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An Evaluation of Suicide Gatekeeper Training for School Counselors and Teachers

The study in this article compared counselors and teachers on measures of suicide knowledge and prevention practices after participation in a statewide training program in student suicide prevention using the "Question, Persuade, and Refer" program. Follow-up surveys conducted an average of 4.7 months after training indicated that trainees (73 counselors and 165 teachers) demonstrated greater knowledge of suicide risk factors and reported making more no-harm contracts than did controls (74 counselors and 98 teachers). In comparison to teachers, counselors demonstrated greater knowledge of risk factors and reported questioning more potentially suicidal students and making more contracts and outside referrals. These findings support the value of gatekeeper training for both counselors and teachers and substantiate the important role of counselors in suicide prevention.

Suicide is the third leading cause of death among adolescents ages 10–24 in the United States (Centers for Disease Control and Prevention, 2004). According to the American Association of Suicidology (AAS), in a typical high school classroom of 33 students, one male and two female students attempt suicide each year (AAS, 2004). Suicidal thoughts and feelings are even more pervasive; according to national findings from the Youth Risk Behavior Survey (Eaton et al., 2006), over the course of 12 months, approximately 28% of high school students reported feeling sad or hopeless almost every day for at least 2 weeks, 17% reported seriously considering suicide, and 13% made plans about how they would attempt suicide.

School counselors also may need to assess suicide risk as part of broader efforts to prevent violence against others in violence risk assessments (Bernes & Bardick, 2007). The Columbine school shooting brought attention to the link between suicide and homicide, and subsequent studies by the Federal Bureau of Investigation (O'Toole, 2000) and the U.S. Secret Service (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002) found that suicidal feelings were frequently observed in students prior to their homicidal attacks. The link between suicide and violence also extends to less serious forms of aggression such as fighting (Swahn, Lubell, & Simon, 2004).

The critical role of school personnel in youth suicide prevention is widely acknowledged. In 1992, the Centers for Disease Control and Prevention issued a resource guide for youth suicide prevention that made "school gatekeeper training" the first of eight recommendations (among other strategies such as general suicide education, peer support, crisis centers, and hotlines). Later that decade, *The Surgeon General's Call to Action to Prevent Suicide* (U.S. Public Health Service, 1999) again emphasized the function of gatekeepers, defined as the individuals in a community who have face-to-face contact with large numbers of people in the community and are in a position to identify students at risk of suicide and refer them for appropriate treatment. The Surgeon General's Call to Action made gatekeeper training a major goal and identified teachers and school staff first in its list of key gatekeepers.

The rationale for gatekeeper training is that suicidal individuals often do not seek help on their own initiative, making it necessary for others to initiate help-seeking on their behalf (Quinnett, 2007). Furthermore, adolescents may be particularly disinclined to seek help from adults because of their developmental needs for autonomy and independence. Suicidal adolescents are often hesitant to initiate conversations with adults about their suicidal thoughts, and even when they share this information with a peer, as few as 25% of these peers contact an adult for help (Kalafat & Elias, 1995). It follows that school personnel must learn to recognize warning signs and take the initiative to question potentially suicidal students (Capuzzi, 2002; Gould & Kramer, 2001; King, 2001; King, Price, Telljohann, & Wahl, 2000).

One of the most widely used forms of gatekeeper suicide prevention training is "Question, Persuade, and Refer," more commonly known as QPR training (Quinnett, 2007). The QPR Institute reports that more than 300,000 citizens have been trained

in QPR and that more than 3,000 individuals have been trained as certified QPR instructors. Quinnett conceptualized QPR as a public health approach analogous to cardiopulmonary resuscitation (CPR) and the "chain of survival" model. In this model, a victim of a heart attack is more likely to survive if there is early recognition that the person is having a heart attack, immediate efforts to keep the person alive (such as CPR), and then efforts to get the person to the hospital for more advanced treatment. Similarly, QPR posits a chain of survival for a suicidal person that involves recognizing warning signs, directly questioning (Q) the person about his or her condition, establishing a dialogue to persuade (P) the person to accept help, and then taking appropriate steps to refer (R) the person for treatment.

