Adolescents at Risk for Suicide: Parents' Perception in Implementing a Mandatory Suicide Screening Schedule and Importance of Parent Involvement

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Abstract

Should parents be more concerned and pay more attention to their adolescents' behaviors? What signs of possible thoughts of suicide should parents be looking out for? This current study proposes the need for mandatory suicide screenings during early and late adolescence to not only help parents but to help our society in monitoring the mental health of our adolescents on a routine, early intervention, and resourceful approach. Nearly 100 parents volunteered to complete a 20-question questionnaire to gather their opinion on whether mandatory suicide screenings are necessary among our adolescents today. Three variables are measured: the belief in suicide prevention, parent involvement, and the need for mandatory screenings. Volunteers were made known of this study through two different platforms. Results showed nearly half of the participants had known someone in their family or close to them who has attempted suicide at least once. A total of 30.43% reported having lost someone in their family or someone close to them to suicide. A positive correlation was seen between individuals with a strong belief in the importance of suicide prevention and their perception of mandatory screenings.

Keywords: suicide, adolescents, screening, parents, pandemic.

Table of Contents

Adolescents at Risk for Suicide: Parents' Perception of Implementing a Mandatory Suicide Screening Schedule and Importance of Parent Involvements

Suicide continues to take the lives of our loved ones. Suicide is death caused by injuring oneself with the intent to die (NIMH, 2021). Last reported in 2019, a total of 47,500 Americans died from suicide, that is, one death every 11 minutes (CDC, 2021). The number of people who think about suicide is reported to be even higher (CDC, 2021). In 2019, 12 million Americans seriously thought about suicide, 3.5 million planned it, and 1.4 million attempted suicide (CDC, 2021). A suicide attempt is when someone harms themselves with the intent to end their life, but they do not die as a result of their actions (NIHM, 2021). Suicide ideations are thoughts about self-harm with deliberate consideration or planning of possible techniques of causing one's death (American Psychiatric Association, 2013). Suicide continues to be the second leading cause of death among individuals between the ages of 10 and 34 (CDC, 2021).

Suicide rates increase from childhood to middle adulthood, jumping sharply at adolescence (Berk, 2018). Adolescents are youths between the ages of 11 and 18, entering the transition between childhood and adulthood. Adolescence is a critical time in human development. According to Erikson's (1963) Stages of Psychosocial Development theory, in complex societies, young people often experience an identity crisis-a temporary period of distress (as cited in Berk, 2018). Teenagers are reported to be among the most vulnerable groups to experience more stress and have less support. In adolescent brain development, the prefrontal cognitive control network cannot manage the stress reactivity and sensation-seeking impulses emanating from the brain's emotional and social network (Berk, 2018). Therefore,

an imbalance contributes to teenagers' tendency to take unnecessary chances with their lives. They may experience the illusion of control over death (Berk, 2018).

What can society do to stop this leading cause of death? Implementing mandatory screening for possible risks of suicidality among adolescents at age 12 and again at age 16 will help detect risks and plan for the appropriate treatment plan early on. Mandatory screening is defined to be required by law. Mandatory screenings are routinely scheduled to be a step towards preventing suicides and allowing time for an intervention.

Early detection may help parents identify unseen challenges and struggles their child may be experiencing. Early detection may help decrease the risk for suicide attempts among adolescents and help improve parent relationships. For example, mandatory screenings may help bring awareness that suicide is real and closer to home than we know. Mandatory screenings may open the doors for parents to communicate and help form relationships with their children. Mandatory screening may thus bring the child's whole community together to help overcome the child's suicidal tendencies. Finally, mandatory screening may allow for scheduled routine screenings to help with early detection for possible suicide risks.

Researchers do not understand the importance of requiring mandatory screening to help from missing red flags for possible suicidality among adolescents and allow for a better follow-up to measure process or need for additional intervention. Literature research includes adolescents treated for suicide attempts who had previous attempts and prior ideations. However, suicide risks may come from direct reports of suicidal thoughts or behaviors and environmental factors. Researchers have rarely investigated the importance of implementing mandatory screenings that show the importance of parent involvement by early detection as a

step toward forming parent relationships and recognizing early on risk for suicide among adolescents.

Literature Review

The current research on suicide prevention among adolescents focuses on a comprehensive approach with evidence-based strategies addressing a range of factors influencing suicide risks (Yand et al., 2021). The following literature review shows the need for regularly scheduled screening for suicide to help with early risk detection. Young persons might represent a group at high risk of suicide and may benefit from scheduled routine screening to help contribute to healthy development and suicide prevention.

The Importance of Early Diagnosing and Early Intervention

King et al. (2019) studied the likelihood of suicide attempts between the baseline emergency room visit and 3-month follow-up. Their goal was to assess how many ED patients would attempt suicide after their initial ED visit. Adolescents ages 12-17 who sought health care treatment in ED settings were consecutively recruited. A total of 6,448, or 60 % of the 10,664 approached patients, were enrolled. Participants completed a baseline suicide risk survey. From the 6,448 adolescents participating, 2,837 (44%) were identified to be at low risk, 1,564 (24.3%) at moderate risk, and 1,642 (25.5%) to be at high risk (King et al., 2019). Among 2,897 adolescents assigned to a 3-month telephone follow-up, only 2,104 completed the follow-up (King et al., 2019). Upon analyzing the process, predictors for a suicide attempt were identified using a multivariable model. Key predictors included experiencing suicide ideations within the past week, lifetime severity of suicide ideations, lifetime history of suicide behaviors, or interpersonal factors (King et al., 2019).

Results indicated a total of 104 adolescents (4.9%) who made a suicide attempt between their initial ED visit and a 3-month follow-up period. Statistics showed adolescent males have a much higher rate of suicide than adolescent females but receive fewer mental health services (King et al., 2019). This study showed the importance of identifying suicide risk factors to help prevent suicide attempts among adolescents. This study also revealed the challenges of adolescents who do not report suicidal thoughts. The proposed thesis study will allow the opportunity to identify suicide risk factors through routinely scheduled mandatory screenings throughout adolescent years.

Weatherly and Smith (2019) investigated the use of suicide risk screenings and assessments by healthcare clinicians in identifying adolescents at high risk for suicidality. The study used the Columbia-Suicide Severity Rating Scale (C-SSRS) and a Patient Health Questionnaire-9 (PHQ-9) modified for teens. The C-SSRS is a 6-question scale used to evaluate suicide by detecting suicidal ideation and behaviors. The PHQ-9 is a 9-question screening tool used to assess patients with symptoms. Questions came from the Diagnostic and Statistical Manual of Mental Disorders (DMS), used to diagnose depressive disorders. This study focused on the connections between depression and the risk for suicide. Depression screenings increase the likelihood of identifying adolescents with suicidal ideations and suicide plans (Weatherly & Smith, 2019). A total of 30 adolescents participated in this study, with 60 % being females and 40% males. The C-SSRS and PHQ-9 were administered to adolescents aged 14 to 18 years who came to the Emergency Department with a chief psychiatric complaint. Sixty percent of participants were also reported to have had a previous psychiatric diagnosis, with 65% of them diagnosed with depression (Weatherly & Smith,

2019). Results showed 33% of participants had a positive C-SSRS and screened moderate-to-severe depression on the PHQ-9.

