raffle for a chance to win one of three $125 Guilford Press gift cards.

Upon review of the questionnaire and vignettes from the aforementioned experts, changes were made to the suicide knowledge measure and the prevention and postvention best practice vignettes based upon the experts' suggestions. After altering the measure, stage two of the research began in which 238 practicing school psychologists across the United States were recruited to complete the knowledge questionnaire and accuracy vignettes. Retired school psychologists and current school psychology students were not included in the sample as the present study looked to determine current practices of school psychologists in the field of suicide, and it is believed that current practicing school psychologists are the best representation of that.

In order to obtain a random sample of participants, school psychology associations for each state were contacted and requested to send a recruitment flyer with the questionnaire link out to their email listserv (Appendix B). In addition, a link to the questionnaire was posted to various professional school psychology groups on social media (e.g., Facebook, Twitter) and made available to practicing school psychologists on

LinkedIn. Upon completion of the study, participants were compensated by being entered into a raffle to win one of ten, $50 Amazon gift cards. After recruitment for the pilot was complete, ten participants were randomly chosen and contacted via email so they can claim their gift card.

Measures

Demographic Questionnaire. A questionnaire about background information was used to collect demographic information about each participant. A separate demographic questionnaire administered to the experts and the pilot participants. Expert reviewers were asked questions such as how long they have been working in the field, their primary employment setting, and the primary grade level the clients are that they work with (Appendix C). Upon their review, changes were made to the demographic questionnaire to reflect the experts' input. When requesting information about ethnicity, the word "Caucasian," was changed to "White" as experts stated "Caucasian" is an outdated term that makes reference to a racist classification system used in the 1700s (Mukhopadhyay, 2018).

Pilot participants were asked the aforementioned questions in addition to information about their graduate or post-graduate training in suicide prevention, postvention, ethics, and laws (Appendix D). Participants were also asked to estimate their current knowledge about suicide prevention, postvention, laws, and ethics in schools. Finally, participants were asked about the number of students they have worked with who have endorsed suicidal ideation and attempted or died by suicide to determine their exposure to students in this population. There was also a routing question at the beginning to ensure they are a current practicing school psychologist for students 18 and

under. If they stated they are not, they were routed to the end of the questionnaire and were not able to participate.

Assessment of Knowledge of Best Practices, Laws, and Ethics. A brief assessment of school psychologists' knowledge regarding suicide prevention and postvention best practices specifically in schools, as well as laws and ethics that correspond with suicide in schools were validated by expert feedback and piloted (Appendix E, F). All items on the knowledge measure were statements that the participant could state is true, false, or that they do not know if the statement is true or false. Do not know (DK) was included as an option as determining what participants do not know is valuable in determining deficits in knowledge. "DK" responses were scored as incorrect. To obtain items for this measure, computer searches were conducted using the following databases: PsycInfo (EBSCO), PsycArticles (ProQuest), PubMed-NCBI, ProQuest Psychology Journals, ProQuest Dissertation & Theses, and the National Library of Medicine (Appendix G). In addition, information for items were taken from resources on the National Association of School Psychologists and American Foundation for Suicide Prevention webpages (2015, 2018). Upon feedback received from experts, minor changes to the wording of few questions were made to increase clarity of the questions. A total of eighteen questions were eliminated as they were deemed to be vague or the experts could not agree on a clear answer. In addition, the experts advised "committed suicide," be changed to "died by suicide," as the phrase "committed suicide," conveys the idea that the suicide victim committed a crime or wrongdoing.

Upon completion of the pilot, the assessment of knowledge of best practices, laws, and ethics questionnaire was once again altered. Items were removed based upon

their response variability as well as their impact on the internal reliability of the measure. Specifically, items that would increase internal reliability for the domain upon removal were removed. Internal reliability of this measure was analyzed using Cronbach's Alpha for each domain (prevention, postvention, laws, and ethics). Upon the removal of selected items, Cronbach's Alpha increased from .56 to .61 for the prevention domain, from .74 to .75 for the postvention domain, from .38 to .46 for the laws domain, and from .57 to .69 for the ethics domain.

Vignettes. As the goal of obtaining knowledge is to translate this knowledge into practice, theoretical vignettes were created to determine participants' accuracy in implementing suicide prevention and postvention best practices in hypothetical scenarios (Wilkins et al., 2013). Six vignettes were used in this study and validated by expert feedback (Appendix H). There were two vignettes per grade level the participant primarily works with (elementary grades K-5th, middle grades 6th-8th, or high school 9th-12th). For each grade level, there was one vignette in regard to suicide prevention in the school and one vignette in regard to suicide postvention in the school. For each vignette, the participant was asked a series of questions about how likely they would be to implement certain practices in that scenario on a Likert scale from 1 (strongly disagree) to 5 (strongly agree).

Upon review of the vignettes and the prevention and postvention best practices questions, more information was added to the postvention vignettes that would give the reader a better idea of the student's social status/visibility. The experts suggested adding this information as the social status/visibility of the student would impact the amount the school psychologist needs to support the students in the school. As such, details about the

student who died by suicide such as the fact that he was involved in football and played the clarinet in the band were added to each postvention vignette. The experts expressed approval of the Likert scale questions for both the prevention and postvention vignettes. Upon review and adjustment to add more information regarding social status and visibility of the student, these vignettes and the Likert scales were then used for the pilot portion (Appendix I).

Procedure

The knowledge measure along with the vignettes were reviewed by expert reviewers as described above to ensure the content of the measure is accurate and appropriate. After clicking on the survey link, experts were brought to a Qualtrics survey with a consent form (Appendix J), demographic questionnaire, assessment of knowledge of best practices, laws, and ethics for suicidal students, and randomly assigned two of the six case vignettes to review and indicate the accuracy of the vignettes. Experts who want to be included in the raffle for one of three $125 Guilford Press gift cards had the option to enter their email address so they can be contacted if they win.

This measure was then piloted during stage two by practicing school psychologists. Similarly, participants who clicked the link on the flyer were brought to a Qualtrics survey with a consent form (Appendix K), demographic questionnaire, assessment of knowledge of best practices, laws, and ethics for suicidal students, and two case vignettes dependent upon the grade level they primarily work with. Specifically, while taking the questionnaire, participants were asked what grade level they primarily work with (elementary grades, middle grades, or high school) and were routed to one prevention and one postvention vignette that is specific to the grade level with which the

participant works. In addition, participants who wanted to enter the raffle for a chance to win one of ten $50 Amazon gift cards had the option to enter their email address so they could be contacted if they won. Participants were not asked to provide their name, or any other identifying information and their email addresses were not associated with their responses to ensure anonymity.

Results

Demographic Characteristics of the Experts

Expert participants' ages ranged between 37 and 71 years old (M=56.5, SD=11.77). In terms of education, 71.4% of the sample had their Ph.D., 21.4% of the sample had their Ed.D., and 7.1% of the sample had their master's degree. These degrees were in clinical, counseling, or general psychology. Experts reported that their years since completing their terminal degree ranged from 7 to 45 years (M=25.71, SD=12.57) and their years of professional experience in their present area of work ranged from 8 to 39 years (M=26.07, SD=10.50). Seven (50%) of the experts reported that they primarily work in a college or university setting. Other settings include private practice, school and community consultant, federal research institute, non-profit organization, and community based mental health clinic. In addition, 50% of the experts reported that they are primarily involved in child and adolescent suicide research with 35.7% indicating that they primarily engage in the training of professionals in suicide prevention, postvention, laws, and ethics. The remaining experts indicated that they engage in direct suicide prevention, intervention, and postvention work with children and adolescents.

Demographic Characteristics of the Pilot Participants

Pilot participants predominantly identified as women (77.7%, *n*=185) and White (76.9%, *n*=183) which is generally consistent with the current gender and ethnic composition of practicing school psychologists (Goforth et al., 2021). Participants' ages ranged from 24 to 69 with a mean of 37.70 (*SD*=10.68). In regard to professional training, 53.8% of participants held a specialist degree[1], 25.5% held a master's degree, 10.5% held a Ph.D., 5.5% held a Psy.D., and 3.4% held an Ed.D. Overall, the sample represented practicing school psychologists from 32 states. The eighteen states that were not represented include: Alaska, Kansas, Maine, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Mexico, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Vermont, Wisconsin, and Wyoming.

The number of years the participant has been employed as a school psychologist ranged from <1 year to 42 years with a mean of 9.90 years (*SD*=9.15). 83.2% of participants primarily worked in a public school setting, 13.4% primarily worked in a private school setting, and 3.4% primarily worked in a different setting including residential settings, charter schools, and specialized public day schools. The primary grade level each participant worked with varied. 38.2% of participants worked primarily with students ages K-5th, 21.8% worked primarily with students ages 6-8th, and 26.1% 9-12th grade. 13.9% of participants worked primarily with a multitude of grade levels that do not fall exactly within the parameters offered as choices. Majority of participants reported that they are involved in the implementation of the crisis intervention plan at their school (71.8%).

[1] A specialist degree is an applied professional degree that entails additional credits above and beyond what is typically required of a master's degree and a full-time internship experience.

Stage Two (Workshop)

As stated previously, during the second stage of this study, the knowledge measure and the vignettes were used to look at the effectiveness of an online workshop in increasing the participants' knowledge of best practices for prevention, postvention, laws and ethics involved in the area of child and adolescent suicide as well as increasing the participants' accuracy in determining which prevention and postvention practices are best to implement in a given situation. This section will discuss the methods and results for stage two of this study.

Materials and Methods

Participants

Based upon past research, a rule of thumb for how many participants are necessary in a regression in order to ensure adequate power is 10 per predictor variable (Klem, 1995). As there were six predictor variables, a minimum of 60 participants are necessary to obtain adequate power. Using an effect size of .5, p of .05 and power of .95, the minimum number of participants necessary to run a dependent t-test and a repeated measures ANOVA using this data is 54 school psychologists (Kahsay et al., 2020; Pounds, 1989). In order to account for attrition, a total of 107 participants were initially recruited for stage three of this study.

As stated, a total of 107 practicing school psychologists were recruited and completed the pre-test knowledge and vignette questionnaires. The school psychologists recruited for this stage are separate from the school psychologists recruited during the first stage of the study. Practicing school psychologists for this stage were recruited by sending a flyer to school psychologists across the United States via state association

listservs (Appendix L). Upon completion of the pre-test, 70 of these practicing school psychologists then attended an online workshop presented by an expert in the field Dr. Scott Poland titled "Youth Suicide: Best Practices for Prevention/Intervention and Postvention in Schools." The workshop entailed a one hour, live, online session. Of those 70 school psychologists who attended the live online workshop, 59 completed the post-test questionnaire within one week after workshop attendance and 50 completed the follow-up questionnaire four weeks after workshop attendance. Participants were compensated by receiving an additional entry into a raffle for a chance to win one of fifteen $50 Amazon gift cards for each time point they completed the questionnaire.

Measures

Demographic Questionnaire. Workshop participants were asked similar questions to those the experts and pilot participants were asked, in addition to information about their graduate or post-graduate training in suicide prevention, postvention, ethics, and laws (Appendix D). Participants were also asked to estimate their current knowledge about suicide prevention, postvention, laws, and ethics in schools. Finally, participants were asked about the number of students they have worked with who have endorsed suicidal ideation and attempted or died by suicide to determine their exposure to students in this population. There was also a routing question at the beginning to ensure they are a current practicing school psychologist for students 18 and under. If they stated they are not, they were routed to the end of the questionnaire and were not able to participate.

Assessment of Knowledge of Best Practices, Laws, and Ethics. Upon altering the knowledge measure as stated above, the final assessment of knowledge questionnaire was then used for the workshop stage of the study (Appendix M). There

was a total of 40 statements in which the participants were asked to respond, "true," "false," or, "do not know." Again, "do not know" responses were considered to be incorrect.

Vignettes. As during the pilot portion, each participant received two vignettes depending upon the grade levels the participant primarily works with, specifically, elementary grades K-5th, middle grades 6th-8th, or high school 9th-12th (Appendix I). For each grade level, there was one vignette in regard to suicide prevention in the school and one vignette in regard to suicide postvention in the school. For each vignette, the participant was asked a series of questions about how likely they would be to implement certain practices in that scenario on a Likert scale from 1 (strongly disagree) to 5 (strongly agree).

Procedure

During stage two, the aforementioned survey components including the consent form (Appendix N), demographic questionnaire, knowledge measure, and two vignettes were given to practicing school psychologists before, immediately after, and 4 weeks after attending Dr. Scott Poland's online workshop on suicide prevention/intervention and postvention in schools. Dr. Scott Poland is internationally recognized as an expert in the area of youth suicide and is a professor and the director of the Suicide and Violence Prevention Office at NSU Florida. Dr. Poland has authored six books in this field and most recently authored a crisis toolkit for educators to help prevent suicide in schools. His workshop sought to complete five objectives including identifying protective and resiliency factors for youth and identifying key myths about suicide, designing a comprehensive best practices model for suicide prevention and intervention in the

schools, identifying the relationship between self-injury and suicide, identifying best practices in suicide postvention, and understanding the complex relationship between bullying and suicide. The author of the present study and Dr. Poland collaborated to ensure that the workshop would encompass the information from the knowledge and accuracy measures. The participants were given the knowledge and accuracy measures before, immediately after and four weeks after the workshop session to determine if there was a change in their knowledge on laws, ethics, and best pre/postvention practices for suicide in schools and their accuracy in implementing suicide prevention and postvention best practices. Upon completion of the measures at each time point, participants received an additional entry into a raffle for a chance to win one of fifteen $50 Amazon gift cards. In addition, upon completion of the pre-test and attendance of the workshop, participants were able to receive one continuing education credit and a certificate of completion.

Results

This section is broken down into five separate subsections. The first subsection examines the demographic composition of the sample who participated in the workshop portion of the study. The second subsection presents two repeated measures analysis of variance (ANOVA) tests to examine the impact of training on knowledge and application of knowledge to hypothetical scenarios (hypotheses one and two). In addition, the current research seeks to examine if other professional variables predict the ability to retain this knowledge or apply this knowledge after the training is completed. These professional variables include hours of graduate training attended, estimation of the amount of graduate training received, hours of post-graduate training attended, and exposure to suicidal cases such as number of cases the school psychologist has worked with that

indicated suicidal ideation, made a suicide attempt, or died by suicide. A series of multiple linear regressions were run to examine the relationship between these variables and knowledge and the application of knowledge (vignette responses) at the pre and post-test time points (hypotheses three and four). Hypothesis four specifically looks to address which of the aforementioned variables is the most predictive of knowledge and vignette scores at the pre and post-test time points. Finally, three dependent t-tests were run to examine the difference between scores on the knowledge measure and the school psychologists' estimation of their knowledge of suicide ethics, laws, and best practices at the pre, post, and follow up time points (hypothesis five). An additional set of six dependent t-tests were run evaluate the difference between suicide prevention and suicide postvention scores on the knowledge measure and vignette scores at the pre, post, and follow up time points (hypothesis six).