The "Q" in QPR involves teaching the gatekeeper to have a high index of suspicion for suicidality in people who exhibit warning signs (Quinnett, 2007). These warning signs can include both direct and indirect expressions of distress. Gatekeepers are encouraged to actively question individuals whom they suspect might be suicidal, and to overcome the reluctance that many people have to raising such a sensitive topic. Gatekeepers must have confidence in their competence, or they may avoid asking questions that are necessary to uncover someone's suicidal intentions.

The "P" in QPR refers to the task of persuading the suicidal person to take positive, life-saving action in accepting professional help (Quinnett, 2007). Suicidal individuals often are reluctant to seek help or to accept when it is offered, so it is important to engage them to accept a referral. Gatekeepers are trained to use a form of motivational interviewing that includes empathic listening, providing support, and encouraging a prompt effort to seek treatment.

The "R" in QPR refers to making a referral for treatment, but it also means that the gatekeeper makes every effort to see that the suicidal person actually follows through on seeking treatment. Gatekeepers are encouraged to accompany the suicidal person to the treating professional if possible, and if not, to secure an agreement to see a professional and then to check to see that the agreement was kept. Gatekeepers are provided with information on all available referral sources in the community and should have an established referral plan and procedure in their institution.

The need for QPR training is supported by the widespread agreement that school professionals need education about suicide warnings signs and risk factors, as well as strategies for responding to at-risk students (Capuzzi, 2002; Debski, Spadafore, Jacob, Poole, & Hixson, 2007; King, 2001). Many school personnel, including school counselors, report feeling less than adequately prepared to deal with suicidal students (Anderson, 2005; Debski et al.; King et al., 1999b). Several studies have identified teacher limitations in knowledge and confidence in dealing with suicidal students (Anderson; Cessna, 1997; MacDonald, 2004; Scouller & Smith, 2002). A study of ethical difficulties faced by school counselors found that the two most challenging dilemmas concerned situations that frequently occur with suicidal students: student confidentiality of personal disclosures and acting on information regarding danger to self or others (Bodenhorn, 2006).

There is evidence that the professional deficiencies in suicide prevention knowledge and confidence in working with suicidal students can be remedied through gatekeeper training. Previous gatekeeper studies have examined the improvement in suicide prevention knowledge immediately after training (Garland & Zigler, 1993; Hayden & Lauer, 2000; Shaffer, Garland, Gould, & Fisher, 1988; Tierney, 1994). At the conclusion of gatekeeper training, school personnel show an increase in knowledge of suicide warning signs (Garland & Zigler; Hayden & Lauer; Shaffer et al.; Tierney) and report feeling more confident in their abilities to recognize and respond to potentially suicidal students (Klingman, 1990). Studies using vignettes to measure questioning and referral practices show that immediately following training, participants are more likely to question students and to refer them to appropriate resources (Davidson & Range, 1997; Tierney). There is a need, however, to show that these positive effects continue after training and that participants apply their new skills with students.

Recently, Wyman et al. (2008) conducted the first randomized controlled trial of QPR gatekeeper training for school personnel. In a sample of 122 trained and 127 untrained staff, they found overall training effects on knowledge of QPR and multiple self-appraisals of ability to engage in effective suicide prevention, but no effects for referral behaviors (such as notifying referral sources) and questioning students about suicide.

According to the American Association of Suicidology, in a typical high school classroom of 33 students, one male and two female students attempt suicide each year.

SCHOOL PERSONNEL DIFFERENCES

QPR was conceptualized as a professional service for health-care providers rather than lay citizens. However, teachers have regular—often daily—contact with their students and are well situated to observe changes in their mood and behavior, as well as other warning signs (Capuzzi, 2002; Davidson & Range, 1997; King, 2001; Scouller & Smith, 2002). Therefore, it seems important that teachers as well as counselors have some form of gatekeeper training.

Several researchers examined the impact of QPR training on teachers as well as counselors and other school personnel. Klingman's (1990) study showed

that both counselors and teachers made positive gains in knowledge on a survey administered before and after gatekeeper training. However, this study used different training programs for each group, so it was not possible to compare outcomes for counselors and teachers.

