Reducing Suicide-Related Stigma through Peer-to-Peer School-Based Suicide Prevention Programming

Jennifer L. Wright-Berryman, Devyn Thompson, and Robert J. Cramer

Youth suicide rates have consistently risen over the past decade, and stigma related to mental health may create a barrier to young people seeking help. Schools are a common intercept point for mental health and suicide prevention programming. Hope Squad, a school-based, peer-to-peer, suicide prevention program, uses trained and mentored students nominated by their peers to perform intentional outreach with fellow students. When a Hope Squad member detects a mental health or suicide crisis in a peer, they alert a trusted adult. We employed a cohort, wait-list–control, cross-sectional survey design. We recruited more than 3,400 students from nine schools—five with Hope Squads and four without—to observe differences in student-body suicide-related stigma. At the end of the academic year, there was significantly lower stigma in Hope Squad schools versus those without the program. Findings suggest that a peer-to-peer, school-based, suicide prevention program may reduce stigmatizing attitudes related to suicide. Next steps include a randomized controlled trial to identify changes in help-seeking and similar protective factors.

KEY WORDS: *peer-to-peer program; school mental health; school-based social work; suicide prevention*

Suicide rates of those aged 10 to 24 years have increased steadily over the past decade. Further, rates have increased by 76 percent among 15- to 19-year-olds (Curtin & Heron, 2019). According to Cha et al. (2018), up to 24 percent of youth experience suicidal ideation. Recently, Greydanus (2017) identified a variety of stressors that can contribute to suicide ideation, including mental illness, family dynamics, and other environmental factors. Due to growing concerns about the mental health and suicidality of youth, schools are often the target for prevention, intervention, and postvention programming.

STIGMA

Stigma can be a major barrier when young people experience mental health and suicide concerns, discouraging them from seeking help from professionals or other trusted adults due to a fear of being rejected by their peers (Freedenthal, 2010). *Stigma* has been defined as the interrelationship between multiple factors, including labeling, discrimination, and associations with negative attributes (Link & Phelan, 2001). Applied to suicide, stigma entails the labeling of people with mental illness with derogatory terms, such as "crazies"; stereotypes of people with suicidal ideation as weak or cowardly; and reactions of fear or disgust toward someone who discloses their experience of suicidal ideation. A body of literature (DeBate et al., 2018; Henderson et al., 2013) suggests that willingness to seek help may increase when perceived stigma remits. As such, fear of being stigmatized is especially salient for youth who are experiencing suicidal ideation (Rickwood et al., 2005).

Nearchou et al. (2018) investigated predictors of help-seeking among adolescents. They studied personal and public forms of stigma and found that although personal (self-directed) stigma decreased with age, perceived public stigma did not. Further, the likelihood of seeking help for mental health concerns decreased with age and perceived public stigma. This effect may be even more pronounced for individuals experiencing suicidal ideation (Niederkrotenthaler et al., 2014). Nearchou et al. (2018) and Niederkrotenthaler et al. (2014) suggested that subpopulations displaying lower help-seeking be-

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havior for their suicidal ideation also experience greater stigma. Both also reported that less exposure to the topic of suicide predicts higher stigma.

Similar barriers to help-seeking have been studied with young adult college students. Yakunina et al. (2010) investigated the *help-negation effect*, defined as the well-established negative relationship between suicidal ideation and help-seeking. Similar to prior studies, they found that stigma concerns significantly negatively impacted willingness to seek help. Unfortunately, the research literature also reveals that when suicidal ideation increases among young people, help-seeking behaviors reduce (Rickwood et al., 2007), and young people have reported not wanting to be viewed as "mental" (Wisdom et al., 2006). Taken together, these studies suggest reducing stigma may be a key factor for promoting help-seeking. Given the relationship between stigma and the help-negation effect, it is possible that interventions targeting stigma may help to combat this effect by reducing stigma and thereby weakening the association between suicidal ideation and decreased help-seeking.

