

The Signs of Suicide (SOS) Prevention Program: A Pilot Study

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Acknowledgements

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Abstract

Suicide is one of the leading causes of death among adolescents in the United States. In recent years there has been increased attention given to suicide and suicidal ideation. It is no secret that depression, self-harming behavior, and suicidal ideation can have a negative impact on social, cognitive, and academic functioning. This pilot study looks at and analyzes the implementation of the Signs of Suicide (SOS) Prevention Program in a suburban high school in Rochester, NY. The study is designed to assess if student knowledge and attitudes towards depression and suicidal ideation changed as a result of the program. The program was implemented in two sections of health class in the fall of 2015. Previous research on suicide education have found that comprehensive prevention education have increased student knowledge and attitudes. This suggests that the SOS program has the potential to have beneficial impact on students' knowledge and attitudes about depression and suicide. In order to gain a clearer sense of the programs benefits additional research would be necessary.

Keywords: suicide, depression, adolescence, school counseling, sos signs of suicide prevention program

The Signs of Suicide (SOS) Prevention Program: A Pilot Study

Suicide is a public health issue among adolescents. Suicide is one of the leading causes of death for youth in the United States (Aseltine & DeMartino, 2004; Katz, Bolton, Katz, Isaak, Tilston-Jones, & Sareen, 2013; Strunk, King, Vidourek, Sorter, 2014). Depression is often a sign that an individual may be suicidal. The literature suggests that the number of adolescents experiencing depressive symptoms has risen in recent years (CDC, 2014; Joe & Bryant, 2007; King, Strunk, & Sorter, 2011; Quiroga, Bisset, & Morin, 2013). According to the American Foundation for Suicide Prevention (2015) the suicide rate in 2000 was 10.4 percent and has steadily risen to 12.6 percent in 2013. While the number has not changed drastically it is a public health issue that needs to be addressed. It begs the question, is there a need to increase education on depression, self-harming behavior, and suicidal ideation in an effort to identify best practices for identification and treatment (Aseltine & DeMartino, 2004; Katz et al, 2013). Depression can impair an adolescents' social, cognitive, and academic functioning. This can lead to academic struggles, school dropout, drug use, alcohol use, or suicide (King et al, 2011; Quiroga et al., 2013; Rotheron, Head, Clark, Klineberg, Cattell, & Stansfield, 2007). Prevention programs have the potential to help adolescents cope with depression, and suicidal ideation.

Research suggests that suicide is the third leading cause of death among adolescents between the ages of 10 and 24 (American Foundation for Suicide Prevention, 2015; Aseltine, James, Schilling, & Glanovsky, 2007; Katz et al, 2013; Jacobs, 2012). In addition to suicide deaths, and the number of reported suicide attempts are alarming. If the number of reported suicides and suicide attempts is alarming, what would the statistics show if all suicides and suicide attempts were reported? In 2014, the Center for Disease Control (CDC) released its annual Youth Risk Behavior Surveillance System (YRBSS) survey results. Of the 13,583 surveys used, 8 percent of those students had attempted suicide one or more times during that 12 month period (Frieden, Jaffe, Cono, et al., 2014). Recognizing and creating awareness may help uncover

prevention and treatment options in a school setting. This is important for school counselors, parents, peers and all other educational personnel because they are in a unique position to directly observe and are often first responders to adolescents struggling with depression, and suicidal ideation (Kirchner, Yoder, Kramer, Lindsey, Thrush, 2000).

The primary goal of this pilot study was to assess whether or not student knowledge and attitudes about depression and suicide changed as a result of the program. This research is important because it will provide a suburban high school in Rochester, New York with data on the effectiveness of the SOS Program. In the spring of 2015 the school district participated in the Monroe County Youth Risk Behavior Survey (YRBS) which has been designed and validated by the CDC (Monroe County Department of Public Health, 2011). “The goals of the survey are: 1.) to assess health risk behaviors among high school students, 2.) to monitor changes in these behaviors over time and 3.) to broadly evaluate the impact of preventive programs” (Monroe County Department of Public Health, 2011, p. 2). A section of the survey asked questions related to mental health, suicidal ideation, and suicide attempts. The 2015 YRBS results for the school district included of 2,862 students, in the four high schools (YRBS, Unpublished results, 2015). The results suggest that there is a need for depression and suicide education. The results showed that:

- 30.51 percent have had serious difficulty concentrating, remembering, or making decisions because of emotional problem.
- 29.20 percent said that in the past 12 months they felt so sad or hopeless almost everyday for two weeks or more in a row that you stopped doing some usual activities.
- 19.63 percent said that they had hurt themselves on purpose by cutting, burning, or bruising etc) without the intention of committing suicide.
- 14.53 percent said that they had seriously considered attempting suicide in the past 12 months.

- 9.34 percent said they had made a plan to attempt suicide in the past 12 months
- 7.60 percent of student said they had attempted suicide at least one time (YRBS, 2015).

These results are concerning because they show that students are at risk. 7.60 percent might seem low to some, but what that means is 214 students attempted suicide. Suicide and depression are treatable. A suicide prevention program can help teach healthy coping skills, and increase student knowledge. The Signs of Suicide (SOS) Prevention Program is a program that can provide students, school staff, and parents with tools on how to deal with issues of depression, self-harm, and suicide. The gap this project addresses is the lack of research on the SOS program.

The SOS program is a comprehensive program that can be utilized by schools. There has been limited research conducted on the SOS program. Yet the findings suggest positive outcomes. There have been a few studies that have evaluated the SOS program. The first study by Aseltine, and DeMartino (2004), found that the program had a significant impact on increasing student knowledge and adaptive attitudes towards suicide and depression. Aseltine, James, Schilling, and Glanovsky, (2007) replicated the previous study and had similar outcomes. They concluded that the SOS program is a useful tool in increasing student knowledge and attitudes about depression and suicide among diverse groups (Aseltine James, Schilling, and Glanovsky, 2007). Aseltine and DeMartino, (2004) stated that their study was the first documented study that had a reduction in self-reported suicide attempts.

The program will be delivered in a classroom setting co-taught by teachers and counselors as part of the health curriculum. Students will be encouraged to participate in each lesson. The lessons are psychoeducational in nature and inform students on how to handle situations that involve depression, self-harm, and suicide. A pretest and posttest will be used to measure student learning. The pretest and posttest are identical. The goals of the tests are to gain a comprehensive understanding of student attitudes and feelings about depression and suicide. In addition to the pretest and posttest participants will fill out a Brief Screen for Adolescent Depression (BSAD).

The BSAD is a self-assessment to help students determine if they need to seek help from a school professional. The BSAD also provides demographic information.

It is hypothesized that as a result of the SOS program student knowledge and attitudes about depression will increase as a result of this program. A secondary hypothesis is that the students who participate in the program will use the tools, and skills learned; and a result help seeking behavior will increase. An increase in help seeking behavior is a secondary goal and will not be measured at part of this evaluation because of the limited time to complete this evaluation. Based on the program results adjustments can be made so that it can be implemented on a larger scale, educating more students about depression and suicide.

Depression Defined

The term depression is defined as a medical condition that involves feelings of sadness or hopelessness that interferes with normal functioning (Merriam-Webster, 2013). Depression can impair typical functioning and lead to self-harm (suicide, cutting) or an increase in risk taking behaviors (e.g. drugs and alcohol use) (King et al., 2011). These feelings are often associated with a mental health diagnosis.

There are a variety of mental health diagnoses that can increase an individual's risk of experiencing suicidal ideation. The SOS program associates symptoms of depression and anxiety with suicidal ideation (Jacobs, 2012). It is worth noting that suicidal ideation is not limited to those two categories and there are often co-occurring diagnoses. For example, the American Psychiatric Association (2013) states that a common feature of all depressive disorders "is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (p 155). Under this category there are a variety of diagnoses (e.g., disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, and substance/medication-induced depressive disorder). Some indicators of depression include but are not limited to: tearfulness, irritability, obsessiveness,

anxiety, academic problems, use of alcohol, use of illegal substances, thoughts of suicide, and acts that involve self-harm (American Psychiatric Association, 2013). When adolescents experience depressive episodes it is often associated with other disorders such as Attention-Deficit disorders, Anxiety Disorders, or Behavioral Disorders (American Psychiatric Association, 2013). Symptoms of depression can manifest in self-defeating thoughts and negative view of the self and there seems to be some connection between those thoughts and academic success (Quiroga et al., 2013).