In a study comparing Australian teachers and physicians, researchers found that only 55% of the teachers recognized that they could play a significant role in suicide prevention (Scouller & Smith, 2002). In a different study, only 41% of high school health teachers reported having confidence to question a potentially suicidal student about intended harm, and even though 70% of the sample believed it was his or her role to identify at-risk students, only 9% of 228 respondents reported confidence in the ability to recognize potentially suicidal students (King, 2001; King, Price, Telljohann, & Wahl, 1999a).

The background and training of counselors make them particularly appropriate for this role (Capuzzi, 2002; King & Smith, 2000; Klingman, 1990; U.S. Department of Health and Human Services, 1992). In a large survey study of British Columbia, Canada, school personnel, school counselors reported feeling more confident in their knowledge of suicide and suicide risk factors than did teachers and administrators (White, Rouse, & Jodion, 1997). School counselors also performed better on measures of general knowledge about suicide than did teachers and administrators (White et al.). In a study of school counselors' understanding of suicide risk factors, the majority of counselors were knowledgeable about suicide risk factors and the appropriate steps to take with a suicidal student (King et al., 2000).

Suicidal adolescents are often hesitant to initiate conversations with adults about their suicidal thoughts.

The Wyman et al. (2008) study compared four groups of school staff (teachers, support staff, administrators, and health/social service staff) and found that training had some positive impact for all groups, but the most consistent effects were found for the small group of staff in health/social service roles (n = 21 trainees). The health/social service staff would be the group most closely associated with school counselors, although findings specifically for school counselors were not provided. The researchers found that the health/social service staff group demonstrated training effects on knowledge and self-appraisals, but not for asking students about suicide. Teachers showed positive effects for knowledge, self-appraisals, and making referrals, but not for asking students about suicide.

PRESENT STUDY

The purpose of the present study was to examine the effects of a gatekeeper model of suicide prevention training on counselors and teachers. In response to a state legislative mandate, the Virginia Department of Health initiated statewide training of school personnel to work with potentially suicidal students. Free training was offered in localities across the state, and it was open to school staff as well as personnel from other community agencies.

Two kinds of gatekeeper training were offered: QPR (QPR Institute, 2005) and applied suicide intervention skills training (ASIST). QPR training was represented as the basic program for all school staff and ASIST was represented as a more advanced training for people who might receive referrals from someone with QPR training. The majority of school personnel chose to enroll in the QPR training, which was presented as a basic, 1-day program. In 1 to 3 hours, QPR training highlighted suicide warning signs and provided school staff with training to identify and refer a potentially suicidal student for help (QPR Institute, 2005). A smaller number completed ASIST, which was a more extensive 2-day training program concerned with advanced intervention topics. The sample for this study consists only of participants in the QPR training (Cornell, Williams, & Hague, 2006).

The current study examined how teachers and school counselors who received QPR training differed from teachers and school counselors who did not participate in training. We hypothesized that trainees would have more knowledge of suicide risk factors and report more behaviors consistent with training goals than would controls. We also expected that trainees would report increased confidence in their ability to recognize potentially suicidal students. Because of their professional background and role in the school, we hypothesized that school counselors would be more knowledgeable and report more prevention efforts than teachers.

METHODS

Participants

The sample of trainees was drawn from all available participants who had completed training in the past 22 months (average 4.7 months). Following gatekeeper training, 1,081 school personnel were asked to participate in the study and 403 (37%) participants completed the survey. Of the 403 participants, 165 identified themselves as teachers and 73 identified themselves as school counselors, for a total of 238 trainees used in this study. Of these trainees, 26 (11%) worked in elementary schools, 123 (53%) worked in middle schools, and 82 (35%) worked in high schools (7 did not report their school setting).

