Title Page

**An Evaluation of School-based Suicide Prevention Services for Adolescents**

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**Abstract**

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**An Evaluation of School-based Suicide Prevention Services for Adolescents**

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**Abstract**

An investigation of how school-based suicide prevention programs impact young adult suicide rates across the country is of great public health significance. The growing rates of suicide in the United States has led to epidemic levels in recent years, and is a major public health concern. Of particular concern is the increasing rates of young adult or adolescent suicides, which continue to rise each year. There are many risk factors that contribute to young adults experiencing suicidal thoughts, behaviors, and actions. However, these risk factors are hard to predict, as they present and are experienced differently in each young adult. Adolescents spend the majority of their time in school systems. Therefore, there has been increased research into how schools can provide prevention and early intervention services for students. The purpose of this essay is to evaluate how school-based suicide prevention services and programs are implemented, and how they could impact this disturbing crisis. Specifically, this analysis will provide the reader with a comprehensive understanding of the prevention resources available to schools, as well as the challenges and limitations that exist in suicide policies and school programs.

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# Introduction

Suicide is a major public health concern that continues to take the lives of hundreds of thousands of people globally each year. Suicide rates in America have reached such epidemic levels that it is currently the tenth leading cause of death across the country ([National Institute of Mental Health, 2019](#_ENREF_17)). A substantial concern is the increasing rate of adolescent suicides, which, according the US Center for Disease Control and Prevention, is the second leading cause of death among ages 10-34, and has reached its highest incidence rate in over forty years ([Prevention, 2019](#_ENREF_20)). Recent research has found that males ages 15-19 is the group experiencing the greatest escalation in suicides ([Miron, Yu, Wilf-Miron, & Kohane, 2019](#_ENREF_15)). Young adults and teens throughout the country are among the most vulnerable of the population and are increasingly susceptible to daily pressures and challenges that can leave them feeling hopeless. Increases in social media and technology use, rates of anxiety and depression, family challenges, and societal daily pressures are amongst some of the contributing concerns associated with adolescent suicide rates ([Miron et al., 2019](#_ENREF_15)). In addition, preventive measures for adolescent suicide present unique challenges and, tragically, the identification of risk factors, mental illnesses, or suicidal tendencies in young adults often occurs too late. Suicide thoughts and behaviors (STBs) are difficult to predict and therefore hard to prevent ([Flores, Swartz, Stuart, & Wilcox, 2020](#_ENREF_7)). These disturbing numbers have led to a public health crisis that demands prevention and early intervention efforts.

Compulsory education laws mandate American children to attend school for a certain amount of time. While some exceptions exist, such as homeschooling or religious considerations, all states have requirements for when children must begin school and how much schooling must be completed regardless of sex, race, or socioeconomic status ([FindLaw, 2016](#_ENREF_6)). Young adults spend a large amount time in schools, an average of 35-45 weeks per year, which has led to increasing interest in research and in the development of several prevention or early intervention strategies that can be implemented or considered within schools ([Craw, 2020](#_ENREF_5)). The existence of these suicide prevention programs and policies vary across the nation, with differing levels of implementation and success. This paper seeks to evaluate the impact of various tools, practices, programs, and policies offered in schools across the United States on adolescent suicide rates.

## Risk Factors

While suicidal thoughts, behaviors, and tendencies are hard to predict and monitor, there are major risk factors that should be considered when developing prevention and early intervention programs. Young adults, specifically ages 12-18, experience many changes throughout their developing years including gaining a sense of identity, obtaining a peer group, navigating new relationships, as well as building independence and self-esteem. Because of the variety of changes this age group experiences over a long period of time, the ability to identify risk factors and behavior can be remarkably difficult. Many studies have found that adolescents with histories of suicide attempt are much more likely to attempt again in the future. For example, a study conducted in 2019 reported that 41.5% of adolescents hospitalized for suicide attempts had a history of past suicide attempts ([Lee et al., 2019](#_ENREF_14)). This potentially becomes an issue if a student has attempted suicide before, could be subject to attempt again soon, but does not demonstrate any current risk. While there are many risk factors that could be considered, the following indicators should be considered:

1. Emotional stress/hopelessness

Altered emotional states such as feelings of stress, depression, anxiety, hopelessness, or fear can contribute to general low self-esteem and loss of control in young adults. Over time, and often coupled with high expectations and pressures from external factors in life, these emotional risks have the potential to led to STBs. There are multiple cohort studies that have found significant relationships between depression and suicide attempts; however, some research suggests that the feeling of hopelessness is related to suicide risk behaviors independent of depression ([Walsh & Eggert, 2007](#_ENREF_27)). This is important, as often times depression and hopelessness are entangled or grouped as the same feeling when they can be experienced individually. In fact, a study based on suicide risk factors for high school students in America found that feelings of hopelessness were predictors of suicidal behaviors ([Perkins & Hartless, 2002](#_ENREF_19)).