Certain anxiety disorders also carry a risk for suicidal ideation, disorders such as specific phobias, and panic disorder. Treating depression and suicidal ideation is not a linear process. When an individual breaks a leg there are a set of procedures and steps to treat the injury and healing time is relatively the same for everyone. When an individual is diagnosed with depression treatment will vary. Some people may need counseling others may need a combination of counseling, and medication. That is why it is so important for counselors to gather as much information about the person before beginning a treatment plan. There are a variety of contributing factors and co-occurring diagnoses and symptoms that contribute to what an individual may be experiencing. For example, an individual diagnosed with specific phobia may be more likely to attempt suicide; which could be due to the presence of an additional diagnosis and other contributing factors like a biological/neurological response to psychotropic medications (e.g., side effects). Based on reported incidence and data on suicide, there are specific populations that seems to be at a higher risk for depression and suicidal ideation. Depressive disorders are reported more often in females than in males but there is no significant difference in symptoms or treatment (American Psychiatric Association, 2013; Masi, Sbrana, Poli, Tomaiuolo, Favilla, & Marcheschi, 2000). It is important for school counselors to create a space where students feel comfortable and safe to express their thoughts and feelings. Counselors need to be mindful and take all warning signs seriously and consult with professionals when developing a treatment plan for someone who may be struggling with depression or suicidal ideation. Treatment is specific to each person, what works on one

person may not be an effective method for another. It may be necessary to use multiple treatment methods such as individual or group therapy.

Depression often begins in adolescence and if not treated can impair individuals long into adulthood (Kirchner et al., 2000). Depression and depressive disorders can be very complex and should not be taken lightly. The goals of school counselors and other educational personnel are to improve academic achievement, personal and social development, while minimizing the negative environmental and institutional road blocks (American Counseling Association, American School Counselor Association, National Education Association, 2008; Education Trust, 2009). Depression is one of these road blocks that can impair success in the classroom. The purpose of teaching adolescents about depression and suicide is to create awareness, coping skills, helping strategies. By gaining a better understanding of depression and challenging societal stigmas associated help create awareness about mental illness. Awareness and prevention should be a comprehensive approach and involves all those entrusted with the education of students. The SOS program is a program designed to engage and create awareness not only for the students but all those involved in the community.

Adolescent Development

Over the course of human life people grow in stages both physically and mentally. Adolescence is a period of time when human development changes exponentially. Many of these physical and mental changes happen concurrently, and these changes can impact multiple aspects of one's life.

Adolescence has been defined as a developmental period that starts with puberty and ends when an individual achieves independence (American Psychology Association, 2002; Blakemore & Robbins, 2012). Previous research studies and a review of the literature identifies the range of age for adolescents to be between 10 to 24 (American Psychology Association, 2002; Berk, 2010; Blakemore et al., 2012; Jung, Pick, Muller, Schmeck, Goth, 2013; Kirchner et al., 2001; Spenrath,

Clarke, Kutcher, 2011). The general consensus is that during adolescence cognitive, physical, social, emotional and behavioral changes occur intrapersonal, and interpersonally (American Psychology Association, 2002; Spenrath et al., 2011). This development involves nature and nurture concept. During puberty, an adolescent is impacted by internal (nature) and external (nurture) influences that play a role in cognitive, physical, social, emotional, and behavioral development (American Psychology Association, 2002; Spenrath et al., 2011).

Research has discovered specific ways the brain develops during adolescence. For example, Schwartz (2008) and Steinberg (2012) outlined structural changes that occur during this time. There is a decrease in grey matter in the prefrontal cortex regions of the brain. This means a pruning of synaptic connections has an impact on the improvement of cognitive abilities and logical reasoning. There is an increase in neurotransmitter dopamine activity as well. Dopamine has an effect on pleasure, and during puberty the connections pathways become denser, and as a result, affect the part of the brain where emotions are processed. There is an increase in white matter in the prefrontal cortex. During this part of brain development, brain circuits become more efficient and as a result information is processed faster. There is an increase in the strength of connection between the prefrontal cortex and the limbic system. The strength of this connection plays a role in emotion regulation and self-control. While the brain is developing, adolescents are exposed to new emotions, new experiences, and trying to figure out how they fit into the world (Schwartz, 2008). These changes can increase adolescent vulnerability, and can play a role in their decision making process. During this period of brain development, it is typical for adolescents to make uninformed decisions because parts of their brain are still developing. Often adults assume that because adolescents are young and still developing that adolescents are defective (Steinberg, 2013). This is not the case. The adolescent mind is growing and is capable of learning which, can be influenced by the environment that surrounds them (Steinberg, 2013). With adequate support and education adolescents can be informed about depression and how they can reach out for help

and support. Depression cannot be cured or fixed, by one single intervention. Depression is complex and there are many factors that influence depression. Depression can impact social-emotional, career, and academic functioning. It is like the African proverb it takes a village to raise a child. In order to help adolescents with depression it takes the combined work of the individual, families, friends, counselors, educators, and the community. These brain developments during adolescence show that adolescents are at a critical stage in development, which can increase their chances of being harmed, wounded, and isolated (Schwartz, 2008). The combination of support and education of all stakeholders can help equip teens with strategies and skills on how to deal with feelings of depression and suicidal ideation.

Importance of Awareness and Prevention

There are several treatment options for depression in adolescents, but many of them are not appropriate for school counselors. Commonly used treatments for depression are psychotherapy and a prescription medication. There are claims that these treatments have been ineffective in adolescents (Brown, Pearson, Braithwaite, Brown, & Biddle, 2013; Ruble, Leon, Gilley-Hensley, Hess, Swartz, 2013). Intensive psychotherapy and prescribing perception medication are out of the scope of practice for school counselors. School counselors can provide some mental health support, but because of high caseloads and time restrictions providing students with enough support can be challenging. Additionally, it is not within the scope of practice to diagnose or prescribe perception medication. How can school counselors help support adolescents who are struggling academically because of depression or suicidal ideation? School counselors can refer students and parents to community resources or other school resources as well as provide students with support while they are in school. Adolescents spend a great deal of time in a school setting which gives school counselors an opportunity to address issues of depression, self-concept, suicide, and the importance of seeking help (King et al., 2011; Watkins, Ellickson, Vaiana, & Hiromoto, 2006). School counselors also provide students with the necessary academic support. An

appropriate treatment or intervention for school counselors is to use a comprehensive school based prevention program like the SOS program. The program teaches students how to identify the signs and symptoms of suicide and depression and how to intervene if they or someone they know is experiencing depression or suicidal ideation.

An important part of any depression and suicide prevention and awareness program is the duration of the program. For a program to be effective it must be conducted over a period of time, and not just a single lesson or session (King et al., 2011; Kirchner et al., 2000). This can be done through classroom lessons, follow up and providing individualized care to those students who need it. Depression and suicide are serious issues among adolescents, and change cannot occur over the course of one 40 minute classroom lesson. If an awareness and prevention program is implemented and is supported by counselors, teachers, administrators, parents, and students, it could benefit the entire school community and may have the potential to improve students' academic achievement. The CDC (2010) data suggests that students who have D's and F's are more likely to feel sad and hopeless, consider suicide, make a plan, and attempt suicide. Academic performance is connected to both self-concept and self-esteem. For example poor performance on a test may cause a student to question their intelligence thus lowering their self-esteem (Masi et al., 2000).

