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School Counsellors' Perceptions on Working with Student High-Risk Behaviour
Les perceptions des conseillers scolaires du travail avec des étudiants à comportement à risque élevé

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ABSTRACT

The current exploratory-descriptive study used a survey design method to examine guidance counsellors' and educational psychologists' perceptions of their preparation, motivation, and effectiveness in preventing, assessing, and intervening into student high-risk behaviour. The study also explored training associated with addressing high-risk behaviour along with the perceived responsibility and roles of school counsellors when faced with such behaviour. Views related to the following seven categories of high-risk behaviour were explored: (a) suicide attempts; (b) self-mutilation (e.g., cutting); (c) bullying; (d) extreme school violence (e.g., school shootings, bombings); (e) eating disorders and related behaviour (e.g., extreme exercising); (f) sexual behaviour leading to risk of HIV or other sexually transmitted infections (STIs); and (g) drug-using behaviour (e.g., IV drug use, needle sharing) leading to risk of HIV or other STIs. Implications for training, practice, and research are discussed.

RÉSUMÉ

Cette étude exploratoire-descriptif utilisait une méthode de conception d'enquête pour examiner les perceptions des conseillers d'orientation et des psychologues scolaires de leur préparation, leur motivation, et leur efficacité dans la prévention, l'évaluation, et l'intervention dans les comportements à risque élevé des étudiants. L'étude explorait aussi la formation pour adresser le comportement à risque élevé ainsi que la responsabilité et les rôles perçus de conseillers scolaires présentés avec de tel comportements. Les sept catégories suivantes de comportement à risque élevé ont été explorées : (a) les tentatives de suicide; (b) l'automutilation (e.g., autolacération); (c) l'intimidation; (d) la violence extrême à l'école (e.g., les fusillades et les attentats à la bombe); (e) les troubles d'alimentation et les comportements reliés (e.g., l'entraînement excessif); (f) le comportement sexuel menant au risque de VIH ou aux autres infections transmissibles sexuellement (ITS); et (g) la consommation de drogues (e.g., l'abus de drogues prises par voie intraveineuse, l'échange d'aiguilles) menant au risque de VIH ou aux autres ITS. Les implications pour la formation, la pratique, et la recherche sont discutées.

High-risk behaviour, such as bullying or drug use, has adverse impacts on society and in our school environments. High-risk behaviour can be hidden or pervasive. It is often dangerous to self and others. Student and teacher safety needs to be a priority within the school setting.

School counsellors (including both guidance counsellors and educational psychologists in this article, unless otherwise noted), given their training and position within the school, have a potential role to play in high-risk behaviour prevention, as well as in its assessment and intervention. Unfortunately, little research has been conducted to explore the role(s) of school counsellors or their perceived preparation, motivation, and effectiveness in addressing these behaviours.

Several studies have found that school counsellors and pre-service school counsellors (i.e., students enrolled in a school counselling training program) can feel ill prepared, or lack confidence, in addressing such behaviour (Carney & Cobia, 2003; King, Price, Telljohann, & Wahl, 2000; Schaefer-Schiumo & Ginsberg, 2003). In addition, research on the training of school counsellors to address these high-risk behaviours is limited.

This article seeks to help elucidate our understanding of the school counsellor's role and preparation to address these behaviours. Specifically, the current article details school counsellors' perceptions of their preparation, motivation, and effectiveness in preventing, assessing, and intervening into student high-risk behaviour. It also discusses training associated with addressing high-risk behaviour along with perceived responsibilities and roles of school counsellors when faced with such behaviour.

School Counsellors and Student High-Risk Behaviour

Strack, Vincent, Hussey, and Kelly (1998) support multifaceted intervention programs for the reduction of many types of high-risk behaviour among youth (e.g., unprotected sexual behaviour). These programs, containing multiple intervention dimensions, often include school and community interventions and typically involve several professionals. School counsellors are often "first line" interveners, and contribute greatly to the overall success of the intervention (Costin, Page, Pietrzak, & Kerr, 2002). In fact, school counsellors are often called upon to be the coordinators or leaders of such services (King et al., 2000; Smaby, Peterson, Bergmann, Zenter Bacig, & Swearingen, 1990). Thus, the school counsellor needs to have the knowledge, skills, abilities, and comfort level to offer prevention, assessment, intervention, and referral strategies.

Research has highlighted the potential importance of school counsellors being involved in several specific high-risk behaviour situations, including high-risk sexual behaviour, drug use, youth violence, suicide/suicidal ideation, and disordered eating. This makes sense, given school counsellors' training/expertise and position within the school environment.

School counsellors can play an important role in preventing HIV and other infectious diseases through guiding and educating teens in engaging in safer sex practices and reducing/eliminating high-risk sexual behaviour as well as dangerous drug use (Stevens-Smith & Remley, 1994). The Public Health Agency of Canada (2005) reports that "the potential exists for the spread of HIV among young Canadians" (p. 1). McFarland and Oliver (1999) suggested that HIV rates are

on the rise among youth, and school counsellors can play an important role in reducing high-risk behaviour that contributes to HIV infection (Cobia, Carney, & Waggoner, 1998; McFarland & Oliver, 1999).

Adelman (1998) and Costin et al. (2002) reported that school counselling is essential for students who are in crisis or dealing with psychosocial issues associated with being infected with, or affected by, HIV. However, some research (e.g., Carney & Cobia, 2003) has suggested that school counsellors and school counsellors-in-training may have limited specialized HIV knowledge and some overall discomfort in counselling situations with this population.

Another area of concern is youth violence. Researchers (e.g., Sandhu, 2000; Schaefer-Schiumo & Ginsberg, 2003) reported that youth violence is a major concern in our society. School counsellors can play an important role in school violence prevention as well as intervention, provided they have the necessary knowledge and skills to deal with such instances (Bauman, 2008; Schaefer-Schiumo & Ginsberg, 2003). Sandhu (2000) reported that "As the pressure to develop [school violence prevention/intervention] programs increases, schools are increasingly turning to school counsellors for leadership and guidance" (p. iv).

Schaefer-Schiumo and Ginsberg (2003) reported that in their research and teaching, graduate counselling students frequently reported needing more preparation and training in dealing with youth violence. Allen et al. (2002) noted that training to deal with violence should be a high priority topic within counsellor education programs. Canada et al. (2007) reported that school counsellors need more training in dealing with school violence, especially when dealing with youth and families from diverse ethnic backgrounds.

Suicide and suicidal ideation are also high-risk behaviours often encountered by school counsellors. In fact, some researchers (e.g., King et al., 2000; King & Smith, 2000; Smaby et al., 1990) suggested that school counsellors should be encouraged to lead crisis prevention and intervention surrounding suicide issues. Peach and Reddick (1991) reported that school counsellors' knowledge and skills in dealing with adolescent suicide risk can have a major impact on schools' overall success in dealing with youth at-risk for suicide. Indeed, King, Price, Telljohann, and Wahl (1999) suggested that many school counsellors believe that it is their responsibility to identify students who may be at risk for suicide. Related legal rulings (e.g., Pate, 1992) have determined that school counsellors have some responsibility for protecting students at risk for suicide.

King et al. (1999) and Popenhagen and Qualley (1998) reported that school counsellors need training in suicide prevention and intervention to be effective in their roles. Some American-based research (e.g., King et al., 2000) suggested that school counsellors are knowledgeable about suicidal risk factors and intervention strategies, but that many do not feel confident that they could identify a student at risk for suicide. Allen et al. (2002) also highlighted the importance of counsellor education programs making suicide training a high priority topic. Canada et al. (2007) noted that school counsellors need additional training in addressing suicide, especially when working with youth and families from diverse ethnic backgrounds.

Another example of high-risk behaviour encountered by school counsellors is disordered eating and weight/body image maintenance patterns. Bardick et al. (2004) noted that school counsellors maintain daily contact with children and adolescents, a group at the highest risk for developing eating disorders. Boes, Ng, and Daviston (2004) suggested that school counsellors need training and education regarding eating disorders, as they are in a position conducive to identification, prevention, and intervention of these types of problems.

Yager and O'Dea (2005) also highlighted the importance of school professionals (i.e., including school counsellors and school psychologists) being involved in the prevention of eating disorders; however, they note that these school professionals have been "largely underutilized as such potential change agents" (p. 273). As seen, little research has been conducted to explore school counsellors' perceived preparation, motivation, and effectiveness levels in dealing with eating disorders.

As noted above, the available research, although sparse, illustrates that some preservice and practicing school counsellors can feel ill prepared when dealing with high-risk behaviour situations. The current article contributes to our understanding of school counsellors' perceived competencies in addressing such behaviour (and consequently their willingness to act). In addition, this article examines school counsellors' perceptions of their training, responsibilities, and roles—areas insufficiently addressed in the current research literature. More specifically, it expands this research, and offers a Newfoundland and Labrador perspective as well.

METHOD

Procedure

The study was conducted within all four English-speaking school districts in Newfoundland and Labrador. Some of these schools were geographically distant from larger centres, with several areas being quite rural and isolated. Initial approval was sought from the four school districts' superintendents, and ethics approval was obtained from Memorial University's Research Ethics Board. One district required permissions from individual principals, so principals from this district were contacted to seek permission.

Potential participants were mailed the study questionnaires, an informed consent form, a postage-paid and addressed return envelope, and a $1.00 MacDonald's coupon. A reminder letter was also mailed out to all potential participants 6 weeks following the initial survey distribution.

Participants

One hundred fifty-nine guidance counsellors and 35 educational psychologists were surveyed, encompassing the entire population of guidance counsellors and educational psychologists in these districts, with the exception of 4 guidance counsellors whose principals refused participation. One hundred ninety-four questionnaire packages were sent either directly to principals (n = 60), to guidance counsellors (n = 99), or to educational psychologists (n = 35).

Of the questionnaires mailed, 26.4% of the guidance counsellors (n = 42), 25.7% of the educational psychologists (n = 9), and 1 guidance counsellor/educational psychologist completed questionnaires (total N = 52; total response rate = 26.8%). The mean age of participants was 43.86 years (SD = 6.73 years), with a range of 30 to 55 years. The sample was 36.5% male (n = 19) and 61.5% female (n = 32). One participant did not reply to this question.

All participants who responded to the item on education (n = 51) had completed a master's degree in an applied area of psychology (e.g., counselling, educational, school, clinical) or general counselling. The majority reported completing a degree in counselling psychology (n = 19) or counselling (n = 16). Fifty-one participants reported a mean of 13.80 years (SD = 7.14 years) since completion of their final degree. In addition, 51 participants also reported a mean of 12.81 years (SD = 7.23 years) of working in their current occupation. Thirty-six participants reported that they worked in a rural setting, 9 reported working in an urban setting, while 5 reported working in both rural and urban settings.

Questionnaires

Demographic questionnaire. Participants received a demographic questionnaire, constructed by the first author with input from other education professionals, measuring several variables (e.g., sex, age, education level, occupation title, tenure, working environment).

Training experiences questionnaire. Participants also received a measure constructed by the first author, assessing formal training (e.g., coursework) over the past 5 years, and self training (e.g., self-directed reading) on high-risk behaviour and actual work experiences in high-risk behaviour areas. To measure each high-risk behaviour category, respondents were asked to estimate the number of hours spent in training or actually dealing with such behaviour.

They were also asked to rate, on a 5-point scale, the importance of specific training formats (e.g., formal university coursework, supervised working experiences) in terms of preparing them to address each high-risk behaviour. The same scale was also used to measure the importance of specific aspects of formal university coursework, seminars, and professional development workshops (e.g., assigned reading, theory, professor/teacher demonstrations) in terms of preparing them to address high-risk behaviour.

High-risk questionnaire. Participants also received a measure constructed by the first author to assess, on a 5-point scale, perceived preparation, motivation, and effectiveness to prevent, assess, and intervene into each of the seven high-risk behaviours (this occurred in Section 1 of the high-risk questionnaire). Participants' views related to the following seven categories of high-risk behaviour were explored through the questionnaire: (a) suicide attempts; (b) self-mutilation (e.g., cutting); (c) bullying; (d) extreme school violence (e.g., school shootings, bombings); (e) eating disorders and related behaviour (e.g., extreme exercising); (f) sexual behaviour leading to risk of HIV or other sexually transmitted infections (STIs); and (g) drug-using behaviour (e.g., IV drug use, needle sharing) leading to risk of HIV or other STIs.

Section 2 of this measure, using a percentage scale, explored current and desired responsibility levels to prevent, assess, and intervene into each of the high-risk behaviours. Sections 3, 4, and 5 explored specific roles (e.g., team leader, bystander, team member) and actions (e.g., assess the situation, consult with a colleague, seek supervision) that participants had taken in dealing with high-risk behaviours.

RESULTS

Data Analysis

All data were entered into SPSS version 15. Descriptive statistics were run on the data as well as correlations and mean comparisons (*t*-test, one way ANOVA). Results are detailed below.

The following advanced organizer highlights the results presented below. The first section of the results, *Training*, includes information on participants' training in relation to preventing, assessing, and intervening into high-risk behaviour. It also focuses on participants' perceptions of the importance of various dimensions of training. The second section, *Perceived Preparation, Motivation, and Effectiveness,* reports on participants' perceived preparation, motivation, and effectiveness in preventing, assessing, and intervening into various high-risk behaviour categories. The final results section, *Responsibility and Responses,* details participants' reported responsibility levels for addressing high-risk behaviour as well as their reported roles and typical responses in dealing with high-risk behaviour.

Training

High-risk behaviour training experiences. Participants' training experiences regarding preventing, assessing, and intervening into high-risk behaviour, over the previous 5 years, varied widely (see Appendix A). Participants tended to report more (in both frequency and quantity) formal training in the prevention, assessment, and intervention of bullying as compared to other high-risk behaviour categories. Roughly half of the sample reported formal training in suicide assessment ($n = 26$) and intervention ($n = 27$). Greater than half of the sample reported formal training in prevention ($n = 28$), assessment ($n = 30$), and intervention ($n = 30$) of student self-mutilation. The majority of participants reported no formal training over the past 5 years, in the prevention, assessment, and intervention of the remaining high-risk behaviours (see Appendix A).

The majority of participants indicated self training, over the past 5 years, in the assessment, prevention, and intervention of suicide attempts, self-mutilation, bullying, extreme school violence, and eating disorders (see Appendix B). The majority also indicated self training in the area of prevention ($n = 27$) and intervention ($n = 28$) of high-risk sexual behaviour, but not in the assessment of high-risk sexual behaviour ($n = 23$) or the prevention ($n = 24$), assessment ($n = 20$), or intervention ($n = 22$) of drug use. The greatest frequency and quantity of self training was again around bullying (see Appendix B).

