QPR Training for Youth Guidelines

Policies and Procedures

Training youth in QPR is a challenging but necessary task to help prevent youth suicide. In order to ensure safety, training youth is approved based on expert advice, youth input, and institutional experience.

Basic QPR training should be framed within a broader context of mental health and wellness and presented as one solution for how to respond to someone who may be struggling with a personal, family or situational crisis. Training should be delivered in a highly structured and protected environment with adult supervision and follow-up. Suicide prevention training that is uninformed, loosely structured, and/or not evidence based may present risks.

Our concerns about training youth in QPR should not lead to a blanket unwillingness to talk to young people about suicide. This can be equally dangerous. Youth talk about suicide amongst themselves and on social media. It is both unrealistic and unsafe to exclude young people from what may be a life-saving conversation about how to seek help for them themselves or how they can help someone they know. Local mental health resources and crisis lines should always be included in discussions.

Guidelines for Schools and Academies

To ensure the safe delivery of QPR training to youth, we recommend the following:

- *Safe Timing.* Requests for QPR training are often made following a student death by suicide. To accomplish all that is required to do in the aftermath of a student suicide, we recommend at least 90 days before initiating QPR training with students. Please review, *After a Suicide: A Toolkit for Schools (second edition)* before proceeding with training. An excellent and highly-endorsed free resource, you may download the PDF at: *http://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf*.
- *Order of Training*. Students should be trained only after the adults (teachers and staff) have completed QPR training.

- *Seniors first*. Begin training the oldest students first, then proceed downward in age into the middle school years.
- *Screen students who may be at risk*. Known at-risk students should be screened by a school health professional prior to training.
- *Small groups only.* A maximum of 20-25 students may trained at one time, with a supervising/teaching school counsellor or nurse attending.
- *Local mental health experts.* To be sure students know referral resources for after school, weekends, holidays and summer vacation, local mental health professionals should be invited to the training.

Key Messages when Training Youth

- QPR training is not done in school assemblies or large groups.
- Assemblies should focus on resiliency, hope and connectedness.
- Friends never let friends keep secrets about suicide – tell an adult!
- No student is totally responsible for the safety of another student.
- Every student should know where to get help immediately.

If these guidelines seem overly cautious, please remember that we have very little published research on the impact of gatekeeper training on youth per se. If at all possible, we want to be very sure that we make every effort possible to minimize the risk of an adverse event.

QPR as a Universal Intervention for Troubled Youth

While the QPR method was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely applied as a universal intervention for anyone who may be experiencing emotional distress. It has been suggested by independent researchers and federal leadership that funded the original assessments of QPR that the QPR intervention could be useful in a much broader application, and not just for the detection of persons at risk for suicide.

Limiting the utility of QPR to the single goal of suicide risk detection accounts for the intervention's origination, but it is not known how many persons emitting distress signals recognized and responded to by individuals trained in QPR methodology were false positives (not suicidal), but still in need of assistance, assessment and perhaps intervention and treatment.

For example, one can imagine that a youth experiencing a personal crisis may very well send interpersonal distress signals/warning signs and would benefit from help of some kind, but may not be considering suicide as a solution. In fact, the NIMH-funded National Comorbidity Survey-Adolescent Supplement (NCS-A) found that about 20 percent of youth are affected by a mental health disorder sometime in their lifetime, but the vast majority of these young people never attempt suicide. These disorders -

mood, anxiety, ADHD, eating disorder, or substance abuse disorder - resulted in a functional impairment of the child's role in family, school, or community activities, but did not lead to a suicide attempt or completion. (Kessler, et al., 2012).

When the use of QPR identifies a distressed youth through its application of knowledge, compassion and understanding, the intervention becomes useful for the detection of a wide range of "troubled" behavior, e.g., nonsuicidal self-injury (NSSI), perfectionism, eating disturbances, sleep problems, bullying and other behavioral indices of youth who may be at risk, identified and treated "upstream" of the onset of suicidal ideation.

Summary

Finally, we recognize that students are potentially critical agents in developing a school culture that encourages identification of, and assistance for, students in need, and that when in trouble students tend to talk/text to other students. Research has repeatedly shown that students send suicide warning signs to friends and family first, and to school health professionals last (if at all). Thus, for a suicide warning sign surveillance system to be effective (trained QPR gatekeepers), as many people in the student's social and school network should be trained as possible.

Citations and Recommended reading

- Centers for Disease Control and Prevention (1992). *Youth suicide prevention programs: A resource guide*. Atlanta: National Center for Injury Prevention and Control.
- Grossman, J. Berman, L. White, et al. (2003). Workshop: Evaluation: Suicide Prevention
- Guo, Bp . & Harstall, C. (2002). *Efficacy of suicide prevention programs for children and youth.* Edmonton, AB: Alberta Heritage Foundation for Medical Research.
- Kessler R, Avenevoli S, Costello J, Georgiades K, Green JG, Gruber M, He J, Koretz D, McLaughlin K, Petukhova M, Sampson N, Zaslavsky A, Merikangas K. Prevalence, persistence and Sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*. April 2012; 69(4):372-380.
- National strategy for suicide prevention: Goals and objectives for action. (2012) Rockville, MD: US Dept of Health and Human Services, Public Health Service.