Another important part of an effective prevention and awareness program targets the whole population not just the target group, which in this case would be depressed adolescents (Rivet-Duval, Heriot, & Hunt, 2011). This is an important aspect of a program because everyone learns about what depression is and how they can help. The goal is twofold: 1) to teach students, parents, teachers, and administrators, how to recognize signs and symptoms of depression and suicide, and 2) to assist them with ways of coping and reaching out for support (King, et al., 2011). Awareness and prevention of depression and suicide involves education of everyone in the school community. In 1999 the Surgeon General recommended that all human service professions receive training in

suicide prevention (King, et al., 2011; Kirchner, et al., 2000). Educating and training educational personnel and parents will give them the tools to effectively help and support students who come to them with issues surrounding depression and suicide (Kirchner, et al., 2000). There are several approaches school counselors can use to educate parents and staff about suicide and depression. Counselors can have parent or staff meeting in the school auditorium or gym. In addition to a parent or staff meeting, counselors could provide a packet of information including signs and symptoms of depression and suicide, and a list of community resources. Another option is to have parents and school staff take an online training course that focuses on depression and suicide prevention. The program that The SOS program suggests is The SOS Signs of Suicide Online Gatekeeper Training (Tuffs University, 2015).

Signs of Suicide (SOS)

Using a program like Signs of Suicide (SOS) for High Schools may help increase knowledge on how one can respond to depression or suicidal ideation. The SOS program is an evidence based approach that teaches awareness and screens students for depression, suicide and other related behaviors (Aseltine & DeMartino, 2004). The seven goals of the SOS program are (Jacobs, 2012)

- decrease suicide and suicide attempts by increasing knowledge and adaptive attitudes about depression among students;
- encourage individual help-seeking and help-seeking on behalf of a friend;
- link suicide to mental illness that, like physical illness, requires treatment;
- engage parents and school staff as partners in prevention by educating them to identify signs of depression and suicidality in youth by providing information about available resources;
- reduce stigma associated with mental health problems by integrating the topic into existing health curriculums;

- increase self-efficiency and access to mental health services for at-risk youth and their families;
- encourage schools to develop community-based partnerships to address issues associated with student mental health (Jacobs, 2012)

The program uses the acronym ACT to create steps for students to follow if they are experiencing or suspect a friend is experiencing depression or suicidal ideation. “A” stands for acknowledge the signs. “C” stands for care or letting the person know that you care. “T” stands for tell a trusted adult (Jacobs, 2012). Educating students and giving them steps they can follow can help empower adolescents to seek help for themselves or their friends (Aseltine & DeMartino, 2004). One of the reasons why it is so important to empower adolescents to ACT is because “peer groups become the primary sphere of social involvement and social investment” (Aseltine & DeMartino, 2004, p. 446). A benefit to the SOS program is how simple the implementation of the program can be. School Counselors, administrators, and teachers are often overworked and find it difficult to fit one more thing into their curriculum. The SOS program does not require time consuming staff training and information can be easily taught, and distributed to all stakeholders.

Conclusion

In conclusion, depression can impact adolescent academic achievement which can lead to issues in adulthood. One of the primary goals of all schools is to teach students the tools that are necessary to become contributing members of society (American School Counselor Association, 2015). The literature suggests that depressive symptoms along with other factors have the potential to impede the academic success of adolescents (Quiroga et al., 2013). Adolescence is a developmental period where there seems to be an increased risk to develop issues of negative self-concept, depression, and suicide ideation (Quiroga et al., 2013). Using the Signs of Suicide (SOS) prevention program can assist in addressing these issues before they start. Depression is a complex issue and there is no simple or perfect solution to the issues that surround depression.

The following is a pilot study of the SOS Program. The main goal of this program review is to provide Greece Central School District with data on the effectiveness of the SOS Program and provide students, school staff, and parents with tools on how to deal with issues of depression, self-harm, and suicide. The gap this project addresses is the lack of research on the evaluation of the SOS Program. The objective of this pilot study is to assess if the goals of the SOS Program are being met. It is predicted that as a result of the SOS program there will be an increase in knowledge and attitudes about depression and suicide.

Method

Participants

This pilot study includes eight students enrolled in health classes at Greece Arcadia High School in Rochester, New York who provided parental consent. Of the eight students who provided parental consent only seven students were present the day the demographic data was collected. The one student missing was absent the day the demographic data was collected. Participant ages were between 15 and 16; six students were 15 years old and one student was 16 years old. There were six females and one male. All Participants were in the 10th grade. Five students identified their race as white, one identified as African American, and one identified as other/multiracial.

Sampling Procedures

The SOS program was purchased by the district in response to a student's suicide in June of 2012. Selection of the participants was a tedious task that involved extensive planning and gathering of materials. The process began in January of 2015 and the program was implemented in October 2015. Planning took place over the course of two school years. In the state of New York students end the school year in June and start the year in September, giving students a summer break in between each school year. During the summer months there was a pause in the planning process because school staff was not required to work throughout summer.

Planning and implantation of this pilot study required approval of the counseling staff, principal, Brockport faculty supervisor, and the Institutional Review Board at The College at Brockport, State University of New York. Approval from the counseling staff was given in February of 2015. Approval from the high school principal and Brockport faculty supervisor was given in April of 2015. IRB approval was given in September of 2015.

In anticipation of approval planning for the program was co-occurring. Initially, the goal for this evaluation was to deliver it to all students in grades 9-12. As the logistics of delivery of the program unfolded it became clear that delivering the program to the entire high school would not be possible based on time and the availability of staff. Through discussing logistical issues with colleagues and supervisors a connection was made with the health teacher. After she agreed to assist in delivering the program the teacher and researcher decided it was logical to deliver the program in the all the health classes in the fall 2015. Choosing to implement this program in the health classes was a logical choice for several reasons;

- depression and suicide are topics already covered in the health curriculum
- the program did not disrupt instruction of other classes like English or social studies
- ability to implement the program on a smaller scale
- because health is a required course all students would be exposed to the program in their high school career
- allowed access to students on a manageable scale
- allowed program evaluation completion based on time restraints of the researcher

Between January 2015 and October 2015 there were several meetings with the health teacher about how to implement the program. During this time it was determined that three classroom lessons would be appropriate to address all the material provided in the program. The focus of all three lessons is to teach students about depression and suicide, and how to respond if the warning signs are present in themselves, a friend, or a loved one. It was also decided that the

lessons would be co-taught with the health teacher and the counselor. Implementation of the program occurred during a one week period in October of 2015. The three lessons occurred during three separate 55 minute classroom periods. The first class received lesson one on Monday, lesson two on Wednesday, and lesson three on Thursday. The second class received lesson one on Tuesday, lesson two on Wednesday, and lesson three on Thursday.

These data were collected through a pretest and a posttest assessing student learning associated with the learning goals for the program. The pretest was conducted in the classroom before the first lesson began. Posttest data were collected at the conclusion of the third lesson. In order to participate in the program students needed parental permission. Students also needed to sign a statement of minor assent before the first lesson began.

One week prior to the implementation information about the program and a community recourses list was provided to parents/guardians and staff. Packets were mailed home to parents/guardians. Staff materials were placed in their school mail boxes. [Copies of the informed consent and assent forms can be found in the appendices.] Student safety was addressed because the discussion of depression and suicide are sensitive topics and it is important to create a safe space for student learning and discussion these topics. Staff, parents, and students were provided with resources they could use to help a student who may be in need. The Friday before the program was to begin students were reminded about the program and given additional consent forms because some students and parents reported that they did not receive the packets that were mailed home. As a result, only eight students returned parental consent forms prior to the first lesson.

Sample Size, Power, and Precision

There were 55 total students split into two sections; one section had 24 students and the second section had 31 students. Only eight students participated in the evaluation, four from each section. All students enrolled in the class were exposed to the program because it was integrated

into the health curriculum. Only the students who returned their consent forms signed by a parent/guardian and signed the assent form were included in the sample.

The sample size was determined because health is a required class that students must pass in order to receive a high school diploma in New York State. Students were recruited according to their enrollment in health class during the first half of the school year.

Pretest and posttest data were collected from all students who provided consent. Health is only a half year course so only students enrolled in health in the first two semesters of the school year received the program.