Implementing a screening process creates a time-efficient method for improving adolescent access to appropriate mental health services. Over 13.8% of high school students have seriously thought about suicide, with 6.8% attempting suicide (Weatherly % Smith, 2019). Weather and Smith (2019) report that one-third of youths with suicide ideation develop a suicide plan, and 60% of them implement their plan within the first year of suicidal ideation onset. Even more alarming is that 50% of first-time suicide attempts are fatal (Weatherly & Smith, 2019). Identifying patients at risk for suicide is a nationwide safety goal and essential to suicide prevention. Mandatory screenings will be a step towards identifying risk factors along with detecting unmanaged depression among adolescents. Adolescents with unmanaged depression are more likely to have non-fatal and fatal self-injurious behaviors such as suicide attempts or completion (Weatherly & Smith, 2019).

The Importance of Parental Monitoring/Involvement

Moon et al. (2020) aimed to test whether parental monitoring predicts suicide behaviors in youths. Their goal was to improve the understanding of social-ecological factors associated with youth suicide behaviors and thus highlight important ideas for prevention. Their interest came from recent statistics that continue to report an increase among youth suicides nationwide. They focused on the association of important community and relational level variables such as parental monitoring with adolescent suicide behaviors. Their hypothesis determined the need for supportive family relationships could reduce the risk for problem behaviors. Parental monitoring was defined as the process whereby parents communicate with their youths about activities, respond as needed to behavioral issues,

specific risk behaviors, or educational needs. Past studies report that youths with authoritative parents tend to exhibit the lowest rates of suicide attempts, whereas youths of rejecting-neglecting parents tend to have higher rates of suicide attempts (Moon et al., 2020).

A total of 12,884 adolescents ages 12-17 were selected. Of the total population, 6,672 were girls, and 7,050 were boys. Suicide behaviors were assessed by asking three questions; 1. “Did you think about killing yourself,” 2. “Did you make a plan to kill yourself,” and 3. “Did you make a suicide attempt or try to kill yourself,” (Moon et al., 2020). Responses were scored yes=2 and no=1. A higher score implies higher suicide behaviors. Parental monitoring was an independent variable used to test the study's hypotheses. Parental monitoring was measured by four questions related to parents’ concerns about their youths. Results indicate lower parental monitoring was associated with higher suicide behaviors (Moon et al., 2020). Parental monitoring appears to impact suicide behaviors showing an important target for prevention programming. Results from this study could identify potential prevention along with interventions to reduce youth suicides. Interventions that teach parents to engage in parental monitoring can impact prevention efforts. Mandatory screenings could help towards teaching parental monitoring by building parental relationships and opening the doors to meaningful conversations.

Bridge et al. (2015) studied suicide trends among children between the ages of 5 and 11. According to Bridge et al. (2015), age 11 marks the beginning of adolescence. They accessed data from the web-based Injury Statistics Query and Reporting System of the Centers for Disease Control and Prevention, collecting information about children whose causes of death were suicide from 1993 - 2012. They compared the sociodemographic characteristics of the children and the methods of death. At a glance, 657 children aged 5-11

committed suicide in the United States, 84% (553) were boys, and 16% (104) were girls. Results showed a significant suicide rate increase in Black children, with hanging/suffocation the leading method for Black boys. Results also indicated a significantly decreased suicide rate in White children. Therefore, a potential racial disparity warrants attention. Bridge et al. (2015) suggested that further studies should monitor emerging trends, identify risks, protective, and precipitating factors relevant to suicide prevention efforts in children.

Aiken et al. (2019) observed distinct patterns of interactions in families of suicide attempters. Families of adolescents who were hospitalized following a suicide attempt were observed. The researchers used observational methods and 2-year longitudinal design. Parent-adolescent interactions were coded for emotional validation, invalidation, and problem-solving constructiveness. Parent-adolescent interactions were captured through videotaped tasks from the first time point. Videotapes were transcribed and coded for several behaviors of interest. The coding manual was adopted from sections of the Codebook for Marital and Family Interaction.

Families were recruited from consecutive adolescent admissions to 4 private psychiatric hospitals, with 48% of families contacted to participate in the suicidal group and 38% in the comparison group. Eligibility for the suicide attempt group required an attempt within the week prior to hospital admission. The attempt group consisted of 51 females and 20 males. Participating parents consisted of 66 mothers and 39 fathers; 62 % of attempters lived with both parents, and the following came from a single-parent household (Aiken et al., 2019). The comparison group consisted of 17 females and 12 males; 55% lived with both of their parents. Parents in this group consisted of 28 mothers and 16 fathers. Families were not

eligible to participate if the adolescent had any known history of suicidal behavior or other physical self-harm (Aiken et al., 2019).

A psychologist or psychology graduate student interviewed both parents and adolescents, predominantly at their homes, with very few conducted at the hospital. Interviews were conducted separately within one month after their hospitalizations. Participants in the comparison group families were interviewed at the initial time point only. The attempt group was re-interviewed four times; at 6-month intervals for two years following their suicide attempt (Aiken et al., 2019). Assessments at the 6-month and 18-month mark were conducted by phone, whereas others were conducted in person. Suicide attempts were assessed at each follow-up by asking the question within the past 6-months if they have tried to kill themselves. Yes/no variables were used in the analyses to indicate whether one or more suicide attempts occurred at any point during the follow-up period. Interpersonal and family dimensions are determined to play a big role in many theoretical accounts of adolescent suicidal behaviors (Aiken et al., 2019).

When analyzing suicide behaviors, possible risk factors, such as lack of problem-solving and coping skills should be considered. Adolescents who had attempted suicide displayed more emotional invalidation than controls. Within the suicide attempt group, maternal constructive problem solving predicted greater declines in youths' suicide ideation. Results were like trends observed with fathers (Aiken et al., 2019). In addition, adolescents who displayed more unconstructive problem solving with fathers were more likely to reattempt suicide during the follow-up (Aiken et al., 2019). Mothers of attempters were less positive, showing lower emotional validation and more negative with higher emotional validation with their sons than with daughters (Aiken et al., 2019). Both parental and

adolescent communication and problem-solving factors are important when designing interventions for families of suicidal youths. Constructive problem-solving skills are needed among adolescents to predict improvement in suicide ideations (Aiken et al., 2019).

Importance of Mandatory Risk Screening

Hiott et al. (2018) evaluated adolescent risk screening instruments available to primary care providers in the US. Their goal was to identify variables that influence successful risk screening. They examined the structures, processes, and outcomes of all the screening tools available in primary care settings. Hiott and colleagues (2018) used library, ancestry, and internet searches. The structures they examined involved the physical, human, and financial resources available for providing care. The processes they examined involved activities that helped identify adolescents at risk, including the administration, interpretation of the screening, and communication between the provider, parent, and adolescent (Hiott et al., 2018). The outcomes they examined explored included the care results and the efficiency and effectiveness of the interaction between the structure and the process.