Demographic Characteristics

As stated above, 107 practicing school psychologists completed the knowledge measure and vignettes at the pre-test time point, 59 of those who participated in the pre-test, participated in the post-test time point, and 50 of those who participated in the pre and post-test also participated at the follow up time point. A missing value analysis (MVA) was run to determine if those who participated in only the pre-test time point significantly differed from those who participated in the post-test and follow up time points. Based on the analysis, those who participated in only the pre-test time point and then dropped out of the study did not significantly differ from those who continued on in the study in knowledge scores at the pre-test time point or in demographics such as gender, age, ethnicity, highest degree earned, years since graduating, primary

employment setting, primary grade level worked with, involvement in crisis intervention plan, hours of graduate training, hours of post-graduate training, graduate school training estimation, and number of students the school psychologist reported working with who endorsed suicidal ideation, made a suicide attempt, or died by suicide. As such, the demographic characteristics only for those who completed the training and measures at all three time points will be described.

As displayed in Table 1, the majority of the participants identified as women and were White. Participants' ages ranged from 26 to 65 with a mean of 41.94 (*SD*=10.20). In regard to professional training, majority of participants held a specialist degree. Overall, the sample represented practicing school psychologists from 24 states. The number of years the participant has been employed as a school psychologist ranged from <1 year to 30 years with a mean of 12.95 (*SD*=9.01). Participants primarily worked in a public school setting and the primary grade level each participant worked with was elementary school aged children. In addition, most participants reported that they are involved with the implementation of the crisis intervention plan at their school.

Participants were also asked about the training they have received in suicide prevention, postvention, laws and ethics both during graduate school and after graduate school. The number of courses taken in graduate school that provided training on suicide prevention and postvention ranged from 0-5 courses with a mean of 1.1 courses (*SD*=1.09). Total number of hours of suicide prevention and postvention training in graduate school ranged from 0-100 hours (*M*=7.22, *SD*=15.58). In regard to post-graduate training, 81.4% of participants stated they have attended workshops after graduate school. The number of workshops participants reported attending after graduate school ranged

from 0-30 workshops a mean of 4.58 workshops (*SD*=6.06). Interestingly, while not significantly different, the average number of workshops attended by those who participated in the pre-test and those who participated in the follow up differed by almost one whole workshop. Specifically, those who completed the pre-test time point reported attending an average of 3.55 suicide workshops after graduate school, while those who chose to complete the study estimated they attended an average of 4.58 workshops. Number of hours of post-graduate training in suicide prevention and postvention ranged from 0-75 hours (*M*=8.55, *SD*=15.05). Again, while not significant, it is notable that those who participated only in the pre-test portion of the study reported a higher number of hours of post-graduate training in suicide on average (*M*=10.63, *SD*=17.47) than those who completed the entire study (*M*=8.55, *SD*=15.05).

Finally, participants were asked about their experiences working with students in which suicide is a concern at varying degrees. School psychologists reported working with 0-100 students who have indicated suicidal ideation with a mean of 15.62 students (*SD*=23.44). In regard to students who have made a suicide attempt, school psychologists reported working with 0-25 students with a mean of 3.48 students (*SD*=6.38). When asked how many students the school psychologists have worked with who have died by suicide, they reported a range of 0-5 students with a mean of .26 (*SD*=.80).

Table 1

Sociodemographic Characteristics of Participants at the Follow-Up Time Point for Stage Three (Workshop)

Variable	*n*	%
Gender		
Woman	46	92.0
Man	4	8.0
Non-binary	0	0
Ethnicity		
White	43	86.0
Black	3	6.0
Asian	2	4.0
Hispanic/Latino	1	2.0
Other	1	2.0
Degree		
Master's Degree	4	8.0
Specialist Degree	35	70.0
Ed.D.	1	2.0
Ph.D.	6	12.0
Psy.D.	3	6.0
Other	1	2.0
Primary Employment Setting		
Public School	50	100.0
Private School	0	0
Primary Grade Level		
Elementary (K-5th)	23	46.0
Middle School (6-8th)	11	22.0
High School (9-12th)	9	18.0
Other	7	14.0

Table 1 (continued)

Variable	*n*	%
Involved in Crisis Intervention		
Yes	34	68.0
No	16	32.0

Note. N=50.

Comparing Knowledge and Vignette Scores at Each Time Point

Knowledge and vignette scores were compared at the pre-test, post-test, and follow up time points. Notably, the variability of the knowledge measure scores during the workshop stage are limited. It is unclear as to why the variability in knowledge scores at each stage of the workshop portion (pre-test M=29.52, SD=4.04; post-test M=32.6, SD=3.25; follow up M=32.56, SD=3.73) was less than the variability in knowledge scores for the pilot portion (M=39.58, SD=7.0). To determine if the workshop resulted in a significant increase in knowledge scores from before the workshop to after the workshop and to determine if the scores remained consistent one week after to four weeks after the workshop, a repeated measures ANOVA was run comparing pre-test, post-test, and follow up scores (Table 2). Mauchly's Test of Sphericity indicated that the assumption of sphericity had been violated, χ^2=6.98, p=.03. As ε=.87, the Huynh-Feldt correction was used as a general rule is when ε>.75 the Huynh-Feldt correction should be used as a more powerful form of correcting for the violation of the sphericity assumption. There was a significant difference in knowledge scores between at least two time points F(1.82,94)=30.93, p<.001. Specifically, post-hoc tests using the Bonferroni correction revealed that knowledge scores significantly increased from pre-test to post-test time point by 3.08 points (p<.001), and significantly increased from pre-test to follow up time

point by 3.04 points (p<.001). Scores on the knowledge measure did not significantly differ from post-test to follow up (p=.91). These results support hypothesis one.

Table 2

Means, Standard Deviations, and Repeated Measures Analyses of Variance for the Effects of Pre, Post, and Follow-Up Time Points on Knowledge and Accuracy Scores

	Pre-Test		Post-Test		Follow-up				
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	$F(2, 98)$	ρ	η^2
Knowledge Score	29.52	4.04	32.60	3.25	32.56	3.73	30.93	<.001	.39
Accuracy Score	84.48	6.97	87.90	6.51	86.70	8.15	10.38	<.001	.18

Note. Knowledge scores are out of a total of 40 points. Accuracy scores are out of a total of 100 points

An additional repeated measures ANOVA was run to compare vignette scores at each time point (Table 2). As discussed previously, each participant reviewed two hypothetical vignettes regarding suicide prevention and postvention scenarios and were then required to rate how likely they were to implement certain practices on a Likert scale. Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated (χ^2=4.09, p=.129) and as such corrections to combat a violation assumption were not necessary. There was a significant difference in vignette scores between at least two time points, F(2,98)=10.38, p<.001. Specifically, post-hoc tests using the Bonferroni correction revealed that vignette scores significantly increased from pre-test to post-test time point by 3.42 points (p<.001), and significantly increased from pre-test to follow up

time point by 2.22 points (p=.013). Scores on the vignettes did not significantly differ from post-test to follow up (p=.08). These results support hypothesis two.

Determining Predictors of Knowledge and Vignette Scores

A series of multiple linear regressions were used to examine if factors such as prior training and exposure to working with suicidal students impacted knowledge and vignette scores at each time point. As hours of suicide training in graduate school, hours of suicide training post graduate school, and number of students worked with who reported suicidal ideation were highly variable (SD=12.26; SD=17.47; SD=22.64), these variables were winsorized such that all outliers were changed to the highest or lowest acceptable extreme value. Predictor variables were hours of graduate training, hours of post-graduate training, graduate school training estimation, reported number of students worked with who had suicidal ideation, attempt or who died by suicide. Graduate school training estimation was determined by adding up the Likert scale estimations of the amount of training received in suicide prevention, postvention, laws, and ethics as asked in demographic questions 16-19. Outcome variables were the knowledge measure or vignette scores at the pre-test, and post-test time points. Therefore, a total of four multiple linear regressions were utilized.

The first multiple linear regression was used to determine if the aforementioned variables significantly predicted knowledge scores at the pre-test time point (Table 3). The overall regression was statistically significant (R^2=.22, F(6, 52)=2.38, p=.042). Hours of graduate training (β=-.29, p=.03) and the number of students the participant estimated working with who have died by suicide (β=.37, p=.009) significantly predicted knowledge scores at the pre-test time point. Hours of post-graduate training, graduate

school training estimation, number of students the participant worked with who expressed suicidal ideation, and number of students the participant worked with who made a suicide attempt did not significantly predict knowledge scores at the pre-test time point.

Table 3

Regression Analysis Summary for Training and Exposure Variables Predicting Knowledge Scores at the Pre-Test Time Point

Variable	*B*	*SE B*	*β*	*t*	*ρ*
Hours of Graduate Training	-.16	.08	-.29	-2.17	.03
Hours of Post-Graduate Training	.11	.06	.27	2.00	.05
Graduate School Training Estimation	.07	.15	.06	.48	.64
Number of Students with Suicidal Ideation	-.05	.06	-.19	-.79	.43
Number of Students with Suicide Attempt	.11	.25	.09	.43	.67
Number of Students Died by Suicide	1.95	.72	.37	2.70	.009

Note. R^2 = .22. (N=59, p =.042).

As displayed in Table 4, a multiple linear regression was used to determine if graduate training, post graduate training, or exposure to suicidal students predicted knowledge scores at the post-test time point. Once again, the overall regression was statistically significant (R^2=.35, F(6, 52)=3.99, p=.002). Participants' scores on the pre-test measure of suicide knowledge is the only variable that significantly predicted knowledge scores at the post-test time point (β=.44, p<.001). These results fail to support hypothesis three.

Table 4

Regression Analysis Summary for Training and Exposure Variables Predicting Knowledge Scores at the Post-Test Time Point

Variable	*B*	*SE B*	*β*	*t*	*ρ*
Pre-test Knowledge Measure Score	.44	.10	.54	4.23	<.001
Hours of Graduate Training	-.06	.06	-.14	-1.04	.31
Hours of Post-Graduate Training	.02	.04	.05	.39	.69
Graduate School Training Estimation	-.002	.11	-.002	-.02	.99
Number of Students with Suicidal Ideation	-.03	.05	-.16	-.69	.49
Number of Students with Suicide Attempt	.22	.19	.24	1.13	.26
Number of Students Died by Suicide	-.33	.58	-.08	-.58	.57

Note. R^2 = .35. (N=59, p =.002).

A multiple linear regression was also used to determine if graduate training, post-graduate training, and exposure to working with suicidal students predicted vignette scores at the pre-test time point (Table 5). The overall regression was not statistically significant (R^2=.18, F(6, 52)=1.95, p=.09). While the overall model was not significant, the number of students the school psychologists worked with who made a suicide attempt significantly predicted vignette scores at the pre-test time point (β=.58, p=.02). However, hours of graduate training, hours of post-graduate training, participants' graduate training estimation, the number of students who have expressed suicidal ideation that the participants have worked with, and the number of students the participants report working with who have died by suicide did not significantly predict vignette scores at the pre-test time point.

Table 5

Regression Analysis Summary for Training and Exposure Variables Predicting Vignette Accuracy Scores at the Pre-Test Time Point

Variable	*B*	*SE B*	*β*	*t*	*ρ*
Hours of Graduate Training	-.17	.13	-.18	-1.26	.21
Hours of Post-Graduate Training	.13	.09	.18	1.29	.20
Graduate School Training Estimation	.02	.27	.01	.08	.94
Number of Students with Suicidal Ideation	-.17	.11	-.41	-1.65	.11
Number of Students with Suicide Attempt	1.09	.44	.58	2.47	.02
Number of Students Died by Suicide	1.24	1.26	.14	.98	.33

Note. R^2 = .18. (N=59, p =.09).

Table 6 displays results from the multiple linear regression used to determine if graduate training, post-graduate training, and exposure to students with varying levels of suicidality predict vignette scores at the post-test time point. Once again, the overall regression was not statistically significant (R^2=.14, F(6, 52)=1.18, p=.33). None of the variables significantly predicted vignette scores at the post-test time point (Table 6). These results fail to support hypothesis three.

Table 6

Regression Analysis Summary for Training and Exposure Variables Predicting Vignette Accuracy Scores at the Post-Test Time Point

Variable	*B*	*SE B*	*β*	*t*	*ρ*
Pre-test Knowledge Measure Score	.17	.23	.11	.73	.47
Hours of Graduate Training	-.08	.13	-.09	-.61	.54
Hours of Post-Graduate Training	.13	.09	.19	1.31	.19
Graduate School Training Estimation	-.17	.25	-.09	-.69	.49
Number of Students with Suicidal Ideation	-.10	.10	-.26	-1.02	.31
Number of Students with Suicide Attempt	.66	.42	.38	1.55	.13
Number of Students Died by Suicide	.38	1.28	.05	.29	.77

Note. R^2 = .14. (*N*=59, *p* =.33).

Notably, multicollinearity between predictor variables may impact the significance of the model. To account for multicollinearity, all of the above regressions were run again after combining the highly correlated suicide exposure variables (students who have made a suicide attempt, expressed ideation, or died by suicide), and combining the graduate training variables (hours of graduate school training and qualitative graduate school training estimation). Ultimately, there was no difference between the above regressions and the regressions run to account for multicollinearity in terms of model significance.

Finally, findings regarding which variable best predicted knowledge and vignette scores were mixed. A stepwise regression was run to determine which variables accounted for the most variance in knowledge measure and vignette scores at each time point. The variable that accounted for the most variance differed depending upon the

measure and the time point. At the pre-test time point, the number of students the school psychologist worked with who died by suicide accounted for the most variance in knowledge measure scores, and the number of students the school psychologist worked with who made suicide attempts accounted for the most variance in vignette scores. As these are both variables that measure exposure to suicidal cases, this supports hypothesis four A. Alternatively, at the post-test time point, pre-test knowledge scores accounted for the most variance in knowledge measure scores, whereas number of students the school psychologist worked with who made a suicide attempt accounted for the most variance in post-test vignette scores. These findings fail to show consistent support for hypothesis four B.