Measures and Covariates

There were two measures used in this evaluation. The first was the pretest and posttest, which are identical. The second was the Brief Screen for Adolescent Depression (BSAD). Both can be found in the appendices. The questions in the pretest and posttest were adapted from the University of Connecticut Health Center's Health Behavior Survey assessing knowledge and attitudes about suicide and depression (University of Connecticut Health Services, 2009). A copy of the pretest and posttest was provided by an employee of the SOS program. The pretest and posttest are not part of the SOS program, but the staff member stated that this was an assessment tool that other districts have used in the past. The Pre/Post SOS Program Questionnaire – Long Version has three parts. Part one includes seven true or false items assessing their knowledge about depression and suicide (e.g., “Most suicide attempts occur without any warning signs;” “Depression is an illness that doctors can treat”). Scores were assessed on the amount of correct responses. Part two includes four items scored on a five point scale ranging from “strongly disagree” or “strongly agree”. These items assessed attitudes about depression and suicide (e.g., “If someone really wants to kill himself/herself, there is not much anyone can do about it”). Part three includes five items measured on a five point scale ranging from “strongly disagree” to “strongly agree.” These items assessed what a student would do if their friend is thinking about

committing suicide (e.g., “I wouldn’t know what to do”; “I would keep it to myself”). Students that left items blank were excluded from the final analysis. In total one pretest was excluded because that participant left items blank, and two posttests were excluded because one participant left items blank and another was absent. Although not ideal, likewise deletion was used in order to compare the results of the participants who fully completed the pretest and posttest (Osborne, 2013). This allowed the number of participants analyzed to be as consistent as possible.

Descriptive statistics were used to analyze pretest and posttest data.

The BSAD was a self -assessment and was included as part of the program. Only the demographic information was used in this program evaluation. The BSAD is a self-assessment and is not intended to assess student learning. That is why the responses to the items in the form were not part of the program evaluation.

Research Design

Participants in the program were exposed to three classroom lessons that were 55 minutes each. The lessons were educational in nature. Participants took a pretest before the first lesson began and a posttest at the conclusion of the third lesson. The reasoning for pretest and posttest data collection was to learn what students knew prior to the lessons and assess what they learned as a result of the lessons.

Experimental Interventions

The objectives of the lessons were to teach the signs and symptoms of depression and suicide and, the ACT acronym (Acknowledge, Care, Tell).

Lesson one: Before the first lesson was delivered students were asked to fill out the pretest. Students watched the Friends for Life DVD and a class discussion followed. At the conclusion of the first lesson students were asked to fill out a student response card, informing the researchers if they need to see someone based on what they saw in the video. The response cards were collected and students who needed follow-up were contacted.

Lesson2: This lesson was designed to build upon what was learned in lesson one. Students were expected to take what they learned in the first lesson and communicate and discuss what the warning signs are. For this lesson students were asked to create a skit and present it to the class about a friend showing signs and symptoms of depression and suicidal ideation. Each group had to insert four or five warning signs in their skit. Examples of warning signs were provided to the students.

Lesson 3: This lesson was a conclusion of the program which involved a class discussion of the myths and facts of depression and suicide. At the conclusion of the third lesson students were asked to read and fill out Brief Screen for Adolescent Depression (BSAD), and the posttest. The pretest and posttest were identical and student responses remained anonymous. [All three lesson plans can be found in the appendices section].

Data Management

To ensure confidentiality participants were instructed not to put their names on the pretest or the posttest. Also, participants were not given identification numbers or coded in any way. The rationale for this was to protect participant's confidentiality and the primary function of this pilot study was to assess if the group learned anything as a result of the program. All data that was collected was locked up and kept in a confidential space.

Data Analysis

Descriptive statistics were used to analyze these data collected in the pretest and posttest. Additional tests will not be analyzed because the sample size is too small. The pretests and posttests will assess knowledge and attitudes by analyzing responses to questions before and after the lessons to see if a change has occurred. The data will be reported in percentages.

Results

The results of this pilot study were evaluated using descriptive statistics. Additional tests such as t-tests or chi-squared were not used because the sample size was not large enough and is

not representative of the population in the school. Additionally, when conducting a t-test, a random sample group is needed and there was no access to a sample group of students to deliver the pretest and posttest. The results of the pretest include an N=7, one participant's responses were excluded because some items were missing. The results of the posttest include an N=6, one student was absent from the posttest and one student left some items missing.

The results from part one asked participants to respond true or false to statements which included questions one through seven. Questions one, two, five, and seven showed no significant change between the pretest and posttest. In question one the pretest and posttest showed that 85% (n=6) and 83% (n=5) of the participants said people who talk about suicide don't really kill themselves was a false statement. Question two, in both the pretest (n=7) and posttest (n=6) 100% responded true to the statement that people who commit suicide are usually suffering from depression or some other mental illness. Question five revealed that 71% (n=5) in the pretest and 83% (n=5) think that the best thing to tell a suicidal friend is to pull yourself together and things will get better is a false statement. The responses to questions one, two and five showed that participants had previous knowledge about suicide and depression prior to the implementation of the SOS program. Question seven revealed that 86% (n=6) in the pretest and 83% (n=5) in the posttest thought that alcohol use is not related to suicidal behavior was a true statement. Questions seven indicates that students did not make the connection that alcohol use could be a sign of someone experiencing depression or suicidal ideation.

Question three states that most suicide attempts occur without any warning signs or clues. Only 42.9% (n=3) said this statement was true in the pretest. The posttest showed that 66.7% (n=4) said this statement was true. Question four states that depression is an illness that doctors can treat. The pretest showed that 71.4% (n=5) thought this statement was true. 100% (n=6) said that statement was true in the posttest. Question six states that if I talk to someone about their suicidal feelings, it may cause them to commit suicide. In the pretest 71.4% said this statement was false

while 50% said this statement was false in the posttest. The results of questions three, four, and six suggest that knowledge about depression and suicide increased between the pretest and posttest.

Part two has four items and responses ranged strongly disagree to strongly agree. Item one reads sometimes young people have so many personal problems they have no other options besides suicide. The pretest, 57.1% (n=4) stated that they neither agreed nor disagreed. The posttest show different results 0% (n=0) chose neither, while 66.6% (n=4) disagreed or strongly disagreed and 33.4% (n=2) agreed or strongly agreed. Item two ask if someone really wants to kill himself/herself there is not much anyone can do about it 100% (n=7) in the pretest and 100% (n=6) in the posttest said that they disagree or strongly disagree with that statement. The same was true for item three 100% of respondents in both pretest (n=7) and posttest (n=6) disagreed or strongly disagreed to the statement that it's none of my business if a friend says he/she wants to kill himself/herself. Item four asks if I were feeling really down, I would talk to a counselor or some other adult about my problem. The pretest revealed that 14.3% (n=1) disagreed, 42.9% (n=3) neither agreed nor disagreed and 42.9% (n=3) agreed or strongly disagreed. The posttest results are as follows; 16.7% (n=1) disagree, 16.7% (n=1) neither agreed nor disagreed and 66.7 (n=4) agreed or strongly agreed. The result showed an increase in willingness to seek help.

Part three has five items with responses ranging from strongly disagree and strongly agree. If a friend told me he/she is thinking of committing suicide I wouldn't know what to do the results showed a regression between the pretest and posttest. 71.5% (n=5) disagreed or strongly disagreed, while only 66.6 % (n= 4) disagreed or strongly disagreed in the posttest. The majority of participants disagreed or strongly disagreed in pretest and posttest when asked if a friend told me he/she is thinking of committing suicide I would keep it to myself. The majority of participants disagreed or strongly disagreed in the pretest and posttest when asked if a friend told me he/she is thinking of committing suicide I would wish that I had not found out about it. If a friend told me he/she is thinking of committing suicide I would keep it a secret if my friend made me promise not

to tell, 42.9% (n=3) neither agreed or disagreed 57.1% (n=4) disagreed or strongly disagreed. The posttest showed that 83.3% (n=5) disagreed or strongly disagreed. When asked if a friend told me he/she is thinking of committing suicide I would tell and adult, 85.7% (n=6) said they agree or strongly agree, while only 66.6% (n=4) responded that way in the posttest.

