

# Suicide Prevention Training in the Child Welfare Workforce: Knowledge, Attitudes, and Practice Patterns Prior to and Following safeTALK Training

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Youth involved in child welfare are at elevated risk for suicide, making child welfare staff an optimal audience for suicide prevention training. This study documents perceived staff needs for suicide prevention resources, explores the immediate impact of safeTALK training on suicide prevention knowledge and attitudes, and examines practice patterns six months following safeTALK. Results show an increase in perceived knowledge, preparedness,

and self-efficacy, and a decrease in reluctance. Identification and referral behaviors significantly increased at follow-up.

Suicide is the second leading cause of death for young people ages 10–24 in the US (CDC, Centers for Disease Control and Prevention, 2017), with the age-adjusted suicide rate increasing by 30% from 2000 to 2016 (Hedegaard et al., 2018). Youth involved in the child welfare system are at significantly elevated risk for suicide as well as a broad range of related socioemotional and behavioral risk factors. Studies estimate that up to 80% of youth in the child welfare system experience emotional, behavioral, or developmental concerns that warrant mental health services (e.g., Farmer et al., 2001; Taussig, 2002). Moreover, youth in the child welfare system report suicidal ideation (He et al., 2015), self-harm behaviors (Gabrielli et al., 2015), and lifetime suicide attempts (Katz et al., 2011) at higher rates than in comparison samples of youth. A meta-analysis by Evans et al. (2017) found that children and young people in care are three times more likely to attempt suicide than those not in state care. Individuals reporting six or more ACEs (Adverse Childhood Experiences) have been shown to have 24.36 times increased likelihood of attempting suicide in their lifetime (Merrick et al., 2017). As they age, youth involved in child welfare continue to be at risk for a number of other poor life outcomes, many of which are known risk factors for suicide (King et al., 2013), including severe psychiatric morbidity (Vinnerljung et al., 2006) and substance abuse problems (Fryar, Jordan, & DeVooght, 2017). Evidence is clear that youth with early exposure to interpersonal trauma are at significantly increased risk for suicide (Castellví et al., 2017).

In addition to their history of interpersonal trauma and/or neglect and parental separation, youth involved in child welfare also possess other psychosocial risk factors that can increase risk for suicide. For example, it is estimated that 11–20% of youth involved in child welfare identify as a sexual or gender minority (Dworsky, 2013; Remlin, Cook, & Erney, 2017), with estimates suggesting that youth who are LGBTQ are at substantially higher risk for suicide relative to their peers who are heterosexual and cisgender (Di Giacomo, Krausz, Colmegna, Aspesi, & Clerici, 2018). Further, in analyzing foster care placement records and Medicaid data in California, Fawley-King & Snowden

(2012) identified a bidirectional relationship between changes in placement and psychiatric hospitalization. They concluded that the instability in the lives of youth in child welfare both causes and is caused by the mental health conditions found in this population. Youth with significant mental health needs can be challenging to care for, yet when caregivers/placements change frequently, there are more barriers to recognizing risk factors and warning signs for suicide. In one of the first large scale studies to explore suicidal ideation, plans, and attempts among youth in foster care, Taussig, Harpin, & Maguire (2014) found through interviews and assessments that two thirds of caregivers were not aware of the child's imminent suicide risk. This lack of suicide risk recognition among those in most frequent contact with youth in child welfare is not unique among caregivers but may also apply to clinicians and child welfare staff.

It has been well documented that medical and behavioral health clinicians do not receive adequate suicide specific training in graduate education or pre-service training placements (Schmitz et al., 2012). Social work graduate programs provide little in suicide prevention education and intervention (Singer & Slovak, 2011), with graduates often perceiving training received as inadequate (Feldman & Freedenthal, 2006). Similarly, although most states require training for foster parents, empirical study of the curricula used for such trainings and the extent to which trainings adequately prepare foster parents to manage the emotional and behavioral health needs of youth is sorely lacking (Dorsey et al., 2008). Evaluations focused on the training of child welfare staff are also limited, although studies suggest that training that prepares and supports the workforce may be an important factor in avoiding high turnover rates in the child welfare workforce (Strolin, McCarthy, & Caringi, 2006).