Comparing Objective and Subjective Knowledge

Objective and subjective knowledge scores were compared at each time point. Knowledge measure scores are considered to be objective knowledge scores and the knowledge estimation in each domain as determined by participants' subjective knowledge to four questions. To compare objective and subjective scores, objective knowledge scores were converted from a 40-point scale to a 5-point scale as the subjective scores were rated on a 5-point Likert scale. To convert these scores from a 40-point scale to a 5-point scale, objective knowledge scores were divided by 40 and then multiplied by 5, such that a perfect score of 40 on the 40-point scale would equate to a perfect score of 5 on the 5-point scale. The four questions regarding knowledge estimation were averaged to determine a subjective knowledge score. In addition, as participants' subjective knowledge or knowledge estimation significantly differed at each time point, their rated subjective knowledge at each time point was used to compare to

their respective objective knowledge scores at the coinciding time point $F(2, 100)=15.17$, $p<.001$.

At the pre-test time point, on average, school psychologists scored better ($t(106)=19.04$, $p<.001$) on the objective measure of knowledge ($M=3.67$, $SD=.47$) than their subjective ratings of knowledge in suicide prevention and postvention best practices, laws, and ethics ($M=2.18$, $SD=.76$). At the post-test time point, on average, school psychologists scored better ($t(58)=14.19$, $p<.001$) on the objective measure of knowledge ($M=4.08$, $SD=.40$) than their subjective ratings of knowledge in suicide prevention and postvention best practices, laws, and ethics ($M=2.48$, $SD=.75$). Finally, at the follow-up time point, on average, school psychologists scored better ($t(49)=13.72$, $p<.001$) on the objective measure of knowledge ($M=4.07$, $SD=.47$) than their subjective ratings of knowledge in suicide prevention and postvention best practices, laws, and ethics ($M=2.52$, $SD=.67$). These results fail to support hypothesis five.

Comparing Suicide Prevention and Suicide Postvention Knowledge Scores

Suicide prevention and suicide postvention knowledge and vignette scores were compared at each time point. At the pre-test time point, there was no significant difference ($t(106)=-1.33$, $p=.19$) on the suicide prevention domain of the knowledge measure ($M=6.81$, $SD=1.61$) and the suicide postvention domain of the knowledge measure ($M=7.10$, $SD=2.04$). Similarly, there was no difference ($t(102)=.921$, $p=.34$) on the suicide prevention vignettes ($M=42.24$, $SD=3.40$) and the suicide postvention vignettes ($M=41.90$, $SD=3.89$). At the post-test time point, there was no significant difference ($t(58)=-1.05$, $p=.296$) between scores on the suicide prevention domain ($M=8.00$, $SD=1.37$) and the suicide postvention domain of the knowledge measure

(*M*=8.25, *SD*=1.47). However, there was a significant difference (*t*(58)=2.65, *p*=.01) between scores on the prevention vignettes (*M*=44.63, *SD*=3.73) and scores on the postvention vignettes (*M*=43.15, *SD*=3.77). At the follow-up time point, there was no significant difference (*t*(49)=.94, *p*=.354) between scores on the suicide prevention domain (*M*=8.32, *SD*=1.19) and the suicide postvention domain of the knowledge measure (*M*=8.08, *SD*=1.87). Likewise, on the vignettes, there was no difference (*t*(1.17), *p*=.25) between the prevention vignette scores (*M*=43.62, *SD*=4.38) and the postvention vignette scores (*M*=43.08, *SD*=4.39). These results overall fail to support hypothesis six.

Chapter III

Discussion

The present study reports data from a survey of practicing school psychologists' knowledge of suicide prevention, postvention, laws and ethics as well as their ability to implement this knowledge when given hypothetical vignettes before, immediately after, and four weeks after attending the "Youth Suicide: Best Practices for Prevention/Intervention and Postvention in Schools" workshop led by Dr. Scott Poland. Notably, the survey was reviewed and amended based upon feedback from experts in the field of child and adolescent suicide as well as upon receiving results after piloting the measures with practicing school psychologists. The present chapter is broken down into six separate sections. The first section discusses the impact the aforementioned workshop had on knowledge of suicide in schools and accuracy in applying prevention and postvention best practices to hypothetical situations and the implications this has for training. The second section discusses prior reported training and prior suicidal case exposure as it predicts knowledge and accuracy in applying knowledge to hypothetical cases and how this relates to prior research. The third section reviews the difference between objective and subjective knowledge and the implications of this difference. Similarly, the fourth section describes the differences between suicide prevention and postvention knowledge and the implications of these differences. The final two sections discuss study limitations and future directions.

Based on the demographic information gathered in this study, the sample for the workshop portion of the study slightly over represented women in the field of school psychology as well as over represented school psychologists who work in a public school

setting with elementary school students as opposed to other settings or grade levels; however, the sample was in agreement with the profession of school psychology on ethnicity, age, degree held, and years in the field (Castillo et al., 2013; Goforth et al., 2021). Notably, knowledge scores did not significantly differ by grade level at each time point. The current sample also captured a range of school psychologists with various experiences working with students who have expressed suicidal ideation, made a suicide attempt, or died by suicide.

School psychologists who participated in the workshop portion of the study reported employment in 24 different states. Less than half of the states were likely represented due to the small sample of school psychologists who participated in this portion of the study. In addition, while many state associations were contacted, not every state association distributed the study information. The hours of graduate training school psychologists reported receiving in suicide varied considerably, however the number of courses in graduate school that pertained to suicide was not nearly as variable. This incongruence may be due to the fact that it is possible those who reported a large number of hours of suicide training may have received training outside of graduate courses such as in independent workshops or at conferences. In addition, the amount of time each course spent on suicide training may have varied widely so while it seems as though all participants took a similar number of courses involving suicide training, the amount of time spent on training in each course may be largely different across participants. Similarly, while the majority of school psychologists reported attending workshops involving suicide prevention/postvention training after graduate school, the number of workshops and number of hours of post-graduate training varied greatly. While the

majority have attended at least one workshop, these workshops or trainings likely varied in length and intensity. In addition, some school psychologists live in states in which suicide training is required annually, or bi-annually, while others live in states without a requirement which could impact the variability in reported post-graduate training (The Jason Flatt Act, 2007). Likewise, it is important to note that those who participated only in the pre-test portion of the study reported a higher number of hours of post-graduate training than those who attended the workshop and completed the study. It is possible those who felt they had a higher level of post-graduate training were less compelled to attend another training session.

Finally, of note, Cronbach's alpha for the suicide laws domain of the knowledge questionnaire during stage one was especially low. The low reliability for the suicide laws domain may provide insight as to the knowledge school psychologists have in regard to suicide laws in schools. Other areas researched have shown that school psychologists have a lack of applicable legal knowledge (Suldo et al., 2010; Waldecker, 2009). As such, it is possible that we would have considerable variability in terms of knowledge and would not expect a high Cronbach's Alpha for the suicide laws domain.

The Impact of Training on Knowledge and Accuracy

School psychologists' scores on the knowledge of suicide prevention, postvention, laws, and ethics measure significantly increased upon participating in the workshop which is consistent with the first hypothesis. Specifically, knowledge scores significantly increased from before to immediately after attending the workshop and from before to four weeks after attending the workshop, however scores from immediately after the workshop did not significantly differ from scores four weeks after the workshop.

This suggests that not only did knowledge scores increase upon participation in an expert-led workshop, but the knowledge acquired was maintained four weeks after the workshop occurred.

Likewise, and in line with the second hypothesis, school psychologists' vignette scores increased upon attending the workshop. Once again, scores on the vignettes increased from before to immediately after and from before to four weeks after workshop attendance, however scores did not differ immediately after to four weeks after workshop attendance. As such, this suggests that improvement in the ability to apply the knowledge obtained to hypothetical cases was maintained from immediately after to four weeks after workshop attendance. In addition, it is important to note that while the knowledge measure and vignette scores increased from the pre-test to post-test time point by 3.08 and 3.42 points respectively it can reasonably be argued that this increase is clinically significant as the newly learned knowledge can help to save a student's life that may not have been saved otherwise. The questions most participants answered correctly during the post-test that they answered incorrectly during the pre-test were questions involving the impact of lasting memorials, the efficacy of suicide contracts, and the limits to confidentiality. Each of these topics involve information that can save a student's life. Even saving one student's life is incredibly meaningful and significant.

While others have researched objective knowledge of suicide prevention, intervention, or postvention improving as a result of training, or researched perceived competency in these areas, the present results represent the first demonstration of the usage of an objective measure that combines knowledge of suicide prevention, postvention, laws, and ethics and incorporates vignettes in an attempt to determine if

school psychologists' knowledge of these domains as well as their accuracy in applying this knowledge increases upon attending a one session virtual workshop (Kahsay et al., 2020; Nader et al., 2013; O'Neill et al., 2020; Suldo et al., 2010). The incorporation of vignettes to determine the participants' ability to apply the knowledge learned is critical as based on past research there is a knowledge-action gap in which the knowledge learned does not impact the clinical decisions made (MacDonald & Frank, 2016; Wilkins et al., 2013). In using hypothetical vignettes as a way to represent what the school psychologist would do during a real-world situation the results suggest that school psychologists were able to better apply their suicide prevention and postvention knowledge to hypothetical situations upon attending the workshop. It is hoped that this response to hypothetical situations would generalize to their actual practice.

In addition, these results are consistent with the claim that live, expert-led workshops lead to an increase in knowledge that can then ideally be translated into practice (Dolan & Collins, 2015; Valenstein-Mah et al., 2020). While Dunn and colleagues (2013) displayed that long-term knowledge retention is better when information is learned in multiple spaced out sessions overtime, the present study's results imply that one session can at least allow for knowledge retention for four weeks. If follow up training is necessary as Dunn and colleagues (2013) state, the present results suggest that an additional training session for suicide prevention, postvention, laws, and ethics is not necessary until at least four weeks have passed since the initial training session assuming a live expert-led training session such as the one utilized in the present study is completed. Furthermore, as Dunn and colleagues (2013) discuss the impact of

repeated training on knowledge retention, the effect of past training experiences was also considered.

Prior Training and Suicidal Case Exposure in Predicting Knowledge and Accuracy

In reviewing the impact of prior training and suicidal case exposure on knowledge scores, the results of this research suggest that before completing the intervention, the hours of graduate training the school psychologist reported undergoing and the number of students they worked with who died by suicide accounted for the most variability in knowledge scores. This is consistent with prior research stating that past training in this area as well as past exposure to working with students with some form of suicidality is associated with more knowledge in this area (Dunn et al., 2013; Jahn et al., 2016; Wilkins et al., 2013). However, after attending the intervention, pre-intervention knowledge scores accounted for the most variability in post-intervention knowledge scores. A compelling explanation for this finding is that those who already had prior knowledge in this area maintained that prior knowledge and the information from the workshop then expanded upon their prior knowledge. This prior knowledge was likely acquired from graduate training and working with students who have died by suicide as these are the variables that predicted knowledge scores at the pre-test time point. These results indicate that prior knowledge in the area of suicide prevention, postvention, laws, and ethics predicts the knowledge someone is able to obtain from an intervention regardless of the way that knowledge is acquired. While evidence-based training and direct experiences are important in order to obtain knowledge as past research by Dunn and colleagues (2013) and Jahn and colleagues (2016) suggests, the current findings suggest that when engaging in follow up training in this area, what is important is if the school psychologist

has a basis of knowledge in this area prior to the training, and not necessarily where that basis of knowledge originated from.

Less clear results were obtained regarding how prior training and case exposure predict vignette scores. In accordance with past research, exposure to suicidal cases, specifically exposure to students who have made a prior suicide attempt, predicted vignette scores before the intervention (Jahn et al., 2016). The present findings provide further support that prior experiences with cases in real life predict a school psychologist's ability to apply the knowledge they have to their practice (Jahn et al., 2016; Wilkins et al., 2013). However, knowledge scores at the pre-test time point, suicidal case exposure, and prior training experience did not predict vignette scores after attending the intervention. These findings are inconsistent with past research that suggest that with repeat training, prior training experiences as well as past exposure to cases should increase actionable knowledge or the ability to apply this knowledge to practice (Wilkins et al., 2013). It is possible these inconsistencies are due to other variables that were not examined as being more predictive of ability to apply knowledge to practice such as the school psychologists' confidence in their ability to intervene in these situations.

Taken together these findings indicate that before completion of the training, exposure to suicidal cases account for the most variance in knowledge and vignette scores, whereas prior knowledge and suicidal case exposure account for the most variance in knowledge and vignette scores after training completion. This aligns with prior research that a highly effective form of training is learning through real life experiences, specifically experiences with suicidal cases (Jahn et al., 2016; Martin et al.,

2013). As such, it may be important to incorporate direct experiences into training. This could be in the form of role-playing during trainings that help to simulate a true experience, which Gryglewicz and colleagues (2019) have found to be useful in increasing clinical skills in this area. As past research has also found that prior exposure to working directly with students who are suicidal helps to increase confidence, incorporating direct work through role-play or other methods may help school psychologists feel more confident in applying their knowledge to their practice (Jahn et al., 2016).

Perceived Knowledge and Objective Knowledge

Contrary to what was hypothesized, subjective and objective knowledge of suicide prevention, postvention, laws, and ethics differed at each time point. Interestingly, at each time point school psychologists scored better on the objective measure of knowledge of suicide than what they estimated their level of knowledge to be. These results are inconsistent with past research that states that clinicians tend to overestimate their knowledge in suicide prevention, postvention, and risk assessment (Gerardi, 2018; Suldo et al., 2010). Inconsistency with past results may be due to the lack of variability in the objective knowledge measure scores. The variability of the knowledge measure scores were low as compared to the variability of knowledge measures from other studies (Sciutto et al., 2016; Wolf, 2009). In addition, only at the pre-test time point were subjective and objective scores significantly correlated with each other. The lack of correlation between subjective and objective scores at the post-test and follow up time points is consistent with past research that states people tend to have poor self-insight when it comes to estimation of their own knowledge (Mills, 2013). This also suggests

that subjective scores did not increase in accordance with the increase in objective knowledge scores. This may have been impacted by the way subjective knowledge was measured. Subjective knowledge was rated on a 5-point Likert scale for perceived knowledge of suicide prevention, suicide postvention, suicide laws, and ethics. An average of these scores was obtained and that was used to compare to objective knowledge scores. As ratings were based on whole numbers, there was not an opportunity to reflect smaller changes in perceived knowledge. That is, if a participant rated themselves as a 4/5 for knowledge in each of these areas, while they may have felt their knowledge improved from before to after attending the workshop, they may have only felt their knowledge improved by .5 rather than one point, however they were not able to increase their subjective knowledge score by .5. The scale structure may have limited their ability to adequately and more accurately express where they believed their knowledge was in each of these areas. Perhaps if subjective knowledge was measured through the use of a scale that provided more options than five points, subjective knowledge would have fluctuated more from time point to time point.