Discussion

The purpose of this pilot study was to assess the effectiveness of the SOS program in a suburban high school. Specifically, this study sought to determine if investigated students' knowledge and attitudes about depression and suicide changed as a result of experiencing the SOS program. The district is interested in the outcomes of this pilot study to assess if they want to implement the program on a larger scale. The data from this study suggest that students' knowledge increased as a result of experiencing the program. This result is similar to the findings of two other studies that evaluated the SOS program. Aseline and DeMartino, (2004) and Aseltine et al., (2007) found that students' who participated in the SOS program had a significant increase in knowledge about suicide and depression as a result of participating in the program.

The results are inconclusive when it analyzing attitudes about suicide and depression. Based on the results students' were hesitant to see help for someone else. This finding contradicts previous research. The research found that in addition to an increase in students' knowledge, attitudes and adaptive behaviors increased, which resulted in fewer reported suicide attempts (Aseline and DeMartino, 2004; and Aseltine et al., 2007). Although data on suicide attempts was not collected as part of this pilot study, three students' that participated in the SOS program sought help about feelings of depression or suicidal ideation from a trusted adult the week the SOS program was implemented. These students' either expressed a concern for themselves or someone else.

Limitations

The present research attempted to measure the benefits of the SOS program, yet there were several limitations that influenced the outcomes. First, IRB approval was received only 18 days before the program was implemented. Late IRB approval impacted planning and implementation of the program. As a result, the research design was weak and consent forms were mailed home to parents 16 days before the program was to begin. The research design was weak for several reasons:

- The researcher had limited experience collecting data.
- Some consent forms were returned minutes before the first lesson was going to begin. This made it impossible to give participants' identification number and their scores on the pretest could be compared to their posttest.
- The return rate for parental consent was extremely low of the 55 students eligible to participate in the study only eight returned the forms.
- Students reported that their parents never received anything in the mail.

Second, there were time restrictions to complete the pilot study from start to finish. The time restriction impacted planning because there was a two month period for summer break when planning was postponed. Also, the pilot study had to be completed within a college semester as part of a graduation requirement.

Third, the research can only be generalized to the students enrolled in health at the time the study was conducted. The reason for this is because participants were not given identification numbers. As a result demographic data, pretest, and posttest were not connected to one another. This made it impossible to analyze the SOS programs effect on race, ethnicity, gender and age.

Fourth, the results are statistically insignificant because the sample size was too small and did not represent the population of the school or community. Asestine et al., (2007) had a sample

size of over 4,100 and determined that the SOS program was efficient in increasing knowledge and attitudes about depression and suicide across race, ethnicity, gender, and age.

Implications for Future Research

Based on the outcomes of this pilot study, there are implications for future research that should be considered. First, increasing the number of researchers involved in planning and implementation of the program. When time restraints are placed on research additional researchers could help improve the quality of research, strengthen research design, or help increase the number of participants. Based on the limitations described earlier it is evident that time restrictions and limited experience conducting research impacted the results. Numbering or tracking participants would provide information about how different demographic groups responded to the SOS program. This is important because many school districts serve diverse populations and knowing the program's effectiveness across demographic groups is important when determining if the SOS program is an appropriate program of a school district. Another suggestion would be to modify the pretests and the posttest so that it included demographic data. Doing this would limit the amount of papers being handed out to students and make tracking or identifying students easier. Lastly, it may be beneficial to deliver the pretest and posttest a week before and a week after the lessons are implemented. This would help maximize classroom time to deliver the classroom lessons.

Implications for Counselors

Implementation of the SOS program has potential implications for school counselors. Previous research suggests that this program can increase student knowledge and attitudes about depression and suicide and decrease the number of reported suicide attempts (Aseltine & DeMartino, 2004; Aseltine, et al., 2007). First, the program could be an effective and comprehensive tool for counselors to use as part of their comprehensive school counseling curriculum. Second, the lessons incorporate ASCA Mindsets & Behaviors for Student Success which are part of a comprehensive school counseling program. ASCA Mindsets & Behaviors for

Student Success “describe the knowledge, skills and attitudes students need to achieve academic success, college and career readiness, and social/emotional development” (American School Counselor Association, 2015). School Counselors perform many tasks and wear many hats which can make planning new programming challenging. The SOS program could help counselors save time in the planning process because the program provides counselors with a guide, resources, and support on implementing the program.

Conclusion

It is no secret that suicide is a serious public health issue among adolescents. Suicide is one of the leading causes of death for adolescences, which is a preventable death (American Foundation for Suicide Prevention, 2015; Aseltine, et al., 2007; Katz et al, 2013; Jacobs, 2012). Previous research suggests that implementing a comprehensive program like the SOS program has the potential to increase knowledge and attitudes towards depression and suicide and decrease the number of suicide attempts among students’ who are exposed to the program (Aseline and DeMartino, 2004; and Aseltine et al., 2007). This pilot study found that student knowledge increased, but further research is necessary to gain more conclusive results. This is important because school counselors, parents, peers and all other educational personnel are in a position to directly observe and are often first responders to adolescents struggling with depression, and suicidal ideation (Kirchner, Yoder, Kramer, Lindsey, Thrush, 2000). The SOS program can teach all stake holders how to respond. Part of the School Counselors role to help students in areas of academic, social/emotional, and career development, so that they can become well-adjusted members of society (American School Counselor Association, 2015). The SOS program can help students become successful in those areas. This matters because a student who struggles with depression or suicidal ideation can increase their chances of facing academic failure and depression and suicidal ideation can have an impact long into their adult years (Quiroga et al., 2013). The SOS program could provide students, parents, teachers, school counselors, and administrators with

a curriculum that teaches the knowledge and skills to approach depression or suicidal ideation (Aseltine et al., 2007).

References

- American Counseling Association, American School Counselor Association, National Education Association. (2008). Who are school counselors?. Retrieved from <http://www.schoolcounselor.org/asca/media/asca/home/WhoAreSchoolCounselors.pdf>
- American Foundation for Suicide Prevention. (2015). Facts and figures. Retrieved from <https://www.afsp.org/understanding-suicide/facts-and-figures>
- American Psychology Association. (2002). *A reference for professionals: Developing adolescents*. Retrieved from <http://www.apa.org/pi/families/resources/develop.pdf>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American School Counselor Association. (2015). ASCA mindsets and behaviors for student success. Retrieved from <http://schoolcounselor.org/school-counselors-members/about-asca/mindsets-behaviors>
- Aseltine, R. H., James, A., Schilling, E.A., & Glanovsky, J. (2007). Evaluating the SOS suicide prevention program: a replication and extension. *BMC Public Health* 7(1):161
- Aseltine, R. H., & DeMartino, R. (2004). An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health*, 94(3), 446–451.
- Berk, L. E. (2010). *Exploring lifespan development*. Boston: Allyn & Bacon
- Blakemore, S. J., & Robbins, T. W. (2012). Decision-making in the adolescent brain. *Nature Neuroscience* 15(9), 1184–1191. doi:10.1038/nn.3177.
- Brown, H., Pearson, N., Braithwaite, R., Brown, W., & Biddle, S. (2013) Physical activity interventions and depression in children and adolescents. *Sports Medicine* 43(3), 195–206. doi:10.1007/s40279-012-0015-8.

Centers for Disease Control and Prevention. (2010). Youth risk behavior surveillance-United States, 2009. Retrieved from

www.cdc.gov/healthyyouth/health_and_academics/pdf/yrbs_slides_violence.ppt

Centers for Disease Control and Prevention. (2014). Youth risk behavior surveillance-United States, 2013. Retrieved from <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>

Education Trust. (2009). Transforming school counselors initiative. Retrieve from <http://www.edtrust.org/dc/tsc/vision>

Frieden, T.R., Jaffe, H. W., Cono, J., et al. (2014). Centers for disease control and prevention: Youth risk behavior surveillance. United States, *MMWR* 63(4):1-172.

Jacobs, D. (2012). SOS signs of suicide high school program: Implementation guide and resources. United States: Screening for Mental Health, Inc.

Joe, S., & Bryant, H. (2007). Evidence-based suicide prevention screening in schools. *Children & Schools*, 29(4), 219–227.