The control sample was drawn from a general sample of school personnel throughout Virginia who worked in localities where the Department of Health's training had not yet been offered. These localities were distributed across the state and

included rural, suburban, and urban communities. In order to approximate the demographics of the training sample, 100 middle schools, 50 elementary schools, and 40 high schools were selected from these areas. Once schools were identified, researchers selected every third school staff member from rosters on school Web sites until 4–5 teachers, 2–3 counselors, and 5 other support staff were chosen. Of the 945 school personnel identified for the control group, 252 (26%) completed the survey. This group included 98 teachers and 74 counselors, resulting in a control group of 172 for the present study. Of the controls, 57 (33%) worked in elementary schools, 40 (23%) worked in middle schools, and 71 (41%) worked in high schools (4 did not report their school setting).

Following QPR training, teachers and school counselors were surveyed either by phone, postal mail, or Internet. The three different survey modes were used to determine the most efficient method with the best return rate (the small differences in return rate are reported in Cornell et al., 2006).

Measures

The Student Suicide Prevention Survey was designed to measure the expected outcomes for gatekeeper training. The survey was developed in a series of steps: (a) Researchers reviewed the training curriculum and prepared a series of items to cover important points, (b) the lead trainers from the Virginia Department of Health reviewed the items, (c) revised items were presented to school personnel for discussion in two focus groups, (d) a draft survey was pilot-tested by telephone to a sample of approximately 120 training participants, and (e) a final version of the survey was prepared and researchers agreed on the final version.

The final version of the survey examined knowledge of suicide risk factors by asking seven questions about student suicide risk in a series of scenarios. The survey also reviewed the participant's post-training case management of suicide referrals by asking about the number of students questioned about suicidal ideation and the number referred to outside mental health services. (Additional questions about the school's policies and programs were not included in this study.) Trainees and control participants were asked the same questions, except that the trainees had four additional questions asking them to evaluate the quality of their training. The key survey questions used in the present study are presented in Appendix A.

RESULTS

We conducted a 2×2 multivariate analysis of covariance (MANCOVA) to assess the effect of training status (training vs. control) and school occupation (school counselor vs. teacher) on suicide knowledge and prevention practices while controlling for the amount of time since training. We found a statistically significant main effect for both training status, Wilks' $\Lambda = .855$, $F(4, 364) = 15.5$, $p < .001$, $\eta^2 = .145$, and occupation, Wilks' $\Lambda = .816$, $F(4, 364) = 20.5$, $p < .001$, $\eta^2 = .184$. (The MANCOVA was rerun controlling for level of school with no difference of results.)

We conducted follow-up 2×2 analyses of covariance (ANCOVAs) to examine between-subject effects, with alpha levels adjusted to $p < .0125$ to account for family-wise error (see Table 1). The first ANCOVA examined participant knowledge scores. There was a significant occupation effect, $F(1, 395) = 9.86$, $\eta = .03$, and training effect, $F(1, 395) = 3.93$, $\eta = .05$. Counselors ($M = 4.7$) made more correct responses than did teachers ($M = 4.2$), and trainees ($M = 4.6$) made more correct responses than did control participants ($M = 4.3$).

The second ANCOVA examined referrals for mental health services and found a significant main effect for training, $F(1, 395) = 13.4$, $\eta = .03$, and occupation, $F(1, 395) = 44.6$, $\eta = .10$. Trainees made fewer referrals than did controls, but counselors made more referrals than did teachers. There also was a significant training times occupation interaction, $F(1, 395) = 9.60$, $\eta = .02$, which indicated that there was a larger difference between counselors and teachers among the controls than the trainees. In the trainee group, counselors ($M = 1.0$) referred more students for mental health services than did teachers ($M = .5$); however, in the control group, the difference between counselors ($M = 2.3$) and teachers ($M = .6$) was larger.

Both training and occupation yielded significant main effects on the number of no-harm contracts made with students. Trainees ($M = 1.4$) made more contracts than did control participants ($M = .5$), $F(1, 395) = 19.1$, $\eta = .05$; and counselors ($M = 1.7$) made more contracts than did teachers ($M = .3$), $F(1, 395) = 56.5$, $\eta = .13$. There also was a significant training times occupation interaction, $F(1, 395) = 11.5$, $\eta = .03$. The difference between counselors ($M = 2.4$) and teachers ($M = .4$) in the trainee group was greater than between counselors ($M = 1.0$) and teachers ($M = .1$) in the control group.