Notably, past research has also suggested that a lack of confidence in one's own knowledge may lead to a decrease in ability to make effective clinical decisions despite having the knowledge required to do so (Erps et al., 2020). This displays the importance of not only acquiring knowledge, but also gaining the confidence to use this knowledge. Based on these findings, despite improving in knowledge scores and vignette accuracy scores, the lower subjective knowledge ratings may indicate a lack of confidence in the school psychologists' knowledge in this area. If the school psychologists believe that they are less knowledgeable, this may create a barrier to applying their knowledge to practice.

Knowledge of Suicide Prevention and Suicide Postvention

Finally, the present study obtained evidence that at the post-test time point, school psychologists performed better on the prevention vignettes than they did on the postvention vignettes. Performing better on a measure of prevention than a measure of postvention is consistent with the idea that there is a greater emphasis on suicide prevention in research and training than on suicide postvention (Boccio & McDonough, 2018; O'Neill et al., 2020). However, overall results contradict this idea as there was no difference in suicide prevention or suicide postvention scores at the pre-test or follow up time points and the only difference at the post-test time was between suicide prevention and suicide postvention vignette scores. Based on this small sample, this may indicate that the field has improved in creating a balance between suicide prevention and suicide postvention training. Likewise, there was a balance in training in suicide prevention and suicide postvention best practices in the workshop the school psychologists attended. This may be why knowledge scores on the suicide prevention and suicide postvention domains remained comparable to each other at the post-test and follow up time points. Suicide prevention and suicide postvention vignette scores may have significantly differed as school psychologists at the post-test time point estimated their suicide prevention knowledge to be higher than their suicide postvention knowledge. As past research has displayed that confidence in one's knowledge impacts one's ability to apply this knowledge to clinical decision making, it is possible that because the school psychologists had less confidence in their postvention knowledge, they applied this knowledge to their choices in a hypothetical postvention situation less than they applied their knowledge to their choices in a hypothetical prevention situation (Erps et al., 2020).

Yet again, these results strongly imply the importance in not only obtaining knowledge, but also obtaining confidence in order to close the knowledge-action gap (Erps et al., 2020; Wilkins et al., 2013).

Limitations

Although the present results clearly support live, expert-led workshops as a way to effectively increase suicide prevention, postvention, laws, and ethics knowledge and ability to apply that knowledge to hypothetical cases, it is appropriate to recognize several limitations. While 14 experts volunteered to review the measures, further review and feedback from other experts in the field may have helped to further improve the questions. In addition, review took place electronically by having the experts complete the knowledge measure/vignettes and type in their comments. Collaboration may have been more effective had the experts been asked to speak with the author directly and review the knowledge measure and vignettes.

In addition, the current sample for the pilot and workshop stages is limited in terms of states and primary employment settings. The number of school psychologists from different employment settings is not representative of the population of school psychologists nationally. Thus, the generalizability of the current findings to the broader population of school psychologists who work in a variety of different settings may be limited. Likewise, neither the pilot sample nor the workshop sample has representation from all 50 states and the number of school psychologists from each state is not representative of the population of school psychologists nationally. Despite contacting all state organizations requesting dissemination of the study information, it is likely not every state organization chose to distribute this information. As such, the organizations

who chose not to disseminate the information are likely less represented in the present study.

As stated earlier, the variability of the knowledge measure scores during the workshop stage are low as compared to the variability of other knowledge measures (Sciutto et al., 2016; Wolf, 2009). It is unclear as to why the variability in knowledge scores at each stage of the workshop portion was less than the variability in knowledge scores for the pilot portion. It is possible this could be due to the questions that were removed in an effort to increase the internal reliability of the measure. The lack of variability however may have impacted the findings and may indicate a limited ability of this measure to differentiate those who are knowledgeable in the area of suicide ethics, laws, and best practices from those who are less knowledgeable in these areas. Possible future directions would be to revise the measure to allow for greater variability in item difficulty and as a result to differentiate across knowledge levels.

An additional limitation is that the current study relies on self-report. School psychologists were required to estimate the number of graduate school courses they took in which they learned about suicide prevention and postvention, the number of hours of training they received in suicide prevention and postvention in graduate school, and the number of hours of training received after graduate school. Estimation of training may be inaccurate and difficult to estimate especially depending upon the amount of time since the school psychologist graduated from their training program or the amount of time since they completed post-graduate training. Inaccurate estimation of these variables may have impacted the current study's findings and limited its ability to determine the impact of prior training on knowledge measure and vignette scores. To rectify this, future

research can look at graduates from specific programs with different levels of documented courses regarding suicide training and can then determine if greater suicide training in graduate school, and what type of training, predicts ability to retain knowledge after attending a workshop later in their career.

Finally, it is difficult to determine if the hypothetical vignettes elicit the same responses as what the school psychologists would do in practice. That is, school psychologists had a longer time to consider and determine what they would do in the hypothetical situation than they likely would if the situation occurred in life, which may have impacted their decisions. As such, it is difficult to state with certainty that high scores on the vignettes equate to generalizability of knowledge to practice. Future research can address this through the usage of virtual platforms in which the school psychologist has to respond to a theoretical situation on the spot through a video recording or by getting information regarding what school psychologists did in real life when prevention and postvention situations arose.

Summary and Future Directions

As suicide rates continue to increase for school aged students, training of school psychologists in suicide prevention, postvention, laws, and ethics is necessary to increase knowledge in these areas and clinical utilization of that knowledge (Miller, 2014). The present study is the first to examine the impact of training on school psychologists' knowledge of four important domains in regards to suicide in schools (prevention, postvention, laws, and ethics) as well as the application of suicide prevention and postvention knowledge through the use of theoretical vignettes. The first key finding was that a one-hour virtual workshop was shown to be an effective form of training in the four

aforementioned domains as knowledge and application of knowledge increased and this increase remained over a four-week period. Past researched trainings have varied widely in the number of sessions or amount of time per training session, and few measured maintenance of knowledge over time (Robinson et al., 2013). Future research should seek to determine if these results last beyond a four-week period and when follow up training is necessary.

A second key finding is that prior exposure to working with suicidal cases appeared to predict knowledge and ability to apply knowledge before attending the training. Clearly, direct experience is an effective form of training in suicide prevention, postvention, laws, and ethics. As such, future training should likely work on emphasizing more direct experiences under the mentorship and guidance of a qualified supervisor that way school psychologists in training can have the opportunity to effectively learn about suicide in schools. A training such as the one utilized in the current study can incorporate simulated direct experiences as past research states that simulated experiences such as role-play or virtual simulation are effective in increasing clinicians' skills and performance in the area of training (Sheen et al., 2021; Stevens & Kincaid, 2015). The training utilized in the present study did not incorporate direct experiences or simulate direct experiences through role-play, however this training still appeared to be especially effective in increasing knowledge when school psychologists already had prior knowledge of these domains before completing the training, regardless of in what way this knowledge was acquired (i.e., via direct experiences or formal trainings). As such, a one-hour online workshop session such as the one in this study may be an effective form of follow up training. Follow up training is necessary based on past research in order to

increase knowledge retention and an effective way to complete repeated training is necessary in order to overcome potential barriers to school psychologists completing this training such as length or cost of the training (Dunn et al., 2013). Future research should determine if this form of training is effective for school psychologists who do not have prior knowledge in this area by comparing results of those who have a limited amount of prior knowledge to those who have prior knowledge in this area to determine if this is an effective form of first-time training or should only be used as a form of follow up training to fill in potential gaps.

In addition, it is important for future research to focus more on not only increasing school psychologists' knowledge of suicide prevention, postvention, laws, and ethics, but also increasing their confidence in applying this knowledge to their practice. The present study found that school psychologists' estimated knowledge was less than their actual knowledge. This is a key finding and important to note as based on past research clinicians who are confident in their knowledge are more likely to apply their knowledge to practice (Jahn et al., 2016). Future research should seek to better determine if this form of training can effectively increase the confidence of school psychologists in applying this knowledge to practice by improving measurement of school psychologists' confidence before and after intervention attendance. This could be done through a more extensive measure of confidence, for example, by providing hypothetical situations and asking how confident the school psychologist is in intervening on a scale from 1 to 10 to allow for more flexibility in responses.

Finally, future research should seek to determine if this form of training actually increases actionable knowledge or whether or not the school psychologist will apply this

knowledge to their practice. While the hypothetical vignettes displayed that school psychologists can apply this knowledge effectively, it is difficult to determine if that means the school psychologists will be able to apply the knowledge during situations in which there is more stress and pressure. As such, future research should focus on an alternative way to determine if the knowledge acquired through training is being applied to practice. This can be done through following up periodically with school psychologists who have completed the study and asking them about the practices that they have implemented in prevention and postvention scenarios that have come up.

Chapter IV

Implications for the Profession of School Psychology

Suicide is preventable, yet suicide rates among children and adolescents continue to rise (Curtin & Heron, 2019). The school community is a unique setting in which students can have contact with a mental health professional on a regular basis who can follow up with the student and monitor their care (O'Neill et al., 2020). Therefore, school psychologists have the opportunity to impact the incidence of suicidal behaviors amongst students. School psychologists also have legal and ethical responsibilities to prevent suicide amongst students, however they need to be equipped with the knowledge and ability to apply this knowledge in order to do so (Miller, 2014). An inability to recognize signs of suicidal behavior or an inability to implement proper prevention strategies can inhibit students from receiving the resources they need and could even lead to the loss of a student's life in the most extreme of circumstances (Robinson et al., 2013). Likewise, an inability to implement proper postvention practices can influence contagion effects which can lead to an increase in suicides in the community (Poland et al., 2019). As such, effective training in this area that leads to application of knowledge in practice is imperative.

The results of the present study reveal the utility of a one-hour expert led, virtual workshop in increasing knowledge and ability to apply knowledge regarding suicide prevention, postvention, laws, and ethics in schools. Despite knowing that repeat training is important for knowledge retention, not all states require regular training in suicide prevention, postvention, laws, or ethics (Dunn et al., 2013; American Foundation for Suicide Prevention, 2018). The training format used in the present study provides a

practical and efficient method for training that could possibly lead to school psychologists feeling more inclined to attend the training or lead to districts becoming more inclined to mandate a training that is shown to be beneficial yet does not take a lot of time or require the training to occur in person. As this training's impact on knowledge is predicted by the school psychologist's background knowledge in the area, it is important that this one-hour, expert led, virtual format is likely utilized as a form of follow up training for school psychologists in the field rather than a stand-alone training that occurs one time or as a school psychologist's initial form of training. This form of training could be utilized as a way for school psychologists to stay up to date on new research and evidence-based practice as well as review their prior knowledge to ensure retention of knowledge.

Training should also focus on incorporating ways to increase school psychologists' confidence in their knowledge and ability to apply their knowledge to practice. As shown in the present study, despite an increase in knowledge upon attending the training, school psychologists still estimated their knowledge to be less than what it actually was. Without confidence in their knowledge, it is likely that the school psychologists will have a more difficult time applying their knowledge to practice, widening the knowledge-action gap (Jahn et al., 2016; Wilkins et al., 2013). As such, it is important that future training focuses on incorporating increasing confidence into the training. This could occur through incorporating aspects such as role playing into the training to allow them to display and reinforce their ability to apply their knowledge as past research has displayed simulated experiences in training increases reported confidence in clinical skills (Sheen et al., 2021). In addition, perhaps providing the

answers and scores of the quizzes the school psychologists take could be an opportunity not only for school psychologists to gain confidence in what they know, but to also display areas that they may need improvement in and may want to focus more on during their next opportunity for training. Overall, in understanding the utility of a one hour, expert-led, virtual workshop in increasing knowledge of suicide prevention, postvention, laws, and ethics, as well as the application of this knowledge and understanding the factors that can help to best predict this increase in knowledge, future training in these areas for school psychologists can be made more approachable and accessible which ideally can lead to better care for students and can impact the suicide incidence rate amongst children and adolescents.

Appendix A:
Recruitment Flyer- Experts

Dear Expert in Youth/Adolescent Suicide,

You are invited to take part in a research study which seeks to create a measure to gain a greater understanding of school psychologists' knowledge of best practices, ethics, and laws for suicide prevention and postvention in schools. The results of this study aim to improve clinical training in this area. This study is being conducted by Veronica Milito, M.S., a doctoral student in school psychology at St. John's University, Jamaica, New York, under the supervision of Dr. Mark Terjesen, Professor of Psychology, at St. John's University.

Participation in this study will involve no more than 25-30 minutes of your time. Any responses or information that you provide will be kept confidential and be used for research purposes only. Participation in this study is completely voluntary. If you choose to participate, you may access this study online at:

[insert link to survey here]

If you participate, you may also choose to be entered into a raffle to receive one of three $125 Guilford Press gift cards. If you have any questions, please contact Veronica Milito at veronica.milito18@stjohns.edu.

Thank you for your time and consideration.

Appendix B:
Recruitment Flyer- Pilot

Dear School Psychologist,

You are invited to take part in a research study which seeks to gain a greater understanding of school psychologists' knowledge of best practices, ethics, and laws for suicide prevention and postvention in schools. The results of this study aim to improve clinical training in this area. This study is being conducted by Veronica Milito, M.S., a doctoral student in school psychology at St. John's University, Jamaica, New York, under the supervision of Dr. Mark Terjesen, Professor of Psychology, at St. John's University.

Participation in this study will involve no more than 25-30 minutes of your time. Any responses or information that you provide will be kept confidential and be used for research purposes only. Participation in this study is completely voluntary. If you choose to participate, you may access this study online at:

[insert link to survey here]

If you participate, you may also choose to be entered into a raffle to receive one of ten $50 Amazon gift cards. If you have any questions, please contact Veronica Milito at veronica.milito18@stjohns.edu.

Thank you for your time and consideration.

Appendix C:
Demographic Information- Experts

Please answer all of the following questions.