Jung, E., Pick O., Schlüter-Müller, S., Schmeck K., & Goth, K. (2013). Identity development in adolescents with mental problems.” *Child & Adolescent Psychiatry & Mental Health* 7(1), 1–8. doi:10.1186/1753-2000-7-26.

Katz, C., Bolton, S., Katz, L. Y., Isaak, C., Tilston-Jones, T., & Sareen, J. (2013). A systematic review of school-based suicide prevention programs. *Depression and Anxiety* 30(10), 1030-1045. doi:10.1002/da.22114

King, K. A., Strunk, C. M., & Sorter, M. T. (2011) Preliminary effectiveness of surviving the teens® suicide prevention and depression awareness program on adolescents’ suicidality and self-efficacy in performing help-seeking behaviors. *Journal of School Health* 81(9), 581–590. doi:10.1111/j.1746-1561.2011.00630.x.

- Kirchner, J. E., Yoder, M. C., Kramer, T. L., Lindsey, M. S., & Thrush, S. R. (2000). Development of an educational program to increase school personnel's awareness about child and adolescent depression. *Education 121*(2), 235.
- Masi, G., Sbrana, B., Poli, P., Tomaiuolo, F., Favilla, L., & Marcheschi, M. (2000). Depression and school functioning in non-referred adolescents: A pilot study. *Child Psychiatry & Human Development 30*(3), 161–171.
- Merriam-Webster, Incorporated. (2013). *Depression*. Retrieved from <http://www.merriam-webster.com/dictionary/depression>
- Monroe County Department of Public Health. (2015). 2014-2015 Monroe county youth risk behavior survey. Retrieved from <http://www2.monroecounty.gov/health-healthdata.php#surveys>
- Osborne, J. W., (2013). Dealing with missing or incomplete data. Best practices in data cleaning; A complete guide to everything you need to do before and after collecting your data. Retrieved from https://us.sagepub.com/sites/default/files/upm-binaries/45664_6.pdf
- Quiroga, C. V., Janosz, M., Bisset, S., & Morin, A. J. S. (2013). Early adolescent depression symptoms and school dropout: Mediating processes involving self-reported academic competence and achievement. *Journal of Educational Psychology 105*(2), 552–560. doi:10.1037/a0031524.
- Rivet-Duval, E., Heriot, S., & Hunt, C. (2011). Preventing adolescent depression in mauritius: A universal school-based program. *Child & Adolescent Mental Health 16*(2), 86–91. doi:10.1111/j.1475-3588.2010.00584.x.
- Rothon, C., Head, J., Clark, C., Klineberg, E., Cattell, V., & Stansfeld, S. (2009). The impact of psychological distress on the educational achievement of adolescents at the end of compulsory education. *Social Psychiatry & Psychiatric Epidemiology 44*(5), 421–427. doi:10.1007/s00127-008-0452-8.

- Ruble, A. E., Leon, P. J., Gilley-Hensley, L., Hess, S. G., & Swartz, K. L. (2013). Depression knowledge in high school students: Effectiveness of the adolescent depression awareness program. *Journal of Affective Disorders, 150*(3), 1025-1030. doi:10.1016/j.jad.2013.05.033
- Russell, S.T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health, (91)*, 1276–1281.
- Schwartz, E. (2008). Adolescent brain development: An oxymoron no longer. *Journal of Youth Ministry 6*(2), 85-93.
- Screening for Mental Health. (2015). Plan, prepare, prevent: The SOS signs of suicide® online gatekeeper training. Retrieved from <http://thci.org/sos/welcome.aspx>
- Spennath, M. A., Clarke, M. E., & Kutcher, S. (2011). The science of brain and biological development: Implications for mental health research, practice and policy. *Journal of the Canadian Academy of Child & Adolescent Psychiatry 20*(4), 298–303.
- Steinberg, L. (2012). Should the science of adolescent brain development inform public policy?. *Issues In Science & Technology, 28*(3), 67-78.
- Strunk, C. M., King, K. A., Vidourek, R. A., Sorter, M. T. (2014). Effectiveness of the surviving the teens® suicide prevention and depression awareness program: An impact evaluation utilizing a comparison group. *Health Education & Behavior, 41*(6), 605-13.
- University of Connecticut Health Services. (2009). Health behavior survey pre-test. Retrieved from <http://www.reginfo.gov/public/do/DownloadDocument?objectID=15246901>
- Watkins, K. E., Ellickson, P. L., Vaiana, M. E., & Hiromoto, S. (2006). An Update on Adolescent Drug Use: What School Counselors Need to Know. *Professional School Counseling, 10*(2), 131-138.
- Youth Risk Behavior Survey, Unpublished results, 2015

Appendix A

SOS Lesson #1 - DVD

Appendix B

<p>Grade Level: High School (9-12)</p> <p>Concepts: Educating students about how they can help themselves or a friend who may be struggling with depression or suicidal ideation.</p> <p>Generalizations: Students will be able to identify the main points of the ACT acronym and recognize the signs and symptoms of suicide.</p> <p>Content Knowledge: Students will learn what the ACT acronym means. Students will begin to learn how to identify signs and symptoms of depression and suicide.</p> <p>Skills: Student will be able to listen, think critically, and discuss what is being presented in the DVD and by instructors</p> <p>ASCA Mindsets & Behaviors: MS: 1 LS: 9 SMS: 5, 7, 9 SS: 1, 2, 3, 9</p> <p>Learning Objectives: During and after the lesson all students will be able to: 1. Identify what ACT stands for. 2. Have a basic understanding of signs and symptoms of depression and suicidal ideation.</p>	<p>Materials:</p> <ul style="list-style-type: none"> • Friends for Life: Preventing Teen Suicide DVD • Response Cards • Pre Tests • Minor Assent Forms • Writing utensils • List of School Resources <p><u>Developmental Learning Activities</u></p> <p>Introduction</p> <p>Essential Question: How can I identify when a situation has gone beyond typical adolescent development? How can I use the ACT model to respond to it? Today you are going to take a pre-assessment so that we can gain a better understanding of what Greece Arcadia High School students know about depression and suicide. We are going to explore the signs and behaviors that are red flags; as well as how to respond when you or a friend is experiencing sadness or loss of energy that is impacting typical daily functioning. Students will learn these skills over the course of the next three lessons.</p> <p>Endearing Understanding: High School can be both an exciting and overwhelming time in a teen’s life. It is not uncommon to feel down or discouraged at times. Being able to identify when these red flags is an important part of knowing when you or a friend needs support from a trusted adult.</p> <p style="padding-left: 40px;">Say – “When I understand what depression and suicide is I can identify the resources I can use to get help for myself or others.”</p> <p>Introductory Activity: Introduce the SOS program and what will be taking place over the next week. The goal of this program is to help you recognize the signs and symptoms of depression and suicidal ideation in yourself, a friend, or a loved one. The goal of this program is not to tell that you have depression, but rather provide you with the knowledge to identify potential warning signs so that you have the tools to know how handle a situation and seek help.</p> <p>Activity: After the introduction students will fill out the Statement of Minor Assent and then fill out the pretest assessing their knowledge of depression and suicidal ideation.</p> <p>Student will watch the Friends for Life: Preventing Teen Suicide DVD. Following the video students will arrange their desks in a circle. The class will have an opportunity to discuss, comment and ask questions about they have about what was shown in the video. It is important to make sure that students know there are no right or wrong responses. Each student should be encouraged to share their knowledge or ask for clarification.</p> <p>At the conclusion of the discussion distribute and explain the student response cards and inform students of resources they can use if they have any other questions or concerns. All forms will be collected at the end of class. IMPORTANT: LOOK THROUGH RESPONSE CARDS AND CONTACT ALL STUDENTS WHO REQUESTED TO SPEAK WITH A COUNSLEOR.</p> <p>Conclusion: The activity will provide students with information and tools they can use to help themselves or others if they or someone they know is experiencing depressive symptoms or suicidal ideation.</p> <p>Assessments</p> <ul style="list-style-type: none"> • Formative: Students will take a pretest assessing their knowledge before the lesson begins. • Summative: Teacher will lead a discussion and review ACT and the signs and symptoms of suicide. • Reflective: Student response cards. <p style="text-align: right;"><i>(Adapted from SOS Signs of Suicide prevention Program, Jacobs, 2012)</i></p>
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<p>Grade Level: High School (9-12)</p> <p>Concepts: Helping students apply the skills learned in SOS Lesson #1.</p> <p>Generalizations: Students will be able to apply the ACT acronym and warning signs of suicide.</p> <p>Content Knowledge: Students will build on their knowledge from the previous lesson. Students will gain a clearer understanding of the warning signs of suicide by applying the ACT acronym as well as using interpersonal communication skills to enhance understanding.</p> <p>Skills: Students will be able to verbalize and discuss the warning signs and identify them in a scenario.</p> <p>ASCA Mindsets & Behaviors: MS: 1,5 LS: 2 SMS: 7, 9 SS: 1, 2, 3, 4, 6, 9</p> <p>Learning Objectives: During and after the lesson all students will be able to: 3. Apply the ACT acronym and create a skit. 4. Identify and discuss the warning signs of suicide.</p>	<p>Materials:</p> <ul style="list-style-type: none"> • Checklists • Hot Line scenarios • Writing utensils • Scrap Paper <p><u>Developmental Learning Activities</u></p> <p>Introduction Essential Question: Can I identify and verbalize the signs and symptoms of depression and suicide? How can I use the ACT in a skit? Today’s lesson we will be working in small groups. As a group you will create a script identifying someone who may be experiencing depression or suicidal ideation.</p> <p>Endearing Understanding: High School can be both an exciting and overwhelming time in a teen’s life. It is not uncommon to feel down or discouraged at times. Being able to identify these red flags are an important part of knowing how to respond and knowing the resources available to get help. Say – “When I can identify the warning signs of depression and suicide I know how to respond and know where I can turn for support.”</p> <p>Introductory Activity: Introduce the agenda for the day. Inform the kids that we will be working in small groups. The goal is to build upon what we learned in the previous class and now apply what we have learned and develop a skit to present to the class.</p> <p>Activity: Students will break into small groups. In their small groups they will be provided with an example of a skit. Staff can read a skit out loud to demonstrate what the expectation is. Each group member will insert 4 to 5 warning signs from the checklist in their skit. Once all groups have completed the skit they will present them to the class. After each skit the class will identify the warning signs and discuss healthy responses to each skit.</p> <p>Conclusion: The activity will allow students to apply what they learned about depression and suicide. At the conclusion of the activity students will be encouraged to share what they are taking away from today’s lesson.</p> <p>Assessments</p> <ul style="list-style-type: none"> • Formative: None. Students will have an open discussion about what they have learned. • Summative: Summarize the signs of depression and suicide. • Reflective: Think about how about would respond to a friend or a loved one. <p style="text-align: right;"><i>(Adapted from SOS Signs of Suicide prevention Program, Jacobs, 2012)</i></p>
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SOS Lesson #3 – Myth or Fact