Participants also reported on their direct involvement in preventing, assessing, and intervening into the various high-risk behaviours over the previous 5 years (see Appendix C). The majority reported involvement with prevention, assessment, and intervention of suicide attempts, self-mutilation, bullying, and eating disorders. A small majority indicated they had engaged in intervention into extreme school violence (n = 28) and high-risk sexual behaviour (n = 27), but not the prevention or assessment of these activities. The majority of respondents indicated that they did not prevent, assess, or intervene into drug-using behaviour.

Training Components. Participants were asked to rate, on a 5-point Likert scale, their perceptions of the importance of different aspects of formal training around high-risk behaviour prevention, assessment, and intervention. Roughly four fifths (82.7%, n = 43) reported that formal university course work, supervised working experiences, and seminars and professional development courses (e.g., continuing education) were an *important* or *strongly important* part of their high-risk behaviour training. In addition, 80.7% (n = 42) reported that supervised practicum or internship training was *important* or *strongly important*. Fewer participants reported *important* or *strongly important* responses for non supervised working experiences (n = 29), independent study (n = 38), and conducting research (n = 23) in the area of high-risk behaviour training. Participants also rated various dimensions of formal coursework, seminars, and professional development courses designed to teach high-risk behaviour training on the same 5-point Likert scale. Here, participants viewed many of the training dimensions as *important*. Interestingly, theory was perceived as the least important training dimension by study participants (M = 3.24, SD = 1.109) (see Appendix D), with 28.6% of the responding sample (n = 14) indicating theory was *strongly not important* or *not important*.

Perceived Preparation, Motivation, and Effectiveness

Participants were asked on a 5-point Likert scale to rate their perceived preparation, motivation, and effectiveness in preventing, assessing, and intervening into each of seven high-risk behaviour categories (see Appendices E–K). Participants' overall responses suggested that they were more highly motivated than prepared or effective on all seven high-risk behaviour dimensions. The actual degree of reported preparation, motivation, and effectiveness varied by high-risk behaviour category. Overall, participants' perceived preparation, motivation, and effectiveness were highest around the bullying high-risk behaviour category (see Appendix G).

Participants reported mean scores in the *moderate* to high *neutral* range for perceived preparation and effectiveness for suicide and self-mutilation (albeit perceived preparation to prevent and be effective around self-mutilation fell in the lower range of the *neutral* category). Participants' mean scores fell in the *disagree* category or the low end of the *neutral* category for the remaining high-risk behaviour categories (i.e., extreme school violence, eating disorders, sexual behaviours, and drug use) in terms of preparation and effectiveness. Again, higher motivation scores suggested that participants may have had more motivation then they had perceived preparation or effectiveness.

Interestingly, there were some significant relationships between actually being directly involved in dealing with aspects of risk and levels of perceived preparation, motivation, and effectiveness for some of the high-risk behaviour categories (see Appendix L). This provided some support for the notion that perceived readiness is related to prevention, assessment, and intervention into high-risk behaviour. Participants who indicated actual work involvement in prevention of self-mutilation reported higher levels of feeling prepared and effective to prevent these behaviours, as compared to those who reported no involvement in prevention activities.

Involvement with any aspect of extreme school violence (i.e., preventing, assessing, or intervening) was significantly related to feeling prepared to act in this area (see Appendix L). Having had work experience in the assessment of extreme school violence versus not having had experience in this area was also significantly related to motivation (i.e., prevention and assessment) as well as all three dimensions of feeling effective (prevention, assessment, and intervention). Thus, school counsellors who had conducted assessments in extreme school violence situations reported higher levels of motivation to prevent and assess extreme school violence as well as higher levels of perceived effectiveness at preventing, assessing, and intervening into extreme school violence as compared to school counsellors reporting no assessment involvement in this area.

Having been involved in preventing eating disorders was significantly related to all three dimensions of feeling effective (i.e., preventing, assessing, and intervening) in this area. Dealing with aspects of sexual behaviour was significantly related to all dimensions of prevention, assessment, and intervention in this area. A similar relationship was noted with drug use. Participants reporting involvement with prevention and intervention activities, versus those with no involvement in this area, reported significant differences on all preparation, motivation, and effectiveness dimensions, with one exception (feeling effective to prevent drug use was not significant regardless of work experience versus no work experience in the intervention of drug use). Finally, having had experience in the assessment of drug use was also significantly related to all three dimensions of feeling prepared as well as feeling effective at assessment.

Few significant differences existed between those participants who reported work involvement in suicide prevention, assessment, and intervention compared to those who did not report work involvement in said activities in terms of self-reported preparation, motivation, and effectiveness in the prevention, assessment, and intervention of suicide.

As also seen, there were a number of moderate to strong correlations within the various high-risk behaviour dimensions (see Appendices E–K). There were strong positive correlations between perceived preparedness and perceived effectiveness among the various high-risk behaviour categories. For all high-risk behaviour categories, there were significant moderate to strong positive correlations ($\leq .01$ level, two-tailed) between perceived preparation and perceived effectiveness.

For all high-risk behaviour categories there were significant mild to moderate positive correlations between perceived motivation and perceived effectiveness, with

the exception of the intervention category for bullying (note: data for this category were not normally distributed). In addition, these correlations were lower than all perceived preparation and perceived effectiveness correlations, with the exception of motivation for assessment and effectiveness for assessment versus preparation for assessment and effectiveness for assessment for the self-mutilation category (.713, ≤ .01 level, two-tailed versus .640, ≤ .01 level, two-tailed, respectively). Significant (at the .01 level, two-tailed), albeit lower, correlations were noted between motivation and preparation among the high-risk behaviour dimensions.

The correlations between preparation and motivation were smaller in size for most of the high-risk behavioural categories (i.e., suicide, self-mutilation, eating disorder, and drug use). There were no significant correlations noted between preparation to prevent and motivation to prevent, preparation to assess and motivation to assess, and preparation to intervene and motivation to intervene for the eating disorder category.

Responsibility and Responses

Responsibility. Participants were asked to rate, on a 0–100% scale, the amount of responsibility they felt they had for preventing, assessing, and intervening into the seven high-risk behaviour dimensions (see Appendix M). Following this, they were asked to rate their desired level of responsibility, on the same scale, for preventing, assessing, and intervening into each of the seven high-risk behaviour dimensions (see Appendix N). Interestingly, there were significant differences between current and desired responsibility levels for suicide (prevention, assessment, and intervention), self-mutilation (assessment and intervention), bullying (assessment and intervention), and eating disorders (intervention) (see Appendix O).

These significant differences reflected participants' wanting less responsibility in addressing these high-risk behaviour dimensions. Participants indicated their highest current responsibilities around the assessment (M = 75.29%, SD = 27.48) and treatment (M = 70.98%, SD = 29.48) of suicide. As seen in Appendix M, participants also reported current responsibility scores in the 60% range for self-mutilation and bullying. However, current responsibility scores were reported in the 50% and 40% range for the remaining high-risk behaviour dimensions. Scores were especially low for sexual behaviour and drug-using behaviour. As noted above, participants' scores suggested they were interested in significantly less responsibility in dealing with suicide, self-mutilation, and bullying. Participants seemed relatively satisfied with current levels of responsibility for the remaining high-risk behaviour dimensions.

There were also some significant differences in terms of responsibility levels between those participants who reported actual work involvement with high-risk behaviour and those reporting no actual work involvement in these activities (see Appendix P). In addition, there were also some significant differences in rated responsibility levels between those participants who reported that it was their role to prevent, assess, or intervene into the specific high-risk behaviours and those who did not report that it was their role to deal with these behaviours (see Appendix Q).

Roles and responses. Participants were also asked to rank order the top three probable actions they may take in dealing with a student high-risk behaviour (see Appendix R). The majority of participants who responded to this question indicated their first response would be to become directly involved in assessing and intervening into each of the high-risk behaviours. This was especially strong for suicide, self-mutilation, and bullying. Participants' second action choice was often to consult with a colleague, and the third was typically to transfer the case to a different type of helping professional. Other response categories were far less endorsed (e.g., seek supervision, bring case to team leader prior to taking action).

Participants were also asked about roles they assumed in dealing with the various high-risk behaviours (see Appendix S). As seen, a large number of participants perceived themselves as taking on a team leader role in dealing with suicide, self-mutilation, and bullying. Fewer participants reported such a role in dealing with the remaining high-risk behaviour dimensions. Importantly, very few respondents reported taking on a "bystander" role.

A small subset of the participants did report "working alone." As noted above, Appendix C highlights those participants reporting actual engagement in prevention, assessment, or intervention activities (i.e., hours worked) over the past 5 years. In contrast, Appendix S shows those who saw prevention, assessment, or intervention as their perceived role. As can be seen, a large number of participants did not endorse these types of roles (e.g., prevention, assessment, intervention) as being part of their professional role. This was especially the case for extreme school violence, eating disorders, sexual behaviours, and drug use. A larger than expected group indicated that prevention, assessment, and intervention of suicide, self-mutilation, and bullying were also not part of their roles. Importantly, not perceiving an activity as part of their role did not preclude participants from actually engaging in the activity over the past 5 years (see Appendix C).

DISCUSSION

Training and Roles

Training was a core consideration in the current study. Several authors (e.g., Carney & Cobia, 2003; Furlong, Babinski, Poland, Munoz, & Boles, 1996) suggested that some school counsellors and school psychologists do not receive sufficient training in dealing with certain high-risk student behaviour. The current study found that a large number of school counsellors received no formal training, over the previous 5 years, in addressing some types of high-risk behaviour. Areas such as sexual behaviour, drug use, and eating disorders were especially unlikely to have been addressed through formal training.

Interestingly, a large number of school counsellors indicated that they did not perceive prevention, assessment, or intervention of these types of high-risk student behaviour as their role. This could be a consequence of not having received formal training in this area. Perhaps in some cases instructors in their training programs did not recognize these as critical to counsellors' roles. It is also possible

that few opportunities exist for formal training in these areas, making it difficult to obtain training.

Nonetheless, several researchers (e.g., Boes et al., 2004; Yager & O'Dea, 2005) have suggested that school counsellors have the potential to have positive impacts on students dealing with, or at risk for, eating disorders, provided they receive sufficient training. In addition, Nagel, Scherer, and Lee (2000) reported that school counsellors in their study noted student substance abuse as their paramount concern. Other researchers (e.g., Cobia et al., 1998; McFarland & Oliver, 1999; Stevens-Smith & Remley, 1994) have suggested that school counsellors can play a role in HIV risk reduction behaviour, including high-risk sexual behaviour, among youth.

While a larger number of participants in the current study reported self-training activities, many also reported no self-training in dealing with high-risk sexual behaviour, drug use, and eating disorders. Again, this likely reflects the reality that some school counsellors do not perceive dealing with these types of student high-risk behaviour as their role. This does raise the question as to which helping professional would address these behaviours and why some school counsellors would perceive it as their role and others would not.

The great majority of participants reported formal training on the topic of bullying. This could reflect the availability of formal course work at the local university. In addition, many participants perceived this area as falling within their roles.

Suicide assessment and intervention, two frequently cited responsibilities of school counsellors (King et al., 2000), were noted by roughly half of the sample as having been a topic of formal training over the past 5 years. The majority indicated self-training in these areas. This highlights the importance of ensuring the availability of high-quality formal training opportunities in the area of suicide assessment and intervention. This is consistent with previous research (e.g., Allen et al., 2002; Canada et al., 2007), which highlights the importance of school counsellor suicide training.

Interestingly, a subset of the participants reported not engaging in prevention, assessment, or intervention of suicide over the past 5 years and a large subset reported this as not being one of their roles. While several authors (e.g., Costin et al., 2002; King et al., 2000; Schaefer-Schiumo & Ginsberg, 2003; Stevens-Smith & Remley, 1994) have reported that school counsellors have a responsibility to prevent, assess, and intervene into various high-risk student behaviour, including student suicide risk, several participants in this study did not see it as their role and wanted less responsibility.

Some of the differences found in the current study could have to do with different types of roles assumed by school counsellors and educational psychologists locally. However, each of these groups is cited in the literature as playing an important role in dealing with student high-risk behaviour (Costin et al., 2002; Furlong, Morrison, & Pavelski, 2000; King et al., 2000), suggesting that each group has a potential role to play. It is possible that the nature of that role may need to be further tailored to individual school counsellors' training background and interests, as well as school needs.

The majority of participants reported engaging in the prevention, assessment, and intervention of suicide attempts, self-mutilation, bullying, and eating disorders (but not in the remaining high-risk behaviours) over the past 5 years. A subset of school counsellors seemed to be engaged in dealing with high-risk student behaviour while not actually seeing it as their role, suggesting the possibility that some school counsellors have had to step outside of their perceived role in times of high-risk student behaviour.

In addition, some school counsellors in this study reported intervening in student sexual behaviour and extreme school violence, but not assessing or acting to prevent these behaviours, suggesting a potential need to intervene in response to such behaviour, even if this may ordinarily fall outside one's professional role. Taken together, this may suggest that school counsellors can be expected to deal with certain high-risk behaviour even if it is not part of their defined role.

Interestingly, data from the current study suggest participants may be more motivated then they are prepared or effective (at least in terms of their personal perceptions) in addressing student high-risk behaviour. Thus, there may be a need to offer training in areas such as extreme school violence and high-risk sexual behaviour, even to those school counsellors who perceive these types of behaviour as falling outside of their professional role. Perhaps an effort should be made to encourage current and future school counsellors to receive training in these high-risk behaviour areas as they may be called upon to assess or intervene into these student high-risk behaviours. It appears that the subset of school counsellors now addressing these behaviours may need and desire further access to training.

Similarly, a majority of participants reported addressing eating disorder behaviours, and they indicated that they received very little or no formal training over the past 5 years in this area. Again this may reflect a need for future formal training. The high proportion of participants reporting self-training in dealing with several high-risk student behaviours could also indicate a desire among school counsellors for more formal training opportunities (e.g., professional development seminars) in these areas. This could highlight a need for universities to increase emphasis in these areas.

Counselling psychology, school psychology, and general counselling have placed a clear emphasis on prevention activities (Beatch et al., 2008). In this study, a similar number of participants reported involvement in formal and self-training in terms of prevention and in assessment and intervention for high-risk behaviour. The same was true for involvement in prevention activities compared to assessment and intervention; similar numbers of participants reported preventing high-risk behaviours and assessing and intervening into high-risk behaviours (one exception to this was found; fewer participants reported prevention of self-mutilation behaviours as compared to intervention and assessment of self-mutilation).