1. What is your gender?
   Male
   Female
   Other

2. Please indicate your age. _____

3. Please select the race/ethnicity group that you identify with.
   American Indian/Alaskan Native
   Asian
   Black or African American
   Caucasian
   Native Hawaiian or Other Pacific Islander
   Hispanic/Latino
   Other: _____
   I prefer not to answer this question

4. Please indicate the highest degree that you have earned
   Bachelor's Degree in _____
   Master's Degree (30+ credits) in _____
   Specialist Degree (60+ credits) in _____
   Doctoral Degree (Ph.D) in _____
   Doctoral Degree (Psy.D) in _____
   Doctoral Degree (Ed.D) in _____
   Other: _____

5. How many years ago did you complete your graduate/training program?
   _____
   Less than one year

6. How many years of professional experience do you have in your present area of work?
   _____

7. Please select your PRIMARY employment setting:

Clinic
Public School
Private School
Hospital
Private Practice
University/College
University/College Center for Psychological Services
In-patient treatment center
Out-patient treatment center
Other _____

8. In what state do you PRIMARILY work in?

_____

9. In the child and adolescent suicide field, please select the area you are PRIMARILY involved with working in.
   Direct work with children and adolescents
   Training of professionals in suicide prevention, postvention, laws, and/or ethics
   Teaching about suicide prevention, postvention, laws, and/or ethics
   Research in the area of child and adolescent suicide
   Creation of policies as it relates to suicide prevention and/or postvention
   Other: _____

Appendix D:
Demographic Information- Pilot and Workshop

Routing Question:
Are you currently engaged in school psychological practice in a school setting for students 18 and under?
Yes (questionnaire continues) No (questionnaire ends)

Please answer all of the following questions.

1. What is your gender?
   Male
   Female
   Other

2. Please indicate your age. _____

3. Please select the race/ethnicity group that you identify with.
   American Indian/Alaskan Native
   Asian
   Black or African American
   White
   Native Hawaiian or Other Pacific Islander
   Hispanic/Latino
   Other: _____
   I prefer not to answer this question

4. Please Indicate the highest degree that you have earned
   Bachelor's Degree in _____
   Master's Degree (30+ credits) in _____
   Specialist Degree (60+ credits) in _____
   Doctoral Degree (Ph.D) in _____
   Doctoral Degree (Psy.D) in _____
   Doctoral Degree (Ed.D) in _____
   Other: _____
5. How many years ago did you graduate from your graduate/training program?
   _____
   Less than one year

6. How many years have you been working as a school psychologist?
   _____

7. Please select your PRIMARY employment setting:

   Public School
   Private School
   Other _____

8. In what state do you PRIMARILY work in?

_____

9. Please select the PRIMARY age/grade level with which you work:
   Early Intervention (0-2 years old)
   Preschool (3-5 years old)
   Elementary Grades (K – 5th grade)
   Middle Grades (6th – 8th grade)
   High School (9th – 12th grade)
   Other: _____

Please indicate your agreement with the following statements:

10. I received adequate training in suicide prevention in my graduate program.

1(strongly disagree), 2, 3 (neither agree nor disagree), 4, 5 (strongly agree)

11. I received adequate training in suicide postvention in my graduate program.

1(strongly disagree), 2, 3 (neither agree nor disagree), 4, 5 (strongly agree)

12. Estimate your level of knowledge about suicide prevention.
1 (not knowledgeable at all), 2, 3, 4 (moderately knowledgeable), 5, 6, 7 (extremely knowledgeable)

13. Estimate your level of knowledge about suicide postvention.
1 (not knowledgeable at all), 2, 3, 4 (moderately knowledgeable), 5, 6, 7 (extremely knowledgeable)

14. Estimate your level of knowledge about laws regarding suicide.
1 (not knowledgeable at all), 2, 3, 4 (moderately knowledgeable), 5, 6, 7 (extremely knowledgeable)

15. Estimate your level of knowledge about ethics involving suicide.
1 (not knowledgeable at all), 2, 3, 4 (moderately knowledgeable), 5, 6, 7 (extremely knowledgeable)

16. During your graduate training program, did you receive formal training in suicide prevention in schools?
1 (no training), 2, 3 (moderate amount of training), 4, 5 (extensive amount of training)

17. During your graduate training program, did you receive formal training in suicide postvention in schools?
1 (no training), 2, 3 (moderate amount of training), 4, 5 (extensive amount of training)

18. During your graduate training program, did you receive formal training in the ethics of suicide prevention and postvention in schools?
1 (no training), 2, 3 (moderate amount of training), 4, 5 (extensive amount of training)

19. During your graduate training program, did you receive formal training in the laws of suicide prevention and postvention in schools?
1 (no training), 2, 3 (moderate amount of training), 4, 5 (extensive amount of training)

20. Please provide the approximate number of courses in your graduate training program that pertained to suicide _____

21. Please provide the approximate total number of hours of suicide training provided in during your graduate training program. _____

22. <u>After your graduate training</u>, have you attended any workshops or conferences that provided training in suicide prevention and postvention? Yes, no

23. *If yes,* How many workshops/conferences have you attended <u>after your graduate training</u> that provided training in suicide prevention and postvention? _____

24. Approximately how many hours of workshops/conferences have you attended <u>after your graduate training</u> that provided training in suicide prevention and postvention? _____

25. Are you involved in the implementation of the crisis intervention plan are your school?
Yes, no

26. *If yes,* Please describe your role in implementing the crisis intervention plan.
    _____

27. Please indicate the approximate number of students you have worked with who have endorsed suicidal ideation _____

28. Please indicate the approximate number of students you have worked with who have attempted suicide _____

29. Please indicate the approximate number of students you have worked with who have died by suicide _____

Appendix E:
Knowledge of Suicide Questions- Experts

Please answer all of the following questions to the best of your ability.

Prevention:

1. Suicide prevention efforts do not need to address non-suicidal self-injury. T, F, DK
2. Bully-victims (students who are bullied and also bully others) are least at risk for suicidal behavior. T, F, DK
3. Non-suicidal self-injury should be recognized and noted in children and adolescents as it is a risk factor for suicide. T, F, DK
4. Schools should implement an empirically supported suicide prevention program. T, F, DK
5. Identifying suicidal behavior and intervening early is critical for preventing suicidal behavior. T, F, DK
6. No members of the crisis team need to know how to conduct a suicide risk assessment. T, F, DK
7. Caregivers cannot provide critical information that may help with determining the level of suicidal risk of the student, as the suicide risk of the student is personal and should not be shared with caregivers. T, F, DK
8. Even if it is determined the student is not in imminent danger, it is recommended that lethal means, such as medications, guns, sharp objects, etc. are made inaccessible. T, F, DK
9. 24-hour community-based referral services do not need to be identified until the event that a student needs to be referred. T, F, DK
10. Schools are obligated to recommend outside agencies for services that offer a sliding scale of fees or are non-proprietary. T, F, DK
11. Suicide contracts are effective and recommended as a strategy to prevent a student from committing suicide. T, F, DK
12. Creating a safety plan with coping strategies and sources of support for when the student feels suicidal is recommended. T, F, DK
13. More females complete suicide than males. T, F, DK
14. Suicide is the second leading cause of death for adolescents aged 10-24. T, F, DK
15. Males have more frequent suicidal ideation and more suicide attempts than females. T, F, DK
16. Males use more lethal means to commit suicide than females such as firearms or hanging. T, F, DK
17. Gatekeeper training programs are effective evidence-based interventions that aim to increase school personnel's knowledge about suicide in youth, warning signs, and risk factors. T, F, DK
18. Screening programs are not an evidence-based approach to early identification of students who may be at risk for suicide and are not recommended for use in schools. T, F, DK

19. Screening programs have two stages: administering the brief screening instrument to identify students at risk, and an individual clinical interview with those identified to determine which students need further support. T, F, DK
20. Screening for suicide risk causes significant distress amongst students. T, F, DK
21. There can be a lot of false positives when screening students for suicide risk depending on what screening instrument is used. T, F, DK
22. Preventing a student's access to lethal means will not prevent suicide as the student will just choose another way to commit suicide. T, F, DK
23. Talking about suicide increases a student's risk for suicidal ideation. T, F, DK

Postvention:

1. After a suicide, it is recommended that students are able to grieve in any way that feels comfortable even if they are sensationalizing suicide by doing things like wearing t shirts with the suicide victim's picture. T, F, DK
2. The facts regarding the student's suicide should not be discussed with the family and/or police. T, F, DK
3. Other schools in the district should not be informed of students related or close to the student who committed suicide as that is a breach of confidentiality. T, F, DK
4. The school should not contact the family to offer condolences and instead should wait for the family to contact the school. T, F, DK
5. The student's personal effects that are at school should be gathered for the family and/or police. T, F, DK
6. Close attention should be paid to other students and staff who may also be at risk for suicide. T, F, DK
7. Schools should assess the level of impact the student's suicide has made on the school community to determine how much postvention support is needed. T, F, DK
8. Adolescents and young adults are least at risk for suicide clusters. T, F, DK
9. Suicide clusters can occur in schools after there has been a suicide. T, F, DK
10. Lasting memorials such as a wall with pictures of the suicide victim are an important part of the grieving process for students and do not sensationalize suicide. T, F, DK
11. Living memorials are recommended such as an event that raises suicide awareness. T, F, DK
12. Pictures of the student who committed suicide should be posted around the school in memoriam. T, F, DK
13. Students should be dismissed early from school upon confirmation that a student committed suicide. T, F, DK
14. If students want to create a permanent memorial such as planting a tree or installing a plaque, it should be done off school grounds. T, F, DK
15. Suicide point clusters (an increase in suicides that occur in a community close in time or space) have not yet occurred in schools. T, F, DK
16. When a student commits suicide, only the student's close friends are at risk for mental health concerns and need ongoing support. T, F, DK

17. A school assembly is beneficial to remember the student who committed suicide and discuss the incident with the school. T, F, DK
18. There should be the same policy in schools for all student deaths regardless of cause. T, F, DK
19. A postvention policy should be established during the prevention phase before a suicide occurs. T, F, DK
20. Buses should be provided for students to attend the funeral if the funeral is held during school hours. T, F, DK
21. Students should be met with in small groups or classrooms to give them accurate information about the suicide, answer questions, and prepare students for what to expect moving forward. T, F, DK
22. The anniversary of a student's suicide should not be acknowledged as it can trigger grief in students and staff. T, F, DK
23. Postvention specialists or mental health professionals from the community should not be brought in to help the school's crisis team as students are most responsive to professionals from the school. T, F, DK

Laws:

1. Documentation is only necessary during psychoeducational assessments and is not necessary during risk assessments. T, F, DK
2. Every school district must create a documentation form for crisis response team members to document their actions. T, F, DK
3. Crisis team members must document communication with the student's caregiver(s). T, F, DK
4. Based on the Family Educational Rights and Privacy Act (FERPA), student information must be kept confidential with no exceptions. T, F, DK
5. All staff members who are responsible for the safety of the student should be provided with only the information necessary to work with the student and keep the student safe. T, F, DK
6. The No Child Left Behind Act states that all schools must have a crisis or safety plan. T, F, DK
7. When signs of suicidal behaviors are observed the student's caregiver(s) does not need to be notified in order to maintain confidentiality and trust with the student if the student does not want their caregiver to know. T, F, DK
8. When it is suspected that child abuse is occurring, protective services should be contacted. T, F, DK
9. My state has the Jason Flatt Act enacted which means every educator in the state must undergo two hours of annual training in suicide awareness and prevention. T, F, DK
10. My state requires school personnel to participate in suicide prevention and awareness training, however it is not on an annual basis. T, F, DK
11. My state has a law in place that makes suicide prevention and awareness training available to school personnel; however, personnel are not mandated to participate in this training. T, F, DK

12. My state requires school suicide prevention, intervention, and postvention policies to be in place in schools by law. T, F, DK
13. My state's law encourages suicide prevention, postvention and intervention policies to be in place in schools, however these policies are not required. T, F, DK

Ethics:

1. School psychologists and mental health professionals have an ethical obligation to identify and risk assess students who are at risk for committing suicide. T, F, DK
2. School Psychologists do not have a code of ethics they are obligated to abide by. T, F, DK
3. Ethically, school psychologists respect the right of students to choose what personal information they disclose. T, F, DK
4. The boundaries of confidentiality should be disclosed with the student before establishing a professional relationship with that student. T, F, DK
5. Confidentiality should not be breached unless asked to do so by the student's caregivers, required by law or if failing to release information would result in danger to the student or to others. T, F, DK
6. All students should have equal access to benefit from school psychological services. T, F, DK
7. School psychologists should engage in any practices students and schools require, even if the school psychologist does not feel fully competent in that area. T, F, DK
8. School psychologists should engage in continued professional development to stay up to date on developments in research and training. T, F, DK
9. School psychologists only need to engage in assessments they feel are proper and are not ethically obligated to engage in evidence-based assessments and practices. T, F, DK
10. School psychologists should collaborate with other mental health professionals in the field to meet the needs of students. T, F, DK
11. School psychologists should be knowledgeable about and respect the laws that pertain to school psychology requirements. T, F, DK
12. School psychologists do not have an ethical responsibility to maintain the safety of the students. T, F, DK
13. Widespread screenings of suicide risk are ethical regardless of whether or not schools are prepared with resources to follow up with students who are found to be at risk. T, F, DK
14. In order to work with this population, school psychologists should be adequately knowledgeable about suicide prevention, postvention, and intervention. T, F, DK

15. Suicidal youth are not any more at risk for marginalization or discrimination by other peers or staff than any other student, so school psychologists do not need to advocate for suicidal youth. T, F, DK

Appendix F:
Knowledge of Suicide Questions- Pilot

Please answer all of the following questions to the best of your ability.