The American Academy of Pediatrics, the Child Welfare League, and the American Academy of Child and Adolescent Psychiatry have each recommended measures to improve the early identification of child-welfare involved youth who are experiencing mental health and developmental concerns in order to improve linkages to appropriate

care for these youth (Leslie et al., 2005). Initiatives aimed at increasing access to mental health services for youth in the child welfare system include screening (Leslie et al., 2005; McCrae & Barth, 2008), inter-organizational collaboration with mental health professionals (Bai et al., 2009) and schools (Chuang & Lucio, 2011) to enhance the referral network, and training. Child-focused curriculums for social work students and child welfare workers that emphasize assessing mental health needs from an ecological perspective (Mathiesen et al., 2006) have been proposed, aiming to improve identification and risk assessment. To our knowledge, there has been only one published study (Osteen et al., 2018) examining training specifically focused on suicide prevention in the child welfare system and no study that has examined existing, widely used, and evidence-based suicide prevention trainings in the child welfare workforce.

The National Strategy for Suicide Prevention advocates for a public health approach that includes identifying vulnerable populations and building capacity within systems that serve them. Child welfare staff are in an especially unique position to prevent suicide considering their engagement with and proximity to youths who are vulnerable. Indeed, child welfare workers and foster parents serve as an optimal point of intervention in identifying youth at risk of suicide and connecting them to life-affirming resources and effective treatment services.

Gatekeeper training is an essential and commonly utilized component within a public health approach to youth suicide prevention (Condrón et al., 2015) and is associated with reduced suicide deaths (Walrath et al., 2015) and attempts (Garraza et al., 2015) in large scale studies in the year following trainings. “Gatekeepers” are individuals who are strategically positioned by virtue of their interaction with youth to recognize and refer a youth at risk of suicide to supportive services (U.S. Department of Health and Human Services, 2012). These personnel can include clinicians, teachers, peers, neighbors, parents, clergy, and caseworkers. The idea of gatekeeper training is predicated on recovery-oriented approaches that assume that, with care and support, high risk individuals can thrive. Learning how to identify youth at risk for suicide,

respond to their risk with empathy, and refer them to helpful supports and services has the potential to create suicide safer communities as well as strengthen the network of persons able and willing to help a youth in crisis (Swanke & Buila, 2010; Gould & Kramer, 2001). Gatekeeper trainings have been implemented for youth and professional staff in schools, health care settings, juvenile justice, law enforcement, and faith communities, although rarely evaluated within a child welfare setting.

Multiple studies have demonstrated increases in knowledge, positive attitudes toward suicide prevention, and confidence in the ability to intervene with an individual at risk following participation in gatekeeper trainings (Ewell Foster et al., 2017; Isaac et al., 2009; Keller et al., 2009; Matthieu et al., 2008; Wyman et al., 2008; Chagnon et al., 2007). Emerging evidence also exists that such changes in knowledge, sense of preparedness, and perceived self-efficacy, may be linked to proactive behavior change post-training (Ewell Foster et al., 2017; Magness et al., 2017; Osteen et al., 2017), especially following participation in lengthier gatekeeper training protocols. More data is needed on the impact of trainings on actual gatekeeper behaviors such as the identification and referral of at-risk youth as well as how to successfully integrate trainings into systems in a sustainable fashion. The evaluation of such trainings in a child welfare context is a critical first step toward policy change in support of increasing accessibility and availability of training for child protective services and foster care staff.