Additionally, feelings of anxiety, fear, or anger are important emotional risk factors for suicide. High levels of emotional distress can contribute to feelings of isolation or loss of control. Stress has been linked with STBs, and many studies have found that increased suicidal risk is associated with stressful life events such as death, violence, assault, or significant trauma of any kind. ([Walsh & Eggert, 2007](#_ENREF_27)). However, it is unclear whether stressful life events trigger suicide ideation or if emotional distress and vulnerability is present before a stressful life event occurs.

1. Family factors

Family factors or “context”, is one of the most important contributors to challenges young adults face, and therefore is extremely important in suicidal risk factor considerations. In fact, research has shown that in an estimated 50% of young adult suicides, family structures and relationships contributed in some way ([Bilsen, 2018](#_ENREF_3)). Family structures are different and can be complex, making their effect on children hard to fully understand or study. There is some indication that a general lack of familial support, supervision, and effective communication can greatly contribute to feelings of isolation in children.

In addition, direct and open conflict within the family causes stress and significant impact on the family environment. One study found that an argument with a family member preceded suicidal behavior in 70.5% of cases ([Walsh & Eggert, 2007](#_ENREF_27)). Complex and unhealthy family dynamics that cause stress or anxiety can have a direct and unfortunate impact on an adolescent.

It is also important to note that a history of mental illness or substance abuse among family members can also be a risk factor. These risk factors not only affect the household environment, but also may indicate a genetic predisposition toward underlying mental and behavioral health issues ([Singer, Erbacher, & Rosen, 2019](#_ENREF_25)).

1. School and student role challenges

School, and the challenges associated with being a student, present specific adolescent suicide risk factors and behaviors. There are various ways in which the challenges of adolescence and school can present as risk factors. Experiencing difficulties in school in addition to other stressors or even depressive emotional states can lead to suicidal behavior, especially when these students have a history of suicide attempts ([Walsh & Eggert, 2007](#_ENREF_27)).

Additionally, research demonstrates that students with learning disabilities may be at increased risk of suicide attempts since they tend to have higher rates of depression. It is unclear, however, whether the disability predisposes students to higher rates of depression, or if learning disabilities and depression are innately comorbid ([Bender, Rosenkrans, & Crane, 1999](#_ENREF_2)).

Unsurprisingly, on the other hand, high academic performance is associated with lower suicide attempt risks overall ([Okado, 2017](#_ENREF_18)). In recent years, however, according to surveys by the Pew Research Center, there has been a significant increase in reports of anxiety related to the pressure of high academic performance. Young adults view anxiety and depression as major problems for themselves and their peers (more so than bullying, drugs, alcohol, and teen pregnancy) and 61% of those surveyed report feeling pressure to get good grades in school ([Horowitz & Graf, 2019](#_ENREF_10)). All these findings demonstrate the different ways school and the role of being a student can result in pressures and unintended feelings of anxiety and depression for adolescents, which are significant risk factors for suicidal thoughts and behaviors. These findings become more alarming when young adults already present with other suicide risk factors or have histories of suicide ideation or past suicide attempts.

# The Role of Schools in Suicide Prevention

As previously described, there are many risk factors associated with suicide, and each has its own degree of influence on adolescent suicidal thoughts, behaviors, and attempts. Because of the large number of risk factors and the challenges associated with trying to address them for each individual, prevention and early intervention strategies should be implemented where as many young adults as possible will be reached. Therefore, schools are an ideal place for prevention programing and early intervention tactics to be implemented.

In addition to addressing risk factors, prevention strategies should also target protective factors ([Kalafat, 1997](#_ENREF_12)). Protective factors are resources or supports that exist within social structures in order to negate risk factors. While community, family, and peer protective factors are all important, young adults spend the majority of their time at school; therefore, they are ideal places for prevention and intervention services. Suicide prevention researchers and public health professionals believe an upstream prevention approach that addresses risk while also promotes protective factors is key in reducing suicide on a population level ([Singer et al., 2019](#_ENREF_25)).