Interestingly, though, participants indicated spending more actual hours involved with the intervention of suicide, self-mutilation, and bullying than they did with the prevention or assessment of these activities (it is important to note that some participants reported extreme scores on the intervention category, which

contributed to larger reported intervention hours worked). Participants reported spending more time in the prevention of some eating disorders, extreme school violence, sexual behaviour, and drug-using behaviour than on intervention and assessment in these areas. This could speak to participants' discomfort levels with intervention and assessment in these high-risk behaviour domains.

Similar numbers of participants reported it was their role to prevent bullying, extreme school violence, eating disorders, sexual behaviours, and drug use as reported it was their role to intervene into and assess these behaviours. Fewer participants (i.e., roughly one third fewer) reported it was their role to prevent suicide and self-mutilation than reported it was their role to offer intervention and assessment into these two behaviours. This suggests that this subset of participants differentiated between prevention and assessment/intervention. In other words, they did not perceive a proactive approach (inasmuch as prevention is the proactive option compared with assessment and intervention) as part of their role for these two high-risk behaviour categories. Overall, there is some indication in this sample that prevention of certain high-risk student behaviour may be perceived as less part of school counsellors' roles/responsibilities than are assessment and intervention. Having said that, prevention was a core activity for many of the participants.

Participants rated a number of training dimensions as being important in helping them feel prepared to deal with high-risk behaviour. "Theory" was rated lower than a number of the other dimensions. In a study of elementary and secondary school counsellors' perceptions of graduate training dimensions, counselling theory was rated in 9th place out of 24 dimensions for elementary school counsellors and 12th out of 24 for secondary school counsellors (Perusse & Goodnough, 2005). This is deemed problematic by the current authors, as theory is an important training dimension. The reasons that some school counsellors do not perceive theory as an important training dimension need to be explored. In addition, instructors and professors need to be aware of this potential perception among some students/trainees. Focusing on the applied aspects of training will be important to help provide students/trainees with what many seem to want, but helping to build in the rationale for theoretically informed practice is also an important dimension of training.

Feeling Able to Address Problems

Participants' perceptions of their preparation, motivation, and effectiveness to address high-risk behaviour varied as to the type of behaviour. Research (e.g., Debski, Spadafore, Jacob, Poole, & Hixson, 2007; Furlong et al., 1996; King et al., 2000; Schaefer-Schiumo & Ginsberg, 2003) suggests that some school counsellors/psychologists in training as well as some school counsellors/psychologists perceive themselves as being unprepared to address certain high-risk behaviour (e.g., suicide, school violence). Overall, participants in this study felt themselves most able to address bullying, the most common high-risk behaviour addressed by the school counsellors in our study.

Researchers have highlighted school counsellors' role in addressing bullying (e.g., Bauman, 2008; Jacobsen & Bauman, 2007; McAdams & Schmidt, 2007). However, researchers have not suggested placing such a higher emphasis on addressing bullying as compared with other forms of high-risk behaviour.

Participants in the current study reported perceiving relatively low levels of preparation and effectiveness in dealing with extreme school violence and drug use. Some researchers (e.g., Bernes & Bardick, 2007; Furlong et al., 2000; Lambie & Davis, 2007; Watkins, Ellickson, Vaiana, & Hiromoto, 2006) have suggested that school counsellors and psychologists can play a key role in addressing these types of high-risk behaviour. School counsellors need training and supervision in these areas and need clear direction to identify these responsibilities as part of their roles.

Some significant relationships were found between participant groups who reported actual work involvement with high-risk student behaviour and those reporting no work involvement in addressing high-risk behaviours in terms of their perceived preparation, motivation, and effectiveness. There are a number of potential explanations for these relationships.

If addressing high-risk behaviour is an expected part of a counsellor's job, it is possible that the counsellor would seek out additional expertise in this area. It is also possible that having work experience in the area may help school counsellors feel more able to address these behaviours. Or perhaps having these responsibilities as part of their professional role results in an enhanced perception of ability, confidence, or legitimacy to deal with these types of issues. Protection motivation theory, highlighting several dimensions that predict motivation to act in high-risk situations, including a threat appraisal indicating risk potential and perceived intervention efficacy (Nagel, Scherer, & Lee, 2000), could help explain the above-noted relationships. Further research could explore the above potential relationships in more depth.

Several authors (e.g., Costin et al., 2002; King et al., 2000; Schaefer-Schiumo & Ginsberg, 2003; Stevens-Smith & Remley, 1994) have highlighted that school counsellors should play an important role in dealing with high-risk student behaviour. Thus, it could be problematic if a counsellor is unprepared or unmotivated to assess or intervene in a case when called upon, especially in a rural area where other options may be harder to identify. In the current study, a small subset of participants reported that addressing some high-risk behaviours were not part of their perceived role, yet they had addressed these behaviours over the past 5 years. It is also important to note that participants' levels of motivation were higher than their perceived preparation and effectiveness for all seven of the high-risk behaviour categories. This suggests a need to help ensure school counsellors are ready for what might happen, despite the possibility that an issue might be outside of one's perceived professional role, and also to help school counsellors feel more effective and prepared to address such issues (i.e., in line with their levels of motivation).

Responsibility

In line with current research (e.g., King et al., 2000), participants reported their highest levels of current responsibility related to dealing with suicide. "Responsibility" is used here in an attempt to capture the degree to which participants feel responsible for dealing with the high-risk behaviour categories included in this article. They also reported high levels of responsibility for dealing with self-mutilation and bullying. Research has highlighted school counsellors' responsibilities in dealing with these types of behaviour (Jacobsen & Bauman, 2007; McAdams & Schmidt, 2007; Moyer, Haberstroh, & Marbach, 2008).

Participants' responses in the current study highlighted significant differences between current responsibility and desired responsibility in dealing with suicide, self-mutilation, and bullying (with the exception of preventing bullying and self-mutilation). This suggests some potential concerns with current responsibility levels in addressing these behaviours. This finding may highlight the importance of counsellors having a say in their job duties when it comes to addressing student high-risk behaviour.

For the most part, there were no significant differences between current responsibility and desired responsibility for the remaining high-risk behaviours (with the exception of intervening into eating disorders). However, for these additional high-risk behaviours, school counsellors reported relatively low levels of current and desired responsibility. These numbers were especially low (in the 40% range) for sexual behaviour and drug-using behaviour. This raises issues regarding whose role it is to address these types of high-risk student behaviour.

A subset of school counsellors in this study indicated that addressing these issues was their role and that they had worked in these areas over the past 5 years. A large group reported that it was not their role, they did not address these activities, and they wanted relatively low levels of responsibility in these areas. This may suggest that other types of professionals need to be involved/trained, or school counsellors need more training/incentives to engage in this type of work.

Perhaps employing a wider systemic/community model of prevention, assessment, and intervention into certain high-risk behaviour could be of benefit, resulting in a higher degree of teamwork and reducing pressures that may be on some school counsellors who do not want to be as involved in these practice areas. It is important to note that current and desired responsibility levels were significantly higher for those participants who indicated having worked in these areas over the past 5 years. This pattern was observed for all high-risk behaviour dimensions. (There was one exception to this: participants with no work experience involving the assessment of bullying over the past 5 years reported a higher degree of current responsibility to prevent bullying compared to participants who had assessment work experience in this area, albeit the relationship was not statistically significant.)

As noted above, there were some significant differences in responsibility levels between those who had involvement working with students around high-risk issues and those having no involvement working with students around high-risk issues.

Thus, having work experience with a particular high-risk behaviour resulted in having a different perspective on responsibility level than those participants with no work experience in that area. Nevertheless, both groups of participants (those having had the work experience and those not having had the work experience) reported desiring less responsibility in preventing, assessing, and intervening into suicide as compared with their current responsibility levels.

Participants reporting no work experience over the past 5 years regarding suicide still reported relatively high levels of current responsibility to deal with student suicidal behaviours. Participants who had not worked in the prevention, assessment, or intervention of self-mutilation reported a desire to have increases in their responsibility level around prevention of this high-risk issue. This might suggest a desire for some participants to take on a more proactive role in dealing with this type of high-risk behaviour.

In the category of extreme school violence, an interesting pattern emerged: participants who had worked in the area of prevention, assessment, and intervention reported a desired increase in responsibility level, while those not working in this area desired less responsibility. This potentially suggests that some school counsellors are keenly interested in working in this area. In contrast, very few differences were noted between current and desired responsibility for addressing drug use for both of the participant groups, suggesting that this may not be an area of as much interest, compared to some of the other dimensions, for many of the school counsellors surveyed.

Roles

Participants in the current study identified various roles they engaged in when addressing specific high-risk behaviour. Interestingly, few participants reported bringing the case to their team prior to taking action, transferring the case to someone in their discipline, or seeking supervision, especially in terms of dealing with suicide and self-mutilation. Participants' most frequent responses were in the areas of offering assessment and intervention, seeking consultation, and transferring the case to another type of professional. Participants often seemed to take an active front-line role with clients.

These results make sense given the nature of the issues in question: crises often necessitate initial action followed, in many instances, by consultation. For all of the high-risk behaviour dimensions, offering an assessment and intervention was a first choice. This may illustrate the position many school counsellors find themselves in. Importantly, most participants indicated that they were team leaders or active team members. Team work is likely occurring, but many participants may still be assessing and intervening alone or as first-line practitioners.

Fewer participants reported assessment and intervention activities around extreme school violence, as compared with the other high-risk behaviour dimensions, suggesting that fewer participants are dealing with these types of high-risk behaviour. In fact, all options tended to be endorsed fewer times in the extreme school violence category as compared with all other high-risk behaviour dimensions. Role

options in dealing with eating disorders, sexual behaviours, and drug use were also endorsed fewer times as compared to dealing with suicide, self-mutilation, and bullying, suggesting that fewer participants were dealing with (at least in terms of the options available) eating disorder, sexual behaviour, and drug use issues.

In line with this, several participants indicated case transfer options for eating disorders, sexual behaviour, and drug use behaviour. A number of participants indicated case consultation for the high-risk behaviour categories, which is quite encouraging. This would seem to suggest that many school counsellors in this study have colleagues to consult with when faced with difficult cases. This is in accord with ethical practice (e.g., the Canadian Counselling Association, the Canadian Psychological Association). It should also be noted that a very small subset of participants endorsed the "bystander" role in dealing with any of the high-risk behaviour categories, suggesting that the great majority of participants may become involved in addressing these behaviours if needed.

Future Directions and Study Limitations

The current study has elucidated several important findings and raised some important questions regarding school counsellors and high-risk student behaviour. School counsellors in this study noted their highest levels of preparation, motivation, and effectiveness in terms of dealing with student bullying. Future research could explore if this perception of preparation and effectiveness actually resulted in an enhanced ability to deal with said behaviour. Further exploring what makes school counsellors feel prepared, motivated, and effective in terms of the bullying dimension would also be useful.

School counsellors reported focusing less (along with less perceived preparation, motivation, and effectiveness) on sexual behaviour and drug use. This raises some important questions about which school professionals are doing the majority of work regarding these types of behaviours and what makes certain school counsellors so much more likely to work with these behaviours. It also raises the questions of what some school counsellors do when they are confronted with these types of issues and what the overall school approach is to addressing these types of issues.

Clearly, issues around school counsellors' role boundaries, and even role uncertainty, need to be examined. Another important focus in the current study was school counsellors' appreciation of theory. Future research could explore how school counsellors are encouraged to develop an appreciation of theoretical foundations regarding high-risk behaviour theories. Overall, a key message in the current study was around training needs and training availability. University programs can offer high-risk behaviour training as part of school counsellor and educational psychologist preparation.

The current results need to be treated cautiously. The current study had a relatively small sample size and focused on school counsellors' perceptions versus actual measures of ability or behaviour. Given the low response rate, it is possible that the characteristics of respondents differed from non-respondents.

There was also a high percentage of rural respondents; this was not necessarily unexpected, given the geographical reality of the population surveyed. In addition, high correlations between preparation, motivation, and effectiveness, although interesting, serve as a potential limitation (i.e., multicollinearity).

The authors also combined data from guidance counsellors and educational psychologists, which made sense for the purpose of the current article. In addition, there is some overlap in the roles and training of school counsellors and educational psychologists in this province. A small subset of participants indicated plus signs (+) or greater than signs (>) for the hours they spent in training or working. These numbers were treated as the number written, which could underestimate hours for a small number of the participants. An additional participant could not estimate the specific hours worked/trained, suggesting that this participant may have worked or received training but did not include the specific numbers.

Concluding Thoughts and Recommendations

School counsellors play a central role in preventing, assessing, and intervening into student high-risk behaviour. Having said that, not all school counsellors perceive this type of work as part of their role or responsibility. Clearly, identifying school counsellors' comfort, desired responsibility, and preferred role(s) in terms of addressing student high-risk behaviour is a key dimension of defining employment expectations. In addition, the current study has illustrated that some school counsellors may have more motivation to prevent, assess, or intervene into student high-risk behaviour than they perceive they have preparation or effectiveness, again highlighting the importance of training availability. In light of the study's findings, the following recommendations are made regarding school counsellor education, school counselling services, and continuing education:

1. Should provide formal coursework and supervised experience through counsellor education programs in the area of high-risk behaviour prevention, assessment, and intervention
2. Should focus on applied skill, along with theory, including a rationale for the importance of theoretically informed practice, during training in the area of high-risk behaviour prevention, assessment, and intervention
3. The desired role of school counsellors should be explicitly clarified in terms of prevention, assessment, and intervention into student high-risk behaviour
4. A prevention, assessment, and intervention team, with various disciplinary members, including school counsellors and psychologists, should be developed to be involved in prevention, assessment, and intervention activities surrounding student high-risk behaviour
5. Focus on assessment and intervention is key, but given the importance of primary prevention with youth, prevention training and activities should be at least as important as assessment and intervention
6. School boards should make available continuing education courses in the areas of prevention, assessment, and intervention of high-risk behaviour.