There are multiple evidence-based gatekeeper trainings, ranging in length from 90 minutes to two full days. SafeTALK is a four-hour training developed by LivingWorks Education, Inc. (SPRC, 2007) that teaches participants to identify warning signs/risk for suicide, supportively respond, and link the individual to professional assistance. SafeTALK has been shown to increase participant confidence and willingness to discuss suicide and knowledge of suicide, as well as increase confidence in one's ability to help a person who may be considering suicide (Bailey et al., 2017; McKay et al., 2012). To our knowledge, this study is one of the first to examine safeTALK in a child welfare context.

Osteen and colleagues (2018) examined the longitudinal impact of a brief suicide prevention gatekeeper training developed specifically for child welfare (SPRC, 2010), finding significant increases in participants' knowledge about suicide intervention and self-efficacy beliefs post-training. However, there were no statistical changes in attitudes toward suicide prevention (which were already very positive prior to training) and only modest improvements in the use of assessment and intervention skills among participants (Osteen et al., 2018) post-training. More research is needed to identify the particular trainings that are most acceptable and feasible within the child welfare system and to evaluate the implementation and impact of these trainings on important outcomes, including knowledge, attitudes, helping behaviors, and ultimately youth outcomes.

Data is clear that youth involved in child welfare are a vulnerable population with high rates of mental health concerns and suicide risk; despite this, there is limited research available to guide efforts to improve the identification and linkage of youth to mental health services. The current study presents the results of a partnership between suicide prevention advocates and a state child welfare agency to quantify the need for and impact of enhanced suicide prevention training among its workforce. The present study aims to address gaps in the literature by: (1) examining the perceived need for suicide prevention training among a sample of child welfare staff; (2) assessing the immediate impact of safeTALK training on child welfare staff's perceived knowledge and attitudes about suicide prevention; and (3) examining changes in practice patterns in youth identification and referral from pre-training to six-month follow-up.

## **Methods**

### ***Participants***

All individuals over the age of 18 who registered to attend a state-funded day-long suicide prevention conference for the child welfare

sector (277 individuals) were eligible to participate in the study. Study participants included 248 child welfare workers ages 21 to 64 years ( $M = 36.78$  years,  $SD = 10.03$ ) who consented to participate and who completed pre- and post-test measures as well as safe-TALK training. The pre-test survey included a demographic form that collected age, gender identity, and racial/ethnic information as well as position within child welfare. More than three quarters of respondents identified as female (80.6 %,  $n = 200$ ). Table 1 provides demographic breakdown, including race/ethnicity and professional affiliation.

### *Procedures*

All subjects participated in a four-hour safeTALK training provided by one of seven certified trainers. Using a quasi-experimental design,

**Table 1. Participant Demographics**

<b>Race/Ethnicity</b>	<b>N (%)</b>
Caucasian/White	151 (65.9%)
African American/Black	52 (22.7%)
Biracial	12 (5.24%)
Other	2 (0.88%)
American Indian/Alaskan Native	1 (0.44%)
Asian/Pacific Islander	1 (0.44%)
Hispanic/Latino	10 (4.37%)
<b>Professional Affiliation</b>	<b>N (%)</b>
Child protective services	53 (21.4%)
Private agency foster care staff	63 (25.4%)
State agency foster care staff	32 (12.9%)
Private agency administrators	46 (18.5%)
State level administrators	26 (10.5%)
Adoption staff	5 (2%)
Foster parents	2 (0.88%)

participants completed paper and pencil pre- and post-test measures prior to and immediately following the training. Six months later, participants were contacted via email with a link to an online follow-up survey through Qualtrics. Those who completed the follow-up survey were entered into a lottery to win a \$50 gift card. Study procedures were approved by the relevant Institutional Review Boards and consent was obtained from all study participants.

### *Measures*

Demographic information was collected at baseline. The Gatekeeper Training Survey, developed by Wyman et al. (2008), was adapted to assess practice patterns (i.e., identification and referral) at baseline and follow-up as well as pre- and post-test perceived knowledge and attitudes toward engaging in suicide prevention activities with youth.