<p>Grade Level: High School (9-12)</p> <p>Concepts: Discussing the facts and dispelling the myths of suicide and depression.</p> <p>Generalizations: Students will be able to recall the information presented to them in the previous two lessons and identify what is a fact and what is a myth.</p> <p>Content Knowledge: Present the common myths and facts about suicide and depression and answer any questions students may have.</p> <p>Skills: Student will be able to use what they have learned from the past two lessons and identify the facts and myths and the reasoning as to what makes them facts vs. myths.</p> <p>ASCA Mindsets & Behaviors: MS: 1 LS: 1, 9 SMS: 5, 7, 9 SS: 1, 2, 3, 9</p> <p>Learning Objectives: During and after the lesson all students will be able to:</p> <ol style="list-style-type: none"> 5. Identify what ACT stands for. 6. Identify the warning signs of depression and suicide. 7. Know the facts and myths of suicide. 8. Identify resources in the school and the community. 	<p>Materials:</p> <ul style="list-style-type: none"> • Facts and Myths Worksheet • BSAD Screening Forms • Student Packet • Post Tests • Writing utensils <p><u>Developmental Learning Activities</u></p> <p>Introduction Essential Question: What are the facts of suicide? What are some common misconceptions of suicide? Today we are going to review what we have been learning about all week. As a class we are going to discuss the facts and myths of suicide and depression. Endearing Understanding: Myths about depression and suicide often separate people from supporting suicide prevention efforts. Say – “When I understand what depression and suicide is I know how to respond.” Introductory Activity: Introduce the agenda for the class. Students will begin the class by filling out the BSAD Screening Form. The instructor will explain the assessment to the class. Once all students have had an opportunity to complete the form the instructor will explain how the assessment is scored. The instructor will collect all forms before moving on.</p> <p>Activity: Once the BSAD is complete students will arrange their desks in a circle. The instructor will hand out the facts and myths sheet. Students will complete the worksheet on their own. Once all students have completed the tasks the class will go through each item and discuss why it is a fact or myth. Instructor should interject and add additional information about depression and suicide.</p> <p>Conclusion: This lesson should dispel myths about depression and suicide. It should also review the information covered in the previous two lesson including ACT acronym and signs and symptoms of depression and suicide.</p> <p>Assessments</p> <ul style="list-style-type: none"> • Formative: Posttests • Summative: Students will discuss what they have learned over the past three lessons. • Reflective: BSAD Student Screening Form <p style="text-align: right;"><i>(Adapted from SOS Signs of Suicide prevention Program, Jacobs, 2012)</i></p>
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Pre/Post SOS Program Questionnaire – Long Version

While this survey is not a formal component of the SOS Program, we know many schools look to assess learning in their students when implementing programming.

We offer two versions of this pre- and post-test. You may consider using this longer version to gain a more comprehensive understanding of your student' education, including Likert scale questions to measure attitudes and feelings. The pre- and post-test questions are identical; you may wish to print them on different color paper to quickly identify which answers you are reviewing. This version would be particularly useful if your school has received and/or is implementing this program due to grant funding, and you are looking for more detailed evaluation tool for reporting.

The shorter version is also available on this resource page if you are looking for a brief assessment to determine the extent to which students have retained the general learning concepts.

Introduction to Students

Before we start, let me tell you a few things about this survey:

- I am going to read the questions out loud. You should follow along with me and fill in the appropriate answer to each question.
- It's very important that you answer as honestly and accurately as you can.
- Please do not skip ahead so that we can be sure that each person has the same amount of time to answer each question.
- DO NOT write your name on this survey. All your answers will be completely anonymous.
- Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.
- When you have completed the survey, please keep it until I collect it from you.

Does anyone have a question before we start?

This survey is not part of the SOS Signs of Suicide Prevention Program. Questions come from the University of Connecticut Health Center's Health Behavior Survey. The Introduction to Students was also adapted from the survey.

SOS SIGNS OF SUICIDE PREVENTION PROGRAM

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Part I: True or False:

Please answer the following questions as best you can.

- | | | |
|--|------|-------|
| 1. People who talk about suicide don't really kill themselves. | TRUE | FALSE |
| 2. People who commit suicide are usually suffering from depression or some other mental illness. | TRUE | FALSE |
| 3. Most suicide attempts occur without any warning signs or clues. | TRUE | FALSE |
| 4. Depression is an illness that doctors can treat. | TRUE | FALSE |
| 5. The best thing to tell a suicidal friend is to "pull yourself together and things will get better." | TRUE | FALSE |
| 6. If I talk to someone about their suicidal feelings, it may cause them to commit suicide. | TRUE | FALSE |
| 7. Alcohol use is not related to suicidal behavior. | TRUE | FALSE |

Part II

Now I'm going to read some statements about depression and suicide, and I'd like to know whether you agree or disagree with them.