According to the authors, outcomes are successful when risk variables are identified. The intent is that the risk screening instrument for older adolescents facilitates self-reporting of feelings and behaviors not noticed by other people (i.e., parents or caregivers) (Hiott et al., 2018). This research focused on the Donabedian Framework, which offers primary care providers a clearer picture of each aspect of the adolescent risk screening process and desired outcomes (Hiott et al., 2018). The integrative articles indicated few instruments are available for screening adolescents for risky behaviors in the primary care setting. The study confirmed the need for successful risk screenings. Risk screening is a vital part of comprehensive

adolescent care. It is also important to ensure that risk screening instruments are comprehensive, brief, understandable, and easy to administer and score (Hiott et al., 2018).

Ben-David et al. (2019) sought to study the high rates of underutilization of mental health services among young people. Research shows young adults at clinical high risk (CHR) for developing psychosis can recognize they have a problem. Yet, a lack of theoretically based research examines the decision-making process involved in young adults being more ambivalent about seeking clinical services. This study sought to break the stigma in seeking mental health services (Ben-David et al., 2019). The research focused on 30 young adults ages 18 and 30 who were clinically high risk from an ethnically diverse eastern city in the US. The researchers collected data from 2015 to 2017. The average age of participants was age 23. Sixty percent of participants were men, 34% were White, 23% Black, 20% Hispanic, 20% Bi-racial, and 3% Asian. Results indicated the decision-making process to seek services at clinic settings involved their attitudes or beliefs about help-seeking, social image beliefs, and emotional reactions towards seeking services. The theoretical model of help-seeking decisions argues that social networks play a role in adolescents utilizing the services needed (Ben-David et al., 2019). Mandatory screenings can help break the stigma of seeking mental health services among young people. It is time to stop the shame in seeking treatment.

Adrian et al. (2021) conducted a study to show the need for more data on promising suicide-specific care for adolescents. Their goals were to report on the feasibility, acceptability, and appropriateness of the Collaborative Assessment and Management of Suicide (CAMS). The CAMS is a suicide-focused intervention framework that has been demonstrated to reduce suicidal risk (Adrian et al., 2021). CAMS is designed to enhance the therapeutic alliance and increase motivation in the patient's effort to engage in treatment plans

effectively. Adolescents were recruited from Seattle Children's Hospital, which provides both short- and long-term community mental health services. Out of 45 screened adolescents, only 22 met CAMS criteria, and of the 22, only 16 completed a follow-up assessment. A 4-item screening assessment measured for suicide ideating, suicide attempts, threats of suicide, and self-reported likelihood of suicide. Assessment measurements were completed at baseline, end of treatment, and a follow-up 6-months after the study. CAMS clinical response criteria determined length for treatment. Treatment strategies targeted and treated patient-defined "drivers" of suicidality such as bullying at school, parent conflicts, or sexual abuse by a family member (Adrian et al., 2021).

An average of 5.22 sessions were completed. Parents were also allowed to participate in at least two CAMS sessions, the first and second sessions. The first session allowed parents to provide their perspective on the adolescent's functioning, and the second session allowed parents to participate in the discussion and problem solving of the Stabilization Plan developed in the first session (Adrian et al., 2021). Although results confirmed CAMS's feasibility, acceptability, and appropriateness, they also confirmed the need for access to larger populations. For example, mandatory routinely screening for suicide risk will be a step closer to ensuring that all adolescents are screened for suicide risk, a step closer to preventing another adolescent's warning signs unseen.

Increase Effect since COVID-19 Pandemic

Yard et al. (2021) studied the increase in the mental health-related emergency department (ER) visits among adolescents aged 12-17 in 2020. The lives of all Americans were affected due to the COVID-19 pandemic. Compared to 2019, an increase of 31% of adolescents ages 12-17 years presented to ER with mental health-related concerns. Among

adults aged 18-24 years, 25% reported experiencing suicidal ideation related to the pandemic (Yard et al., 2021). By early May 2020, ED visit counts for suspected suicide attempts increased among adolescents aged 12-17 years, especially girls (Yard et al., 2021). By February 21-March 20, 2021, the mean of weekly ED visit counts for suspected suicide attempts showed to be 50.6% higher (Yard et al., 2021). The pandemic particularly affected adolescents by mitigation measures such as physical distancing that prevented them from experiencing connectedness to schools and peers. On the other hand, the pandemic allowed parents more time with adolescents, thus becoming more aware of suicidal thoughts and behaviors (Yard et al., 2021). Mandatory suicide screenings can be used as reminders for parents and the community to allow time to pay attention to risk factors even after the pandemic.

Wright and Wachs (2021) aimed to examine the moderating effect of perceived teacher support in the relationships between self-isolation during the beginning of the pandemic and negative health outcomes. Health outcomes consisted of suicidal ideations, non-suicidal self-harm, subjective health complaints, and depression, measured in mid-April of 2020. Wright and Wachs (2021) studied the relationship between self-isolation and adolescents' health outcomes at the beginning of school closures due to the COVID-19 pandemic. A total of 467 adolescents in grades 7th and 8th of schools in lower- to middle-income neighborhoods participated. Of 467, 51% were girls, and participants' ages ranged from 12-15 years old. Parents completed an electronic parental permission form and were then emailed a website address for their child to complete online surveys (Wright & Wachs, 2021).

Adolescents completed online questionnaires on their self-isolation during the beginning of the COVID-19 pandemic. The researchers measured self-isolation practices in

three items: avoiding special events, avoiding going to stores or restaurants, or avoiding interacting with other people besides people in their household. Items were rated on a scale of 1 (never) to 5 (all the time). Results revealed that self-isolation harms adolescents' psychological outcomes. This study might inform policy development with strategies to help improve health outcomes for adolescents during the COVID-19 crisis and future pandemics.

Summary and Research Question

Among 6,448 adolescents ages 12-17 who presented to the ER, King et al. (2019) found nearly 5% attempted suicide again within three months after their initial visit. Hiott et al. (2018) discovered outcomes to be the most successful when risk variables are identified. Moon et al. (2020) found parental monitoring to impact suicide behaviors. At a glance, Bridge et al. (2015) found 657 children aged 5-11 committed suicide in the United States, with 84% (553) being boys and 16% (104) being girls from 1993 - 2012. Aiken et al. (2019) found that parental and adolescent communication and problem-solving factors are important when designing interventions for families of suicidal youths. Weatherly and Smith (2019) reported that one-third of youths with suicide ideation develop a suicide plan, and 60% of them implement their plan within the first year of their suicidal ideation onset, with 50% of first-time suicide attempts being fatal.

Ben-David et al. (2019) sought to break the stigma of mental health services. They found the decision-making process in seeking services in clinic settings involved their attitudes or beliefs about help-seeking, social image beliefs, and emotional reactions towards services. Adrian et al. (2021) showed the need for more data on promising suicide-specific care for adolescents' prevention. Yard et al. (2021) found an increase of 31% of adolescents aged 12-17 years who presented to ER with mental health concerns. Among adults aged 18-24

years, 25% reported experiencing suicidal ideation related to the pandemic. Wright and Wachs (2021) examined the moderate effect of perceived teacher support in the relationships between self-isolation during the pandemic, revealing that self-isolation harms adolescents' psychological outcomes.

The literature reviewed suggests the need for additional research in suicide prevention among adolescents. These findings showed increased suicidal ideations among adolescents, although risk factors varied among the studies. Researchers detected suicide behaviors after a suicide attempt in the ten studies reviewed. The current study aims to address this concern. Therefore, do mandatory scheduled screenings impact outcomes of suicide behaviors and parent-adolescents' relationships in ways necessary to decrease the risk for suicide?