Additionally, it is important to consider how suicide affects a school community in general. There have been many studies on the phenomenon of “suicide-related contagion”, which is the theory that one suicide can lead to another suicide attempt as a result of social ties or as a way of dealing with grief and loss ([Singer et al., 2019](#_ENREF_25)). Young adults who have lost a friend or peer to suicide manifest increased suicide ideation, depression, and/or post-traumatic stress disorder among .In fact, students who have lost a friend to suicide are 3.7 times more likely to have STBs ([Singer et al., 2019](#_ENREF_25)).

Because young people spend a majority of their day in school, it allows for educators, administrative staff, and coaches to interact with them five days a week. They are in the unique position to identify risk and respond with early intervention practices. Because emotional distress can have such a high effect on learning and social interaction, classrooms are ideal places for identifying early displays of STBs. Additionally, schools have the ability to create broad programs and universal policies, where homes or other social settings might lack this wide-reaching capability.

Prevention programs in schools are among some of the best emerging practices for addressing adolescent mental health and early STB identification ([Joshi, Jassim, & Mani, 2019](#_ENREF_11)). While school environments are excellent places for specific policy and program development, there are limitations and challenges with the actual implementation and evaluations of said programs ([Singer et al., 2019](#_ENREF_25)). Not all programs or interventions are uniform in practice, and wide variations or lack of prevention programs causes limitations when evaluating which programs and policies are most effective. Often times, school leaders and educators understand the need for programing, but lack the information or funding needed to successfully implement services. The remainder of this paper will focus on the various development, implementation, and evaluation of suicide prevention frameworks, programs, and policies in schools.

## A School Framework for Prevention Programs: Multi-tiered Support Systems (MTSS)

As discussed, schools should have suicide prevention programming. However, it can be a daunting task for administrators to create and implement programs and policies without a framework. Many schools across the nation have already developed tiered systems of support that exist for academic school programing. These tiered systems are composed of hierarchical layers that provide targeted support and instruction for students at each level.

Tiered systems allow educators and school administrators to have procedures and protocols in place for when students require additional support or need a unique approach for a problem. This has been proven to be beneficial because these systems can serve as templates for multi-tiered systems of support (MTSS), which are believed to be one of the best public health approaches to suicide prevention ([Singer et al., 2019](#_ENREF_25)).

MTSS is meant to be a comprehensive approach in addressing the behavioral health of all students in a school body by providing universal, selective, and targeted programs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), universal services aid all students in developing social and emotional skills, while targeted or intensive services are designed for students who display risk factors or other problematic behaviors as well as those who suffer from mental illness ([Administration., 2019](#_ENREF_1)). It is also important to note that MTSS are not meant to exist independently, but instead should be integrated into overarching school mental health services, teaching practices, or learning environments in general. In order for the MTSS to work effectively, data must be collected on students in order to decipher which students need additional support or specific programs, as well as what programs are working, and which are not. This data is collected through screening, which allows schools to obtain information on behavior and mental health that they would not normally be able to gather.

## Screening

In order for MTSS to work effectively within a school, data on which students are at-risk must be collected and identified. Screening is the best tool for this measurement. While screening in schools is used for academic purposes (such as identifying the level of learning students are at), suicide screening is different. This specific type of screening is useful for early identification and assessment of potential behavioral concerns or need for additional mental health support. Screening is administered by either a mental health professional or someone formally trained in the execution of screening. A study conducted in 2004 estimates the costs of school-wide mental health screening for middle schoolers (grades 6-8) is between $149 to $234 per student ([Chatterji, Caffray, Crowe, Freeman, & Jensen, 2004](#_ENREF_4)). This finding raises the issue of cost barriers for schools to implement screening effectively.

The goal of mental health screening is not to make a diagnosis, since only certified mental health or medical professionals are qualified to make diagnoses, but to identify at-risk students through a non-invasive or intimidating process. Once students are identified as at-risk for potentially poor mental health outcomes, schools can make informed decisions on further needs such as more testing, monitoring, early interventions, additional educational assistance or a referral to more professional help ([Administration., 2019](#_ENREF_1)). The screening also allows for assessments to be made on the effectiveness of schools education on social, emotional, or behavioral subjects and is a valuable tool within some existing MTSS.

Screening is currently an expanding practice in schools across the country. There is a wide belief that it is important to shift away from a “waiting to fail” mentality, where students are identified as having STBs to late or even retrospectively post-suicide ([Administration., 2019](#_ENREF_1)). Screenings improve the detection of young adults in need of additional mental health resources, and is considered to be an effective upstream approach to suicide prevention in schools overall ([Singer et al., 2019](#_ENREF_25)).

