Building Schools & Communities that Prevent Youth Suicide

The Final Report of the Social Worlds & Youth Well-Being Study, Western Slope, Colorado

Seth Abrutyn (Co-I) & Anna S. Mueller (PI)

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Special Notes

While we understand that the district sometimes uses district-specific language, to protect the identity of the district we use broadly accepted language in education to refer to some groups/programs for which the district has determined locally appropriate names (for example, we refer to students who are not Native English speakers as English Language Learners).

We have done everything we can to improve the accessibility of this report for disabled individuals. The color scheme we have chosen is one that is specifically acceptable for color blind individuals.

Executive Summary (in English)

The *Social Worlds & Youth Well-Being Study* examines the impact of social environments on youth's mental health and resilience to identify strategies for improving youth suicide prevention in schools and communities. This study is guided by two primary research questions: (1) How can we build strong and enduring cultures of belonging that encourage effective help-seeking among youth?; and (2) How can we build better mental health safety systems in schools and communities to help youth who are struggling and to improve suicide prevention? This study grew out of a shared desire between the Western Slope Public School District (WSPSD) (a pseudonym) and the research team to identify new, sustainable, effective, and equitable strategies to improve suicide prevention in schools and their communities. This executive summary presents our main findings from the study in an abridged format.

Methodology

This report presents results from interview, fieldwork, and survey data collected between August 2019-September 2023. Combined, this data represents 281 interviews with youth, school staff, parents, and community mental health providers; 36 months of fieldwork in schools and at school and community events; and two different surveys, one with WSPSD families (with 701 family respondents) and one with WSPSD school staff (with 568 staff respondents).

Notably, the data collected for this research make it clear that each school in the district is filled with adults who are concerned about their students' well-being. School staff care about being trusted adults and about preventing suicide. Outside of school, district personnel and local families also had strong desires for schools to help keep youth happy and safe.

School Strategies to Support Youth Well-Being

In this report, we identify eight areas we observed as critical to promoting youth well-being and preventing suicide: (1) Listening to Youth Voices; (2) Enabling Staff's Suicide Prevention Work; (3) Integrating the Whole Child in all Core Aims of Education; (4) Expanding the Culture of Belonging; (5) Including Mental Health in Multi-Tiered System of Supports; (6) Overcoming Communication Barriers; (7) Improving Trauma Responsiveness; and (8) The Role of the District. We discuss each in turn below.

1. Listening to Youth Voices

We conducted 47 formal interviews with youth (though we got to know approximately 83 students during our fieldwork) and spent many hours in classrooms, counselor waiting rooms and offices, and administrative offices. The most important suggestion youth made for suicide prevention was to listen to them and take their concerns seriously. Listening means showing empathy and allowing youth to express anger and anxiety freely. This includes showing concern for what they are struggling with in the present rather than telling them "Things will get better" in the future. Youth also want adults to listen without judging them. This is essential for youth to feel safe enough to share difficult topics with adults in their lives. Additionally, many youth told us that labeling them or their peers as "bad" is alienating and reduces their trust in adults. This is something that youth that we spoke with experienced, and it hurt. They request adults avoid this and have faith that they are doing their best, even in difficult circumstances.

In addition, youth expressed desires for improvements to district mental health protocols. In their current forms, youth feel that the protocols reduce students' willingness to seek help from school staff. Students are most concerned that school staff, especially school counselors,

will tell their parents or guardians what students discuss with them. School counselors (like all school staff) are often professionally obligated to share information they learn about students with the students' parents or guardians to ensure student safety and well-being. Most counselors (or other staff members) try to do this with care and transparency. Two things appeared to improve the experience of having confidentiality broken among youth. We suggest that all school staff members keep these strategies in mind as best practices. First, it helps when school staff are as transparent as reasonably possible with students about the limits of confidentiality, so that students understand what to expect. Second, when school staff have to break confidentiality, youth feel better about the experience when staff collaborate with youth in the process of sharing information with their parents or guardians. For example, staff can give youth options about how to structure the conversation with their families (e.g., the staff member can do the talking with the student present or the student can do the talking with the staff member present). This strategy can transform a stressful situation into a positive opportunity for school staff to facilitate conversations between students and their families. This collaborative approach can also strengthen trust between all parties – students, families, and school staff. Therefore, it's important for school staff to navigate these situations thoughtfully and carefully, keeping the goal of building trust between all parties in mind.

Finally, an important takeaway from our interviews with youth is that youth *want* adults' help. They do not simply see school staff as authority figures, but rather as fellow members of the school community. In short, they want to trust adults. Thus, listening to youth is important as it (1) empowers youth; (2) provides opportunities to build trust and community with youth; (3) encourages effective help-seeking; and (4) builds partnerships that strengthen the mental health safety system.