Prevention:

1. Bully-victims (students who are bullied and also bully others) are least at risk for suicidal behavior. T, F, DK
2. Non-suicidal self-injury should be recognized and noted in children and adolescents as it is a risk factor for suicide. T, F, DK
3. Even if it is determined the student is not in imminent danger, it is recommended that lethal means, such as medications, guns, sharp objects, etc. are made inaccessible. T, F, DK
4. 24-hour community-based referral services do not need to be identified until the event that a student needs to be referred. T, F, DK
5. Schools are obligated to recommend outside agencies for services that offer a sliding scale of fees or are non-proprietary. T, F, DK
6. Suicide contracts are effective and recommended as a strategy to prevent a student from dying by suicide. T, F, DK
7. Creating a safety plan with coping strategies and sources of support for when the student feels suicidal is recommended. T, F, DK
8. More females complete suicide than males. T, F, DK
9. Suicide is the second leading cause of death for adolescents aged 10-24. T, F, DK
10. Males have more frequent suicidal ideation and more suicide attempts than females. T, F, DK
11. Males use more lethal means to complete suicide than females such as firearms or hanging. T, F, DK
12. Gatekeeper training programs are effective evidence-based interventions that aim to increase school personnel's knowledge about suicide in youth, warning signs, and risk factors. T, F, DK
13. Screening for suicide risk causes significant distress amongst students. T, F, DK
14. There can be a lot of false positives when screening students for suicide risk depending on what screening instrument is used. T, F, DK
15. Preventing a student's access to lethal means will not prevent suicide as the student will just choose another way to die by suicide. T, F, DK
16. Talking about suicide increases a student's risk for suicidal ideation. T, F, DK

Postvention:

1. After a suicide, it is recommended that students are able to grieve in any way that feels comfortable even if they are sensationalizing suicide by doing things like wearing t shirts with the suicide victim's picture. T, F, DK

2. The facts regarding the student's suicide should not be discussed with the family and/or police. T, F, DK
3. Other schools in the district should not be informed of students related or close to the student who died by suicide as that is a breach of confidentiality. T, F, DK
4. Schools should assess the level of impact the student's suicide has made on the school community to determine how much postvention support is needed. T, F, DK
5. Adolescents and young adults are least at risk for suicide clusters. T, F, DK
6. Lasting memorials such as a wall with pictures of the suicide victim are an important part of the grieving process for students and do not sensationalize suicide. T, F, DK
7. Living memorials are recommended such as an event that raises suicide awareness. T, F, DK
8. Pictures of the student who died by suicide should be posted around the school in memoriam. T, F, DK
9. Students should be dismissed early from school upon confirmation that a student died by suicide. T, F, DK
10. If students want to create a permanent memorial such as planting a tree or installing a plaque, it should be done off school grounds. T, F, DK
11. Suicide point clusters (an increase in suicides that occur in a community close in time or space) have not yet occurred in schools. T, F, DK
12. When a student dies by suicide, only the student's close friends are at risk for mental health concerns and need ongoing support. T, F, DK
13. A school assembly is beneficial to remember the student who died by suicide and discuss the incident with the school. T, F, DK
14. There should be the same policy in schools for all student deaths regardless of cause. T, F, DK
15. A postvention policy should be established during the prevention phase before a suicide occurs. T, F, DK
16. Students should be met with in small groups or classrooms to give them accurate information about the suicide, answer questions, and prepare students for what to expect moving forward. T, F, DK
17. The anniversary of a student's suicide should not be acknowledged as it can trigger grief in students and staff. T, F, DK

Laws:

1. Documentation is only necessary during psychoeducational assessments and is not necessary during risk assessments. T, F, DK
2. Every school district must create a documentation form for crisis response team members to document their actions. T, F, DK
3. Crisis team members must document communication with the student's caregiver(s). T, F, DK
4. Based on the Family Educational Rights and Privacy Act (FERPA), student information must be kept confidential with no exceptions. T, F, DK

5. All staff members who are responsible for the safety of the student should be provided with only the information necessary to work with the student and keep the student safe. T, F, DK
6. The No Child Left Behind Act states that all schools must have a crisis or safety plan. T, F, DK
7. When signs of suicidal behaviors are observed the student's caregiver(s) does not need to be notified in order to maintain confidentiality and trust with the student if the student does not want their caregiver to know. T, F, DK
8. My state has the Jason Flatt Act enacted which means every educator in the state must undergo two hours of annual training in suicide awareness and prevention. T, F, DK
9. My state requires school personnel to participate in suicide prevention and awareness training, however it is not on an annual basis. T, F, DK
10. My state has a law in place that makes suicide prevention and awareness training available to school personnel; however, personnel are not mandated to participate in this training. T, F, DK
11. My state requires school suicide prevention, intervention, and postvention policies to be in place in schools by law. T, F, DK

Ethics:

1. School psychologists and mental health professionals have an ethical obligation to identify and risk assess students who are at risk for dying by suicide. T, F, DK
2. Ethically, school psychologists respect the right of students to choose what personal information they disclose. T, F, DK
3. The boundaries of confidentiality should be disclosed with the student before establishing a professional relationship with that student. T, F, DK
4. Confidentiality should not be breached unless asked to do so by the student's caregivers, required by law or if failing to release information would result in danger to the student or to others. T, F, DK
5. All students should have equal access to benefit from school psychological services. T, F, DK
6. School psychologists should engage in any practices students and schools require, even if the school psychologist does not feel fully competent in that area. T, F, DK
7. School psychologists should engage in continued professional development to stay up to date on developments in research and training. T, F, DK
8. School psychologists only need to engage in assessments they feel are proper and are not ethically obligated to engage in evidence-based assessments and practices. T, F, DK
9. School psychologists should collaborate with other mental health professionals in the field to meet the needs of students. T, F, DK

10. School psychologists should be knowledgeable about and respect the laws that pertain to school psychology requirements. T, F, DK
11. Widespread screenings of suicide risk are ethical regardless of whether or not schools are prepared with resources to follow up with students who are found to be at risk. T, F, DK
12. Suicidal youth are not any more at risk for marginalization or discrimination by other peers or staff than any other student, so school psychologists do not need to advocate for suicidal youth. T, F, DK

Appendix G:
All Knowledge of Suicide Questions with Citations

	Item	Answer	Citation
Prevention	1. Suicide prevention efforts do not need to address non-suicidal self-injury.	F	(American Foundation for Suicide Prevention et al., 2018; National Association of School Psychologists, 2015)
	2. Bully-victims (students who are bullied and also bully others) are least at risk for suicidal behavior.	F	(National Association of School Psychologists, 2015)
	3. Non-suicidal self-injury should be recognized and noted in children and adolescents as it is a risk factor for suicide.	T	(American Foundation for Suicide Prevention et al., 2018; National Association of School Psychologists, 2015)
	4. Schools should implement an empirically supported suicide prevention program.	T	(Miller, 2014; National Association of School Psychologists, 2015)
	5. Identifying suicidal behavior and intervening early is critical for preventing suicidal behavior.	T	(O'Neill et al., 2020; National Association of School Psychologists, 2015)
	6. No members of the crisis team need to know how to conduct a suicide risk assessment.	F	(Boccio & McDonough, 2018; National Association of School Psychologists, 2015)
	7. Caregivers cannot provide critical information that may help with determining the level of suicidal risk of the student, as the	F	(Miller, 2014; National Association of School Psychologists, 2015)

	suicide risk of the student is personal and should not be shared with caregivers.		
8.	Even if it is determined the student is not in imminent danger, it is recommended that lethal means, such as medications, guns, sharp objects, etc. are made inaccessible.	F	(Barber & Miller, 2014; National Association of School Psychologists, 2015)
9.	24-hour community-based referral services do not need to be identified until the event that a student needs to be referred.	F	(National Association of School Psychologists, 2015)
10.	Schools are obligated to recommend outside agencies for services that offer a sliding scale of fees or are non-proprietary.	T	(National Association of School Psychologists, 2015)
11.	Suicide contracts are effective and recommended as a strategy to prevent a student from committing suicide.	F	(Robinson et al., 2013; National Association of School Psychologists, 2015)
12.	Creating a safety plan with coping strategies and sources of support for when the student feels suicidal is recommended.	T	(National Association of School Psychologists, 2015)
13.	More females complete suicide than males.	F	(Curtin & Heron, 2019; Heron, 2019)

14. Suicide is the second leading cause of death for adolescents aged 10-24.	T	(Heron, 2019)
15. Males have more frequent suicidal ideation and more suicide attempts than females.	F	(Curtin & Heron, 2019; Heron, 2019)
16. Males use more lethal means to commit suicide than females such as firearms or hanging.	T	(Barber & Miller, 2014; Callanan & Davis, 2012)
17. Gatekeeper training programs are effective evidence-based interventions that aim to increase school personnel's knowledge about suicide in youth, warning signs, and risk factors.	T	(Boccio & McDonough, 2018; Robinson et al., 2013)
18. Screening programs are not an evidence-based approach to early identification of students who may be at risk for suicide and are not recommended for use in schools.	F	(Boccio & McDonough, 2018; Miller, 2014; Robinson et al., 2013)
19. Screening programs have two stages: administering the brief screening instrument to identify students at risk, and an individual clinical interview with those identified to determine which	T	(Robinson et al., 2013)

	students need further support.		
	20. Screening for suicide risk causes significant distress amongst students.	F	(Boccio & McDonough, 2018; Robinson et al., 2013)
	21. There can be a lot of false positives when screening students for suicide risk depending on what screening instrument is used.	T	(Robinson et al., 2013)
	22. Preventing a student's access to lethal means will not prevent suicide as the student will just choose another way to commit suicide.	F	(Barber & Miller, 2014; Roberts et al., 2013)
	23. Talking about suicide increases a student's risk for suicidal ideation.	F	(American Foundation for Suicide Prevention et al., 2018; Dazzi et al., 2014)
Postvention	1. After a suicide, it is recommended that students are able to grieve in any way that feels comfortable even if they are sensationalizing suicide by doing things like wearing t shirts with the suicide victim's picture.	F	(American Foundation for Suicide Prevention et al., 2018; National Association of School Psychologists, 2015)
	2. The facts regarding the student's suicide should not be discussed with the family and/or police.	F	(Miller, 2014; National Association of School Psychologists, 2015)

3.	Other schools in the district should be informed of students related or close to the student who committed suicide.	T	(O'Neill et al., 2020; National Association of School Psychologists, 2015)
4.	The school should not contact the family to offer condolences and instead should wait for the family to contact the school.	F	(National Association of School Psychologists, 2015)
5.	The student's personal effects that are at school should be gathered for the family and/or police.	T	(National Association of School Psychologists, 2015)
6.	Close attention should be paid to other students and staff who may also be at risk for suicide.	T	(American Foundation for Suicide Prevention et al., 2018; Haw et al., 2013; National Association of School Psychologists, 2015)
7.	Schools should assess the level of impact the student's suicide has made on the school community to determine how much postvention support is needed.	T	(American Foundation for Suicide Prevention et al., 2018; National Association of School Psychologists, 2015)
8.	Adolescents and young adults are	F	(Haw et al., 2013; O'Neill et al., 2020)

least at risk for suicide clusters.		
9. Suicide clusters can occur in schools after there has been a suicide.	T	(Haw et al., 2013; Poland et al., 2019)
10. Lasting memorials such as a wall with pictures of the suicide victim are an important part of the grieving process for students and do not sensationalize suicide.	F	(American Foundation for Suicide Prevention et al., 2018; National Association of School Psychologists, 2015)
11. Living memorials are recommended such as an event that raises suicide awareness.	T	(Lieberman et al., 2019; National Association of School Psychologists, 2015)
12. Pictures of the student who committed suicide should be posted around the school in memoriam.	F	(American Foundation for Suicide Prevention et al., 2018; National Association of School Psychologists, 2015)
13. Students should be dismissed early from school upon confirmation that a student committed suicide.	F	(American Foundation for Suicide Prevention, et al., 2018)
14. If students want to create a permanent memorial such as planting a tree	T	(American Foundation for Suicide Prevention, et al., 2018; National Association of School Psychologists, 2015)

or installing a plaque, it should be done off school grounds.		
15. Suicide point clusters (an increase in suicides that occur in a community close in time or space) have not yet occurred in schools.	T	(Poland et al., 2019)
16. When a student commits suicide, only the student's close friends are at risk for mental health concerns and need ongoing support.	F	(Gould et al., 2014; Poland et al., 2019)
17. A school assembly is beneficial to remember the student who committed suicide and discuss the incident with the school.	F	(American Foundation for Suicide Prevention et al., 2018; Lieberman et al., 2019)
18. There should be the same policy in schools for all student deaths regardless of cause.	T	(American Foundation for Suicide Prevention, et al., 2018)
19. A postvention policy should be established during the prevention phase before a suicide occurs.	T	(Lieberman et al., 2019; National Association of School Psychologists, 2015)

	20. Buses should be provided for students to attend the funeral if the funeral is held during school hours.	F	(American Foundation for Suicide Prevention, et al., 2018)
	21. Students should be met with in small groups or classrooms to give them accurate information about the suicide, answer questions, and prepare students for what to expect moving forward.	T	(American Foundation for Suicide Prevention, et al., 2018; Lieberman et al., 2019)
	22. The anniversary of a student's suicide should not be acknowledged as it can trigger grief in students and staff.	F	(American Foundation for Suicide Prevention, et al., 2018; Owens, 2015)
	23. Postvention specialists or mental health professionals from the community should not be brought in to help the school's crisis team as students are most responsive to professionals from the school.	F	(American Foundation for Suicide Prevention, et al., 2018; O'Neill et al., 2020)

Laws	1. Documentation is only necessary during psychoeducational assessments and is not necessary during risk assessments.	F	(Miller, 2014; National Association of School Psychologists, 2015)
	2. Every school district must create a documentation form for crisis response team members to document their actions.	T	(National Association of School Psychologists, 2015)
	3. Crisis team members must document communication with the student's caregiver(s).	T	(Miller, 2014; National Association of School Psychologists, 2015)
	4. Based on the Family Educational Rights and Privacy Act (FERPA), student information must be kept confidential with no exceptions.	F	(Miller 2014; National Association of School Psychologists, 2015)
	5. All staff members who are responsible for the safety of the student should be provided with only the information necessary to work with the student and keep the student safe.	T	(National Association of School Psychologists, 2015)
	6. The No Child Left Behind Act states that all schools must have a crisis or safety plan.	T	(No Child Left Behind Act, 2011)
	7. When signs of suicidal behaviors are observed the student's	F	(Miller, 2014; National Association of School Psychologists, 2015)

caregiver(s) does not need to be notified in order to maintain confidentiality and trust with the student if the student does not want their caregiver to know.		
8. When it is suspected that child abuse is occurring, protective services should be contacted.	T	(National Association of School Psychologists, 2015; Office of Children and Family Services, 2019)
9. My state has the Jason Flatt Act enacted which means every educator in the state must undergo two hours of annual training in suicide awareness and prevention.	Depends on state	(The Jason Flatt Act, 2007)
10. My state requires school personnel to participate in suicide prevention and awareness training, however it is not on an annual basis.	Depends on state	(American Foundation for Suicide Prevention, 2018)
11. My state has a law in place that makes suicide prevention and awareness training available to school personnel; however, personnel are not mandated to participate in this training.	Depends on state	(American Foundation for Suicide Prevention, 2018)
12. My state requires school suicide prevention, intervention, and postvention policies	Depends on state	(American Foundation for Suicide Prevention, 2018)

	to be in place in schools by law. 13. My state's law encourages suicide prevention, postvention and intervention policies to be in place in schools, however these policies are not required.	Depends on state	(American Foundation for Suicide Prevention, 2018)
Ethics	1. School psychologists and mental health professionals have an ethical obligation to identify and risk assess students who are at risk for committing suicide.	T	(Miller, 2014; Singer et al., 2019)
	2. School Psychologists do not have a code of ethics they are obligated to abide by.	F	(National Association of School Psychologists, 2020)
	3. Ethically, school psychologists respect the right of students to choose what personal information they disclose.	T	(National Association of School Psychologists, 2020)
	4. The boundaries of confidentiality should be disclosed with the student before establishing a professional relationship with that student.	T	(Miller 2014; National Association of School Psychologists, 2020)
	5. Confidentiality should not be breached unless asked to do so by the student's caregivers, required	F	(National Association of School Psychologists, 2020; Office of Children and Family Services, 2019)

	by law or if failing to release information would result in danger to the student or to others.		
6.	All students should have equal access to benefit from school psychological services.	T	(National Association of School Psychologists, 2020)
7.	School psychologists should engage in any practices students and schools require, even if the school psychologist does not feel fully competent in that area.	F	(National Association of School Psychologists, 2010; O'Neill et al., 2020)
8.	School psychologists should engage in continued professional development to stay up to date on developments in research and training.	T	(National Association of School Psychologists, 2020)
9.	School psychologists only need to engage in assessments they feel are proper and are not ethically obligated to engage in evidence-based assessments and practices.	F	(National Association of School Psychologists, 2020)
10.	School psychologists should collaborate with other mental health professionals in the	T	(National Association of School Psychologists, 2020)

	field to meet the needs of students.		
	11. School psychologists should be knowledgeable about and respect the laws that pertain to school psychology requirements.	T	(Miller 2014; National Association of School Psychologists, 2010)
	12. School psychologists do not have an ethical responsibility to maintain the safety of the students.	F	(National Association of School Psychologists, 2020; Singer et al., 2019)
	13. Widespread screenings of suicide risk are ethical regardless of whether or not schools are prepared with resources to follow up with students who are found to be at risk.	F	(Miller, 2014)
	14. In order to work with this population, school psychologists should be adequately knowledgeable about suicide prevention, postvention, and intervention.	T	(Miller, 2014; National Association of School Psychologists, 2020)
	15. Suicidal youth are not any more at risk for marginalization or discrimination by other peers or staff than any other student, so school psychologists do not need to advocate for suicidal youth.	F	(Miller, 2014)