Method

How can our society work together to help prevent suicide among our adolescents? Parents are responsible for monitoring possible suicide risk factors among their children. Can we, as a society, benefit from mandatory suicide screenings for all adolescents?

Participants

Participants have learned of the study through research announcement flyers. Flyers were posted in two different data sources, including Facebook and a non-profit organization that serves families with children. Staff received the research announcement flyer through email. Permission was received by the organization's Executive Director.

Volunteers were made known of the research announcement flyer was on Facebook pages of several open-access groups frequented by parent support groups such as TIC plus or dedicated to mental health research such as the Arizona Department of Health Services; see Appendix B for the announcement's text. Facebook's terms of service permit such research

postings; see www.facebook.com/terms. The Research Announcement remained on the social media sites for four weeks, and where the researcher re-posted it repeatedly to keep the announcement appearing in the news feed for the selected groups. Some Facebook groups have moderators; others do not. Some groups include language in their terms, disallowing posting on their research and data collection pages. The researcher only posted the Research Announcement on Facebook pages whose terms allow postings for research or data collection purposes. If this is unclear from the terms, the researcher attempted to contact the group moderator to request permission to post the Research Announcement. No response was received from moderators granting permission.

The Research Announcement included a link to an anonymous survey, accessible via SurveyMonkey. The link took subjects to SurveyMonkey, where subjects first were required to read and agree to the Informed Consent; see Appendix C for the text of Informed Consent. Participants who agreed to the Informed Consent, were allowed to the next step in completing the initial screening. Participants who did not agree to the Informed Consent, were automatically sent to a thank you page where the survey came to an end. Although it is unlikely, participants who experienced any emotional discomfort resulting from completing the survey, were instructed to contact the Emotional Distress Hotline, a national mental health hotline, available 24/7 for free at 1-800-LIFENET. After several weeks, the SurveyMonkey survey closed, and data was analyzed

Participants were not excluded based on their age, sex or gender, ethnicity, racial characteristics, or educational background. Participants were required to be parents to move from the initial screening to the final questionnaire. Ideal participants are parents of children under 18 years old. Volunteers with close a personal history of suicide were disqualified due

to possible bias in the study. Flyers contained all the information needed. Volunteers who were interested in participating in this study went directly to the URL address to access the survey.

Participants were first required to complete an initial screening survey, questions 1-5. See Appendix E for the full text of the screening survey. Qualified participants moved to the next step of completing the full questionnaire. Participants had as much time as needed to complete the questionnaire in one session. Participants took an average of 3 minutes in completing the survey.

Measures

The questionnaire gathered participants' perspectives on suicide prevention and consisted of 20 questions. Variable one measured the beliefs about suicide prevention, the ability to detect risk factors, and the importance of talking about suicide. These items comprised questions 11 through question 15. Questions 11-15 measured the beliefs associated with suicide prevention. Variable two measured the behaviors and effects on parent involvement. These items comprised questions 16 through question 20. Questions 16-20 measured the involvement of parents, effects on behaviors, and the risk of suicide ideations among adolescents with the lack of or over-parenting involvement. Variable 3 measured participants' interest or disinterest in implementing mandatory screenings. These items comprised questions 21 through question 25. Questions 21-25 measured participants' interest in mandatory screenings.

Demographics Questionnaire

A demographic questionnaire was included to assess the characteristics of my participants. Demographic questions identified participants' race/ethnicity, sex, age, and education level. Questions 6-10 measured participants' demographics.

The School-Family Partnership Model

Parent involvement was measured using the School-Family Partnership Model (Hanover Research, 2016; Joyce Epstein, 2004). It consists of six types of involvement and partnership and six items measuring parenting, communicating, volunteering, learning at home, decision making, and collaborating with the community (Hanover, 2016). A framework Likert scale was used to rate the strength of the partnership, the need for focus or direction, and areas in need of change. Each type of involvement was assessed using a Strongly disagree (1) to Strongly agree (4) four-point rating scale. See Appendix E for the School-Family Partnership Model and rating scale. According to Hanover Research (2016), the School-Family Partnership Model can help parents become involved at school and home in various ways that meet students' needs. This model stems largely from overlapping families, schools, and communities to help influence student learning. All analyses should account for potential biasing factors to help increase accountability and establish analytical validity.

Behavioral Indicators Questionnaires

The survey was developed with primarily closed-ended questions. Questions include demographics and key content related to the research question or suggested by the literature review. Questions were developed based on the School-Family Partnership Model and directly from the NIMH Suicide Prevention. See Appendix E for the full text of the survey. A doctoral-level researcher specializing in survey design reviewed and edited the survey, improving its face and content validity. Face validity suggests that the survey measures what

it aims to measure based upon a simple reading of the questions. Content validity indicates that the instrument represents all key aspects of the construct it should measure; an expert appraisal can partially assess content validity (Miller & Lovler, 2015). Nevertheless, the researcher developed the new survey for the present research and had no existing data on the reliability or validity of the questions or the instrument beyond the face and content validity.

Procedures

Research announcement flyers included information about the study and its purpose. A URL link was provided for participants could assess the survey. All participants were required to sign the consent to participant before proceeding. Once participants signed the consent, participants moved to the next step in completing the initial screening. The initial screening survey is required to determine if the participant qualified for the study. Those who did not qualify to complete the study were directed to a "Thank You" page, where the survey came to an end. Participants who qualified were allowed access to the final step in completing the 20-question questionnaire. The study was concluded when the participant finished the survey. Participants were directed to a "Thank You" page for participating.

Data Management

To ensure the anonymity of the survey participants, in using SurveyMonkey, the researcher did not collect IP addresses. For this study, all data was transferred from SurveyMonkey into an SPSS database for analysis. The results were presented in an aggregated form to protect all participants' identities. Completed surveys were maintained on an encrypted flash drive, kept in a locked file cabinet. Researcher parties only had access to the password protected by the SPSS dataset. The dataset contained no coded identifiers and was completely anonymous.

All electronic data was stored on an encrypted flash drive and not on any computer hard drive. Retained the data set and related files for a minimum of five years after the study completion, in case questions arise about the analyses. After five years, all data will be destroyed using the current Department of Defense data destruction standards.

Statistical Analysis

Descriptive statistics, including frequencies, mean, average, and range were used. Descriptive statistics involved parents' genders, education level, involvement, age group, and culture. Correlation analysis were run on the participants' interest in implementing mandatory suicide screening, their beliefs in suicide prevention, and the range of the age(s) of their child/children. A correlation analysis was also completed on interest in mandatory screening and parent involvement.

Each measure measured using a 5-point Likert scale. See Appendix E for the full 5-point Likert scale. Participants were asked to indicate a degree of disagreement and agreement with each series of statements. Each scale item had five response categories ranging from strongly disagree to strongly agree. Each statement was assigned a numerical score ranging from 1 to 5. Each degree of agreement was given a numerical score. Participants' total scores were computed. The total score of participants revealed their opinion/belief on each measure.