Although the literature demonstrates a strong association between stigma and lack of disclosure of mental health and suicide-related problems, evaluation of suicide prevention programs has produced little evidence to highlight the impact this work has on student attitudes toward peers who are suffering. One particular method of outreach, peer support, has shown some promise.

Peer Support and Stigma

Prior research demonstrates that when youth are in suicide distress, they often reveal their feelings to peers as opposed to an adult or a mental health professional (Cigularov et al., 2008) and that youth may not initially disclose their distress to those prepared to help them (Fulginiti & Frey, 2020). Further, findings from Yakunina et al. (2010) indicate that informal help-seeking is significantly mediated by the level of perceived peer support. Other research shows the effect of peer support on formal help-seeking as well. A study of suicide crisis hotline usage by adolescents receiving psychiatric treatment reported that a third of the participants were concerned about what others would think about them if they called a suicide crisis hotline, but most also reported that they would be more likely to call a crisis hotline if a peer encouraged them to do so (Budinger et al., 2015). Budinger et al. (2015) suggested that, for adolescents, support from their peers is a major factor in determining help-seeking behavior because higher perceived support reduces anxiety about stigma.

This explanation may be supported by other cross-sectional work. Among undergraduate college students experiencing suicidal ideation, evidence suggests that individuals who express having fewer positive personal relationships with their peers tend to perceive higher stigma among the public (Downs & Eisenberg, 2012). This perception also seems to play out in practice. One group at heightened risk of experiencing stigma is those discharged from psychiatric hospitalization for suicidal ideation (Moses, 2014). In a six-month follow-up study with 80 adolescents, a majority experienced stigmatizing attitudes from others after their hospitalization, and the types of relationships they had with peers (i.e., the supportiveness of the relationships) moderated the likelihood of feeling stigmatized. Further, research suggests that perceived peer support is a significant predictor of the severity of suicidal ideation as well as suicide attempt history among adolescents (Miller et al., 2015). Other reviews of the literature report that reducing mental health stigma may encourage students to act as gatekeepers to facilitate their peers' seeking help for suicidal ideation (Rickwood et al., 2005).

Due to the relationship between peer support and stigma, student-led peer support programming in schools could have an impact on suicide attitudes, thereby improving student help-seeking (Wright-Berryman et al., 2018; Wyman et al., 2010). However, few suicide prevention peer programs exist in schools, and the research on effectiveness is limited. A systematic review of suicide prevention programs targeted toward adolescents and young adults identified only 29 randomized controlled trials and assessed that only preliminary evidence was available for these programs due to a roughly even split between significant and non-significant results among the studies (Calear et al., 2016). However, they suggested that school-based interventions with a universal model were a point of particular interest needing expanded research. Additionally, Hom et al. (2015) conducted a review of the literature available on factors and

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programs that increase help-seeking for suicidal behavior, concluding that a need exists for trials utilizing a multisite model and employing data collection over longer periods. In this study, we expand this literature by providing initial findings from an examination of one such program across multiple schools.

School Social Work and Suicide Prevention

School-based social work plays a critical role in the prevention of youth suicide, given that 88 percent of school social workers (SSWs) reported working with suicidal youths, with the high school social worker rate being nearly 100 percent (Singer & Slovak, 2011). SSWs are commonly a bridge between the school and the community; they typically bring resources and programs, including suicide prevention, from the community into the school (Schmidt et al., 2015). This article intends to inform SSWs of a program that may assist in identifying and addressing suicide risk and resources in K–12 education settings.

Hope Squad

Hope Squad is a school-based, peer-to-peer suicide prevention program across the United States in more than 1,000 schools across 33 states; the program has greater than 30,000 student members (see https://hopesquad.com/). A Hope Squad is a team of students nominated by their peers because those students are perceived as safe and trusted people to talk to about emotional distress. Hope Squad members are supervised and mentored by adult advisers at the school who often are teachers, school counselors, social workers, administrators, and coaches. These advisers train the Hope Squad members on the curriculum phases, which include suicide prevention skills, mental health, grief, how to help a friend, self-care, bullying, and other relevant topics.