We found a significant occupation effect, $F(1, 395) = 14.68$, $\eta = .04$, and training effect, $F(1, 395) = 12.37$, $\eta = .03$, when examining how many students were questioned about suicidal ideation by participants. Counselors ($M = 2$) questioned more students than did teachers ($M = .4$) in the trainee group. Counselors ($M = 3.5$) also questioned more students than did teachers ($M = 2.2$) in the control group.

Trainees reported positive benefits from attending

School staff who attended QPR training demonstrated greater knowledge of suicide risk factors and reported more active involvement in making no-harm contracts than did control personnel.

Table 1. Analysis of Covariance Controlling for Time

	Adjusted Means				Occupation			Training			Interaction			Covariate		
	Training (n = 238)	Control (n = 172)	Teacher (n = 263)	Counselor (n = 147)	F	p	η^2	F	p	η^2	F	p	η^2	F	p	η^2
Participant knowledge score	4.6	4.3	4.2	4.7	9.86	.002	.026	3.93	.048	.010	.87	.352	.002	2.81	.095	.008
Students referred for mental health services.	73	1.5	.55	1.6	44.6	.001	.103	13.4	.001	.033	9.6	.002	.024	19.5	.001	.048
Contracts made with students	1.4	.44	.28	1.6	56.5	.001	.128	19.1	.001	.047	11.5	.001	.029	.30	.587	.001
Students questioned	1.2	2.9	1.3	2.8	14.7	.001	.036	12.4	.001	.031	.144	.705	.000	15.4	.001	.038

Note. The trainee follow-up survey was completed on average 4.7 months after training (range: 1–22 months). Control participants answered regarding the previous 3 months.

QPR training. Of the 238 trainees, 208 (89%) said that they found training to be helpful, 173 (74%) said that it increased their confidence in dealing with potentially suicidal students, and 199 (85%) said that training increased their knowledge and expertise in dealing with potentially suicidal students. There was not a significant difference between counselor and teacher responses.

DISCUSSION

This study found positive effects for student suicide prevention training with different results for counselors and teachers. School staff who attended QPR training demonstrated greater knowledge of suicide risk factors and reported more active involvement in making no-harm contracts than did control personnel. Although previous studies (Davidson & Range, 1997; Klingman, 1990; Scherff, Eckert, & Miller, 2005; Shaffer et al., 1988; Tierney, 1994) have reported similar findings at the conclusion of training, this study examined effects an average of 4–5 months (approximately one semester) after training. Moreover, we were able to ask participants to recall actual practices with students rather than project how they expected to interact with students after training.

Participants reported that the training was helpful and increased their confidence in working with suicidal students. Previous studies have shown that school counselors and teachers report lacking confidence in their ability to recognize potentially suicidal students (King, 2001; King et al., 1999a, 1999b; Schepp & Biocca, 1991). This study found that participants gained confidence following training, but results for suicide prevention behaviors in their schools were less straightforward.

Although participants showed clear benefits from QPR training in increased knowledge and greater involvement with suicidal students, some training effects were unexpected. Trainees reported questioning fewer potentially suicidal students than did control participants and they reported referring fewer students to mental health services than did control participants. These findings are surprising because the training emphasizes that one should ask a student about suicidal ideation whenever one thinks a student may be suicidal and to take an active role in referring suicidal students for mental health services.

A possible explanation for these unexpected findings is that trainees may have experienced increased confidence and knowledge, so that they felt less need to question or refer students. Trainees may have been less prone to false negatives in their assessments of potentially suicidal students, although further research is necessary to affirm this conclusion. An alternate explanation is that control participants may overestimate their interactions with suicidal students. Training participants may be more attentive

to their suicide cases after training, whereas control participants may judge themselves to have more contact with at-risk students than actually takes place.

Several previous studies found that such training increased knowledge immediately after training but did not determine whether that knowledge persists and is reflected in changes in working with students (Kalafat, 2003; Mazza, 1997; Scherff et al., 2005). The Wyman et al. (2008) study found increases in knowledge over a follow-up period of approximately 1 year, which is consistent with the findings from the present study, but did not have a group of school counselors. The Wyman et al. study found the strongest effects for knowledge and self-appraisals of prevention efficacy rather than changes in reported behavior with potentially suicidal students.