Results

Participant and Demographic Characteristics

A total of 18.26% of participants (21 out of a total of 117 individuals) were disqualified during the initial screening due to not being parents. Two participants decided to skip answering the five initial screening questions. Most participants were Caucasian (56.04%), 37.36% Hispanic, 5.49% African American, and 1.10% another race. The majority

of participants were females (95.60%) with only four participants being males (4.40%). All participants were over the age of 24 with nearly 40% falling between the age range of 35-44. More than half of participants (59.34%) indicated having a bachelor's degree. Many participants indicated having children ages 1-5 (42.86%) and (37.36%) having children over the age of 18. Participants with children in the 11-14 age group (17.58%) and (19.78%) in the 15-17 age group. See Appendix F Table 1 for the complete demographic summary.

Suicide Prevention

Variable one measured participants belief about suicide prevention, the ability to be able to detect risk factors, and the importance of talking about suicide. The range of degree of agreeing that family or friends are most likely to recognize warning signs ranged from strongly agree to agree; 14.29% strongly agreed with 32.97% agreeing. Interesting enough, 28.57% of participants disagreed. Most participants strongly agreed or agreed that warning signs of suicide make individuals higher at risk for danger; 50.65% strongly agreed with 40.66% agreed. Similarly, many participants also agreed coping strategies, resources, and evidence-based interventions help people at risk. What was interesting to see is that although many participants agreed that family and friends are more likely to recognize warning signs, more than half (57.14%), with a total of 87.91%, agreeing that it is difficult to tell who will act on suicidal thoughts or actions. Table 1 summarizes participants scores on their belief in suicide prevention.

Parent Involvement

Variable two measured parents' behaviors and involvement. The average of parents reported helping their child with their homework as well as having set rules in their homes, a total of 91.21% agreed. Volunteering at their child's school score was a bit different. Only a

total of 54.95% reported to having had volunteered at their child's school. A total of 45.06% received scores of 3 or below, neither agreeing nor disagreeing, disagreeing, or strongly disagreeing. Although all parents reported to listening when their child speaks, participants scores ranged from 5-4. Surprisingly enough, a total of 20.88% reported to not having talked to their child about their future such as college. Table 2 summarizes participants score on their parent involvement.

Mandatory Screenings

Variable three measures participants' opinion on implementing mandatory screenings. Although most participants agreed to the fact that suicide does not discriminate and agreed that stressful life events and interpersonal stressors can contribute to the risk for suicide, 26.37% neither agreed nor disagreed with 6.59% reporting to disagreeing that personalized safety plans can help reduce suicidal thoughts or actions. Same with electric health records helping identify people with suicide risk, 47.25% neither agreed nor disagreed with only 8.79% disagreeing. Interesting enough 24.18% of participates neither agreed nor disagreed that individuals at risk often also suffer with mental illnesses or substance use problems; a total of 14.29% disagreed. Table 3 summarizes participants' scores on their opinion in mandatory screenings.

Discussion

Data from this sample supports the perception that early detection can help decrease risk for attempts. Participants agreed in the importance of suicide prevention and the fact that warning signs can be missed or fail to be recognized or reported. Although research results did not support the original hypothesis that thorough prevention and

monitoring will help improve parent relationships, results supported the need for an effective follow-up measure for suicide prevention.

Implications

Participants' level of agreement on the effects of suicide prevention was in favor of the idea of implementing mandatory screenings. It was important to see the responses and opinions of the participants since they were parents of adolescents under the age of 18. It was interesting that all participants reported listening when their child spoke. It was also important to see that all participants understood that suicide does not discriminate and can happen to anyone.

Correlational Analyses

A correlation relationship was conducted to be measured between parent involvement (variable two) and the opinion on mandatory suicide screenings (variable three), as well as measuring the relationship between the belief in suicide prevention (variable one) and the implementation of mandatory screenings (variable three). Data from this study showed a negative correlation between parent involvement and mandatory screening. In contrast, this study's data showed a positive correlation between belief in suicide prevention and mandatory screenings. Participants with a high-level belief in suicide prevention showed an interest in implementing mandatory suicide screenings. See Appendix F Table 4 and 5 for the full correlation tables.

Similarities and Differences

Current research findings were similar to past research on the importance of prevention and the need for effective screening tools. As Weatherly Smith (2019) discussed, implementing a screening process can help create a time-efficient method for

improving adolescent access to appropriate mental health services. Current research also supported past studies in understanding factors such as stress can increase the risk for suicide. Aiken et el. (2019) indicated the importance of having constructive problem-solving skills needed among adolescents to predict improvement in suicide ideations. Current research differs from previous studies focused on measuring parent involvement and its benefit in predicting adolescents' behaviors. Whereas current research did not support the importance of the parenting level but showed the importance of effective communication between parents and adolescents. There may be a difference in what may be considered effective parenting now due to the rise in mental health and emotional distress due to the recent pandemic resulting in isolation. As mentioned earlier, Yard et al. (2021) reported that the pandemic affected adolescents by physically distancing themselves from their peers and experiencing connectedness at school.

Limitations

This study was limited to a small sample size and the fathers' responses. The majority of participants were mothers. It would have been interesting to get more of a variety of responses from the father's point of view on this subject matter. The average time it took participants to complete the entire questionnaire was also concerning. The average time was 3 minutes. If participants took more time to consider each response, the level of agreement may have differed. The age group of participants' children was also limited to the desired age of adolescence. Nearly 40% of participants had children over the age of 18. The ideal population would be parents of children during their adolescent years. It was also difficult to identify participants' matching responses. It would have been ideal to identify the responses of the participants with the desired age group since they are

currently living in that risk group. Parents with children under adolescence may not understand teens' challenges and risks.

Conclusions

The idea of mandatory suicide screenings is important for the future of adolescents and young adults. The United States continues to struggle everyday with mental health and suicide ideations. Nearly 50% of participants in my study alone reported to having known someone who has attempted suicide. Suicide has always been close to home. It is important for society to speak more about the risk, danger, and the cry for help by monitoring risk factors before it is too late.

Adverse Childhood Experiences (ACEs) are potentially traumatic events in a child's life that can have negative and lasting effects on a person's physical, mental, and emotional health (ACEs Indiana Coalition, 2020). These experiences increase the risk of injury and is the leading cause of suicide. We learned that toxic stress from ACEs can change brain development and affect in attention, decision-making, and response to stress. According to the Center for Disease Control and Prevention, ACEs are common in all populations, with nearly two-thirds having reported to at least one ACEs and more than one in five reported to three or more ACEs. Monitoring of possible risk factors can begin very early on.

Why wait until a tragedy occurs? The United States has suffered long enough. The deadliest mass shooting in this year occurred on May 24, 2022, at Robb Elementary school when 18-year-old, opened fired in a classroom, fatally shooting 19 students and 2 educators (Long, 2022). Were there several warning signs leading to this mass shooting that could have potentially prevented this horrible act? The National Education

Association (2022) report this is the time to pay attention to our children, watch for signs they may want to talk, and the importance of observing children's emotional state.

Parents should be educated on how to talk to their teens. Parents have a harder job in keeping their teens safe and our in this society. Firefly Children and Family Alliance discussed teen suicide and what families need to know. Teens are one of the highest at-risk groups for suicide (Firefly, 2022). Warning signs can be verbal, behavioral, or situational. Therefore, communication is key. Talking can save lives. Parents must learn to be direct when asking their teens how they feel. When asking their teens about suicide, parents may fear that it may increase their risk of suicide, when in fact, asking directly to help teens feel shows them that you are aware of what is going on and can reduce their anxiety about opening up.