Curricula are available for each school level (i.e., elementary, junior high, high school, and college), so the content of the phases differs, depending on the grade of the members. Hope Squad students learn to recognize suicide warning signs and risk factors through the Question-Persuade-Refer gatekeeper training (Quinnett, 2012) and how to compassionately engage with a peer who expresses anything concerning (it does not have to be suicide related). Characteristics of Hope Squad members vary, but a recent study with parents of Hope Squad members revealed that three primary characteristics are consistent across these helpers: (1) inclusivity, (2) previous experience with suicide (loss of someone or personal struggle), (3) and religion/faith (Wright-Berryman et al., 2022). When a Hope Squad member refers a student to the adviser or school counselor, parents are contacted by the school, and the school counselor or social worker evaluates the referred student to determine if they need additional mental health services, or if emergency/crisis services are needed (Wright-Berryman et al., 2018).

Hope Squads not only perform intentional outreach with peers in distress, but also educate the entire school on suicide prevention (including mental health awareness and other relevant topics) by conducting activities throughout the school year. They may use positive messaging, mental health campaigns, fundraisers, random acts of kindness, and other initiatives to build a community of care and suicide prevention in their schools. Each Hope Squad also has a *Hope Week*, an entire week devoted to this awareness raising and community building. By combining intentional outreach and engaging and educating peers, Hope Squads aim to change the culture of the school through peer, staff, and faculty engagement activities that may reduce stigma and increase help-seeking.

STUDY AIM

The aim of this study was to compare student-body stigmatizing attitudes toward suicide at the end of the first year of implementation of Hope Squad versus schools without Hope Squad. We hypothesized that in comparison with schools without the program, Hope Squad schools would report significantly fewer stigmatizing attitudes than schools without a Squad.

METHOD

Participants

Students ($N = 3,425$) were drawn from nine midwestern high schools that were matched on location (i.e., rural, urban, and suburban), approximate student enrollment, and public versus private status (i.e., two Catholic schools). Table 1 contains demographic information for the sample. The sample was approximately three-quarters White (77 percent) and primarily female (56 percent) and non-

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Table 1: Demographic and Attitudinal Descriptive Statistics ($N = 3,425$)			
Variable	***n* (%)**	***M* (*SD*)**	**α**
Race			
Black/African American	122 (3.6)		
Caucasian	2,634 (76.9)		
Asian American	211 (6.2)		
Native American/Alaskan Native	49 (1.9)		
Native Hawaiian/Pacific Islander	17 (0.5)		
Other	300 (8.8)		
Missing	92 (2.7)		
Gender			
Male	1,304 (38.1)		
Female	1,915 (55.9)		
Transgender	34 (1.0)		
Nonbinary	39 (1.1)		
Do not wish to state	50 (1.5)		
Missing	83 (2.4)		
Ethnicity			
Hispanic/Latinx	195 (5.7)		
Non-Hispanic/Latinx	3,100 (90.5)		
Missing	130 (3.8)		
Grade			
9th	1,159 (33.8)		
10th	1,048 (30.6)		
11th	717 (20.9)		
12th	422 (12.3)		
Missing	79 (2.3)		
Religiosity			
Religious	1,570 (45.8)		
Spiritual but not religious	597 (17.4)		
Not a believer/atheist	568 (16.6)		
Missing	690 (20.1)		
Treatment condition			
Control	1,382 (40.4)		
Hope Squads	1,821 (53.2)		
Missing	222 (6.5)		
SOSS Stigma		18.15 (6.96)	.89
SOSS Isolation/Depression		15.44 (3.72)	.86
SOSS Normalization/Glorification		9.80 (3.54)	.81

Note: SOSS = Stigma of Suicide Scale.