Overall, school counselors had higher suicide knowledge scores than teachers, consistent with prior research (Klingman, 1990; U.S. Department of Health and Human Services, 1992; White et al., 1997). Counselors also reported more instances of questioning and referring potentially suicidal students than did teachers, providing support that increased knowledge is an important step in suicide prevention. Interestingly, the Wyman et al. (2008) study found that training affected staff differently based on their baseline levels. Training had no overall effect on increasing staff asking students about suicide, but for the small group of staff who reported experience asking students about suicide at baseline, there appeared to be a training benefit. Those staff who had previously questioned students about suicide showed an increase in asking students after training, although the other staff did not. This finding suggests that staff reluctance to question students about suicide is substantial, and it might not be easily overcome by training.

One implication from this finding is that training might have different goals for teachers and for counselors. School counselors, by nature of their training and occupational role, should be more willing to ask students about suicide, whereas teachers may feel that such questions exceed the limits of their role. If teachers are consistently reluctant to question students about suicide, then a logical alternative would be to use training to encourage them to contact school counselors and to allow the counselors to undertake questioning. Training for school counselors would focus on helping them to increase their skill and willingness to question students about suicide.

Study Limitations

Our findings are consistent with the view that gatekeeper training produces beneficial effects in participants, but this was a quasi-experimental study rather than a randomized controlled study, so it is not possible to conclude that group differences were caused by the training program. Training participants either volunteered to attend training or were sent to it by their supervisors. The control group was selected by contacting school personnel in localities where training had not yet been offered. Therefore, the design of this study cannot rule out preexisting differences between trainees and controls. However, the Wyman et al. (2008) study was a randomized trial, and although it had a teacher group but not a counselor group, its results are consistent with the present findings.

There is reason to believe that the trainees in this study did undergo change from their baseline prior to training. The larger study from which this sample was drawn (Cornell et al., 2006) included a subgroup of 174 school personnel who completed the survey before training and approximately 3 months later. In this subgroup, trainees showed an increase in knowledge of suicide risk factors and an increased number of referrals for mental health services for potentially suicidal students.

Another limitation is that our assessment of suicide prevention practices was based on participant self-report. School personnel might not have accurately remembered their interactions with potentially suicidal students. A future study could document changes in suicide prevention practices through a review of records, direct observation, or collection of other collateral sources of information.

These findings support the need for additional studies that randomly assign school personnel to training and control groups, and then follow up with blind, independent assessments of training impact on the participants and the students in their schools. Further research should be conducted on differences among teachers, counselors, and other school occupations in order to provide individuals in different professions with training that is tailored to the skills that they will need to question, persuade, and refer potentially suicidal students. For school counselors, training should focus on questioning these students about their suicidal ideation, persuading them to not harm themselves, and referring them to outside mental health agencies. For teachers, the training may place more emphasis on approaching and questioning students, and determining whether to refer them to the school counselor for further assessment.

Implications for School Counselors

Nearly a decade ago, surging rates of adolescent suicide prompted the Surgeon General to issue a national Call to Action to Prevent Suicide (U.S. Public Health Service, 1999). In follow-up, the U.S. Department of Health and Human Services (2001) developed a National Strategy for Suicide Prevention that specifically set an objective to increase the

proportion of schools using evidence-based suicide prevention programs and to make greater use of gatekeeper training. The present study shows that gatekeeper training is especially appropriate for school counselors.

School counselors can obtain more information on QPR training from the QPR Institute (http://www.qprinstitute.com). School counselors who become certified as QPR trainers would be able to provide training to the teachers and other personnel in their school. Like CPR, the philosophy of QPR is to have as many responsible adults as possible trained in its techniques so that it is more likely that someone will recognize a suicidal student at an early stage and initiate prompt intervention before a suicide attempt is made.