Appendix H:
Prevention and Postvention Vignettes- Experts

1. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith Elementary School in which there are kindergarten through fifth grade students attending. You have been working at this school for five years. Your superintendent is new and has just tasked you with developing a suicide prevention plan for the entire school. How likely are you to implement the following procedures within the suicide prevention plan you develop?

1. Creating a multidisciplinary crisis team trained in the areas of crisis preparedness	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Avoid talking about suicide to discourage suicidal behavior	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Offer a gatekeeper training program for staff and students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Administer a screening instrument to detect students who may be at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Educate only staff and not students about suicide risk factors and warning signs	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Educate students on how and where to receive help and engage in school resources	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Arrange an assembly program about suicide prevention to students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Distribute and review the school suicide prevention policy annually with staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Hold staff accountable for being aware of and properly carrying out suicide prevention policies	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Only focus on preventing suicide in students who have a disorder	Very unlikely	Unlikely	Neutral	Likely	Very Likely

2. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith Middle School in which there are sixth, seventh, and eighth grade students attending. You have been working at this school for five years. Your superintendent is new and has just tasked you with developing a suicide prevention plan for the entire school. How likely are you to implement the following procedures within the suicide prevention plan you develop?

1. Creating a multidisciplinary crisis team trained in the areas of crisis preparedness	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Avoid talking about suicide to discourage suicidal behavior	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Offer a gatekeeper training program for staff and students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Administer a screening instrument to detect students who may be at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Educate only staff and not students about suicide risk factors and warning signs	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Educate students on how and where to receive help and engage in school resources	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Arrange an assembly program about suicide prevention to students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Distribute and review the school suicide prevention policy annually with staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Hold staff accountable for being aware of and properly carrying out suicide prevention policies	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Only focus on preventing suicide in students who have a disorder	Very unlikely	Unlikely	Neutral	Likely	Very Likely

3. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith High School in which there are ninth through twelfth grade students attending. You have been working at this school for five years. Your superintendent is new and has just tasked you with developing a suicide prevention plan for the entire school. How likely are you to implement the following procedures within the suicide prevention plan you develop?

1. Creating a multidisciplinary crisis team trained in the areas of crisis preparedness	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Avoid talking about suicide to discourage suicidal behavior	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Offer a gatekeeper training program for staff and students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Administer a screening instrument to detect students who may be at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Educate only staff and not students about suicide risk factors and warning signs	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Educate students on how and where to receive help and engage in school resources	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Arrange an assembly program about suicide prevention to students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Distribute and review the school suicide prevention policy annually with staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Hold staff accountable for being aware of and properly carrying out suicide prevention policies	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Only focus on preventing suicide in students who have a disorder	Very unlikely	Unlikely	Neutral	Likely	Very Likely

4. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith Elementary School in which there are kindergarten through fifth grade students attending. You have just been notified that one of your fifth-grade students, 10-year-old John, has died by suicide. John left his family a letter stating he no longer wanted to live and accessed his parents' gun which he used to carry out the suicide. John has a seven-year-old sister who also attends Smith Elementary School. The superintendent has now tasked you with creating a postvention plan for the entire school in order to manage the school's reaction to John's suicide. How likely are you to implement the following procedures within the suicide postvention plan you develop?

1. Arrange an assembly to notify the school and mourn the loss of the student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Disseminate truthful information about the suicide to faculty, students, and parents	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Have extra counselors and mental health professionals available on site for students and staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Provide information about where students can go for help both in school and in the community	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Identify other students at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Focus only on providing postvention support to the student's closest friends, unless other students request support	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Make special arrangements to send all students from a class or the school to the funeral	Very unlikely	Unlikely	Neutral	Likely	Very Likely

8. Acknowledge the anniversary of the death and provide additional support during this time for students and staff close to the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Monitor social media to dispel rumors, look for students indicating they may be at risk, and eradicate derogatory messages about the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Establish a permanent memorial such as installing a bench or plaque	Very unlikely	Unlikely	Neutral	Likely	Very Likely

5. Please read the scenario below and answer the following questions.

You are the school psychologist at Smith Middle School in which there are sixth, seventh, and eighth grade students attending. You have just been notified that one of your eighth-grade students, 13-year-old John, has died by suicide. John left his family a letter stating he no longer wanted to live and accessed his parents' gun which he used to carry out the suicide. John has an 11-year-old sister who also attends Smith Middle School. The superintendent has now tasked you with creating a postvention plan for the entire school in order to manage the school's reaction to John's suicide. How likely are you to implement the following procedures within the suicide postvention plan you develop?

1. Arrange an assembly to notify the school and mourn the loss of the student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Disseminate truthful information about the suicide to faculty, students, and parents	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Have extra counselors and mental health professionals available on site for students and staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely

4. Provide information about where students can go for help both in school and in the community	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Identify other students at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Focus only on providing postvention support to the student's closest friends, unless other students request support	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Make special arrangements to send all students from a class or the school to the funeral	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Acknowledge the anniversary of the death and provide additional support during this time for students and staff close to the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Monitor social media to dispel rumors, look for students indicating they may be at risk, and eradicate derogatory messages about the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Establish a permanent memorial such as installing a bench or plaque	Very unlikely	Unlikely	Neutral	Likely	Very Likely

6. Please read the scenario below and answer the following questions.

You are the school psychologist at Smith High School in which there are ninth through twelfth grade students attending. You have just been notified that one of your twelfth-grade students, 17-year-old John has died by suicide. John left his family a letter stating he no longer wanted to live and accessed his parents' gun which he used to carry out the suicide. John has a 15-year-old sister who also attends Smith High School. The superintendent has now tasked you with creating a postvention plan for the entire school

in order to manage the school's reaction to John's suicide. How likely are you to implement the following procedures within the suicide postvention plan you develop?

1. Arrange an assembly to notify the school and mourn the loss of the student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Disseminate truthful information about the suicide to faculty, students, and parents	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Have extra counselors and mental health professionals available on site for students and staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Provide information about where students can go for help both in school and in the community	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Identify other students at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Focus only on providing postvention support to the student's closest friends, unless other students request support	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Make special arrangements to send all students from a class or the school to the funeral	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Acknowledge the anniversary of the death and provide additional support during this time for students and staff close to the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Monitor social media to dispel rumors, look for students indicating they may be at risk, and eradicate derogatory messages about the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Establish a permanent memorial such as installing a bench or plaque	Very unlikely	Unlikely	Neutral	Likely	Very Likely

Appendix I:
Prevention and Postvention Vignettes- Pilot and Workshop

1. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith Elementary School in which there are kindergarten through fifth grade students attending. You have been working at this school for five years. Your superintendent is new and has just tasked you with developing a suicide prevention plan for the entire school. How likely are you to implement the following procedures within the suicide prevention plan you develop?

1. Creating a multidisciplinary crisis team trained in the areas of crisis preparedness	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Avoid talking about suicide to discourage suicidal behavior	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Offer a gatekeeper training program for staff and students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Administer a screening instrument to detect students who may be at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Educate only staff and not students about suicide risk factors and warning signs	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Educate students on how and where to receive help and engage in school resources	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Arrange an assembly program about suicide prevention to students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Distribute and review the school suicide prevention policy annually with staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Hold staff accountable for being aware of and properly caring out suicide prevention policies	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Only focus on preventing suicide in students who have a disorder	Very unlikely	Unlikely	Neutral	Likely	Very Likely

2. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith Middle School in which there are sixth, seventh, and eighth grade students attending. You have been working at this school for five years. Your superintendent is new and has just tasked you with developing a suicide prevention plan for the entire school. How likely are you to implement the following procedures within the suicide prevention plan you develop?

1. Creating a multidisciplinary crisis team trained in the areas of crisis preparedness	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Avoid talking about suicide to discourage suicidal behavior	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Offer a gatekeeper training program for staff and students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Administer a screening instrument to detect students who may be at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
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8. Distribute and review the school suicide prevention policy annually with staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Hold staff accountable for being aware of and properly caring out suicide prevention policies	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Only focus on preventing suicide in students who have a disorder	Very unlikely	Unlikely	Neutral	Likely	Very Likely

3. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith High School in which there are ninth through twelfth grade students attending. You have been working at this school for five years. Your superintendent is new and has just tasked you with developing a suicide prevention plan for the entire school. How likely are you to implement the following procedures within the suicide prevention plan you develop?

1. Creating a multidisciplinary crisis team trained in the areas of crisis preparedness	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Avoid talking about suicide to discourage suicidal behavior	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Offer a gatekeeper training program for staff and students	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Administer a screening instrument to detect students who may be at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
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8. Distribute and review the school suicide prevention policy annually with staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Hold staff accountable for being aware of and properly caring out suicide prevention policies	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Only focus on preventing suicide in students who have a disorder	Very unlikely	Unlikely	Neutral	Likely	Very Likely

4. Please read the scenario below and answer the following questions.

You are a school psychologist at Smith Elementary School in which there are kindergarten through fifth grade students attending. You have just been notified that one of your fifth-grade students, 10-year-old John, has died by suicide. John left his family a letter stating he no longer wanted to live and accessed his parents' gun which he used to carry out the suicide. John has a seven-year-old sister who also attends Smith Elementary School. In addition, John was involved in football and played clarinet in band. The superintendent has now tasked you with creating a postvention plan for the entire school in order to manage the school's reaction to John's suicide. How likely are you to implement the following procedures within the suicide postvention plan you develop?

1. Arrange an assembly to notify the school and mourn the loss of the student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Disseminate truthful information about the suicide to faculty, students, and parents	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Have extra counselors and mental health professionals available on site for students and staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Provide information about where students can go for help both in school and in the community	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Identify other students at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Focus only on providing postvention support to the student's closest friends, unless other students request support	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Make special arrangements to send all	Very unlikely	Unlikely	Neutral	Likely	Very Likely

students from a class or the school to the funeral					
8. Acknowledge the anniversary of the death and provide additional support during this time for students and staff close to the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Monitor social media to dispel rumors, look for students indicating they may be at risk, and eradicate derogatory messages about the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Establish a permanent memorial such as installing a bench or plaque	Very unlikely	Unlikely	Neutral	Likely	Very Likely

5. Please read the scenario below and answer the following questions.

You are the school psychologist at Smith Middle School in which there are sixth, seventh, and eighth grade students attending. You have just been notified that one of your eighth-grade students, 13-year-old John, has died by suicide. John left his family a letter stating he no longer wanted to live and accessed his parents' gun which he used to carry out the suicide. John has an 11-year-old sister who also attends Smith Middle School. In addition, John was involved in football and played clarinet in band. The superintendent has now tasked you with creating a postvention plan for the entire school in order to manage the school's reaction to John's suicide. How likely are you to implement the following procedures within the suicide postvention plan you develop?

1. Arrange an assembly to notify the school and mourn the loss of the student	Very unlikely	Unlikely	Neutral	Likely	Very Likely

2. Disseminate truthful information about the suicide to faculty, students, and parents	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Have extra counselors and mental health professionals available on site for students and staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
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6. Focus only on providing postvention support to the student's closest friends, unless other students request support	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Make special arrangements to send all students from a class or the school to the funeral	Very unlikely	Unlikely	Neutral	Likely	Very Likely
8. Acknowledge the anniversary of the death and provide additional support during this time for students and staff close to the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Monitor social media to dispel rumors, look for students indicating they may be at risk, and eradicate derogatory messages about the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Establish a permanent memorial such as installing a bench or plaque	Very unlikely	Unlikely	Neutral	Likely	Very Likely

6. Please read the scenario below and answer the following questions.

You are the school psychologist at Smith High School in which there are ninth through twelfth grade students attending. You have just been notified that one of your twelfth-grade students, 17-year-old John has died by suicide. John left his family a letter stating he no longer wanted to live and accessed his parents' gun which he used to carry out the suicide. John has a 15-year-old sister who also attends Smith High School. In addition, John was involved in football and played clarinet in band. The superintendent has now tasked you with creating a postvention plan for the entire school in order to manage the school's reaction to John's suicide. How likely are you to implement the following procedures within the suicide postvention plan you develop?