Hispanic (91 percent). All students were in the ninth through 12th grades, although a majority were from the ninth and 10th grades (64 percent). Although almost half of students identified as religious (46 percent), spiritual and Atheist subgroups were sizable. More than half of the student sample was from the schools that chose to implement the Hope Squad in the first year of the study. Missing demographic data ranged from 2.3 percent to 20.1 percent (religiosity was the variable with a high rate of missing data).

Procedure

This study was approved by the university institutional review board. We employed a cohort, waitlist–control design. Schools self-selected whether

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they were going to begin the Hope Squad program in either fall 2018 or fall 2019. Nine midwestern schools participated—five with Hope Squads and four without Hope Squads—and students were asked to participate in a voluntary, online, cross-sectional survey at the end of academic year 2018 to 2019. The survey was developed using Qualtrics and was distributed by school personnel using student school email (with a unique Qualtrics link).

Ethical Considerations

Ahead of the survey distribution, parents were sent an information sheet and were instructed to alert the school if they wished for their child to be removed from the survey email distribution list (opt-out). Students were given approximately three to four weeks (based on the length of the academic year for each school) to complete the survey. In the assent provided to students in the survey, they were instructed that by completing the survey, they were giving their assent.

After the data collection period ended, data were coded and cleaned. Data were then analyzed using SPSS Version 26.

Measures and Data Collection

Demographics collected were the student's grade, gender, race, ethnicity, and religiosity (see Table 1). Suicide-related stigma was measured using the Stigma of Suicide Scale–Short Form (SOSS-SF, Batterham et al., 2013). The SOSS-SF is a 16-item scale ranging from 1 = strongly disagree to 5 = strongly agree, designed to measure attitudes toward characteristics commonly associated with suicidality. The three-factor structure had strong internal consistency: .95 for stigma, .88 for isolation/depression, and .86 for glorification/normalization (Batterham et al., 2013). The SOSS-SF has been tested with youth and young adult populations and has demonstrated acceptable validity and reliability (Batterham et al., 2013). In a recent study of a large adolescent population (Fong et al., 2022), the SOSS-SF performed well with the three-factor structure, demonstrating moderate to strong validity for the subscales ($\alpha = .52$ to .93) and acceptable reliability ($\omega = .78$). For this study, the SOSS-SF was used across a cohort of high school students to measure stigmatizing attitudes and perceptions of how isolation/depression, and glorification/normalization are attributed to suicidality.

RESULTS

No significant demographic differences were found between students in Hope Squad and non–Hope Squad schools. Missing data on SOSS-SF items ranged from 9.6 percent to 18.9 percent. Before analysis of primary research questions, missing data were handled via multiple imputation (Enders, 2017; Horton & Lipsitz, 2001). Internal consistency values were also run, yielding acceptable values for Stigma of Suicide Scale (SOSS) subscales and mental health service use total score (see Table 1).

A series of independent-samples t tests examined attitudinal differences between students in Hope Squads schools versus comparison schools. Significant differences were observed in suicide stigma attitudes, $t(17{,}712) = 7.96$, $p < .001$. Students in Hope Squad schools reported significantly less suicide-related stigma ($M = 17.73$, $SD = 6.87$, Cohen's $d = -.12$, negative statistic indicating a smaller mean for this effect) compared with students in comparison schools ($M = 18.57$, $SD = 7.01$). Significant differences were observed in isolation/depression attitudes, $t(17{,}730) = 3.69$, $p < .001$. Students in Hope Squads schools reported significantly higher isolation/depression attitudes ($M = 15.35$, $SD = 3.88$, Cohen's $d = .06$) compared with students in comparison schools ($M = 15.56$, $SD = 3.54$). Nonsignificant differences were observed in glorification/normalization attitudes, $t(17721) = 0.32$, $p = .75$.

None of the nine schools participating in the study reported a suicide death during the study time frame.