Single items were used to determine changes in *Identification* (How many times in the last six months have you thought a youth's behavior might indicate s/he was considering suicide?) and *Referral* (In the last six months, how many youths did you personally refer to a mental health professional because you were concerned that a youth might be suicidal?) behaviors from baseline to follow-up. Composite variables were created to assess *Knowledge*, *Preparedness*, *Self-Efficacy*, and *Reluctance* according to Wyman and colleagues' (2008) methodology. All items within these four scales were measured on a seven-point Likert scale, with higher values indicating higher levels of perceived knowledge, preparedness, self-efficacy, or reluctance. The overall mean of the items within each scale was used to examine changes in knowledge and attitudes from pre- to post-test.

*Knowledge* (pre-test  $\alpha = .95$ , post-test  $\alpha = .94$ ) refers to the gatekeeper's perception of knowledge regarding basic suicide prevention information, such as warning signs or why a youth might not disclose their suicidality (e.g., "How much do you feel you know about signs

or symptoms of suicide ideation or attempt?”). *Preparedness* (pre-test  $\alpha = .94$ , post-test  $\alpha = .91$ ) is defined as the gatekeeper’s self-assessed preparation to engage in suicide prevention activities, such as asking appropriate questions about suicide, completing a safety plan, and persuading a youth to seek help (e.g., “I am prepared to appropriately report suicide ideation or attempts.”). *Self-efficacy* (pre-test  $\alpha = .74$ , post-test  $\alpha = .64$ ) refers to the gatekeeper’s belief that they can adequately engage in suicide prevention activities with youth, including confidence in their ability to recognize a youth contemplating suicide by the way they behave and confidence in their awareness of the warning signs for suicide (e.g., “I have the necessary skills to discuss suicide issues with a youth on my caseload.”). *Reluctance* (pre-test  $\alpha = .65$ , post-test  $\alpha = .72$ ) measures the gatekeeper’s ambivalence around engaging with suicidal youth and was measured with items such as, “Child welfare staff should not be responsible for discussing suicide with youth.”; “If a young person contemplating suicide does not seek assistance there is nothing I can do to help.”; and “I am too busy to participate in suicide prevention activities.”

### *Plan for Analysis*

Data analyses focused on the following questions: (1) What is the perceived need for suicide prevention training among child welfare staff? (2) What is the immediate impact of safeTALK training on participants’ perceived knowledge and attitudes about suicide prevention? And (3) To what extent does safeTALK impact participants’ practice patterns six months post-training?

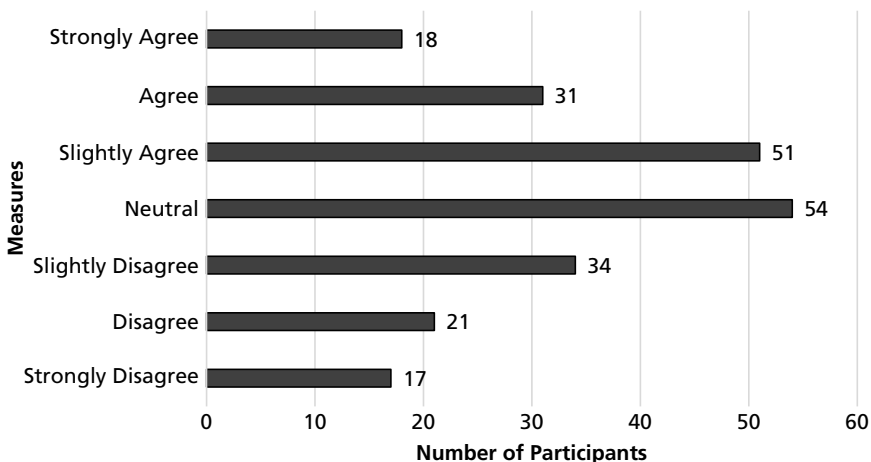
Data analyses were performed with SPSS version 25. Descriptive statistics were utilized to describe baseline characteristics of the sample and to document participant input regarding need for suicide prevention training. Paired-samples *t-tests* were used to compare pre- and post-test knowledge, preparedness, self-efficacy, and reluctance attitudes as well as to examine changes in gatekeeper identification and referral behaviors from baseline to follow-up.