1. Sometimes young people have so many personal problems they have no other options besides suicide.

<i>STRONGLY DISAGREE</i>	<i>DISAGREE</i>	<i>NEITHER AGREE OR DISAGREE</i>	<i>AGREE STRONGLY</i>	<i>AGREE</i>
1	2	3	4	5

2. If someone really wants to kill himself/herself, there is not much anyone can do about it.

<i>STRONGLY DISAGREE</i>	<i>DISAGREE</i>	<i>NEITHER AGREE OR DISAGREE</i>	<i>AGREE STRONGLY</i>	<i>AGREE</i>
1	2	3	4	5

Appendix E

Statement of Informed Consent

Dear Parent/Guardian:

I, [REDACTED] am a graduate student in the [REDACTED]. I am currently doing my school counseling internship at [REDACTED], under the supervision of [REDACTED]. I am conducting a program evaluation to determine the effectiveness of the SOS Signs of Suicide Prevention Program. The possible benefit from being part of this program evaluation is that the information collected may help school counselors, teachers, administrators, parents, and students become more informed about depression and suicide, and provide teens with resources they can use to help themselves or a friend.

The SOS Signs of Suicide Prevention Program is part of the regular curriculum and the program will be delivered in all Health classes. The program evaluation is voluntary. If you choose for your student to take part, they will be asked to read and fill out a pretest and a post test, which will be administered before the program starts and after it is completed. The questionnaires will take 10-15 minutes to complete. While every student is participating in the SOS Signs of Suicide Prevention Program, only the ones who choose to do so will take the pre- and post-test. Possible risks to participating in this program evaluation are some of the questions and topics discussed may be upsetting to your student.

Your student's participation in this program evaluation is completely voluntary. Participation or refusing to partake in the program evaluation will not affect your student's grades or academic standing. S/he is free to change his/her mind and may withdraw from the program evaluation at any time, even after it has begun.

If you wish to have your students participate in the program evaluation and agree with the statements below, please sign your name in the space provided below.

I understand that:

1. My student's participation is voluntary and s/he has the right to refuse to answer any questions. S/he will have a chance to discuss any questions s/he has about the study with their teacher after completing the questionnaire.
2. My student's confidentiality is protected. Her/his name will not be written on the questionnaire. There will be no way to connect my student to the written questionnaire. If any publication results from this research, s/he will not be identified by name. Results will be given anonymously and in group form only, so that participants cannot be identified. Participation has no effect on grades.

- 3. There is no personal benefit to my student in being part of this program evaluation. The time it will take to complete the questionnaire in minimal.
- 4. My student’s participation involves reading a written survey of 12 questions and answering those questions in writing, circling, or checking a response. It is estimated that it will take 10-15 minutes to complete the questionnaire.
- 5. A maximum of 1,126 students will take part in this program evaluation. The results will be used for the completion of a research projects by the primary researcher.
- 6. Data and consent forms will be kept separately in a locked filing cabinet by the researcher and will be destroyed by shredding when the research has been completed

I am 18 years of age and older. I understand the information in this form and agree to allow my student to participate as a participant in this project. I have read and understand the above statements. All my questions about my student’s participation in this program evaluation have been answered to my satisfaction.

***Disclosure Agreement:** The only exception to breaking confidentiality would be if in talking with your student, project staff finds that there is something happening in your students’ life that may put them in immediate and serious danger to their health or physical safety. In that case, you or other professionals might have to be contacted.*

If you have any questions or concerns please feel free to contact any of the following people.

9th Grade Counselor

[Redacted]

10th – 12th Grade Counselor

[Redacted]

Parent/Guardian Signature

Date:

Student’s Name

Appendix F

Statement of Minor Assent

Dear Student:

I [REDACTED], am a graduate student in the [REDACTED] [REDACTED]. I am currently doing my school counseling internship at [REDACTED], under the supervision of [REDACTED]. I am conducting a program evaluation to determine the effectiveness of the SOS Signs of Suicide Prevention Program.

The SOS Signs of Suicide Prevention Program is part of the regular Health curriculum. The program evaluation is voluntary. If you choose to take part, you will be asked to read and fill out a pretest and posttest, which will be administered before the program starts and after it is completed. The questionnaires will take 10-15 minutes to complete. While every student is participating in the SOS Signs of Suicide Prevention Program, only the ones who choose to do so will take the pre- and post-test.

Possible risks of participating in this program evaluation are that some questions may be upsetting. You do not have to answer any questions you do not want to answer. You will have a chance to discuss any questions you have about the program evaluation with your teacher after you complete the questionnaire. The possible benefit from being part of this program evaluation is an increase in knowledge about depression, suicide and how to respond when these topics come up.

Any information that you provide in this program evaluation will remain confidential. There will be no way to connect you to the written questionnaire. If the program evaluation is published you will not be identified.

Your participation in this program evaluation is completely voluntary. You are free to change your mind or withdraw from the program evaluation at any time, even after it has begun.

Disclosure Agreement: *The only exception to breaking confidentiality would be if in talking with you, project staff finds that there is something happening in your life that may put you immediate and serious danger to your health or physical safety. In that case, your parents or other professionals might have to be contacted.*

If you have any questions or concerns please feel free to contact any of the following people.

9th Grade Counselor

[REDACTED]

10th – 12th Grade Counselors



Signature of participant (under 18)

Date:

Appendix G

Letter to Parents

Dear Parent/Guardian:

I, [REDACTED], am a graduate student in the [REDACTED]. I am currently doing my school counseling internship at [REDACTED], under the supervision of [REDACTED].

This fall I am conducting a program evaluation to determine the effectiveness of the suicide prevention program here at [REDACTED]. The name of the program is *SOS Signs of Suicide Prevention Program*. I will be working directly with [REDACTED] teacher [REDACTED] and the [REDACTED] counseling staff to deliver the program. The suicide prevention program is part of the mental health unit in you students health class. The program will begin on October 5th 2016 and conclude on October 9th 2016.

This packet contains information for parents/guardians regarding suicide and issues connected to suicide. As well as providing you with information there is information about how to act and how to reach out of help. Please read over the materials provided and consider having your student participate in this program evaluation. If you choose to have your student participate please read and sign the enclosed informed consent form and return it to [REDACTED].

The program highlights the relationship between depression and suicide, teaching that most often suicide is a fatal response to a treatable disorder – depression. Through the SOS program, school staff, students, and their parents will learn about depression, suicide and associated risks of alcohol use. SOS teaches the action steps individuals should take if they experience signs of depression or suicide within themselves or encounter these signs within a friend: **ACT**: Acknowledge your friend has a problem, tell the person you Care, and Tell a trusted adult.

If you have any questions or concerns please feel free to contact any of the following people.

9th Grade Counselor

[REDACTED]

Health Teacher

[REDACTED]

Appendix H

Letter to Staff

Dear Staff:

I, [REDACTED], am a graduate student in the [REDACTED]. I am currently doing my school counseling internship at [REDACTED], under the supervision of [REDACTED].

This fall I am conducting a program evaluation to determine the effectiveness of the suicide prevention program here at [REDACTED]. The name of the program is *SOS Signs of Suicide Prevention Program*. I will be working directly with [REDACTED] teacher [REDACTED] and to deliver the program. The suicide prevention program is part of the mental health unit. The program will begin on October 5th 2016 and conclude on October 9th 2016.

This packet contains information about the signs and symptoms of depression and suicide, and how to handle a student who may be experiencing depression or suicidal ideation. Please read over the materials provided and please contact [REDACTED] or any of the counselors should you have any questions of concerns.

The program highlights the relationship between depression and suicide, teaching that most often suicide is a fatal response to a treatable disorder – depression. Through the SOS program, school staff, students, and their parents will learn about depression, suicide and associated risks of alcohol use. SOS teaches the action steps individuals should take if they experience signs of depression or suicide within themselves or encounter these signs within a friend: **ACT**: Acknowledge your friend has a problem, tell the person you Care, and Tell a trusted adult.

If you have any questions or concerns please feel free to contact any of the following people.

9th Grade Counselor

[REDACTED]

10th – 12th Grade Counselor

[REDACTED]

Health Teacher

[REDACTED]

Supplemental Material for

**SOS High School Suicide Prevention Program, Student Screening Form, Brief
Screen for Adolescent Depression (BSAD)**

Screening for Mental Health Inc., (2009).

Files:

<http://www.canyonisd.net/cms/lib/TX01000615/Centricity/Domain/87/Student%20BSAD%20Screening%20Form.pdf>