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Appendix A
Formal Training

Means and standard deviations of hours actually involved in formal training (i.e., last 5 years) and frequency counts of school counsellors actually involved in formal training (i.e., last 5 years) (i.e., yes/no)

High-risk behaviour	*Prevention*	*Assessment*	*Intervention*
Suicide attempts	M: 1.35 SD: 2.12 Yes: 24 No: 28	M: 1.43 SD: 2.00 Yes: 26 No: 26	M: 1.67 SD: 2.39 Yes: 27 No: 25
Self-mutilation (e.g., cutting)	M: 1.02 SD: 1.32 Yes: 28 No: 24	M: 1.18 SD: 1.36 Yes: 30 No: 22	M: 1.40 SD: 1.58 Yes: 30 No: 22
Bullying	M: 5.92 SD: 9.43 Yes: 41 No: 11	M: 3.26 SD: 4.78 Yes: 36 No: 16	M: 4.88 SD: 5.85 Yes: 40 No: 12
Extreme school violence (e.g., school shootings, bombings)	M: 1.13 SD: 1.98 Yes: 22 No: 30	M: 1.17 SD: 2.20 Yes: 21 No: 31	M: 1.11 SD: 2.12 Yes: 20 No: 32
Eating disorders and related behaviour (e.g., extreme exercising)	M: .54 SD: 1.19 Yes: 19 No: 33	M: .630 SD: 1.32 Yes: 20 No: 32	M: .54 SD: 1.36 Yes: 18 No: 34
Sexual behaviours leading to risk of HIV or other STIs	M: .59 SD: 1.47 Yes: 18 No: 34	M: .29 SD: .65 Yes: 16 No: 36	M: .29 SD: .65 Yes: 17 No: 35
Drug-using behaviours leading to risk of HIV or other STIs (e.g., IV drug use, needle sharing)	M: .50 SD: 1.24 Yes: 15 No: 37	M: .43 SD: 1.15 Yes: 14 No: 38	M: .35 SD: 1.02 Yes: 13 No: 39

Appendix B
Self Training

Means and standard deviations of hours actually involved in self training (i.e., last 5 years) and frequency counts of school counsellors actually involved in self training (i.e., last 5 years) (i.e., yes/no)

High-risk behaviour	*Prevention*	*Assessment*	*Intervention*
Suicide attempts	M: 4.09 SD: 4.14 Yes: 40 No: 12	M: 3.31 SD: 3.53 Yes: 42 No:10	M: 4.49 SD: 5.06 Yes: 41 No: 11
Self-mutilation	M: 2.79 SD: 3.92 Yes: 32 No: 20	M: 2.47 SD: 2.55 Yes: 36 No: 16	M: 3.54 SD: 4.66 Yes: 38 No: 14
Bullying	M: 13.67 SD: 17.12 Yes: 48 No: 4	M: 10.72 SD: 16.84 Yes: 44 No: 8	M: 20.94 SD: 46.23 Yes: 50 No: 2
Extreme school violence	M: 3.93 SD: 5.67 Yes: 34 No:18	M: 2.78 SD: 4.60 Yes: 29 No: 23	M: 3.37 SD: 4.99 Yes: 32 No: 20
Eating disorders and related behaviour	M: 3.02 SD: 5.23 Yes: 33 No: 19	M: 3.16 SD: 5.35 Yes: 33 No: 19	M: 3.89 SD: 6.62 Yes: 33 No: 19
Sexual behaviours leading to risk of HIV or other STIs	M: 2.78 SD: 4.26 Yes: 27 No: 25	M: 2.09 SD: 3.92 Yes: 23 No: 29	M: 3.83 SD: 7.11 Yes: 28 No: 24
Drug-using behaviours leading to risk of HIV or other STIs	M: 2.16 SD: 3.95 Yes: 24 No: 28	M: 1.63 SD: 3.49 Yes: 20 No: 32	M: 2.52 SD: 5.06 Yes: 22 No: 30

Appendix C
Involvement in Activities

Means and standard deviations of hours actually involved in activities and frequency counts of school counsellors reporting hours involved in activities (i.e., no/yes)

High-risk behaviour	*Prevention*	*Assessment*	*Intervention*
Suicide attempts	M: 15.98 SD: 34.72 No: 10 Yes: 40	M: 13.24 SD: 23.77 No: 11 Yes: 39	M: 27.20 SD: 65.17 No: 13 Yes:37
Self-mutilation	M: 10.84 SD: 30.16 No: 17 Yes: 33	M: 10.56 SD: 30.16 No: 7 Yes:43	M: 18.09 SD: 41.24 No: 9 Yes: 41
Bullying	M: 79.91 SD: 118.81 No: 2 Yes: 48	M: 75.84 SD: 184.42 No: 3 Yes: 47	M: 180.91 SD: 619.91 No: 1 Yes: 49
Extreme school violence	M: 7.24 SD: 20.78 No: 33 Yes: 17	M: 4.48 SD: 16.69 No: 36 Yes: 14	M: 6.11 SD: 17.19 No: 22 Yes: 28
Eating disorders and related behaviour	M: 6.22 SD: 9.99 No: 22 Yes: 28	M: 5.47 SD: 8.18 No: 18 Yes: 32	M: 5.76 SD: 8.80 No: 23 Yes: 27
Sexual behaviours leading to risk of HIV or other STIs	M: 13.18 SD: 25.76 No: 25 Yes: 25	M: 9.89 SD: 20.17 No: 25 Yes: 25	M: 10.24 SD: 19.89 No: 23 Yes: 27
Drug-using behaviours leading to risk of HIV or other STIs	M: 6.84 SD: 15.76 No: 36 Yes: 14	M: 3.36 SD: 10.41 No: 37 Yes: 13	M: 4.04 SD: 12.79 No: 35 Yes: 15

Appendix D
Training Dimensions

Means and standard deviations of training dimensions

Training dimensions	*Mean*	*SD*
1. Assigned readings	3.86	.913
2. Study of theory	3.24	1.109
3. Supervised practicum/internship	4.39	.759
4. In-class mock counselling/training	4.24	.778
5. Professor/teacher demonstrations	4.18	.782
6. Study of counselling methods/skills	4.14	.890
7. Study of assessment methods/skills	4.22	.896
8. Class discussions	4.33	.753
9. Class group projects	3.94	.852
10. Class assignments	3.86	.866

*n = 49

Appendix E
Suicide (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention 1-3: Prepared; 4-6: Motivated; 7-9: Effective

Variable	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1	3.65	1.03	-	.749**	.666**	.407**	.241	.357*	.783**	.704**	.732**
2	3.94	.83		-	.832**	.488**	.472**	.495**	.776**	.858**	.823**
3	3.92	.76			-	.383**	.370**	.390**	.654**	.679**	.818**
4	4.18	.88				-	.925**	.974**	.553**	.636**	.628**
5	4.29	.71					-	.961**	.420**	.541**	.567**
6	4.22	.86						-	.486**	.644**	.636**
7	3.82	.87							-	.813**	.780**
8	3.98	.74								-	.885**
9	3.98	.72									-

Note. Motivated (prevention and intervention) categories are not normally distributed.
* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix F
Self Mutilation (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention 1-3: Prepared; 4-6: Motivated; 7-9: Effective

Variable	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1	3.17	.90	-	.555**	.596**	.372**	.362*	.363*	.618**	.506**	.521**
2	3.52	.87		-	.819**	.534**	.532**	.525**	.252**	.640**	.436**
3	3.49	.78			-	.472**	.472**	.463**	.286*	.618**	.572**
4	3.98	.88				-	.959**	.973**	.437**	.641**	.483**
5	4.02	.88					-	.987**	.475**	.713**	.561**
6	4.04	.87						-	.449**	.703**	.552**
7	3.30	.93							-	.531**	.588**
8	3.72	.83								-	.811**
9	3.60	.86									-

* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix G

Bullying (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention			1-3: Prepared; 4-6: Motivated; 7-9: Effective								
Variable	M	SD	1	2	3	4	5	6	7	8	9
1	4.23	.67	-	.791**	.713**	.475**	.524**	.513**	.598**	.552**	.437**
2	4.31	.67		-	.630**	.342**	.395**	.419**	.389**	.618**	.197
3	4.25	.72			-	.270	.318*	.377**	.361**	.487**	.616**
4	4.42	.81				-	.954**	.938**	.335*	.388**	.188
5	4.39	.80					-	.954**	.382**	.444**	.224
6	4.41	.80						-	.375**	.478**	.254
7	4.16	.64							-	.627**	.717**
8	4.20	.57								-	.531**
9	4.06	.76									-

Note. Motivated (prevention, assessment, and intervention) categories are not normally distributed. Effective (intervention) category is not normally distributed.
* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix H

Extreme School Violence (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention			1-3: Prepared; 4-6: Motivated; 7-9: Effective								
Variable	M	SD	1	2	3	4	5	6	7	8	9
1	2.77	1.08	-	.837**	.826**	.557**	.532**	.495**	.843**	.666**	.655**
2	2.88	1.23		-	.889**	.636**	.624**	.588**	.760**	.742**	.693**
3	2.79	1.18			-	.558**	.538**	.503**	.757**	.757**	.712**
4	3.37	1.26				-	.959**	.967**	.568**	.600**	.596**
5	3.46	1.16					-	.934**	.541**	.591**	.521**
6	3.48	1.18						-	.503**	.522**	.516**
7	2.86	1.13							-	.840**	.821**
8	2.92	1.15								-	.835**
9	2.82	1.07									-

* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix I

Eating Disorders (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention 1-3: Prepared; 4-6: Motivated; 7-9: Effective

Variable	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1	3.06	.97	-	.747**	.865**	.211	.158	.158	.607**	.548**	.613**
2	3.20	.98		-	.846**	.284*	.253	.253	.507**	.654**	.540**
3	3.06	1.05			-	.240	.168	.190	.617**	.579**	.641**
4	3.84	.87				-	.921**	.947**	.429**	.418**	.374**
5	3.84	.89					-	.974**	.327*	.429**	.342*
6	3.84	.89						-	.350*	.407**	.319*
7	2.94	1.02							-	.775**	.898**
8	3.20	1.05								-	.823**
9	3.04	1.03									-

* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix J

Sexual Behaviour (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention 1-3: Prepared; 4-6: Motivated; 7-9: Effective

Variable	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1	3.16	1.08	-	.957**	.933**	.451**	.464**	.466**	.638**	.731**	.683**
2	3.18	1.07		-	.941**	.429**	.441**	.426**	.643**	.739**	.672**
3	3.20	1.20			-	.392**	.403**	.406**	.590**	.686**	.673**
4	3.62	1.10				-	.984**	.992**	.447**	.471**	.435**
5	3.66	1.20					-	.992**	.464**	.490**	.468**
6	3.64	1.10						-	.446**	.472**	.451**
7	3.12	1.00							-	.907**	.873**
8	3.04	1.05								-	.965**
9	3.08	1.08									-

* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix K
Drug Use (Prevention, Assessment, Intervention)

1, 4, 7: prevention; 2, 5, 8: assessment; 3, 6, 9: intervention 1-3: Prepared; 4-6: Motivated; 7-9: Effective

Variable	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1	2.84	1.03	-	.875**	.840**	.446**	.409**	.428**	.743**	.656**	.646**
2	2.85	1.01		-	.924**	.392**	.388**	.373**	.602**	.661**	.616**
3	2.78	1.03			-	.434**	.398**	.414**	.627**	.666**	.707**
4	3.42	1.20				-	.979**	.993**	.573**	.563**	.608**
5	3.44	1.21					-	.987**	.535**	.557**	.572**
6	3.40	1.20						-	.557**	.546**	.592**
7	2.90	1.07							-	.879**	.894**
8	2.86	1.09								-	.943**
9	2.84	1.13									-

* Correlation is significant at the 0.05 level (2-tailed) ** Correlation is significant at the 0.01 level (2-tailed)

Appendix L
Work Experience versus No Work Experience

Involvement in prevention, assessment, or intervention of specific high-risk behaviour versus non-involvement in prevention, assessment, or intervention of specific high-risk behaviour for Perceived Preparation (Prep), Motivation (Mot), and Effectiveness (Eff). Prevention=Prev; Assessment=Assess; Intervention=Inter

The following table compares participants who report work experience with those who do not report work experience in relation to high-risk behaviour work. The impacts of work experience on how participants rate themselves in terms of personal preparation, motivation, and effectiveness are explored. For example, *Sui-Prev* refers to suicide prevention work. Participants reporting work experience in suicide prevention had a mean score of 3.76 (*SD*: .925) on preparation to prevent suicide (Prep-Prev) whereas participants not reporting work experience in suicide prevention had a mean score of 3.40 (*SD*: 1.24) on preparation to prevent suicide. As illustrated in the table, this was non significant ($F = 1.296$, $p > .05$).