## Results

### *Child Welfare Workforce Perceptions of Need for Suicide Prevention Training and Resources*

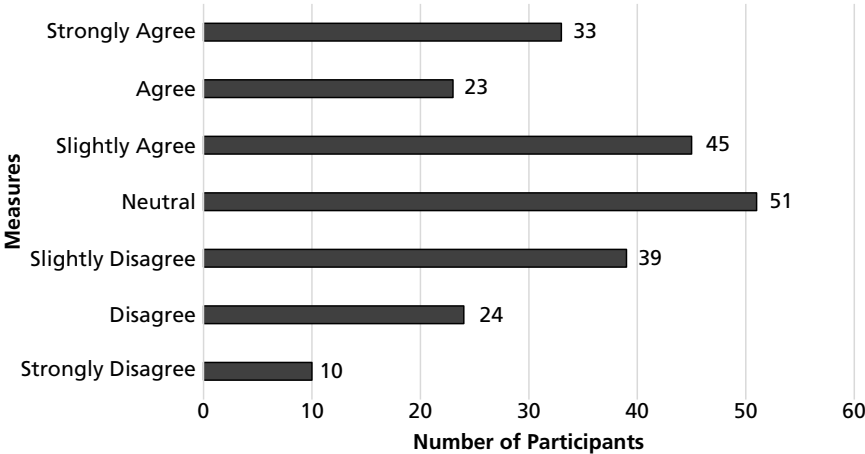
At pre-test, 60.1% of participants ( $n = 149$ ) indicated they had a professional experience with suicide and 58.1% ( $n = 144$ ) indicated they had a personal experience with suicide. In regard to training exposure, 25.8% ( $n = 64$ ) of respondents indicated they had no previous suicide prevention training. Participants estimated receiving (adjusted, outliers removed) an average of 4.98 hours ( $Mdn = 4.00, SD = 5.37$ ) of suicide prevention training, ranging from 0 to 20 hours. About half (47.6%,  $n = 118$ ) of participants indicated they were familiar with their agency's policies for helping youth contemplating suicide, while only 39.1% ( $n = 97$ ) reported their referral network was adequate in terms of linking youth to needed care. Child welfare staff were also asked at baseline the extent to which they had received sufficient training to assist youth who are contemplating suicide and whether their workplace encourages them to ask youth about thoughts of suicide, depicted in Figures 1 and 2,

**Figure 1. Pre-test: Sufficient Training**



Note: "I have sufficient training to assist youth who are contemplating suicide."

**Figure 2. Pre-test: Workplace Encouragement**



Note: “My workplace encourages me to ask youth about thoughts of suicide.”

respectively. In both measures, the greatest number of participants indicated they were “Neutral” on a 7-point Likert scale from “Strongly Agree” to “Strongly Disagree.” When asked if their training in suicide prevention was sufficient, 51% of respondents reported feeling neutral or disagreeing with the statement.

***Changes in Knowledge and Attitudes Following safeTALK Training***

Mean levels of the four scales—*Knowledge*, *Preparedness*, *Self-Efficacy*, and *Reluctance*—are reported in Table 2. From pre-test to post-test, participants reported significant improvement in all scales. Suicide knowledge, preparedness, and self-efficacy increased significantly, whereas reluctance to intervene with at-risk youth significantly decreased immediately following participation in safeTALK. These results suggest that safeTALK had an immediate and positive impact on gatekeepers’ perceptions of their own knowledge related to the warning signs and appropriate responses to youth experiencing suicide risk, as well as in their confidence and willingness to engage with and support them.