DISCUSSION

Stigmatizing attitudes among youth directed toward peers with suicide-related concerns can prevent risk disclosure and help-seeking (Freedenthal, 2010). Extant literature in child and adolescent mental health suggests that reducing stigma can improve risk identification and access to care (Gronholm et al., 2018). However, a dearth of research exists highlighting specific school-based programs that mitigate suicide-related stigma. The purpose of this study was to evaluate whether a universal, school-based, peer-to-peer, suicide prevention program successfully reduces student-body stigmatizing attitudes toward those with suicidality.

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Although a significant difference in stigmatizing attitudes was detected between Hope Squad and non–Hope Squad schools, effect size was negligible. Therefore, this finding should be interpreted with caution. Other school-based programs that target stigma have shown some success (Chen et al., 2018); however, those programs do not directly measure attitudes related to suicide. We found that Hope Squad school students' attitudes regarding isolation/depression (meaning, isolation and depression were perceived as contributors to suicidality) were also significantly different than those of non–Hope Squad schools, although this effect size was also negligible. Students who suffer from mental health disorders may not be identified as suicidal, and, conversely, those who consider suicide may not meet criteria for a mental health diagnosis (Gluckman, 2017; Jobes et al., 2019). If students understand this mental health–suicide relationship, they may better identify peers at risk. Therefore, it is important to identify attitudes specific to suicide-related concerns among youth to provide programming and identification tactics to assist those suffering with hidden suicidal thoughts.

Previous work measuring stigmatizing attitudes directly related to suicide has been done using university samples in Australia (Batterham et al., 2013; Chan et al. 2014). This work highlights the pervasiveness of stigma along with low "suicide literacy" among adolescents and young adults. Batterham et al. (2013) presented a call to action, claiming that enhancing knowledge and understanding of the suicide phenomenon can improve help-seeking. However, simple mental health education programs may not be enough to aid those in suicide distress in accessing help for suicide-related concerns, and the effect may be time limited (Feiss et al., 2019). Hope Squad employs peer-to-peer outreach in addition to student-body education in suicide prevention. Peer support has a body of evidence suggesting that peers provide a more trusted and engaging method of accessing care, especially for youth (Budinger et al., 2015).

Some limitations of this study should be considered. First, schools were not randomized to either treatment or control. Both Hope Squad and non–Hope Squad schools self-selected to receive the program; however, the wait-list–control schools chose to delay implementation for a school year because they felt they were not yet prepared to implement the program. Therefore, these findings cannot be generalized because there may be a difference in schools that self-select to acquire the Hope Squad program. Second, this was a cross-sectional survey study; as such, comparisons were limited to treatment and control schools at a single time point. To mitigate this limitation, control schools had not planned to implement other suicide prevention programming during the time of the study. Further, all the schools selected were located in the Midwest, where rates of suicide are above the national average but not as high as in the western states.

CONCLUSION

SSWs play a vital role in both mental health and suicide prevention programming in schools. This study highlights how school-based peer programming can provide support for SSWs in identifying risk among students through monitoring and referring peers to trusted adults.

The findings from this comparison study suggests Hope Squad, through student-body education, outreach, and referral of peers at risk, could aid in promoting positive attitudes and lower suicide-related stigma among students exposed to the program. This study is the result of the first year of implementation using a nonrandom design, and effect sizes were negligible, so results should be interpreted with caution. A longitudinal, repeated measure study would reveal whether change could be attributed to the program or other influences. Future research will include a randomized trial investigating changes in help-seeking and protective factors, such as connectedness. CS

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Jennifer L. Wright-Berryman, PhD, *is associate professor of social work, College of Allied Health Sciences, University of Cincinnati, PO Box 210108, HSB 171, Cincinnati, OH 45221-0108, USA; email: wrigh2jb@ucmail.uc.edu.* ***Devyn Thompson, MSW,*** *is a social work therapist, Mindfully, Cincinnati, OH, USA.* ***Robert J. Cramer, PhD,*** *is professor, Department of Public Health Sciences, University of North Carolina at Charlotte, Charlotte, NC, USA.*

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