One-Way ANOVA (Hours vs no Hours)	Prep-Prev	Prep-Assess	Prep-Inter	Mot-Prev	Mot-Assess	Mot-Inter	Eff-Prev	Eff-Assess	Eff-Inter
Sui-Prev	F=1.296 M_1=3.76 M_0=3.40 SD_1=.925 SD_0= 1.24	F= 2.410 M_1=4.05 M_0=3.67 SD_1=.664 SD_0= 1.11	F=8.678* M_1= 4.11 M_0= 3.46 SD_1= .614 SD_0= .915	F= .069 M_1=4.21 M_0= 4.13 SD_1=.880 SD_0=.915	F= 1.004 M_1= 4.35 M_0= 4.13 SD_1= .646 SD_0= .834	F= .011 M_1= 4.23 M_0= 4.20 SD_1= .877 SD_0=.862	F= 3.700 M_1= 3.97 M_0= 3.47 SD_1= .747 SD_0= 1.06	F= .083 M_1= 4.00 M_0= 3.93 SD_1= .686 SD_0= .884	F= 2.603 M_1= 4.01 M_0= 3.73 SD_1=.668 SD_0=.799

One-Way ANOVA (Hours vs no Hours)	Prep-Prev	Prep-Assess	Prep-Inter	Mot-Prev	Mot-Assess	Mot-Inter	Eff-Prev	Eff-Assess	Eff-Inter
Sui-Assess	F= .057 M_1= 3.68 M_0= 3.60 SD_1= .973 SD_0= 1.18	F= 3.817 M_1= 4.08 M_0= 3.60 SD_1= .640 SD_0= 1.12	F= 6.044* M_1= 4.08 M_0= 3.53 SD_1= .640 SD_0= .915	F= .936 M_1= 4.00 M_0= 4.26 SD_1=.898 SD_0=.845	F= 3.730 M_1= 4.41 M_0= 4.00 SD_1= .657 SD_0= .756	F= 1.401 M_1= 4.31 M_0= 4.00 SD_1= .867 SD_0= .845	F= 1.370 M_1= 3.91 M_0= 3.60 SD_1= .853 SD_0= .910	F= 1.268 M_1= 4.06 M_0= 3.80 SD_1= .639 SD_0= .941	F= 4.352* M_1= 4.12 M_0= 3.67 SD_1=.640 SD_0=.817
Sui-Inter	F= .024 M_1= 3.64 M_0= 3.69 SD_1= .932 SD_0= 1.32	F= 1.605 M_1= 4.03 M_0= 3.69 SD_1= .668 SD_0= 1.18	F= 2.925 M_1= 4.03 M_0= 3.62 SD_1= .623 SD_0= 1.04	F= .255 M_1= 4.22 M_0= 4.08 SD_1=.898 SD_0=.862	F= 3.010 M_1= 4.39 M_0= 4.00 SD_1= .645 SD_0= .817	F= .477 M_1= 4.27 M_0= 4.08 SD_1= .871 SD_0= .862	F= .058 M_1= 3.84 M_0= 3.77 SD_1= .834 SD_0= .873	F= .101 M_1= 4.00 M_0= 3.92 SD_1=.667 SD_0=.954	F= 1.521 M_1= 4.06 M_0= 3.77 SD_1=.630 SD_0=.927
Self-Mut-Prev	F= 10.644* M_1= 3.47 M_0= 2.70 SD_1= .842 SD_0= .801	F= 3.216 M_1= 3.69 M_0= 3.25 SD_1= .780 SD_0=.967	F= 4.090* M_1= 3.66 M_0= 3.21 SD_1= .787 SD_0= .713	F= 1.427 M_1= 4.10 M_0= 3.80 SD_1=.772 SD_0=1.01	F= 1.281 M_1= 4.14 M_0= 3.85 SD_1= .743 SD_0= 1.04	F= .893 M_1= 4.14 M_0= 3.90 SD_1= .743 SD_0= 1.02	F=11.707** M_1=3.63 M_0= 2.80 SD_1= .765 SD_0= .951	F= 3.685 M_1= 3.90 M_0= 3.45 SD_1=.662 SD_0=.999	F= 8.348* M_1= 3.87 M_0= 3.20 SD_1=.629 SD_0=1.01
Self-Mut-Assess	F= .930 M_1= 2.36 M_0= 3.00 SD_1= 1.01 SD_0= .612	F= 1.697 M_1= 3.63 M_0= 3.29 SD_1= .843 SD_0= .920	F= 1.202 M_1= 3.57 M_0= 3.31 SD_1= .850 SD_0= .602	F= .049 M_1= 4.00 M_0= 3.94 SD_1=.916 SD_0=.827	F= .209 M_1= 4.06 M_0= 3.94 SD_1= .876 SD_0= .218	F= .057 M_1= 4.06 M_0= 4.00 SD_1= .878 SD_0= .866	F= .987 M_1= 3.39 M_0= 3.12 SD_1= .998 SD_0= .781	F= .638 M_1= 3.79 M_0= 3.59 SD_1=.857 SD_0=.795	F= 3.444 M_1= 3.76 M_0= 3.29 SD_1=.830 SD_0=.839
Self Mut-Inter	F= 2.340 M_1= 3.28 M_0= 2.85 SD_1= .972 SD_0= .555	F= 3.156 M_1= 3.64 M_0= 3.15 SD_1= .843 SD_0= .899	F= 2.766 M_1= 3.59 M_0= 3.17 SD_1= .818 SD_0= .577	F= 1.017 M_1= 4.06 M_0= 3.77 SD_1=.924 SD_0=.725	F= 1.463 M_1= 4.11 M_0= 3.77 SD_1= .887 SD_0= .832	F= .894 M_1= 4.11 M_0= 3.85 SD_1= .887 SD_0= .801	F= 1.008 M_1= 3.38 M_0= 3.08 SD_1= .982 SD_0= .760	F= 2.954 M_1= 3.84 M_0= 3.38 SD_1=.834 SD_0=.768	F= 7.396* M_1= 3.78 M_0= 3.08 SD_1=.787 SD_0=.862

One-Way ANOVA (Hours vs no Hours)	Prep-Prev	Prep-Assess	Prep-Inter	Mot-Prev	Mot-Assess	Mot-Inter	Eff-Prev	Eff-Assess	Eff-Inter
Bull-Prev	F= .945 M_1= 4.267 M_0= 4.00 SD_1= .654 SD_0= .817	F= .257 M_1=4.29 M_0=4.43 SD_1=.695 SD_0= .535	F= 1.027 M_1= 4.30 M_0= 4.00 SD_1= .668 SD_0= 1.00	F= .220 M_1= 4.44 M_0= 4.29 SD_1=.825 SD_0=.756	F= .140 M_1=4.41 M_0= 4.28 SD_1=.816 SD_0=.756	F=.196 M_1= 4.43 M_0= 4.29 SD_1=.818 SD_0= .756	F=.476 M_1= 4.18 M_0= 4.00 SD_1= .620 SD_0= .817	F= .200 M_1= 4.18 M_0= 4.29 SD_1=.582 SD_0=.488	F= 1.694 M_1= 4.11 M_0= 3.71 SD_1=.618 SD_0=1.38
Bull-Assess	F= .248 M_1= 4.21 M_0= 4.33 SD_1= .675 SD_0= .675	F= .445 M_1=4.28 M_0= 4.44 SD_1= .666 SD_0= .726	F=.129 M_1=4.24 M_0= 4.33 SD_1= .726 SD_0= .707	F= .010 M_1= 4.41 M_0= 4.44 SD_1=.836 SD_0=.726	F= .046 M_1=4.38 M_0= 4.44 SD_1= .825 SD_0= .726	F= .102 M_1= 4.43 M_0= 4.33 SD_1= .866 SD_0= .801	F= .644 M_1= 4.19 M_0= 4.00 SD_1= .552 SD_0= 1.00	F= .637 M_1= 4.17 M_0= 4.33 SD_1=.537 SD_0.=.707	F= .542 M_1= 4.10 M_0= 3.89 SD_1=.726 SD_0=.928
Bull-Inter	F= 2.312 M_1= 4.28 M_0= 3.80 SD_1= .649 SD_0= .837	F= 1.161 M_1= 4.34 M_0= 4.00 SD_1= .668 SD_0= .707	F= .697 M_1=4.28 M_0= 4.00 SD_1= .720 SD_0= .707	F= 1.508 M_1= 4.47 M_0= 4.00 SD_1=.786 SD_0=1.00	F= 1.334 M_1= 4.43 M_0= 4.00 SD_1= .779 SD_0= 1.00	F= 1.466 M_1= 4.46 M_0= 4.00 SD_1= .781 SD_0= 1.00	F= .324 M_1= 4.17 M_0= 4.00 SD_1= .643 SD_0= .707	F= .000 M_1= 4.20 M_0= 4.20 SD_1=.582 SD_0.=.447	F= .189 M_1= 4.04 M_0= 4.20 SD_1=.788 SD_0=.447
ExVio-Prev	F= 7.033* M_1= 3.26 M_0= 2.48 SD_1= .872 SD_0= 1.09	F= 4.984* M_1= 3.37 M_0= 2.61 SD_1= 1.01 SD_0= 1.27	F= 6.677* M_1= 3.32 M_0= 2.48 SD_1= 1.00 SD_0= 1.18	F= .578 M_1= 3.56 M_0= 3.27 SD_1=1.10 SD_0=1.35	F= .469 M_1=3.61 M_0= 3.38 SD_1= .850 SD_0= 1.31	F= .113 M_1= 3.56 M_0= 3.44 SD_1= 1.10 SD_0= 1.24	F= 3.963 M_1= 3.28 M_0= 2.64 SD_1= 1.07 SD_0= 1.11	F= 1.279 M_1= 3.17 M_0= 2.79 SD_1=.924 SD_0=1.24	F= .751 M_1= 3.00 M_0= 2.73 SD_1=1.03 SD_0=1.10
ExVio-Assess	F= 13.675** M_1= 3.42 M_0= 2.39 SD_1= .769 SD_0=1.006	F=16.445** M_1= 3.68 M_0= 2.42 SD_1= .946 SD_0= 1.15	F=14.989** M_1= 3.53 M_0= 2.36 SD_1= 1.02 SD_0= 1.06	F= 5.012* M_1= 3.89 M_0= 3.09 SD_1=.963 SD_0=1.33	F= 5.296* M_1= 3.94 M_0= 3.19 SD_1= .639 SD_0= 1.31	F= 3.539 M_1= 3.89 M_0= 3.25 SD_1= .963 SD_0= 1.24	F=10.495* M_1= 3.50 M_0= 2.52 SD_1= .857 SD_0= 1.12	F= 6.416* M_1= 3.44 M_0= 2.64 SD_1=.616 SD_0=1.27	F= 4.089* M_1= 3.22 M_0=2.61 SD_1=.878 SD_0=1.12

One-Way ANOVA (Hours vs no Hours)	Prep-Prev	Prep-Assess	Prep-Inter	Mot-Prev	Mot-Assess	Mot-Inter	Eff-Prev	Eff-Assess	Eff-Inter
ExVio-Inter	F= 6.154*	F= 7.849*	F= 8.921*	F= 1.367	F= 1.144	F= .496	F= 4.177*	F= 1.340	F= .968
	M_1= 3.18	M_1= 3.41	M_1= 3.32	M_1= 3.62	M_1= 3.67	M_1= 3.62	M_1= 3.24	M_1= 3.14	M_1= 3.00
	M_0= 2.47	M_0= 2.50	M_0= 2.40	M_0= 3.20	M_0= 3.31	M_0= 3.38	M_0= 2.60	M_0= 2.77	M_0= 2.70
	SD_1= .958	SD_1= 1.10	SD_1= 1.13	SD_1=1.16	SD_1= .966	SD_1= 1.16	SD_1= .238	SD_1=.964	SD_1=1.05
	SD_0= 1.07	SD_0= 1.20	SD_0= 1.07	SD_0=1.32	SD_0= 1.28	SD_0= 1.21	SD_0= .201	SD_0=1.25	SD_0=1.09
Eat-Prev	F= 2.462	F=2.416	F= 2.088	F= 2.228	F= .627	F= .627	F= 8.448*	F=4.305*	F=13.589**
	M_1= 3.24	M_1= 3.38	M_1= 3.24	M_1= 4.00	M_1=3.93	M_1= 3.93	M_1= 3.29	M_1= 3.46	M_1=3.46
	M_0= 2.82	M_0= 2.95	M_0= 2.82	M_0= 3.64	M_0= 3.73	M_0= 3.73	M_0= 2.50	M_0= 2.86	M_0= 2.50
	SD_1= .872	SD_1= .942	SD_1= .988	SD_1=.861	SD_1= .856	SD_1= .858	SD_1= .810	SD_1=.793	SD_1=.744
	SD_0= 1.05	SD_0= .999	SD_0= 1.10	SD_0=.847	SD_0= .935	SD_0= .935	SD_0= 1.10	SD_0=1.25	SD_0=1.10
Eat-Assess	F= .119	F= .312	F= .002	F= 1.626	F= .337	F= .337	F= 1.164	F= .676	F= 1.139
	M_1= 3.10	M_1=3.26	M_1=3.06	M_1= 3.97	M_1=3.90	M_1= 3.90	M_1= 3.07	M_1= 3.30	M_1= 3.17
	M_0= 3.00	M_0= 3.10	M_0= 3.05	M_0= 3.65	M_0= 3.75	M_0= 3.75	M_0= 2.75	M_0= 3.05	M_0= 2.85
	SD_1= .978	SD_1= .999	SD_1= 1.09	SD_1=.890	SD_1= .885	SD_1= .885	SD_1= 1.05	SD_1=.988	SD_1=.986
	SD_0= .973	SD_0= .968	SD_0= .999	SD_0=.813	SD_0= .910	SD_0= .910	SD_0= .967	SD_0=1.15	SD_0=1.09
Eat-Inter	F= .005	F= .373	F= .042	F= 1.465	F= .275	F= .275	F= 1.110	F= .759	F= 1.146
	M_1= 3.07	M_1=3.27	M_1=3.03	M_1= 3.97	M_1=3.90	M_1= 3.90	M_1= 3.07	M_1= 3.31	M_1= 3.17
	M_0= 3.05	M_0= 3.10	M_0= 3.10	M_0= 3.67	M_0= 3.76	M_0= 3.76	M_0= 2.76	M_0= 3.05	M_0= 2.86
	SD_1= .980	SD_1= 1.01	SD_1= 1.10	SD_1= .906	SD_1= .900	SD_1= .900	SD_1= 1.07	SD_1=1.00	SD_1=1.00
	SD_0= .973	SD_0= .944	SD_0= .995	SD_0= .796	SD_0= .889	SD_0= .889	SD_0= .943	SD_0=1.12	SD_0=1.03
Sex-Prev	F= 17.642**	F= 16.538**	F= 20.790**	F=7.638**	F= 9.728*	F= 8.631*	F= 7.507*	F=8.457*	F= 9.869*
	M_1= 3.72	M_1= 3.72	M_1= 3.80	M_1=4.04	M_1= 4.13	M_1= 4.08	M_1= 3.50	M_1= 3.46	M_1= 3.54
	M_0= 2.62	M_0= 2.65	M_0= 2.62	M_0= 3.23	M_0= 3.23	M_0= 3.23	M_0= 2.77	M_0= 2.65	M_0= 2.65
	SD_1= .737	SD_1= .737	SD_1= .707	SD_1=.859	SD_1= .797	SD_1= .830	SD_1= .659	SD_1=.721	SD_1=.779
	SD_0= 1.10	SD_0= 1.10	SD_0= 1.10	SD_0=1.18	SD_0= 1.18	SD_0= 1.18	SD_0= 1.14	SD_0=1.16	SD_0=1.16