References

ACEs Indiana Coalition. (2020). *Growing awareness and building community*. https://www.acesindiana.org/

Adrian, M., Blossom, J. B., Chu, P. V., Jobes, D., & McCauley, E. (2021). Collaborative assessment and management of suicidality for teens: A promising frontline intervention for addressing adolescent suicidality. *Practice Innovations.* http://dx.doi.org/10.1037/pri0000156

Aiken, C. S., Wagner, B. M., & Hinnant, J. B. (2019). Observed interactions in families of adolescent suicide attempters. *Suicide and Life-Threatening Behavior*. *49*(*1)*, 104-119. http://doi.org/10.1111/sltb.12423

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Ben-David S., Cole A., Brucato G., Girgis RR., & Munson MR. (2019). Mental health services use decision-making among young adults at clinical high risk for developing psychosis. *Early Intervention in Psychiatry*, *13* (5), 1050-1055. https://doi.org/10.1111/eip.12725

Berk, L.E. (2018). *Development through the lifespan*. (7th ed). Pearson Education.

Bridge JA., Asti L., Horowitz LM., Greenhouse JB., Fontanella CA., Sheftall AH., Kelleher KJ., & Campo JV. (2015). Suicide trends among elementary school-aged children in the united states from 1993 to 2012. *American Medical Association*, *169*(7), 673-7. https://doi.org/10.1001/jamapediatrics.2015.0465

Centers for Disease Control and Prevention. (2021). *Facts about suicide.* U.S. Department of Health and Human Services, National Center for Injury Prevention and Control. https://www.cdc.gov/suicide/facts/index.html

Firefly Children and Family Alliance. (2022). Teen Suicide: What families need to know. https://fireflyin.org/resources/news-library/teen-suicide-what-families-need-to-know/

Hanover Research. (2016, October). *Best practices in measuring parent engagement.* https://www.sanjuan.edu/cms/lib/CA01902727/Centricity/Domain/2397/Best%20Practices%20in%20Measuring%20Parent%20Engagement.pdf

Hiott, DB., Phillips, S., & Amella E. (2018). Adolescent risk screening instruments for primary care: An integrative review utilizing the Donabedian Framework. *Comprehensive Child and Adolescent Nursing, 41*(4), 255-275. https://doi.org/10.1080/24694193.2017.1330372

King, C. A., Grupp-Phelan, J., Brent, D., Dean, J. M., Webb, M., Bridge, J. A., Spirito, A., Chernick, L. S., Mahabee-Gittens, E. M., Mistry, R. D., Rea, M., Keller, A., Rogers, A., Shenoi, R., Cwik, M., Busby, D. R., & Casper, T. C. (2019). Predicting 3-month risk for adolescent suicide attempts among pediatric emergency department patients. *Journal of Child Psychology and Psychiatry, 60*(10), 1055-1064. http://doi.org./10.1111/jcpp.13087

Long, C. (2022, May 24). *Talking to students about the Texas Elementary school shooting.* National Educational Association. https://www.nea.org/advocating-for-change/new-from-nea/talking-students-about-texas-elementary-school-shooting

Moon, S. S., Kim, Y. J., & Parrish, D. (2020). Understanding the linkages between parental monitoring, school academic engagement, substance use, and suicide among

adolescents in U.S. *Child & Youth Care Forum*, *49*(6), 953-968. http://doi.org/10.1007/s10566-020-09570-5

National Institute of Mental Health. (2021). *Suicide prevention.* U.S. Department of Health and Human Services, National Institutes of Health. https://www.nimh.nih.gov/health/topics/suicide-prevention#part_9890

Rogers, K. (2022, April 25) *Adolescent suicide increased in 5 US states during the pandemic. Why parents should be concerned.* CNN Health. https://www.cnn.com/2022/04/25/health/teen-suicide-increase-pandemic-study-wellness/index.html#:~:text=The%20number%20of%20suicides%20among,journal%20JAMA%20Pediatrics%20on%20Monday.

Weatherly, A. H., & Smith, T. S. (2019). Effectiveness of two psychiatric screening tools for adolescent suicide risk. *Pediatric Nursing*, *45*(4), 180-183.

Wright, M. F., & Wachs, S. (2021). Self-isolation during the beginning of the COVID-19 pandemic and adolescents' health outcomes: The moderating effect of perceived teacher support. *School Psychology*. http://dx.doi.org/10.1037/spq0000460

Yard, E., Radhakrishnan, L., Ballesteros, M. F., Sheppard, M., Gates, A., Stein, Z., Hartnett, K., Kite-Powell, A., Rodgers, L., Adjemian, J., Edlman, D. C., Holland, K., Idaikkadar, N., Ivey-Stephenson, A., Martinez, P., Law, P., & Stone, D. M. (2021). Emergency department visits for suspected suicide attempts among persons aged 12-25 years before and during the COVID-19 pandemic-United States, January 2019-May 2021. *Morbidity and Mortality Weekly Report, 70*(24), 888-894.

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Institutional Review Board

550 West Van Buren

Chicago, Illinois 60607

Expedited Review – Final Approval

June 2, 2022

Ms. Janet Mota

Purdue University Global

janetmota1@student.purdueglobal.edu

Re: Protocol #22-31 – **"Adolescents at Risk for Suicide: Parents' Perception in Implementing a Mandatory Suicide Screening Schedule and Importance of Parent Involvement."**

Dear Ms. Mota:

Your proposed project was reviewed by the Purdue University Global Institutional Review Board (IRB) for the protection of human subjects under an Expedited Category. It was determined that your project activity meets the expedited criteria as defined by the DHHS Regulations for the Protection of Human Subjects (45 CFR 46) and is in compliance with this institution's Federal Wide Assurance 00010056.

Please notify the IRB immediately of any proposed changes that may affect the expedited status of your project. You should report any unanticipated problems involving risks to human subjects or others to the IRB.

If you have any questions or need additional information, please contact feel free to contact me at spettine@purdueglobal.edu. I wish you well with your project!

Sincerely,

Susan B. Pettine

Susan B. Pettine, Ph.D., CBM

IRB Chair

Purdue University Global

cc: Dr. Gabrielle Blackman

Research Announcement

I am conducting research through Purdue University Global to obtain a master's degree in Psychology.

The research aims to explain suicide prevention strategies among our adolescents and to gather parents' perspectives on whether mandatory screening for suicide risk factors is needed within our society.

If you are interested in being part of this study and would like to take the survey, please click here for more information: URL

The survey will take no more than 5 minutes of your time.

This study will be confidential, so your personal information will be protected securely according to all applicable laws and regulations.

The research study is in no way sponsored by, endorsed, administered by, or associated with the Facebook. Participants release Facebook of any responsibility or liability associated with participating in this research.

Thank you for your support and participation.

Click here to participate! URL

Suicide Prevention

Are you a parent?

Mental Health is Real

Seeking Parent's Perceptions

Volunteers Needed

Interested?

Click here to Participant: URL

Master's Research Program

PURDUE UNIVERSITY GLOBAL

Nearly 46,000 people died by suicide in 2020

1 Death every 11 minutes

The number of people who think about or attempt suicide is even higher.