**Table 2. Pre-test to Post-test**

Measure	Pre-test Mean (SD) N	Post-test Mean (SD) N	T-Score (DF)
Knowledge	4.31 (1.25) N = 242	5.86 (.77) N = 242	22.88* (241)
Preparedness	4.60 (1.24) N = 243	5.85 (.77) N = 243	19.44* (242)
Self-Efficacy	4.67 (.91) N = 228	5.61 (.75) N = 228	16.71* (227)
Reluctance	2.04 (.60) N = 222	1.83 (.65) N = 222	5.62* (221)

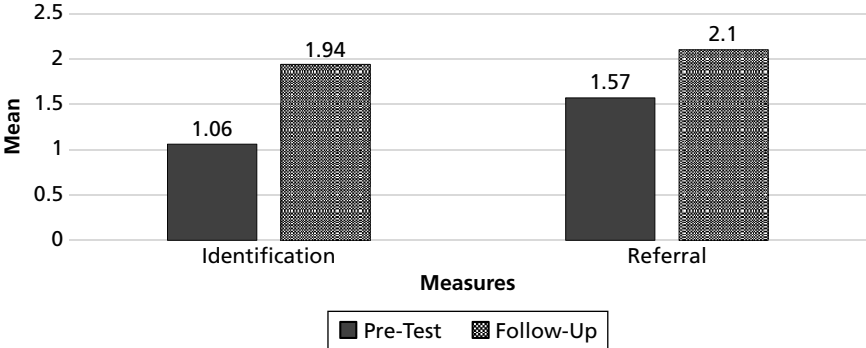
Note: \* $p < .001$ .

***Practice Patterns Six Months Post-Training***

Of the 248 child welfare staff who completed pre- and post-test measures, 103 participated in the six-month follow-up (42%). Participants who completed the follow-up did not differ significantly from those who did not complete the follow-up in terms of age, gender, race, ethnicity, or self-reported numbers of youth identified in the six months prior to training. Pre-test referral rates, on the other hand, differed significantly between the two groups (completed follow-up: *Mean Number of youth referred* = 1.57, *SD* = 1.67; did not complete follow-up: *Mean Number of youth referred* = 1.10, *SD* = 1.48;  $p = .014$ ), suggesting that child welfare staff who were more frequently connecting youth to treatment prior to the training were also more likely to participate in the six-month follow-up survey.

As demonstrated in Figure 3, child welfare participant reports of the extent to which they were able to identify a youth as being at risk based on his/her behavior increased significantly from pre-test to follow-up (Pre-test:  $M = 1.06$ ,  $SD = 0.99$ ; Follow-up:  $M = 1.94$ ,  $SD = 1.05$ ;  $p < .001$ ). The number of youth participants referred to a mental health professional due to suicide-related concerns also increased significantly at follow-up (Pre-test:  $M = 1.57$ ,  $SD = 1.67$ ; Follow-up:  $M = 2.10$ ,

**Figure 3. Pre-test to Follow-Up: Average Identification and Referral Rates**



*SD* = 1.47; *p* < .01), although differential attrition impacts our ability to draw firm conclusions regarding this data. And though both identification and referral were statistically significant, the change was moderate for referral, but larger for identification (Identification *d* = 0.86; Referral *d* = 0.34).

### Discussion

The development of suicide prevention capacity within systems that serve youth who are vulnerable is a national priority (National Strategy for Suicide Prevention. 2012). This study presents findings based on a partnership between suicide prevention and child welfare agencies. Designed to both document the need for and potential impact of suicide prevention gatekeeper training for individuals in close contact with youth involved with the child welfare system, this study is, to our knowledge, one of the first to measure the outcomes of implementing a suicide-specific training within the child welfare workforce.