One-Way ANOVA (Hours vs no Hours)	Prep-Prev	Prep-Assess	Prep-Inter	Mot-Prev	Mot-Assess	Mot-Inter	Eff-Prev	Eff-Assess	Eff-Inter
Sex-Assess	F= 8.000* M_1= 3.58 M_0= 2.78 SD_1= .929 SD_0= 1.09	F= 9.254* M_1= 3.63 M_0= 2.78 SD_1= .924 SD_0= 1.05	F= 9.838* M_1= 3.67 M_0= 2.78 SD_1= .917 SD_0= 1.09	F= 7.032* M_1= 4.04 M_0= 3.26 SD_1=.878 SD_0=1.16	F=7.243* M_1= 4.09 M_0= 3.30 SD_1= .848 SD_0= 1.17	F= 6.329* M_1= 4.04 M_0= 3.30 SD_1= .880 SD_0= 1.17	F= 4.496* M_1= 3.43 M_0= 2.85 SD_1= .728 SD_0= 1.14	F=5.185* M_1= 3.39 M_0= 2.74 SD_1=.783 SD_0=1.16	F= 4.919* M_1= 3.43 M_0= 2.78 SD_1=.843 SD_0=1.19
Sex-Inter	F=8.349* M_1= 3.61 M_0= 2.79 SD_1= .656 SD_0= 1.23	F= 9.691* M_1= 3.65 M_0= 2.79 SD_1= .647 SD_0= 1.20	F= 10.332* M_1= 3.70 M_0= 2.79 SD_1= .635 SD_0= 1.23	F= 8.188* M_1= 4.09 M_0= 3.2 SD_1=.811 SD_0=1.17	F= 8.506* M_1= 4.14 M_0= 3.29 SD_1= .774 SD_0= 1.18	F= 7.440* M_1= 4.09 M_0= 3.29 SD_1= .811 SD_0= 1.18	F= 10.308* M_1= 3.59 M_0= 2.75 SD_1= .666 SD_0= 1.08	F=10.97* M_1= 3.55 M_0= 2.64 SD_1=.739 SD_0=1.10	F= 12.832** M_1= 3.64 M_0= 2.64 SD_1=.727 SD_0=1.13
Drug-Prev	F= 11.519** M_1= 3.47 M_0= 2.53 SD_1= .717 SD_0= 1.02	F= 10.152* M_1= 3.41 M_0= 2.53 SD_1= .795 SD_0= .992	F= 9.103* M_1= 3.35 M_0= 2.50 SD_1= .786 SD_0= 1.02	F= 6.102* M_1= 4.00 M_0= 3.15 SD_1=.632 SD_0=1.31	F= 5.454* M_1= 4.00 M_0= 3.18 SD_1= .632 SD_0= 1.34	F= 5.163* M_1= 3.94 M_0= 3.15 SD_1= .680 SD_0= 1.31	F= 6.565* M_1= 3.44 M_0= 2.65 SD_1= .727 SD_0= 1.12	F= 9.561* M_1= 3.50 M_0= 2.56 SD_1= .632 SD_0= 1.13	F= 7.423* M_1= 3.44 M_0= 2.56 SD_1=.727 SD_0=1.19
Drug-Assess	F= 7.096* M_1= 3.46 M_0= 2.63 SD_1= .660 SD_0= 1.05	F= 5.861* M_1= 3.38 M_0= 2.63 SD_1= .768 SD_0= 1.02	F= 4.894* M_1= 3.31 M_0= 2.61 SD_1= .751 SD_0= 1.05	F= 2.820 M_1= 3.92 M_0= 3.26 SD_1=.669 SD_0=1.29	F= 3.528 M_1= 4.00 M_0= 3.26 SD_1= .603 SD_0= 1.31	F= 3.075 M_1= 3.92 M_0= 3.24 SD_1= .669 SD_0= 1.28	F= 2.658 M_1= 3.33 M_0= 2.76 SD_1= .779 SD_0= 1.13	F= 4.421* M_1= 3.42 M_0= 2.68 SD_1= .669 SD_0= 1.14	F= 3.133 M_1= 3.33 M_0= 2.68 SD_1=.779 SD_0=1.19
Drug-Inter	F= 9.185* M_1= 3.50 M_0= 2.59 SD_1= .650 SD_0= 1.04	F= 5.864* M_1= 3.36 M_0= 2.62 SD_1= .745 SD_0= 1.04	F= 4.976* M_1= 3.29 M_0= 2.59 SD_1= .726 SD_0= 1.07	5.813*F= M_1= 4.08 M_0= 3.19 SD_1=.760 SD_0=1.24	F= 6.781* M_1= 4.15 M_0= 3.19 SD_1= .689 SD_0= 1.27	F= 6.237* M_1= 4.08 M_0= 3.16 SD_1= .760 SD_0= 1.24	F= 3.781 M_1= 3.38 M_0= 2.73 SD_1= .768 SD_0= 1.12	F= 5.906* M_1= 3.46 M_0= 2.65 SD_1= .660 SD_0= 1.14	F= 4.349* M_1= 3.38 M_0= 2.65 SD_1=.768 SD_0=1.18

* Significant at the 0.05 level (2-tailed) ** Significant at the 0.01 level (2-tailed)

Appendix M
Current Responsibility

Perception of *current* responsibility for each of the following high-risk behaviours (i.e., participants were asked to rate on a 0–100% scale)

High-risk behaviours	*Prevention*	*Assessment*	*Intervention*
Suicide attempts	M: 66.00 SD: 30.30	M: 75.29 SD: 27.48	M: 70.98 SD: 29.48
Self-mutilation	M: 60.82 SD: 35.58	M: 69.60 SD: 32.64	M: 68.80 SD: 33.36
Bullying	M: 63.67 SD: 26.35	M: 67.35 SD: 23.34	M: 68.40 SD: 24.27
Extreme school violence	M: 44.49 SD: 30.89	M: 50.61 SD: 28.31	M: 50.83 SD: 29.45
Eating disorders and related behaviour	M: 49.39 SD: 33.44	M: 54.40 SD: 31.05	M:57.92 SD: 34.82
Sexual behaviours leading to risk of HIV or other STIs	M: 44.80 SD: 33.94	M: 45.00 SD: 32.62	M: 48.16 SD: 35.57
Drug-using behaviours leading to risk of HIV or other STI's	M: 44.08 SD: 34.15	M: 42.50 SD: 33.42	M: 43.67 SD: 35.51

Appendix N
Desired Responsibility

Perception of *desired* responsibility for each of the following high-risk behaviours (i.e., participants were asked to rate on a 0–100% scale)

High-risk behaviours	*Prevention*	*Assessment*	*Intervention*
Suicide attempts	M: 56.67 SD: 26.52	M: 61.25 SD: 23.12	M: 60.00 SD: 26.09
Self-mutilation	M: 59.57 SD: 27.48	M: 58.72 SD: 24.46	M: 59.15 SD: 26.69
Bullying	M: 56.25 SD: 22.84	M: 58.78 SD: 20.17	M: 57.08 SD: 22.21
Extreme school violence	M: 43.83 SD: 26.91	M: 47.23 SD: 26.84	M: 46.52 SD: 27.67
Eating disorders and related behaviour	M: 50.64 SD: 27.30	M: 52.77 SD: 23.75	M: 50.43 SD: 25.90
Sexual behaviours leading to risk of HIV or other STIs	M: 42.13 SD: 27.74	M: 42.13 SD: 25.45	M: 41.30 SD: 26.13
Drug-using behaviours leading to risk of HIV or other STI's	M: 42.61 SD: 28.47	M: 42.67 SD: 25.80	M: 43.64 SD: 27.03

Appendix O
Current and Desired Responsibility

Paired samples *t*-tests (difference between current and desired responsibility)

High-risk behaviour	*Prevention*	*Assessment*	*Intervention*
Suicide attempts	t= 2.850, p= .007**	t= 4.499, p=.000**	t=4.036, p= .000**
Self-mutilation	t= 1.107, p= .274	t= 3.865, p=.000**	t= 3.723, p= .001**
Bullying	t=1.827, p=.074	t= 2.400, p=.020*	t=2.811, p=.007**
Extreme school violence	t=.467, p=.643	t=1.476, p=.147	t=1.425, p=.161
Eating disorders and related behaviour	t=.000, p= 1.00	t=.759, p=.452	t=2.451, p=.018*
Sexual behaviours leading to risk of HIV or other STIs	t=1.297, p=.201	t=1.026, p=.310	t=1.956, p=.057
Drug-using behaviours leading to risk of HIV or other STIs	t=1.070, p=.291	t=.000, p=1.00	t=.496, p=.623

* Significant at the 0.05 level (2-tailed) ** Significant at the 0.01 level (2-tailed)

Appendix P
Current and Desired Responsibility (Work versus No Work Experience)

Current (Cur) and desired responsibility for participants indicating actual involvement in the prevention (Prev), assessment (Assess), or intervention (Inter) of specific high-risk behaviours versus participants indicating non-involvement in the prevention, assessment, or intervention of specific high-risk behaviours

The following table compares participants who report work experience with those who do not report work experience in relation to high-risk behaviour work. The impacts of work experience on how participants rate their current and desired responsibility levels for prevention, assessment, and intervention activities are explored. For example, Suicide-Prev refers to suicide prevention work. Participants reporting work experience in suicide prevention had a mean score of 72.00 (*SD*: 28.78) on current responsibility to prevent (Cur Res Prev) suicide whereas participants not reporting work experience in suicide prevention had a mean score of 52.00 (*SD*: 30.05) on current responsibility to prevent (Cur Res Prev) suicide. As illustrated in the table, this was significant ($F = 4.941$, $p < .05$).

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Suicide-Prev	F= 4.941*	F= 2.810	F= 7.332**	F= 6.833*	F= 2.648	F= 9.727**
	M_1=72.00	M_1= 79.44	M_1= 77.78	M_1= 63.03	M_1= 64.85	M_1= 67.27
	M_0=52.00	M_0= 65.33	M_0= 54.67	M_0= 42.67	M_0= 53.33	M_0= 44.00
	SD_1=28.78	SD_1= 25.52	SD_1= 25.20	SD_1=22.98	SD_1=20.02	SD_1=21.12
	SD_0=30.05	SD_0= 31.59	SD_0= 33.35	SD_0=29.15	SD_0=27.95	SD_0=29.47

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Suicide-Assess	F= .255	F= .971	F= 2.337	F= 1.692	F= .063	F= 2.905
	M_1=67.42	M_1= 77.78	M_1=75.00	M_1=60.00	M_1= 61.82	M_1=64.24
	M_0= 62.67	M_0= 69.33	M_0= 61.33	M_0= 49.33	M_0= 60.00	M_0= 50.67
	SD_1= 29.54	SD_1= 26.09	SD_1= 26.35	SD_1=23.98	SD_1=21.43	SD_1=22.78
	SD_0=32.83	SD_0=31.95	SD_0=35.02	SD_0=31.05	SD_0=27.26	SD_0=31.05
Suicide-Inter	F= .376	F= .197	F= 1.261	F=.476	F= .051	F=1.568
	M_1=67.57	M_1= 76.32	M_1=73.68	M_1=58.29	M_1= 61.71	M_1=62.86
	M_0= 61.54	M_0= 72.31	M_0= 63.08	M_0= 52.31	M_0= 60.00	M_0= 52.31
	SD_1= 29.57	SD_1=26.24	SD_1= 27.94	SD_1=26.29	SD_1=21.89	SD_1=25.73
	SD_0=33.13	SD_0=33.20	SD_0=33.51	SD_0=27.74	SD_0=27.08	SD_0=26.51
Self-Mut-Prev	F= 7.704**	F= 10.252**	F= 10.009**	F= 4.989*	F=6.545*	F=15.410**
	M_1=71.33	M_1= 80.67	M_1= 80.00	M_1= 66.21	M_1= 65.52	M_1= 69.66
	M_0= 44.21	M_0= 53.00	M_0= 52.00	M_0= 48.24	M_0= 47.78	M_0= 42.22
	SD_1= 30.03	SD_1=21.96	SD_1=24.63	SD_1=22.11	SD_1=19.20	SD_1=18.99
	SD_0= 38.05	SD_0= 39.08	SD_0= 38.06	SD_0=32.45	SD_0=28.40	SD_0=29.01
Self-Mut-Assess	F= 4.965*	F= 4.463*	F= 5.442*	F= 2.406	F=1.689	F= 6.626*
	M_1=68.75	M_1= 76.36	M_1=76.36	M_1=63.87	M_1= 61.88	M_1= 65.63
	M_0= 45.88	M_0= 56.47	M_0= 54.12	M_0= 50.67	M_0= 52.00	M_0= 45.33
	SD_1= 31.70	SD_1= 25.72	SD_1=27.14	SD_1=23.90	SD_1=22.35	SD_1=22.85
	SD_0= 38.58	SD_0= 40.76	SD_0= 39.85	SD_0=32.83	SD_0=28.08	SD_0=29.73
Self	F= 2.482	F= 1.537	F=2.95	F= .442	F= 2.098	F= 2.747
Mut-Inter	M_1=65.56	M_1= 72.97	M_1=73.51	M_1=61.18	M_1=61.71	M_1=62.86
	M_0= 47.69	M_0= 60.00	M_0= 55.38	M_0= 59.57	M_0=50.00	M_0= 48.33
	SD_1=32.29	SD_1=27.17	SD_1=27.91	SD_1=25.56	SD_1=21.89	SD_1=24.80
	SD_0=42.29	SD_0=44.72	SD_0=44.09	SD_0=33.17	SD_0=30.15	SD_0=30.10
Bullying-Prev	F= .496	F= .806	F= .098	F= 4.452*	F= 3.611	F= 3.543
	M_1= 64.76	M_1= 68.57	M_1=68.84	M_1= 59.02	M_1= 60.95	M_1=59.51
	M_0= 57.14	M_0=60.00	M_0= 65.71	M_0=40.00	M_0=45.71	M_0= 42.86
	SD_1= 25.68	SD_1= 23.43	SD_1=24.02	SD_1=22.34	SD_1=19.23	SD_1=21.67
	SD_0=31.47	SD_0=23.09	SD_0=27.60	SD_0=20.00	SD_0=22.25	SD_0=21.38