Behavioral and mental health screening can be conducted either universally to specific grades or age levels, or to a targeted group of students. While it is widely believed that universal screening would be the most effective in identifying at-risk students, the ability to target and screen smaller groups within schools is a beneficial option if cost or resources within the school are scarce ([Administration., 2019](#_ENREF_1)). A study performed in 2019 in the state of Pennsylvania looked to determine if universal screening or targeted screening was more effective in identifying at-risk high school students. The results indicated that universal screening is most beneficial for young adults and is a prevention measure that effectively addresses the suicide epidemic. Minimally, the study showed that engaging schools in identifying and preventing suicide risk is a critical step in addressing the issue at large. ([Sekhar et al., 2019](#_ENREF_24)).

While the benefits of universal screening have been identified, questions remain about how best to implement such a program. Less is known about frequency or the optimal ages at which to screen. Similarly, questions remain around the economics of screening, the optimal process for referring at-risk students for assistance, and even determining which screening test to use,. Still, some guidance exists. SAMHSA recommends the following be addressed before implementing any screening tools:

* Obtaining district, staff and family buy-in
* Allocating resources (fiscal and staffing) to support the screening process
* Defining roles and responsibilities of all staff involved in the screening process
* Addressing ethical and legal/liability considerations (e.g., parental consent and student

assent; communication; confidentiality)

* Selection of the right standardized screener(s) for your school/district (contextual fit)
* Training and professional development regarding screening (administration, data analyses, decision-making, intervention selection, and decision-rules)
* Developing/expanding your data systems
* Identifying and coordinating resources necessary to support students in need of additional intervention ([Administration., 2019](#_ENREF_1)).

## TeenScreen

TeenScreen is a specific universal screening tool developed by a team of researchers at Columbia University for use in school settings to assess risk factors for suicide. In studies on effectiveness, it was found to have a 75-100% validity rate of sensitivity in identifying the students who were at-risk, and furthermore that these students had not been identified by any other prevention method they had used ([Katz et al., 2013](#_ENREF_13)).

One potential challenge is that it is a time-dependent tool, meaning it will not identify students who are not actively at-risk when screened. A measure of TeenScreen success is partially dependent on identified youth obtaining referral services and following through with using the referral after their screening. Identified at-risk students who are screened are more likely to get outside mental health referrals than students who are never screened, although this finding is not necessarily causal ([Katz et al., 2013](#_ENREF_13)). Referrals can be made to a multitude of places including school-based services or community-based mental health services.

# Universal Educational Programs for Suicide Prevention

In addition to screening tools, there are evidence-based programs that have been used in schools as suicide and mental health prevention tactics. There are many different types of programs, but each can be characterized as either educational, skills training, or peer leadership ([Katz et al., 2013](#_ENREF_13)). Educational programs are taught in classrooms through video or reading material, skills training teaches a specific skill (such as how to identify at-risk behavior), and peer leadership allows students to lead instead of teachers or school staff. Each of these programs attempt to destigmatize mental health topics and increase suicide awareness, as well as improve recognition of suicidal signs in others. While these programs are evidence-based, evaluations of the effectiveness of these programs are difficult to determine. This is because the outcome measures being sought is not only a decrease in suicide rates, but also a decrease in STBs, which is difficult to evaluate. Additionally, an increase in knowledge and awareness of suicide and mental health issues doesn’t seem to correlate with a change in behavior, which potentially limits the effectiveness of these programs ([Katz et al., 2013](#_ENREF_13)). Finally, the paucity of studies and evaluations on the effectiveness of suicide prevention programs is important to note. However, it is important to evaluate popular school programs in order to address what is and what isn’t useful in terms of best public health practices.

The following table reviews three programs that are characterized as either educational, skills training, or peer leadership.