Suicide is the second leading cause of death for people ages 10-14.

Suicide is preventable.

Everyone has a role to play to save lives.

Strategies to prevent suicide are needed

CDC.gov 2022

Appendix C1

Purdue University Global
Consent for Participation in Research
"Adolescents at Risk for Suicide: Parents' Perception in Implementing a Mandatory Suicide Screening Schedule and Importance of Parent Involvement"

CONCISE SUMMARY

You are being asked to be a participant in a research study about suicide prevention among adolescents and whether mandatory screening is needed to help parents be more aware of the possible risk factors. If you agree to participate, you will complete a quick screening survey. If you are the ideal candidate, you will then be asked to complete a questionnaire.

Why am I being asked?

You are being asked to be a participant in a research study about suicide prevention among adolescents and whether mandatory screening is needed to help parents be more aware of the possible risk factors. This research study is being conducted by Janet Mota, a Master of Science in Psychology student at Purdue University Global. You have been asked to participate in the research because you are a parent of a child under the age of 18 years old and may be eligible to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the research.

Your participation in this research is voluntary. Your decision on whether to participate will not affect your current or future relations with Purdue University Global. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

What is the purpose of this research?

This research aims to gather parents' perceptions of suicide prevention among adolescents. This study focuses on whether parents believe mandatory screenings are needed to help detect risk factors early on during adolescence to prevent and/or decrease any forms of suicide ideations.

What procedures are involved?

If you agree to be in this research, we will ask you to do the following:

Complete a quick screening survey. If you are the ideal candidate, you will then be asked to complete a questionnaire.

Approximately 100 may be involved in this research at Purdue University Global.

What are the potential risks and discomforts?

The research may involve some discomfort in learning facts about why adolescents may turn to suicide ideations. If you or someone you know is in a suicidal crisis or emotional distress, get emergency help right away. Contact the National Suicide Prevention Lifeline at 1-800-273-8255. Access the United Healthcare website for additional behavioral health support for your teens and adolescents https://www.uhc.com/health-and-wellness/mental-health/parent-and-youth.

Are there benefits to taking part in the research?

Suicide is preventable. Everyone has a role to play to save lives and create healthy and strong individuals, families, and communities. As a parent in our society, your perspective is needed.

What about privacy and confidentiality?

No one will know that you are a research subject because this research is totally anonymous. No information about you or provided by you during the research can ever be disclosed to others because no information that can possibly identify you as an individual will be collected. When the research results are published or discussed at conferences, no information will be included that could ever reveal your identity.

Will I be reimbursed for any of my expenses or paid for my participation in this research?

At this time, no reimbursement is available for participation in this research.

Can I withdraw from the study?

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and remain in the study.

Whom should I contact if I have questions?

The researcher conducting this study is Janet Mota. You may ask any questions you have now. If you have questions later, you may contact the researchers at: 219-201-5412. You may also contact the researcher's thesis adviser, Dr. Gabrielle Blackman PhD, at gblackman@purdueglobal.edu.

What are my rights as a research subject?

If you feel you have not been treated according to the descriptions in this form, or you have any questions about your rights as a research subject, you may contact the Institutional Review Board (IRB) at Purdue University Global through the following representative:

Susan Pettine, IRB Chair

Email: spettine@purdueglobal.edu

Remember: Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Purdue University Global, First Steps, or Gilbert Services. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

You may keep a copy of this form for your information and your records.

Signature of Subject

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I have been given a copy of this form.

_____ _____

Signature Date

_____

Printed Name

_____ _____

Signature of Researcher Date (must be same as subject's)

Appendix D

Table 1.

Survey Development Plan

Objective	Operational Definition	Number and Type of Items
To assess the belief in suicide prevention	I define the belief in suicide prevention as the degree to which participants are content with the following statements: - Family and friends are often the first to recognize warning signs of suicide. - Someone showing warning signs of suicide may be at higher risk for danger. - Coping strategies, people, and resources can help in a crisis. - Evidence-based interventions help people at risk for suicide. - It is difficult to tell who will act on suicidal thoughts and action.	These items comprise Q11 - Q15 of my questionnaire.
To assess parent involvement	I define parent involvement as the degree to which participants are content with the following statements: - I help my child with homework. - I have set rules at home. - I volunteer at my child's school. - I listen when my child speaks. - I discuss future graduation plans with my child.	These items comprise Q16 – Q20 of my questionnaire.
To assess interest in implementing mandatory suicide screenings	I define participants interest in mandatory screenings as to the degree to which participants are content with the following statements: - Personalized safety plans help reduce suicidal thoughts and actions. - Electric health records can help identify people with	These items comprise Q21 - Q25 of my questionnaire.

	suicide risk. - Suicide does not discriminate. - Many individuals at risk for suicide often have a mental illness or substance use problems. - Stressful life events and interpersonal stressors may contribute to risk suicide risk.	

Appendix E

Initial Screening Survey

1. Are you a parent?
    a. yes
    b. no
2. Is your child under the age of 18?
    a. yes
    b. no
3. Has anyone in your family or someone close to you attempted suicide?
    a. yes
    b. no
4. Has anyone in your family or someone close to you lost their live to suicide?
    a. yes
    b. no

Questionnaire

1. What is your race/ethnicity?

    a. American Indian or Alaskan Native
    b. Asian/Pacific Islander
    c. Black or African American
    d. Hispanic
    e. White/Caucasian
    f. Multiple ethnicity/other (please specify): _____
    g. Prefer not to answer

2. What is your gender identity?
    a. Woman
    b. Man
    c. Transgender
    d. Non-binary/non-conforming
    e. Other (please specify): _____
    f. Prefer not to answer

3. What is your age range?
    a. 18-25
    b. 26-30
    c. 31-35
    d. 36-40
    e. 40-45
    f. 46-50
    g. 50+
    h. Prefer not to answer

4. What is the highest level of education you have attained?
    a. Less than a high school diploma
    b. High School degree or equivalent (GED)
    c. Some college, but no degree
    d. Associate degree
    e. Bachelor's degree
    f. Master's degree
    g. Doctoral degree
    h. Other (please specify): _____

5. What age group is your child/children?
    a. 1-5
    b. 6-10
    c. 11-14
    d. 15-17

e. 18+

6. Family and friends are often the first to recognize warning signs of suicide.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

7.Someone showing warning signs of suicide may be at higher risk for danger.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

8. Coping strategies, people, and resources can help in a crisis.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

9. Evidence-based interventions help people at risk for suicide.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

10. It is difficult to tell who will act on suicidal thoughts and action.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

11. I help my child with homework.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

12. I have set rules at home.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

13. I volunteer at my child's school.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

14. I listen when my child speaks.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

15. I discuss future graduation plans with my child.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

16. Personalized safety plans help reduce suicidal thoughts and actions.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

17. Electric health records can help identify people with suicide risk.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

18. Suicide does not discriminate.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

19. Many individuals at risk for suicide often have a mental illness or substance use problems.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

20. Stressful life events and interpersonal stressors may contribute to risk suicide risk.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

Figure 1.2: The School-Family Partnership Model (Joyce Epstein)