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Bullying-Assess	F= .198 M_1= 62.93 M_0= 67.50 SD_1=26.67 SD_0=26.05	F= .000 M_1= 67.32 M_0= 67.50 SD_1=23.56 SD_0=23.75	F= .013 M_1=68.57 M_0=67.50 SD_1= 24.25 SD_0=26.05	F= 1.991 M_1=58.46 M_0= 46.67 SD_1=20.72 SD_0=30.00	F= .277 M_1= 59.50 M_0= 55.56 SD_1=19.47 SD_0=24.04	F= 2.514 M_1=59.49 M_0= 46.67 SD_1=19.73 SD_0= 30.00
Bullying-Inter	F= 3.248 M_1= 65.91 M_0= 44.0 SD_1= 24.62 SD_0= 35.78	F=4.070* M_1= 69.55 M_0= 48.00 SD_1=20.90 SD_0=36.33	F= 2.620 M_1=70.22 M_0= 52.00 SD_1= 22.00 SD_0= 38.99	F= .724 M_1=57.21 M_0= 48.00 SD_1=22.92 SD_0=22.80	F= .623 M_1=59.55 M_0= 52.00 SD_1=19.99 SD_0=22.80	F=.932 M_1=58.14 M_0= 48.00 SD_1=22.17 SD_0=22.80
Extreme Violence-Prev	F= 316 M_1=51.11 M_0= 40.65 SD_1= 32.34 SD_0= 29.88	F= .865 M_1= 55.56 M_0= 47.74 SD_1=29.55 SD_0=27.65	F= .736 M_1=55.56 M_0= 48.00 SD_1= 33.29 SD_0=27.09	F=7.589** M_1= 56.67 M_0= 35.86 SD_1=26.79 SD_0=24.13	F=9.185** M_1= 61.11 M_0= 38.62 SD_1=24.22 SD_0=25.03	F=9.839** M_1= 61.11 M_0= 37.14 SD_1=24.23 SD_0=25.94
Extreme Violence-Assess	F= .572 M_1= 48.89 M_0= 41.94 SD_1=34.45 SD_0=28.92	F= 2.507 M_1= 58.89 M_0=45.81 SD_1=29.48 SD_0=26.93	F= 2.210 M_1=58.89 M_0= 46.00 SD_1= 33.24 SD_0=26.34	F=6.160* M_1= 55.56 M_0= 36.55 SD_1=27.91 SD_0=23.95	F=15.871** M_1= 64.44 M_0=36.55 SD_1=23.32 SD_0=23.34	F=11.812** M_1=62.22 M_0=36.43 SD_1=25.57 SD_0=24.38
Extreme Violence-Inter	F= .179 M_1= 46.67 M_0= 42.86 SD_1=31.83 SD_0=30.65	F= .981 M_1= 55.24 M_0= 47.14 SD_1= 28.92 SD_0=27.87	F= .832 M_1=55.24 M_0= 47.41 SD_1=32.19 SD_0= 27.26	F= 2.386 M_1=50.48 M_0= 38.46 SD_1=28.72 SD_0=24.61	F= 7.031* M_1= 58.10 M_0= 38.46 SD_1=26.76 SD_0=23.95	F= 5.155* M_1= 56.19 M_0= 38.40 SD_1= 28.01 SD_0=25.11
Eating Disorders-Prev	F= 8.696** M_1=60.71 M_0= 34.29 SD_1= 31.50 SD_0= 30.43	F= 10.004** M_1= 65.71 M_0= 40.00 SD_1=28.21 SD_0=28.95	F= 7.109* M_1=68.57 M_0= 43.00 SD_1=33.74 SD_0=31.30	F= 7.865* M_1= 60.00 M_0=39.05 SD_1=24.66 SD_0=26.44	F= 4.655* M_1= 59.23 M_0= 44.76 SD_1=18.31 SD_0= 27.50	F= 6.436* M_1= 58.46 M_0= 40.00 SD_1=21.85 SD_0=27.53

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Eating Disorders-Assess	F= 1.239 M_1= 53.79 M_0= 43.00 SD_1= 35.50 SD_0= 29.93	F= 3.192 M_1= 60.67 M_0= 45.00 SD_1= 28.10 SD_0= 32.36	F=2.311 M_1=64.29 M_0= 49.00 SD_1=34.58 SD_0= 34.01	F= 1.501 M_1=54.81 M_0= 50.64 SD_1=25.17 SD_0=29.65	F= .467 M_1= 54.81 M_0= 50.00 SD_1=20.45 SD_0=27.91	F= .815 M_1=53.33 M_0= 46.32 SD_1=22.19 SD_0=30.59
Eating Disorders-Inter	F= 2.407 M_1= 55.71 M_0= 40.95 SD_1=35.01 SD_0=29.98	F= 4.515* M_1= 62.07 M_0=43.81 SD_1=28.46 SD_0=32.01	F= 4.297* M_1=66.43 M_0=46.00 SD_1= 33.58 SD_0= 33.78	F= 3.234 M_1=56.92 M_0= 42.86 SD_1=24.46 SD_0=29.18	F= 1.815 M_1= 56.92 M_0= 47.62 SD_1=19.34 SD_0=27.91	F= 2.244 M_1=55.38 M_0= 44.00 SD_1= 21.40 SD_0= 30.16
Seual Behaviour-Prev	F= 5.306* M_1= 55.83 M_0= 34.62 SD_1=28.88 SD_0=35.58	F= 6.110* M_1= 56.52 M_0= 34.40 SD_1= 28.06 SD_0=33.43	F= 8.899** M_1= 62.50 M_0=34.40 SD_1= 31.38 SD_0=34.41	F= 4.458* M_1= 50.91 M_0= 34.40 SD_1=23.69 SD_0=29.17	F= 8.318** M_1= 52.73 M_0= 32.80 SD_1=23.54 SD_0=23.72	F= 9.599** M_1= 52.73 M_0=30.83 SD_1= 23.54 SD_0=24.30
Sexual Behaviour-Assess	F= 3.903 M_1= 54.78 M_0= 36.3 SD_1=29.06 SD_0=35.96	F= 6.413* M_1= 57.27 M_0=34.62 SD_1=27.81 SD_0=33.25	F= 8.224** M_1= 62.61 M_0= 35.38 SD_1= 30.93 SD_0=35.01	F= 3.636 M_1=50.48 M_0= 35.38 SD_1=24.18 SD_0=29.01	F= 6.962* M_1= 52.38 M_0= 33.85 SD_1= 24.06 SD_0= 23.85	F= 8.029** M_1= 52.38 M_0= 32.00 SD_1=24.06 SD_0=24.49
Sexual Behaviour-Inter	F= 5.828* M_1= 57.27 M_0= 35.00 SD_1=28.48 SD_0= 35.12	F= 12.478** M_1= 61.90 M_0=31.85 SD_1=25.22 SD_0=31.99	F= 11.498** M_1= 65.45 M_0= 34.07 SD_1= 29.72 SD_0= 34.11	F= 5.922* M_1= 53.00 M_0= 34.07 SD_1=23.64 SD_0=28.18	F= 8.876** M_1= 54.00 M_0= 33.33 SD_1= 23.49 SD_0= 23.53	F=14.568** M_1= 56.00 M_0= 30.00 SD_1= 22.10 SD_0= 23.49
Drug Use-Prev	F= 1.457 M_1= 52.50 M_0= 40.00 SD_1= 29.10 SD_0= 36.06	F= 3.015 M_1= 54.67 M_0= 36.97 SD_1= 28.75 SD_0= 34.32	F= 3.812 M_1=57.50 M_0= 36.97 SD_1= 32.56 SD_0= 35.40	F= 3.320 M_1=53.33 M_0=37.42 SD_1=24.69 SD_0=29.09	F= 5.350* M_1= 54.67 M_0=36.67 SD_1=21.10 SD_0= 25.78	F= 8.218** M_1= 58.67 M_0= 35.86 SD_1=20.66 SD_0=26.93

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Drug Use-Assess	F= .472	F= 2.536	F= 1.638	F= .745	F= 3.245	F= 3.436
	M_1= 50.00	M_1= 56.36	M_1=55.00	M_1=49.09	M_1= 54.55	M_1=56.36
	M_0= 42.16	M_0= 38.38	M_0= 40.00	M_0= 40.57	M_0= 38.82	M_0= 39.39
	SD_1= 30.15	SD_1=26.56	SD_1= 33.17	SD_1=25.87	SD_1= 23.82	SD_1= 21.57
	SD_0= 35.52	SD_0= 34.44	SD_0= 35.90	SD_0=29.30	SD_0= 25.56	SD_0= 27.61
Drug Use-Inter	F= .674	F= 1.706	F= 1.963	F= 1.096	F= 2.920	F= 4.112*
	M_1= 50.77	M_1= 53.33	M_1=55.38	M_1=50.00	M_1= 53.33	M_1= 56.67
	M_0= 41.67	M_0= 38.89	M_0= 39.44	M_0= 40.00	M_0= 38.79	M_0= 38.75
	SD_1= 29.00	SD_1= 27.41	SD_1= 31.78	SD_1=28.92	SD_1= 23.09	SD_1=25.35
	SD_0= 35.90	SD_0= 34.79	SD_0= 36.25	SD_0=28.28	SD_0= 25.95	SD_0= 26.37

* Significant at the 0.05 level (2-tailed) ** Significant at the 0.01 level (2-tailed)

Appendix Q
Current and Desired Responsibility (Role versus Non-Role)

Current (Cur) and desired responsibility for participants indicating it is their role to engage in prevention (Prev), assessment (Assess), or intervention (Inter) of specific high-risk behaviours versus participants indicating a non-role in the prevention, assessment, or intervention of specific high-risk behaviours

The following table compares participants who report that it is their role to prevent, assess, or intervene into specific high-risk behaviour with those who do not report that it is their role to prevent, assess, or intervene into specific high-risk behaviour. The impacts of perceived role on how participants rate their current and desired responsibility levels for prevention, assessment, and intervention activities are explored. For example, Suicide-Prev refers to suicide prevention role. Participants reporting a perceived role in suicide prevention had a mean score of 72.38 (*SD* = 28.62) on current responsibility to prevent (Cur Res Prev) suicide whereas participants not reporting a perceived role in suicide prevention had a mean score of 62.96 (*SD* = 29.72) on current responsibility to prevent (Cur Res Prev) suicide. As illustrated in the table, this was non significant ($F = 1.225$, $p > .05$).

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Suicide-Prev Role	F= 1.225	F= 2.768	F= 5.702*	F=13.147**	F= 3.544	F= 9.329**
	M_1=72.38	M_1= 83.81	M_1= 82.86	M_1= 70.53	M_1= 68.42	M_1= 72.63
	M_0= 62.96	M_0= 71.43	M_0= 64.29	M_0= 45.19	M_0=55.56	M_0= 50.37
	SD_1=28.62	SD_1=21.56	SD_1=23.05	SD_1=25.27	SD_1=23.40	SD_1=24.23
	SD_0=29.72	SD_0=28.51	SD_0= 29.49	SD_0=21.90	SD_0=22.42	SD_0=24.41

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Suicide-Assess Role	F= .206	F= .177	F= .113	F= 1.236	F= .953	F= .652
	M_1= 65.52	M_1= 78.00	M_1=73.33	M_1= 59.26	M_1=63.70	M_1=62.22
	M_0= 69.47	M_0= 74.74	M_0=70.53	M_0=50.53	M_0=56.84	M_0=55.79
	SD_1= 30.19	SD_1=26.44	SD_1=28.45	SD_1= 28.54	SD_1=25.44	SD_1=28.47
	SD_0=28.57	SD_0=26.53	SD_0=28.57	SD_0=22.48	SD_0=20.29	SD_0=23.64
Suicide-Inter Role	F= 2.500	F= 5.329*	F= 7.871**	F= 6.933*	F= 3.184	F= 9.650**
	M_1= 72.41	M_1= 83.33	M_1= 80.67	M_1= 63.70	M_1= 65.93	M_1= 68.89
	M_0= 58.95	M_0=66.32	M_0=58.95	M_0= 44.21	M_0= 53.68	M_0= 46.32
	SD_1=28.99	SD_1=23.54	SD_1=24.90	SD_1=26.62	SD_1=24.06	SD_1=25.01
	SD_0=28.65	SD_0=27.53	SD_0=28.65	SD_0=21.68	SD_0=21.14	SD_0=23.14
Self-Mut-Prev Role	F= 1.293	F= 2.921	F= 4.437*	F= 6.698*	F= 4.919*	F= 9.325**
	M_1= 69.41	M_1=81.18	M_1= 82.35	M_1= 73.33	M_1= 69.33	M_1= 74.67
	M_0= 57.33	M_0=65.16	M_0=62.58	M_0=51.72	M_0= 52.67	M_0=50.67
	SD_1=34.00	SD_1=22.88	SD_1= 28.18	SD_1= 23.50	SD_1=18.31	SD_1=19.22
	SD_0=35.52	SD_0=34.63	SD_0= 32.55	SD_0= 27.53	SD_0=25.99	SD_0=27.16
Self-Mut-Assess Role	F= .213	F= .974	F= 1.204	F= 2.441	F= 2.335	F= 2.240
	M_1= 63.85	M_1=74.81	M_1= 74.07	M_1= 65.00	M_1= 63.20	M_1=64.00
	M_0= 59.05	M_0=65.71	M_0=63.81	M_0=52.00	M_0=52.00	M_0= 52.00
	SD_1=32.99	SD_1=28.06	SD_1=31.29	SD_1=27.82	SD_1=22.86	SD_1= 25.82
	SD_0=38.20	SD_0=35.86	SD_0=33.24	SD_0=27.07	SD_0=26.28	SD_0=27.83
Self-Mut-Inter Role	F= 2.762	F= 5.682*	F=10.033**	F= 5.257*	F= 8.411**	F=13.249**
	M_1= 68.89	M_1= 80.00	M_1= 81.48	M_1= 67.50	M_1= 67.50	M_1= 70.83
	M_0= 52.00	M_0=59.05	M_0=54.29	M_0=49.00	M_0=47.62	M_0=44.76
	SD_1=35.23	SD_1=24.81	SD_1=24.76	SD_1=24.18	SD_1=21.11	SD_1=22.05
	SD_0=33.34	SD_0=36.04	SD_0=34.72	SD_0=29.36	SD_0=24.88	SD_0=26.00
Bullying-Prev Role	F= 4.885*	F= 11.064**	F=11.669**	F= .892	F= 2.011	F= .785
	M_1= 70.00	M_1= 75.00	M_1= 76.36	M_1=58.00	M_1= 61.29	M_1=58.67
	M_0= 53.33	M_0=54.67	M_0=54.67	M_0=51.25	M_0=52.50	M_0=52.50
	SD_1=20.95	SD_1=16.06	SD_1=17.65	SD_1=24.83	SD_1=20.61	SD_1=24.03
	SD_0=29.92	SD_0=25.60	SD_0=25.60	SD_0=19.28	SD_0=19.15	SD_0=19.15