Table 1 Three School Suicide Prevention Programs

|  |  |
| --- | --- |
| Educational Program:  Signs of Suicide (“SOS”) | A program used to educate and promote suicide awareness through videos and class discussions. It is administered universally, meaning in schools that it is used, it is used on all students. The goal is for students to be made aware of the signs that suicidal peers demonstrate, and how to properly notify an adult of the danger. There have been two studies on the effectiveness of SOS, both of which were randomized control trials. Both studies found significant short-term effects of the program, such as decreased self-reported suicide attempts and increased self-reported suicide knowledge. While both studies demonstrated that the SOS program leads to better knowledge and self-reported attitudes towards suicide, they failed to show any changes in help-seeking behavior ([Katz et al., 2013](#_ENREF_13)). This is an important limitation because the monitoring of help-seeking behaviors is one of the few measures in suicide prevention programs. The inability to identify whether students feel more comfortable seeking help after a program has been implemented is a limitation. Another limitation also includes self-reporting as a measure in general since self-reported answers can be exaggerated or tailored to give the answers respondents believe are expected of them. Finally, the belief that at-risk students potentially have limited peer relationships and therefore do not demonstrate signs as clearly as the program teaches could be a SOS disadvantage. |
| Skills Training:  **Table 1 Continued**  Gatekeeper (“QPR”) | Gatekeeper training is cited frequently in suicide prevention research, and teaches students and educators how to identify risk factors, warning signs, and help-seeking behaviors in peers and students ([Singer et al., 2019](#_ENREF_25)). Specifically, “Question, Persuade, Refer” or QPR gatekeeper training is used in schools as a universal program that has four steps:   1. learning how to recognize suicide warning signs 2. training all of the school staff in the QPR method 3. training all school counselors on assessing at-risk students 4. organizing access or referral to outside professional treatments ([Katz et al., 2013](#_ENREF_13)).   The training also provides the opportunity to practice role-play situations, which could be extremely beneficial in allowing for simulated hands-on rehearsal. There has been evidence that when trained in gatekeeping, those that had longer trainings versus shorter trainings were able to identify more at-risk youth ([Singer et al., 2019](#_ENREF_25)). Other studies have found that while QPR provides beneficial self-reported knowledge, preparedness, and access to resources, it does not typically demonstrate any effect on the use of mental health services or referrals. Another interesting note is that gatekeeper training is usually reserved for educators and staff, and that allowing all students to partake in the training could lead to different or improved outcomes. |
| Peer Leadership:  **Table 1 Continued**  Sources of Strength | This program is specific to students and focuses on peer leadership training for suicide prevention. In doing so, the program uses positive health messages delivered by students to enhance protective factors instead of only focusing on identifying suicide risk factors ([Singer et al., 2019](#_ENREF_25)). Positive health messages are best seen in the Sources of Strength Wheel, which is a multi-colored wheel with eight topics or strengths- such as mental health, positive friendships, family support- written on it. This wheel is the token logo for the program, as it embodies what the program hopes to achieve through discussion of these topics. Because Sources of Strength focuses on peer leadership for implementation, it is a program that is the first of its kind; and is designed to promote healthy coping skills within the school while also addressing social isolation and non-help seeking behaviors. Peers within the school are selected by the school staff and are then trained to encourage positive mental health and inform their peers on how to seek help when they need to. The program has been evaluated by several randomized control trials and is believed to be the first suicide prevention program to effectively reduce suicide rates in schools through the use of peer leadership. Furthermore, in one randomized control study, results found that students designated as peer leaders were four times more likely to notify an adult when they were made aware of a peer having suicidal inclinations, and had overall increased positive attitudes and knowledge on suicidal behaviors and how to help ([Katz et al., 2013](#_ENREF_13)). |

These programs are just three examples of the various school-based prevention programs that exist across the country. While there is consensus in the need to educate and create improved awareness of suicide and mental health within schools, questions of effectiveness on the outcome of suicide still remain. Many of these questions could be explored with further studies, however there are limitations presented with randomized control trials, such as the accuracy of self-reporting. Self-reporting can result in bias, unreliable memory, and answers that participants believe they are expected to report or will portray themselves positively. Perhaps most importantly, is the need for uniformity of suicide prevention programs school-wide across America. This does not mean that only one program should be selected and implemented; indeed, the literature suggests that a combination of several programs would be most effective. Having consistent standards and protocols on programs could facilitate better results and outcomes on a larger scale. Unfortunately, school-buy in to such prevention programs, or the decision to make them a priority within schools, often comes as a result of a student suicide death ([Singer et al., 2019](#_ENREF_25)). However, there has been some recent legislation changes that force schools to mandate suicide prevention efforts on a larger scale ([Moutier & Marshall, 2019](#_ENREF_16)).

# School Suicide Prevention Policies and Laws

Just as there is nonuniformity in suicide prevention programs across school districts, there are also gaps in the comprehensive policies in place for schools to address suicide across the nation. The existence of many different prevention programs, educational trainings and curriculum for schools to choose from can create a lot of variation. Therefore, there needs to be uniformity in policies and programs established within schools across the nation in order to be effective. Many states require schools to have policies in place for the prevention of impulsive behaviors and suicide risk, but some school boards and administrators have difficulties with drafting policy and establishing standards for their prevention measures. To address this challenge, a collaboration between The National Association of School Psychologists, American Foundation for Suicide Prevention, The Trevor Project (a leading national organization that provides suicide prevention services to LGBTQ youth), and the American School Counselor Association ([Vaillancourt & Bassin](#_ENREF_26)) developed a “Model Policy” as a starting place for school districts. The Model Policy provides schools with a template and best practices guide for suicide prevention measures, early intervention, and even postvention protocols. While established as a flexible model for schools to adapt as needed, the policy does require a school-employed mental health professional to play a critical role in implementation.