The child welfare staff who participated in this study not only reported exposure to suicide in their professional and personal lives but also identified a need for suicide prevention-specific training in their workplace. A majority of participants did not agree that their suicide

prevention training was sufficient or that their workplace encouraged engagement and identification of youth at risk for suicide. Additionally, the relatively low proportion of staff who were familiar with agency policy in assisting youth at risk and those who believed the existing referral network was adequate for those identified is of particular concern. These findings identify the need for structural implementation of suicide prevention protocols and enhanced referral networks that allow for assessment, identification, and referral of high risk youth to needed services, paired with the awareness and administrative support of child welfare leadership to prioritize these safety measures.

Using a time series quasi-experimental design, this study examined the potential impact of a suicide prevention gatekeeper training on child welfare workers' perceived knowledge, attitudes, and suicide prevention practices. The results demonstrated that the 4-hour safeTALK gatekeeper training had a positive impact on participants' knowledge and attitudes towards suicide prevention. More specifically, among this cohort, there was a significant increase in participants' perceived suicide knowledge, self-efficacy, and preparedness, and a decrease in reluctance to engage in suicide prevention activities with the youth they serve immediately following participation. Our results also suggest the potential for a fairly brief gatekeeper training to positively impact the behaviors of some participants (identification and referral of youth at-risk for suicide six months following training).

Effective implementation of suicide prevention practices requires specific policies and procedures, adequate referral networks, and environmental support systems be in place for employees. Furthermore, integration of suicide prevention into the workplace's values, culture, and leadership is needed to support the delivery of suicide prevention activities to this particularly vulnerable population of youth. This study is an initial step towards addressing a gap in the literature by documenting the perceived need for and impact of additional suicide prevention training within the child welfare workforce. While suicide risk among child welfare involved youth is well documented (Evans et al., 2017;

Merrick et al., 2017; Castellví et al., 2017), as is the variability of mental health service receipt, there is little evidence to guide us on the feasibility or implementation of evidence-based suicide prevention interventions among child welfare workers (Maher et al., 2009). Our findings suggest that a four-hour time commitment is feasible for this workforce and may result in important benefits for staff and the youth they serve. Furthermore, this study supplements the dearth of knowledge regarding the training and preparedness of the child welfare workforce to engage in suicide prevention activities.

This study has several important limitations, including the attrition rate at follow-up, reliance on self-report methods, the fact that participants were self-referred/interested in the topic of suicide prevention rather than mandated to attend, and the quasi-experimental design with lack of a control group. Nevertheless, the results are consistent with previous findings regarding improvements in knowledge and attitudes post-training and extends these findings to the child welfare workforce in particular. The differential attrition at follow-up limits the generalizability of findings regarding changes in practice patterns over time. Participants who were already more likely to refer youth to treatment at baseline were more likely to participate in the follow-up. This may have skewed our follow-up data in a positive direction. Even with more “natural helpers,” in our follow-up sample, statistically significant changes in referral rates post training were noted. This finding is consistent with prior literature focused on the implementation of QPR (Question Persuade Refer), a 90-minute training, with K-12 educators (Wyman et al., 2008). This study found that teachers who identified themselves as “natural helpers,” prior to training—teachers whose professional identity included the provision of emotional support to students—were more likely to utilize what they had learned in training and to alter their behaviors going forward. It is possible that child welfare staff who see themselves as “natural helpers,” may demonstrate a similar pattern of differential efficacy of training. This possible interpretation of our findings requires future study.

## Conclusion

Youth involved in the child welfare system are a highly vulnerable population. Child welfare staff are in a unique position to identify and connect youth at risk to prevention and intervention services. Partnerships between suicide prevention advocates and leadership within the child welfare sector can support the delivery of suicide prevention activities including comprehensive policy development, training child welfare staff and foster care parents in youth suicide prevention, and improved collaboration between youth-serving agencies. Results from this study help advance our understanding of the potential impact of gatekeeper training on specific populations serving youth who are vulnerable, as well as inform pre-service training and continuing education practices for child welfare agencies.

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