It is important for counselors to be able to recognize warning signs and be prepared to question students about suicide, despite the fear and reluctance that many professionals have to inquire about such a sensitive subject (Quinnett, 2007). If a student is at risk, the school counselor should begin a process aimed at persuading the student not to harm himself or herself and to accept a referral for mental health treatment and other services aimed at ameliorating the student's difficult circumstances. The term *persuasion* does not imply that the task is easy or straightforward. Quinnett asserted that the ability to persuade a troubled individual to accept professional evaluation and treatment depends on a series of factors, including (a) the quality of the relationship that the counselor can establish with the suicidal person; (b) the counselor's ability to motivate the suicidal person through empathic, active listening and persuasive verbal skills; (c) the ready availability of professional services; (d) the suicidal student's mental status; (e) the suicidal student's previous experiences with mental health services; and (f) the suicidal student's fears and assumptions about accepting mental health services.

Although all school staff could learn more about suicide prevention from training, school counselors should take a lead role in school prevention efforts.

School counselors must be knowledgeable about appropriate community resources available to refer students and develop a plan that the student is able and willing to carry out. The counselor may need to accompany the student to a referral agency or treatment provider in order to overcome initial resistance and assure a transition in services.

The American Counseling Association (2006) presents five common myths about adolescent suicide on its Web site taken from Capuzzi (2002). All five myths are addressed in QPR training and demonstrate the common ground between QPR training and best practices in school counseling.

Myth 1: Adolescents who talk about suicide never attempt suicide. QPR training emphasizes that adolescents almost always talk about suicide before making an attempt. QPR participants are trained to listen for both direct and indirect statements of suicidal intent. Many students express their suicidal thoughts in a disguised or indirect manner because they are ambivalent about their feelings and intentions, and unsure about the response they will receive (Quinnett, 2007).

Myth 2: Suicide happens with no warning. QPR training teaches that students who are suicidal usually show warning signs to their friends, parents, or school personnel. QPR provides trainees with the knowledge to recognize potential warning signs in order to understand that a student is at risk and to actively inquire whenever there is a question about a student's status. For example, students may prepare for departure by giving away favorite possessions.

Myth 3: Adolescents from wealthy families attempt or complete suicide more often than adolescents from poor families. Trainees learn that adolescent suicide occurs at all socioeconomic levels. QPR training covers multiple warning signs, including students with substance abuse problems, with gender identity conflicts, and with recent losses.

Myth 4: Once an adolescent is suicidal, he or she is suicidal forever. Counselors understand that suicidal feelings are not permanent and that counseling can help an adolescent to overcome the conflict or problem that led to suicidal thinking.

Myth 5: Never use the word "suicide" when talking to adolescents because it may give some of them the idea. One of the principal goals of QPR training is to overcome the natural reluctance to ask questions about suicide. Counselors must become comfortable talking with students about their suicidal feelings.

This study demonstrated that both teachers and counselors benefited from QPR training. Although all school staff could learn more about suicide prevention from training, school counselors should take a lead role in school prevention efforts (King et al., 2000; King & Smith, 2000; Smaby, Peterson, Bergmann, Zentner Bacig, & Swearingen, 1990). With their knowledge of suicide prevention, school counselors can help other school staff to develop a greater awareness of suicide risk factors and a willingness to refer at-risk students for evaluation (Capuzzi, 2002; King et al.; Smaby et al.). ▮

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APPENDIX A

Survey Questions Used in Analyses

1. Since completing your training (in the past 3 months), how many students have you questioned about suicide?
2. Since completing your training (in the past 3 months), how many students have you referred for counseling or some form of mental health services where suicide was a concern?
3. Since completing your training (in the past 3 months), how many times have you made a contract with a student not to engage in suicidal behavior?
4. Knowledge of suicide risk—a sum of seven questions about risk factors in hypothetical situations.
5. Looking back at your suicide prevention training, would you say it was helpful or not helpful?
6. Looking back at your training, how did it affect your confidence in working with potentially suicidal students?
7. Looking back at your training, would you say it increased your knowledge and expertise in working with potentially suicidal students?
8. Looking back at your training, would you say it changed the way you work with potentially suicidal students?

Note. Control participants responded to questions asking for their behaviors in the past 3 months. Only trainees were asked questions 5–8.