Table 2 Model Policy

|  |  |
| --- | --- |
| 1. Prevention | The policy recommends that school districts designate a “suicide prevention coordinator” aka a school psychologist or mental health counselor at each school or district. This position is the core of infusing the mental health and suicide prevention measures into the curriculum and school. This coordinator/professional will;   * be in charge of planning and implementing prevention measures and programs within the schools. * be the point of contact when there is concern or identification of a student at-risk for suicide. * provide education and information to educators and staff on warning signs of suicide * be responsible for keeping up to date with best practices for risk assessment and intervention tools. |
| 2. Assessment and Referral | In the event that a student makes a verbal or written suicide threat, or presents as a threat in any way. the student is to be seen by the school psychologist, provided the school has one, the same day where a risk assessment will be done. Afterwards, if needed, the student will be referred to any outside mental health agency for further assistance. It is important that during this phase, the student is under constant supervision in the school and that parents or guardians are notified. In the case of a suicide attempt taking place on school grounds, the school should evacuate.  **Table 2 Continued** |
| 3.Re-entry procedure | The Model Policy recommends three components be a part of any students re-entry plan.   1. A designated school mental health professional coordinates re-entry with the student, family, and any other mental health agency or contact that was involved. 2. The parent or guardian is to present documentation from a healthcare provider that states that the student is no longer considered a threat. 3. The school mental health professional determines what else, if anything, is needed for the students readjustment into the school and continues to regularly meet with the student until further notice. |
| 4. Postvention | The final section of the Model Policy considers postvention, or what should be done in the aftermath of a student suicide. This part of the policy focuses on recommendations for sharing information, having additional support services for the student body, and how to conduct an appropriate school memorial. |

The Model Policy outlines clear guidelines for each step in a potential school suicide prevention policy adaptation, while also possessing plenty of language flexibility for schools to implement and adjust as they need.

A barrier to implementation is that many schools lack the funds or resources to employ a mental health professional who can implement this policy. The American School Counselor Association recommends a 250:1 student-to-counselor ratio in a district. However, access to counselors in schools varies widely across states, with rural areas more likely to lack any school counselors and only 17.8% of all districts meeting the recommended ratio ([Gagnon & Mattingly, 2016](#_ENREF_8)). Requiring a mental health professional assumes that enough resources are available for the school to be able to have this position filled and implement the policy. The cost of employing school counselors or mental health professionals varies across states, and there are further considerations such as degree levels and salary expectations that also differentiate widely in the United States.

Another interesting gap is the absence of any direction for what prevention programs specifically to use in the school. There is no mention of screening tools, or specifics on how at-risk adolescents are identified. Perhaps the policy leaves out this discussion in order to allow schools the liberty for applying the prevention programs they have space for. However, this could be problematic, as policy adaptation does not mean that the school will then be actively using any of the prevention tools previously discussed. While the requirement to have policy is important for schools to take steps in having suicide prevention policy, it does not lend to them actively addressing prevention measures.

Research has found that having more health positions, teams, and people involved on both school and district levels was positively influenced the ability for schools to implement effective school mental health policies ([Guerra, Rajan, & Roberts, 2019](#_ENREF_9)). Additionally, having more health educators working together on local and state levels positively affects the development of school suicide prevention through the implementation of policies and practices. This means that increasing the presence of professional health roles within a school lends to the development, implementation, and success of policies that address suicide and mental health for the students ([Guerra et al., 2019](#_ENREF_9)). Creating a school environment that emphasizes the importance of mental health, provides supports and programs addressing prevention and coping skills, and implementing comprehensive policies is what all schools should strive for across the nation. However, when not required or mandated to have suicide prevention, schools may opt out of developing these policies efficiently or at all.

## State Policies

In 2016, California became the first state in the United States to pass a bill requiring suicide prevention, intervention, and follow-up procedures by all local state school districts for grades 7-12 ([Project., 2016](#_ENREF_22)). The legislation, referred to as AB 2246, specifically addressed the needs of students identifying as LGBTQ, who are identified as high-risk adolescents. It mandated all California schools to implement prevention policies in coordination with suicide experts, stakeholders, community members, and school mental health professionals. The bill also required the state to reimburse schools for costs due to implementation of policy and procedures. The California legislation acknowledged that adolescents spend a significant amount of time in school environments, and that educators are often the first line of defense in identifying changes in student behavior, or acknowledging that additional mental help is needed. However, there is significant variance among state laws concerning whether training is required for educators in suicide prevention, how often trainings occur, and the requirements of training programs.