1. Arrange an assembly to notify the school and mourn the loss of the student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
2. Disseminate truthful information about the suicide to faculty, students, and parents	Very unlikely	Unlikely	Neutral	Likely	Very Likely
3. Have extra counselors and mental health professionals available on site for students and staff	Very unlikely	Unlikely	Neutral	Likely	Very Likely
4. Provide information about where students can go for help both in school and in the community	Very unlikely	Unlikely	Neutral	Likely	Very Likely
5. Identify other students at risk for suicide	Very unlikely	Unlikely	Neutral	Likely	Very Likely
6. Focus only on providing postvention support to the student's closest friends, unless other students request support	Very unlikely	Unlikely	Neutral	Likely	Very Likely
7. Make special arrangements to send all	Very unlikely	Unlikely	Neutral	Likely	Very Likely

students from a class or the school to the funeral					
8. Acknowledge the anniversary of the death and provide additional support during this time for students and staff close to the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
9. Monitor social media to dispel rumors, look for students indicating they may be at risk, and eradicate derogatory messages about the deceased student	Very unlikely	Unlikely	Neutral	Likely	Very Likely
10. Establish a permanent memorial such as installing a bench or plaque	Very unlikely	Unlikely	Neutral	Likely	Very Likely

Appendix J:
Consent Form- Experts

Introduction:
As an expert in the field of adolescent suicide, you are being asked to participate in a research study conducted by Veronica Milito and Dr. Mark Terjesen of St. John's University. The decision to participate in this study is entirely up to you. You can decide to stop participating in this study at any time. If you have any questions, you may contact one of the principal investigators.

Procedures:
The purpose of this study is to develop a measure to gain a greater understanding of school psychologists' knowledge of best practices, ethics, and laws for suicide prevention and postvention in schools and the practices school psychologists would implement for a hypothetical case. This research may be useful for professionals who work with children to know as it could affect their clinical training.

If you agree to participate, we request that you read two short hypothetical vignettes and complete a brief questionnaire. We also request you complete a brief questionnaire regarding your background in the field of adolescent suicide. In total, the questionnaires will take approximately 25-30 minutes to complete. All information will be de-identified.

Benefits:
There are no direct benefits to you for your participation in this study. However, the information obtained from this study will further advance the knowledge and understanding of suicide prevention and postvention practices that are being implemented in schools.

Payment to you:
You will be entered into a raffle for a chance to win one of three $125 Guilford Press gift cards.

Risks, Inconvenience, Discomfort:
There are no physical risks involved with participation in this study. The questions included in the survey are not of a sensitive or personal nature, and the likelihood that you experience any psychological distress or discomfort as a result of your participation is negligible, and if you do feel discomfort you can terminate participation immediately without any negative implications for you.

Alternatives:
The alternative to this study is not participating. Your decision to not participate in this study will not have any negative implications for you; you may decide to withdraw from the study at any time.

Confidentiality:
All information from this study will be kept strictly confidential and only seen by the

researchers. If any publications result from this study, you will not be identified. Any data from this study will be reported in aggregate form only; individual data responses will not be reported. Data will be transferred in a HIPAA-compliant manner and will be kept in de-identified, password-protected files.

Questions:

If you have any questions regarding this research study please contact either Veronica Milito or Dr. Terjesen at (718) 990-5860. For questions regarding your rights as a research participant, please contact Dr. Marie Nitopi from the Institutional Review Board at (718) 990-1440.

Thank you very much for your consideration. If you agree to participate, please consent by pressing the button below. Please print a copy of this form for your records.

- I voluntarily give my consent to participate in this research study. I understand that my pressing this button indicates that I have read and understood the information provided here. I understand that my participation is completely voluntary, and that my name will not be tied to the information I am providing. If at any time, I do not wish to further participate, I have the right to withdraw my participation.
- I do not wish to participate

Appendix K:
Consent Form- Pilot

Introduction:
You are being asked to participate in a research study conducted by Veronica Milito and Dr. Mark Terjesen of St. John's University. The decision to participate in this study is entirely up to you. You can decide to stop participating in this study at any time. If you have any questions, you may contact one of the principal investigators.

Procedures:
The purpose of this study is to gain a greater understanding of school psychologists' knowledge of best practices, ethics, and laws for suicide prevention and postvention in schools and the practices school psychologists would implement for a hypothetical case. This research may be useful for professionals who work with children to know as it could affect their clinical training.

If you agree to participate, we request that you read a short hypothetical vignette and complete a brief questionnaire. We also request you complete a brief questionnaire regarding your background in the field of psychology and your general knowledge of suicide prevention and postvention practices. In total, the questionnaires will take approximately 25-30 minutes to complete. All information will be de-identified.

Benefits:
There are no direct benefits to you for your participation in this study. However, the information obtained from this study will further advance the knowledge and understanding of suicide prevention and postvention practices that are being implemented in schools.

Payment to you:
You will be entered into a raffle for a chance to win one of ten $50 Amazon gift cards.

Risks, Inconvenience, Discomfort:
There are no physical risks involved with participation in this study. The questions included in the survey are not of a personal nature, and the likelihood that you experience any psychological distress or discomfort as a result of your participation is negligible. If you do feel discomfort you can terminate participation immediately without any negative implications for you.

Alternatives:
The alternative to this study is not participating. Your decision to not participate in this study will not have any negative implications for you; you may decide to withdraw from the study at any time.

Confidentiality:
All information from this study will be kept strictly confidential and only seen by the researchers. If any publications result from this study, you will not be identified. Any

data from this study will be reported in aggregate form only; individual data responses will not be reported. Data will be transferred in a HIPAA-compliant manner and will be kept in de-identified, password-protected files.

Questions:

If you have any questions regarding this research study please contact either Veronica Milito or Dr. Terjesen at (718) 990-5860. For questions regarding your rights as a research participant, please contact Dr. Marie Nitopi from the Institutional Review Board at (718) 990-1440.

Thank you very much for your consideration. If you agree to participate, please consent by pressing the button below. Please print a copy of this form for your records.

- I voluntarily give my consent to participate in this research study. I understand that my pressing this button indicates that I have read and understood the information provided here. I understand that my participation is completely voluntary, and that my name will not be tied to the information I am providing. If at any time, I do not wish to further participate, I have the right to withdraw my participation.
- I do not wish to participate

Appendix L:
Recruitment Flyer- Workshop

Dear School Psychologist,

You have registered to attend Dr. Scott Poland's three part online workshop "Youth Suicide: Best Practices for Prevention/Intervention and Postvention in Schools". You are being asked to participate in a research study which seeks to gain a greater understanding of school psychologists' knowledge of best practices, ethics, and laws for suicide prevention and postvention in schools. The results of this study aim to improve clinical training in this area. This study is being conducted by Veronica Milito, M.S., a doctoral student in school psychology at St. John's University, Jamaica, New York, under the supervision of Dr. Mark Terjesen, Professor of Psychology, at St. John's University.

Participation in this study will involve taking a questionnaire once before, once immediately after, and once four weeks after attending the one-hour virtual workshop. The questionnaire should take no more than 25-30 minutes of your time. Any responses or information that you provide will be kept confidential and be used for research purposes only. Participation in this study is completely voluntary. If you choose to participate, you may access this study online at:

[insert link to survey here]

If you participate, you may choose to be entered into a raffle for a chance to win one of fifteen $50 Amazon gift cards. For each questionnaire completed (before, after, and four weeks after the workshop), you will receive an additional raffle entry. If you have any questions, please contact Veronica Milito at veronica.milito18@stjohns.edu.

Thank you for your time and consideration.

Appendix M:
Knowledge of Suicide Questions- Workshop

Please answer all of the following questions to the best of your ability.

Prevention:

1. Bully-victims (students who are bullied and also bully others) are least at risk for suicidal behavior. T, F, DK
2. 24-hour community-based referral services do not need to be identified until the event that a student needs to be referred. T, F, DK
3. Schools are obligated to recommend outside agencies for services that offer a sliding scale of fees or are non-proprietary. T, F, DK
4. Suicide contracts are effective and recommended as a strategy to prevent a student from dying by suicide. T, F, DK
5. More females complete suicide than males. T, F, DK
6. Males have more frequent suicidal ideation and more suicide attempts than females. T, F, DK
7. Gatekeeper training programs are effective evidence-based interventions that aim to increase school personnel's knowledge about suicide in youth, warning signs, and risk factors. T, F, DK
8. Screening programs are an evidence-based approach to early identification of students who may be at risk for suicide and are recommended for use in schools. T, F, DK
9. Preventing a student's access to lethal means will not prevent suicide as the student will just choose another way to die by suicide. T, F, DK
10. Talking about suicide increases a student's risk for suicidal ideation. T, F, DK

Postvention:

1. After a suicide, it is recommended that students are able to grieve in any way that feels comfortable even if they are sensationalizing suicide by doing things like wearing t shirts with the suicide victim's picture. T, F, DK
2. Other schools in the district should be informed of students related or close to the student who died by suicide as that is a breach of confidentiality. T, F, DK
3. Lasting memorials such as a wall with pictures of the suicide victim are an important part of the grieving process for students and do not sensationalize suicide. T, F, DK
4. Pictures of the student who died by suicide should be posted around the school in memoriam. T, F, DK
5. Students should be dismissed early from school upon confirmation that a student died by suicide. T, F, DK
6. If students want to create a permanent memorial such as planting a tree or installing a plaque, it should be done off school grounds. T, F, DK

7. Suicide point clusters (an increase in suicides that occur in a community close in time or space) have occurred in schools. T, F, DK
8. A school assembly is beneficial to remember the student who died by suicide and discuss the incident with the school. T, F, DK
9. Students should be met with in small groups or classrooms to give them accurate information about the suicide, answer questions, and prepare students for what to expect moving forward. T, F, DK
10. The anniversary of a student's suicide should not be acknowledged as it can trigger grief in students and staff. T, F, DK

Laws:

1. Documentation is only necessary during psychoeducational assessments and is not necessary during risk assessments. T, F, DK
2. Every school district must create a documentation form for crisis response team members to document their actions. T, F, DK
3. Crisis team members must document communication with the student's caregiver(s). T, F, DK
4. Based on the Family Educational Rights and Privacy Act (FERPA), student information must be kept confidential with no exceptions. T, F, DK
5. All staff members who are responsible for the safety of the student should be provided with only the information necessary to work with the student and keep the student safe. T, F, DK
6. When signs of suicidal behaviors are observed the student's caregiver(s) does not need to be notified in order to maintain confidentiality and trust with the student if the student does not want their caregiver to know. T, F, DK
7. My state has the Jason Flatt Act enacted which means every educator in the state must undergo two hours of training in suicide awareness and prevention that may or may not be done annually. T, F, DK
8. My state requires school personnel to participate in suicide prevention and awareness training, however it is not on an annual basis. T, F, DK
9. My state has a law in place that encourages suicide prevention and awareness training; however, personnel are not mandated to participate in this training. T, F, DK
10. My state requires school suicide prevention, intervention, and postvention policies to be in place in schools by law. T, F, DK

Ethics:

1. School psychologists and mental health professionals have an ethical obligation to identify and risk assess students who are at risk for dying by suicide. T, F, DK
2. The boundaries of confidentiality should be disclosed with the student before establishing a professional relationship with that student. T, F, DK

3. All students should have equal access to benefit from school psychological services. T, F, DK
4. School psychologists should engage in any practices students and schools require, even if the school psychologist does not feel fully competent in that area. T, F, DK
5. School psychologists should engage in continued professional development to stay up to date on developments in research and training. T, F, DK
6. School psychologists only need to engage in assessments they feel are proper and are not ethically obligated to engage in evidence-based assessments and practices. T, F, DK
7. School psychologists should collaborate with other mental health professionals in the field to meet the needs of students. T, F, DK
8. School psychologists should be knowledgeable about and respect the laws that pertain to school psychology requirements. T, F, DK
9. Widespread screenings of suicide risk are ethical regardless of whether or not schools are prepared with resources to follow up with students who are found to be at risk. T, F, DK
10. Suicidal youth are not any more at risk for marginalization or discrimination by other peers or staff than any other student, so school psychologists do not need to advocate for suicidal youth. T, F, DK

Appendix N:
Consent Form- Workshop

Introduction:
You are being asked to participate in a research study conducted by Veronica Milito and Dr. Mark Terjesen of St. John's University. The decision to participate in this study is entirely up to you. You can decide to stop participating in this study at any time. If you have any questions, you may contact one of the principal investigators.

Procedures:
The purpose of this study is to gain a greater understanding of school psychologists' knowledge of best practices, ethics, and laws for suicide prevention and postvention in schools and the practices school psychologists would implement for a hypothetical case. This research may be useful for professionals who work with children to know as it could affect their clinical training.

If you agree to participate, we request that you read a short hypothetical vignette and complete a brief questionnaire. We also request you complete a brief questionnaire regarding your background in the field of psychology and your general knowledge of suicide prevention and postvention practices. In total, the questionnaires will take approximately 25-30 minutes to complete. We are asking you complete this questionnaire once before attending Dr. Scott Poland's one-hour online workshop, "Youth Suicide: Best Practices for Prevention/Intervention and Postvention in Schools," once again immediately after the workshop, and once more four weeks after attending the workshop. All information will be de-identified.

Benefits:
There are no direct benefits to you for your participation in this study. However, the information obtained from this study will further advance the knowledge and understanding of suicide prevention and postvention practices that are being implemented in schools.

Payment to you:
Upon completion of the questionnaire at each time point, participants will receive an additional entry into a raffle for a chance to win one of fifteen $50 Amazon gift cards.

Risks, Inconvenience, Discomfort:
There are no physical risks involved with participation in this study. The questions included in the survey are not of a personal nature, and the likelihood that you experience any psychological distress or discomfort as a result of your participation is negligible. If you do feel discomfort you can terminate participation immediately without any negative implications for you.

Alternatives:
The alternative to this study is not participating. Your decision to not participate in this study will not have any negative implications for you; you may decide to withdraw from

the study at any time.

Confidentiality:
All information from this study will be kept strictly confidential and only seen by the researchers. If any publications result from this study, you will not be identified. Any data from this study will be reported in aggregate form only; individual data responses will not be reported. Data will be transferred in a HIPAA-compliant manner and will be kept in de-identified, password-protected files.

Questions:
If you have any questions regarding this research study please contact either Veronica Milito or Dr. Terjesen at (718) 990-5860. For questions regarding your rights as a research participant, please contact Dr. Marie Nitopi from the Institutional Review Board at (718) 990-1440.

Thank you very much for your consideration. If you agree to participate, please consent by pressing the button below. Please print a copy of this form for your records.

- I voluntarily give my consent to participate in this research study. I understand that my pressing this button indicates that I have read and understood the information provided here. I understand that my participation is completely voluntary, and that my name will not be tied to the information I am providing. If at any time, I do not wish to further participate, I have the right to withdraw my participation.
- I do not wish to participate

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