Type	Definition	Understand...
Parenting	Help all families establish home environments to support children as students.	*"Workshop"* to mean more than a meeting about a topic held at the school building at a particular time. It may also mean making information about a topic available in a variety of forms that can be viewed, heard, or read anywhere, anytime, in varied forms.
Communicating	Design effective forms of school-to-home and home-to-school communications about school programs and children's progress.	*"Communications about school programs and student progress"* to mean two-way, three-way, and many-way channels of communication that connect schools, families, students, and the community.
Volunteering	Recruit and organize parent help and support.	*"Volunteer"* to mean anyone who supports school goals and children's learning or development in any way, at any place, and at any time -- not just during the school day and at the school building.
Learning at Home	Provide information and ideas to families about how to help students at home with homework and other curriculum-related activities, decisions, and planning.	*"Homework"* to mean not only work done alone, but also interactive activities shared with others at home or in the community, linking schoolwork to real life. *"Help"* at home to mean encouraging, listening, reacting, praising, guiding, monitoring, and discussing -- not "teaching" school subjects.
Decision-making	Include parents in school decisions, developing parent leaders and representatives.	*"Decision making"* to mean a process of partnership, of shared views and actions toward shared goals, not just a power struggle between conflicting ideas. *Parent "leader"* to mean a real representative, with opportunities and support to hear from and communicate with other families.
Collaborating with Community	Identify and integrate resources and services from the community to strengthen school programs, family practices, and student learning and development.	*"Community"* to mean not only the neighborhoods where students' homes and schools are located but also any neighborhoods that influence their learning and development. *"Community"* rated not only by low or high social or economic qualities, but by strengths and talents to support students, families, and schools. *"Community"* means all who are interested in and affected by the quality of education, not just those with children in the schools.

Source: Joyce Epstein[11]

this process.

Rating Scale

1. **Never**. This strategy does not happen at our school.
2. **Rarely**. Happens in only one or two classrooms or classes. Receives isolated use or little time. Clearly not emphasized in the school's parent involvement plan.
3. **Sometimes**. Happens in some classes. Receives minimal or modest time or emphasis across grades. Included in, but not a notable part, of the school's parent involvement plan.
4. **Frequently**. Happens in most or all classes or grade levels. Receives substantial time and emphasis. An important part of the school's parent involvement plan.

Wisconsin Department of Public Instruction • Tony Evers, State Superintendent
125 South Webster Street • PO Box 841 • Madison, WI 53707-7841 • 800-441-4563

Likert Scale

It was developed Rensis Likert. Here the respondents are asked to indicate a degree of agreement and disagreement with each of a series of statement. Each scale item has 5 response categories ranging from strongly agree and strongly disagree.

5	4	3	2	1
Strongly agree	Agree	Indifferent	Disagree	Strongly disagree

Each statement is assigned a numerical score ranging from 1 to 5. It can also be scaled as -2 to +2.

-2	-1	0	1	2

Appendix F

Table 1

Respondents' Sociodemographic Characteristics (N=91)

Measure	All Subjects
Age	43.13 (16.09)
Gender Status	
Woman	95.60%
Man	4.40%
Transgender	0.00%
Non-binary/non-conforming	0.00%
Other (specify)	0.00%
Prefer not to answer	0.00%
Race and Ethnicity	
American Indian or Alaskan Native	0.00%
Asian	0.00%
Black or African American	5.49%
Hispanic or Latino	37.36%
Native Hawaiian or Pacific Islander	0.00%
White or Caucasian	56.04%
Other	1.10%
Level of Education	
Associate degree	4.40%
Bachelor's degree	59.34%

Doctoral degree	3.30%
Master's degree	20.88%
High School degree or equivalent (GED)	5.49%
Less than a high school diploma	0.00%
Some college, but no degree	6.59%
Other (please specify) _____	0.00%

Child/Children Age Group	
1-5	42.86%
6-10	38.46%
11-14	17.58%
15-17	19.78%
18+	37.36%

Table 2

Responses on the Questionnaire (N=91, Mean=4.11)

Subscales	Mean	SD
Belief in Suicide Prevention	4.11	0
Parent Involvement	4.16	.05
Opinion on Mandatory Screening	4.06	-.05

Table 3

Responses on the x Survey (N=91, Mean=4.06))

Items (Opinion in Implementing Mandatory Screenings)	Mean	SD
1. Personalized safety plans help reduce suicidal thoughts and actions.	3.87	-.19
2. Electric health records can help identify people with suicide risk.	3.44	-.62
3. Suicide does not discriminate.	4.75	.69
4. Many individuals at risk for suicide often have a mental illness or substance use problems.	3.67	-.39
5. Stressful life events and interpersonal stressors may contribute to risk suicide risk.	4.57	.51
Total		

Table 4

Parent Involvement and Opinion in Mandatory Suicide Screenings (N=91, Mean)

Parent Involvement	Mandatory Screenings
4.08	3.87
4.33	3.44
3.58	4.75
4.5	3.67
4.29	4.57

Table 4.1

Correlation Between Parent Involvement and Opinion in Mandatory Suicide Screenings (Mean)

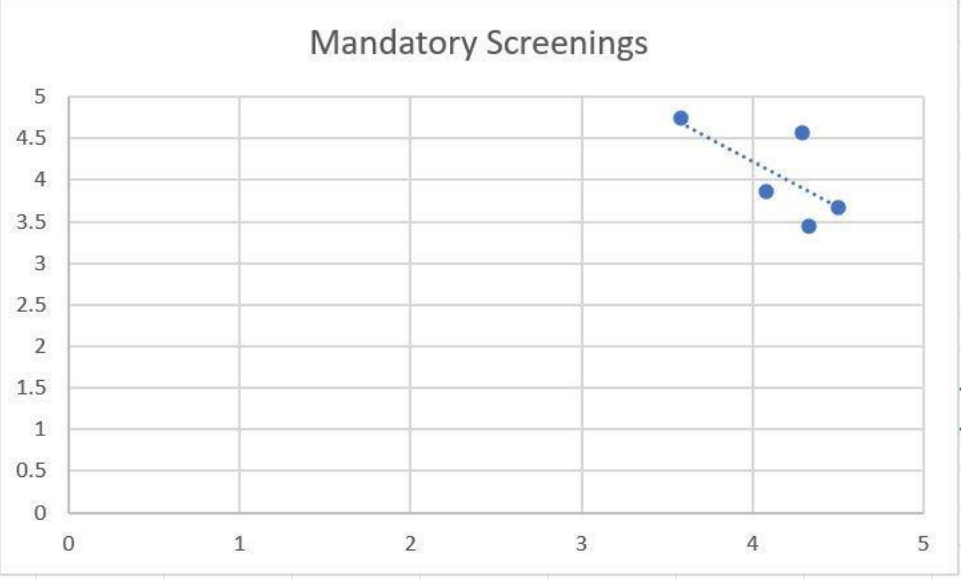

Table 5

Belief in Suicide Prevention and Opinion in Mandatory Suicide Screenings (N=91, Mean)

Belief in Suicide Prevention	Mandatory Screenings
3.31	3.87
4.42	3.44
4.52	4.75
4.15	3.67
4.16	4.57

Table 5.1

Correlation Between Belief in Suicide Prevention and Opinion in Mandatory Suicide Screenings (Mean)