Currently, 13 states require annual school suicide prevention training annually. The only uniformity across these state laws is that the trainings are to be conducted each year. Details on training requirements such as time spent training, material development, and which personnel is to complete trainings varies greatly interjurisdictionally.

Table 3 State Training Requirements

|  |  |
| --- | --- |
|  | **States with Annual Mandated Training** |
| Alaska | Requires training for teachers, administrators, counselors, and specialists |
| Delaware | Requires 90 minutes of training for all public school employees; training materials developed from Department of Health and Social Services, Services for Children Youth and Families and Department of Education |
| Georgia | Requires training for all public school employees; materials from the Department of Education |
| Hawaii | Requires 2 hours of training each year for all public school employees; materials from Department of Education and Department of Health |
| Idaho | Requires the state board of education to adopt supporting suicide prevention training; training can be within existing professional development frameworks |
| Iowa | Requires at least 1 hour training for all school employees who hold a license from the board of education |
| Kansas | Requires school boards to provide a minimum of 1 hour suicide prevention programming to all school staff |
| Louisiana | Requires 2 hours of training each year for public teachers, counselors, principals and other administrators |
| Maryland | Requires all certified school employees complete a training each year |
| Nebraska | Requires at least 1 hour of training for all public school nurses, teachers, counselors, school psychologists, administrators, school social workers. Requires the Department of education to develop training materials  **Table 3 Continued** |
| New Hampshire | Requires at least 2 hours of training each year for all school districts and public school employees. Training can be included in part of ongoing professional development |
| Tennessee | Requires 2 hours of training each year for all school employees |
| Texas | Requires staff development for teachers in suicide prevention. Training must be based on Department of State Health Services |

Another 18 states[[1]](#footnote-1)1 require suicide prevention training for their school educators and staff, but it is not annual. This means that educator training in suicide prevention in these states is also inconsistent in duration and development. This is a major point of concern when considering that suicide is the second cause of death among young adults (ages 10-34) and that educators have a large role in being able to identify at-risk students.

Finally, 15 states[[2]](#footnote-2)2 “encourage” suicide prevention training for all school employees. ([Rafa, 2018](#_ENREF_23)). The laws vary with some states defining “encouragement” as incorporating training into professional development for educators, while other state legislators put training procedures in place but allow them to be optional. Additionally, these states allow grant funding for suicide prevention training, but they do not mandate it ([Prevention;](#_ENREF_21)).

# Practicum-Based Example: Outreach as a Prevention Model

## History and Structure

Outreach Teen & Family Services (“Outreach”) is a Pittsburgh based non-profit that focuses on adolescent mental health prevention and intervention services for its immediate community. The organization operated originally as a teen drop-in center in the late 1960s and early 1970s, and was officially established in 1974 under a grant from the Pennsylvania State Law Enforcement Assistance Administration. For over four decades, Outreach has been responding to the needs of its community by counseling children between the ages 5-21, as well as parents and families altogether. The nonprofit infrastructure consists of counselors, an executive director, and a board of directors. Outreach reduces or removes financial barriers to counseling services by offering free or partially subsidized therapy to clients who cannot afford services, and has a price cap of $50 for clients who can afford services. This is because Outreach does not want financial burden to be an issue for young adults and families seeking mental health services. Additionally, the majority of Outreach’s clients are high school students. It has a partnership with a local school district that allows for prevention services to be provided by the nonprofit agency itself instead of by the schools. Instead of prevention programing being provided and implemented by the school itself, Outreach administers mental health prevention programs to the school as an outside agency.

## Outreach Prevention Model

Outreach has existed in its community for over 45 years. They have many external stakeholders such as the police department, hospital administrators, school principals, the municipality, local families, nonprofits, and more who benefit directly from the services and programs that are offered by the agency. In addition to individual and family counseling, Outreach provides services and programs that cover a multitude of educational, early intervention, and prevention. For its educational component, Outreach offers parent consultations, which are a free service for parents to talk about the issue they face with their child or children, and then have a counselor assist them with a written plan to implement at home. Outreach also offers a parent discussion series, which are free presentations on challenges for parents today. Topics include homework battles, technology, building child self-esteem, and more. Education programs provide parents with information, resources, and skills to better equip them with parenting and handling situations with their young adult(s).