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Bullying-Assess Role	F= .662 M_1=67.14 M_0= 61.05 SD_1=23.86 SD_0=27.06	F= 5.447* M_1= 74.29 M_0=60.00 SD_1=17.94 SD_0=24.04	F= 6.296* M_1= 75.86 M_0=60.00 SD_1=18.81 SD_0=24.94	F= 1.455 M_1= 59.23 M_0= 51.00 SD_1=25.60 SD_0=18.89	F= 3.514 M_1= 62.96 M_0=52.00 SD_1=20.53 SD_0=18.81	F= 2.201 M_1= 60.77 M_0=51.00 SD_1=24.32 SD_0=18.89
Bullying-Inter Role	F= .387 M_1= 66.25 M_0= 61.33 SD_1=25.62 SD_0=24.46	F= 5.449* M_1= 73.55 M_0=58.75 SD_1=18.89 SD_0=23.63	F= 6.119* M_1= 75.00 M_0= 58.75 SD_1=20.32 SD_0=23.63	F= .016 M_1=55.33 M_0=56.25 SD_1=25.56 SD_0=18.21	F= .574 M_1=60.00 M_0= 55.29 SD_1=21.66 SD_0=18.07	F= .305 M_1=57.93 M_0=54.12 SD_1=25.27 SD_0=16.98
Extreme Violence-Prev Role	F= 7.500** M_1= 63.08 M_0= 37.65 SD_1=26.89 SD_0=29.03	F= 7.434** M_1= 67.69 M_0=44.71 SD_1=17.39 SD_0= 28.31	F= 6.598* M_1= 67.69 M_0=44.85 SD_1=20.88 SD_0=29.17	F= 1.878 M_1= 51.67 M_0=39.39 SD_1=28.87 SD_0=25.73	F= 4.646* M_1= 60.00 M_0= 41.21 SD_1=22.56 SD_0=26.90	F= 1.342 M_1= 53.33 M_0=42.50 SD_1=27.41 SD_0=27.71
Extreme Violence-Assess Role	F= 2.449 M_1= 54.67 M_0= 40.00 SD_1=30.67 SD_0=29.62	F= 8.131** M_1= 66.67 M_0= 43.75 SD_1= 19.52 SD_0= 28.03	F= 4.679* M_1= 64.00 M_0= 45.16 SD_1= 25.30 SD_0=28.74	F=1.536 M_1= 50.00 M_0=39.35 SD_1=28.01 SD_0=26.07	F= 5.924* M_1= 60.00 M_0= 40.00 SD_1=23.53 SD_0=26.33	F=2.136 M_1=54.29 M_0= 41.33 SD_1=27.66 SD_0=27.26
Extreme Violence-Inter Role	F= 2.449 M_1= 54.67 M_0= 40.0 SD_1=30.67 SD_0=29.62	F= 2.378 M_1=60.00 M_0= 46.88 SD_1=22.68 SD_0=29.01	F= 3.670 M_1= 62.67 M_0= 45.81 SD_1=26.04 SD_0=28.84	F= .560 M_1=47.14 M_0=40.65 SD_1=26.73 SD_0=27.07	F= 1.861 M_1= 54.29 M_0= 42.58 SD_1=25.33 SD_0=27.20	F=1.478 M_1= 52.86 M_0=42.00 SD_1=27.85 SD_0=27.47
Eating Disorders-Prev Role	F= 2.034 M_1= 58.82 M_0= 44.67 SD_1=29.56 SD_0=34.31	F= 1.084 M_1=61.18 M_0= 51.61 SD_1=30.39 SD_0=30.45	F= 1.185 M_1= 65.88 M_0= 54.48 SD_1=33.74 SD_0=34.60	F= 2.001 M_1= 57.50 M_0= 45.52 SD_1= 30.88 SD_0=25.01	F= 2.904 M_1= 60.00 M_0= 47.59 SD_1=23.09 SD_0=23.55	F= 2.421 M_1= 57.50 M_0= 45.00 SD_1=30.00 SD_0=22.85

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Eating Disorders-Assess Role	F= .560 M_1=54.00 M_0= 46.67 SD_1=35.00 SD_0=31.87	F= 3.926 M_1=65.00 M_0=47.86 SD_1= 25.03 SD_0= 32.36	F= 1.614 M_1= 66.32 M_0= 53.33 SD_1=30.59 SD_0=36.37	F= .658 M_1=53.68 M_0=46.92 SD_1= 29.10 SD_0=26.50	F= 2.049 M_1= 57.89 M_0= 47.69 SD_1=22.99 SD_0=24.05	F= 3.645 M_1= 57.89 M_0= 43.20 SD_1=27.40 SD_0=23.58
Eating Disorders-Inter Role	F= 5.360* M_1= 63.33 M_0= 41.38 SD_1=28.49 SD_0=33.35	F= 5.561* M_1= 67.78 M_0=47.33 SD_1=26.69 SD_0=30.39	F= 5.053* M_1= 72.94 M_0= 50.34 SD_1=28.23 SD_0=35.30	F= 3.095 M_1= 58.82 M_0= 44.29 SD_1=22.88 SD_0=28.99	F= 5.674* M_1= 62.35 M_0=45.71 SD_1=18.55 SD_0=24.86	F= 9.571** M_1= 63.53 M_0=40.74 SD_1= 21.49 SD_0=25.10
Seual Behaviour-Prev Role	F= 10.232** M_1= 63.33 M_0= 34.00 SD_1= 29.31 SD_0=31.58	F= 5.260* M_1= 58.82 M_0= 37.24 SD_1=29.56 SD_0=31.50	F= 4.754* M_1= 62.22 M_0= 40.00 SD_1=34.90 SD_0=33.38	F= 9.092** M_1= 56.25 M_0=32.41 SD_1=29.41 SD_0=22.94	F=13.952** M_1= 57.50 M_0=31.72 SD_1=21.76 SD_0=22.37	F= 8.303** M_1= 53.75 M_0= 32.14 SD_1=28.95 SD_0=20.61
Sexual Behaviour-Assess Role	F= 5.014* M_1= 57.89 M_0= 36.55 SD_1=31.90 SD_0=32.54	F= 4.878* M_1= 57.78 M_0=37.14 SD_1=29.01 SD_0=32.07	F= 2.899 M_1= 58.95 M_0=41.43 SD_1= 30.89 SD_0= 36.89	F= 4.581* M_1= 51.76 M_0=34.29 SD_1=27.44 SD_0=26.02	F=13.372** M_1= 56.47 M_0= 31.43 SD_1=22.62 SD_0= 22.06	F= 9.962** M_1= 54.12 M_0= 31.11 SD_1=28.08 SD_0=20.25
Sexual Behaviour-Inter Role	F= 12.745** M_1= 68.00 M_0= 34.55 SD_1=23.66 SD_0=32.51	F= 12.342** M_1=66.67 M_0= 34.55 SD_1= 24.69 SD_0=30.54	F=18.386** M_1= 76.00 M_0=35.63 SD_1=21.65 SD_0=33.21	F=10.042** M_1= 58.57 M_0= 32.90 SD_1= 24.13 SD_0=25.59	F=23.227** M_1= 62.86 M_0= 30.97 SD_1=18.99 SD_0=21.19	F=20.442** M_1= 61.43 M_0=30.00 SD_1=24.13 SD_0=20.17
Drug Use-Prev Role	F= 10.253** M_1= 65.33 M_0= 34.38 SD_1=31.59 SD_0= 30.58	F= 8.847** M_1= 62.86 M_0= 33.75 SD_1= 30.24 SD_0=30.66	F= 7.108* M_1=62.67 M_0=35.00 SD_1=37.70 SD_0=30.90	F= 7.253* M_1= 57.14 M_0=34.00 SD_1=29.20 SD_0=25.27	F=11.738** M_1= 58.57 M_0= 33.10 SD_1=21.43 SD_0= 23.47	F= 5.737* M_1= 55.71 M_0=35.71 SD_1=27.38 SD_0=24.56

One-Way ANOVA	*Cur Res Prev*	*Cur Res Assess*	*Cur Res Inter*	*Desired Res Prev*	*Desired Res Assess*	*Desired Res Inter*
Drug Use-Assess Role	F= 9.780**	F= 5.919*	F= 4.946*	F= 3.820	F= 7.830**	F= 3.510
	M_1= 62.22	M_1= 56.67	M_1= 57.78	M_1= 51.11	M_1= 53.33	M_1= 51.11
	M_0= 33.10	M_0= 33.57	M_0= 35.17	M_0=34.62	M_0=32.80	M_0= 35.83
	SD_1= 30.59	SD_1=30.10	SD_1=32.82	SD_1=29.28	SD_1=22.75	SD_1= 26.76
	SD_0= 31.29	SD_0= 32.23	SD_0=34.50	SD_0=26.26	SD_0= 24.41	SD_0=25.69
Drug Use-Inter Role	F= 10.253**	F= 13.382**	F=19.754**	F= 4.353*	F=16.728**	F=10.501**
	M_1= 65.33	M_1= 65.33	M_1= 72.00	M_1= 53.33	M_1= 60.00	M_1= 58.67
	M_0= 34.38	M_0=31.61	M_0=30.63	M_0= 35.17	M_0=31.43	M_0=33.33
	SD_1=30.67	SD_1=26.69	SD_1=28.08	SD_1=26.90	SD_1=20.00	SD_1=24.46
	SD_0=30.10	SD_0=30.45	SD_0=30.47	SD_0=27.60	SD_0=22.72	SD_0=24.18

* Significant at the 0.05 level (2-tailed) ** Significant at the 0.01 level (2-tailed)

Appendix R
Responses to High-Risk Behaviour

Ranked responses in addressing high-risk behaviour: 1=Typical First Response; 2=Typical Second Response; 3= Typical Third Response

The following table ranks participants' action responses to each of the high-risk behaviour categories. For example, 32 participants reported that, in encountering a student/client presenting as suicidal, their first response would be to assess the situation and offer an intervention. Two participants reported that, in encountering a student/client presenting as suicidal, their second response would be to assess the situation and offer an intervention. One participant reported that, in encountering a student/client presenting as suicidal, his/her third response would be to assess the situation and offer an intervention.

High-risk behaviours	*Assess the situation and offer an intervention*	*Consult with a colleague*	*Seek supervision*	*Transfer the case to a different type of helping professional*	*Transfer the case to another helping professional in your discipline*	*Bring the case to your team leader or team prior to taking any action*	*Another response (please describe)*
Suicide attempts	1 = 32	1 = 3	1 = 0	1 = 1	1 = 0	1 = 0	1 = 0
	2 = 2	2 = 20	2 = 2	2 = 12	2 = 0	2 = 0	2 = 0
	3 = 1	3 = 6	3 = 3	3 = 13	3 = 6	3 = 2	3 = 2
Self-mutilation	1 = 34	1 = 0	1 = 0	1 = 0	1 = 0	1 = 1	1 = 0
	2 = 0	2 = 18	2 = 2	2 = 11	2 = 0	2 = 1	2 = 2
	3 = 0	3 = 6	3 = 2	3 = 8	3 = 6	3 = 1	3 = 3
Bullying	1 = 35	1 = 1	1 = 0	1 = 0	1 = 1	1 = 0	1 = 0
	2 = 0	2 = 26	2 = 2	2 = 1	2 = 3	2 = 2	2 = 1
	3 = 1	3 = 3	3 = 3	3 = 5	3 = 6	3 = 6	3 = 4

High-risk behaviours	*Assess the situation and offer an intervention*	*Consult with a colleague*	*Seek supervision*	*Transfer the case to a different type of helping professional*	*Transfer the case to another helping professional in your discipline*	*Bring the case to your team leader or team prior to taking any action*	*Another response (please describe)*
Extreme school violence	1 = 12 2 = 3 3 = 2	1 = 3 2 = 6 3 = 1	1 = 1 2 = 4 3 = 2	1 = 0 2 = 1 3 = 6	1 = 0 2 = 1 3 = 4	1 = 2 2 = 3 3 = 1	1 = 0 2 = 0 3 = 2
Eating disorders/related behaviour	1 = 23 2 = 4 3 = 3	1 = 5 2 = 13 3 = 5	1 = 0 2 = 2 3 = 2	1 = 5 2 = 9 3 = 10	1 = 0 2 = 2 3 = 4	1 = 0 2 = 0 3 = 0	1 = 0 2 = 0 3 = 2
Risky sexual behaviour	1 = 25 2 = 0 3 = 0	1 = 1 2 = 9 3 = 4	1 = 1 2 = 1 3 = 2	1 = 0 2 = 12 3 = 9	1 = 0 2 = 3 3 = 3	1 = 0 2 = 0 3 = 1	1 = 0 2 = 1 3 = 2
Risky drug use	1 = 19 2 = 0 3 = 0	1 = 1 2 = 10 3 = 2	1 = 1 2 = 0 3 = 2	1 = 1 2 = 8 3 = 8	1 = 0 2 = 2 3 = 3	1 = 0 2 = 1 3 = 1	1 = 0 2 = 1 3 = 2

Appendix S
Roles in Dealing with High-Risk Behaviour

Roles assumed when dealing with high-risk behaviour

I take the following roles:	*Team Leader*	*Active Team Leader*	*Bystander*	*Work Alone*	*Prevent Role*	*Assessor Role*	*Intervene Role*	*Another Response*
Suicide attempts	Yes: 30 No: 20	Yes: 17 No: 33	Yes: 2 No: 50	Yes: 11 No: 39	Yes: 21 No: 29	Yes: 30 No: 20	Yes: 30 No: 20	Yes: 4 No: 46
Self-mutilation	Yes: 26 No: 24	Yes: 14 No: 36	Yes: 1 No: 49	Yes: 13 No: 37	Yes: 17 No: 33	Yes: 28 No: 22	Yes: 28 No: 22	Yes: 2 No: 48
Bullying	Yes: 26 No: 24	Yes: 37 No: 13	Yes: 1 No: 49	Yes: 8 No: 42	Yes: 34 No: 16	Yes: 30 No: 20	Yes: 33 No: 17	Yes: 3 No: 47
Extreme school violence	Yes: 8 No: 42	Yes: 26 No: 24	Yes: 1 No: 49	Yes: 3 No: 47	Yes: 13 No: 37	Yes: 15 No: 35	Yes: 15 No: 35	Yes: 1 No: 48
Eating disorders/related behaviour	Yes: 12 No: 38	Yes: 16 No: 34	Yes: 2 No: 48	Yes: 11 No: 39	Yes: 18 No: 32	Yes: 20 No: 30	Yes: 19 No: 31	Yes: 5 No: 45
Risky sexual behaviour	Yes: 12 No: 38	Yes: 16 No: 34	Yes: 3 No: 47	Yes: 9 No: 41	Yes: 18 No: 32	Yes: 19 No: 31	Yes: 15 No: 35	Yes: 4 No: 46
Risky drug use	Yes: 8 No: 42	Yes: 15 No: 35	Yes: 3 No: 47	Yes: 5 No: 45	Yes: 15 No: 35	Yes: 18 No: 32	Yes: 15 No: 35	Yes: 5 No: 45