Outreach also offers intervention programs with young adults who have been identified as or diagnosed with a mental health difficulty. These programs are designed to address issues that affect young adults. Two examples are the Aggression Replacement Training (ART) for managing anger and aggression, and the Kids At Risk Effort (KARE) program for youth who find themselves involved with the juvenile system and are determined to be at-risk for further mental health and behavioral issues.

The prevention programs that Outreach offers are intended to prevent the onset of a mental health condition. Prevention programs include: Choices- Drug & Alcohol Education Program for Teens, Substance Use & Abuse Evaluations, and TeenScreen. TeenScreen is administered by Outreach, and is used as a targeted service to screen adolescents who may have behavioral issues or present as at-risk. Outreach has designated counselors who provide this on-site service for the school while ensuring continuity of daily educational procedures in the school. Outreach is the only licensed provider in Pennsylvania, facilitating their ability to provide TeenScreen in schools and the community. Outreach also assists with conducting drug and alcohol assessments with the school.

The Outreach example, of a school utilizing a local mental health agency, is a different prevention approach than the previously described models. While the school discussed in this example has school counselors and behavioral policies of their own, they also use Outreach as an additional resource for providing mental health services. There are several benefits to this model; it provides a direct community partnership between the two entities, exists as a direct referral for the students, and delivers prevention programing conducted by professionals. However, not all schools or school districts have access to local mental health organizations. Additionally, there is no current evidence that partnering with a local mental health organization decreases student suicide rates or is a best practice prevention model.

# Discussion

While there has been growing interest in research, program development, and legislation surrounding adolescent suicide prevention programs in schools, there is still much to be considered moving forward.

Schools should use their existing tiered systems of support as templates in creating MTSS. This is the best known framework for approaching suicide prevention and at-risk student identification within schools. In order to do so, schools should implement universal screening, which has been demonstrated as the most effective way to detect which students need additional mental health resources. However, there are still many questions that remain surrounding screening and how to implement the program. The guidelines that have been provided by SAMHSA are seemingly vague and a lack of uniformity and clarity. This could present variability and confusion, especially for schools that already have minimal resources for behavioral and mental health assessment. Additionally, cost, frequency of screening, and age requirements of screening are variables that need to further clarification.

The examples of school prevention programs discussed in this paper raise additional issues with determining best public health practices. There is no question that there is a need to educate students on and increase awareness of adolescent suicide and mental health issues. Educational, skills training, and peer leadership programs all present with benefits and limitations that should be considered. Research has suggested that a combination of several programs would be the most effective, however this combination should be uniform across school districts in order to be most effective. Consistent suicide prevention programing across schools, instead of wide variation, will create standards and positive results.

Additionally, the partnership of schools and local mental health agencies, such as Outreach, is an interesting option to explore moving forward. When school resources are scare, community involvement and assistance could be helpful. Minimally, referrals for at-risk kids would be made to a trusted and community oriented organization instead of hospitals or doctors. While there is not much research on this model, it provides interesting insight on an alternative option that could prove to be beneficial in local communities.

Funding, at the federal or state level, for schools to be able to employ school mental health professionals is critical for all schools to be able to implement the Model Policy (or a version of the policy). Increased presence of mental health professionals in all school districts would hopefully mean more focus and emphasis on suicide prevention programming nation-wide. Likewise, uniformity across all the states on rules and regulations regarding school employee suicide training would be a great place for change to begin. Perhaps a federal law tied to educator training would diminish the inconsistencies and variations that currently exist state to state. This law could provide funding to school districts for employing mental health professionals and creating prevention programs that are evidence-based and uniform across the country.

# Conclusion

While there is much to be done moving forward, there has been positive growth in increasing mental health education and awareness within schools, which is crucial in eliminating stigma and opening doors for transparent conversations. There are many resources available to schools, but without consistency and uniformity across all school districts, progress is still limited. Having legislative and program uniformity would halt variation across state lines. Students in every school in every state should be subject to the same educational tools and resources, but the country still has a long way to go. Through the efforts of all types of protective factors- family, peers, educators, and community- coupled with uniformity in training, programming, and effort within schools will adolescent suicide be addressed and hopefully someday truly eliminated.

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1. 1 Arizona, Arkansas, Connecticut, Illinois, Indiana, Kentucky, Maine, Mississippi, Nevada, New Jersey, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, Washington, and Wyoming, [↑](#footnote-ref-1)
2. 2 Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Missouri, Montana, New York, North Dakota, Oklahoma, Oregon, Rhode Island and Wisconsin [↑](#footnote-ref-2)