2. Enabling Staff's Suicide Prevention Work

It is clear from our data that suicide prevention is very much on the minds of school staff. Over 90 percent of WSPSD school staff and families reported in our surveys that schools should play a role in supporting the mental health of their students. While this work is not always easy, schools are broadly considered one of the most important places for suicide prevention. By preparing and supporting staff as they do suicide prevention work, both school safety and youth's feelings of connectedness can improve. Through our research, we identified five factors that can better enable staff to support struggling students in schools.

(1) *School leaders should make it clear that suicide prevention is part of every staff member's job*. We found that school counselors and most administrators recognized suicide prevention as their job, but embracing this role was not always easy. For school counselors, they often struggled to balance their work to prevent suicide and support students' mental health needs with their other obligations (such as academic scheduling, testing, etc). School administrators also struggled, but generally because they felt less prepared to implement suicide prevention than the mental health team in their buildings. Teachers were the least likely to acknowledge suicide prevention as part of their job, though the majority did still report that knowing things like the warning signs for suicide are a part of their job. Making sure that all school staff understand that supporting student mental health and helping with suicide prevention, our research shows, will encourage staff to contribute to this important work. As the district and school leadership works to offer this clarity, being specific about expectations would be helpful. For example, teachers need not be therapists, but they should be able to identify students who are struggling, have basic compassionate and supportive conversations with the

student, and ensure they get connected with a mental health staff member for additional support.

(2) *Schools should make high-quality suicide prevention training mandatory for all staff.* We found that only 23 percent of staff had participated in high-quality suicide prevention training, and many staff members told us in interviews that they desired more training in suicide prevention. Having this training will better prepare staff to identify, process, and triage distressed students. Furthermore, high-quality suicide prevention training will increase staffs' confidence and comfort in supporting student's mental health and talking about stigmatized topics (like suicide and mental health) in a safe, helpful, and compassionate manner.

(3) S*chools should also provide staff with training in understanding trauma and social emotional development.* Teachers who felt confident that they understood trauma and that they knew how to support youth struggling with trauma, on average, engaged more in suicide prevention work than their peers who had less knowledge about trauma-informed practices. Overall, empowering school staff, but especially teachers, with knowledge about identifying students exhibiting signs of trauma and with pedagogical practices designed to support students with post-traumatic stress disorder will improve staff comfort in working with all students in their classrooms and likely improve students' experiences and ability to learn in classrooms.

(4) *School leaders should address the barriers that stop school staff from doing suicide prevention work.* Fortunately, most staff reported that nothing would stop them from asking an extremely distressed student if they were thinking about suicide. However, some staff reported that fears of legal liability, knowledge gaps, time scarcity, and low emotional bandwidth prevented them from asking a distressed student if they were thinking about suicide. Reducing these barriers will improve the number of staff willing and able to promote mental health and reduce youth suicide. Fears about legal liability as a barrier can be reduced by ensuring that all protocols conform to best practices and – in turn – by educating school staff in that protocols conform to best practices and that that helps protect the school against litigation. Knowledge gaps can be addressed through evidence-based training. Time scarcity can be addressed by setting aside time during the school day for work associated with mental health (rather than requiring staff do this labor after hours) and by carefully assigning work loads to not overburden any particular staff category to the extent possible. It can be challenging to address staff's sometimes low emotional bandwidth. Principals may need to check in with their staff to understand how to best address this pervasive challenge in education for the people in their building.

(5) *Lastly, schools should implement strategies and supports that reduce the amount of secondary trauma that staff may experience from engaging in suicide prevention work.* Among teachers, we found that, on average, teachers who do more work to prevent suicide and support student mental health report higher levels of secondary trauma. However, by addressing teachers' concerns about legal liability, having strong evidence-informed policies for suicide prevention, ensuring teachers have enough time to meet all of their professional responsibilities, equipping staff with the knowledge needed to support students facing difficult life events, encouraging teachers to support each other, and to turn to each other for information can all facilitate staff well-being.

3. Integrating the Whole Child in all Core Aims of Education

WSPSD has taken significant strides to prioritize a whole child educational philosophy, both inside and outside the classroom, which positively contributes to the school culture and likely also to student learning. A whole child educational philosophy recognizes that educating students requires considering not just students' academic learning needs, but also their psycho-social developmental needs, physical needs, and their mental health. Our conversations with staff and families and our observations in schools revealed that the whole child educational philosophy positively builds connectivity and a sense of belonging for youth. We encourage continuing this approach and expanding it into all aspects of school life to the extent possible. Listening more to youth voices and addressing the factors that would better enable staff to do suicide prevention work are two examples of how to integrate the whole child approach further. We believe that being deliberate and creative about expanding the culture of belonging and including mental health in the district's Multi-Tiered System of Supports (MTSS) are two additional steps that school and district leaders can take in prioritizing a whole child philosophy.

4. Expanding the Culture of Belonging

Feeling like you belong is one of the most powerful protections against suicidal thoughts and attempts. Additionally, a culture of belonging cultivates trust between students, staff, and families, which can encourage youth to disclose their mental health struggles with adults. In turn, this allows schools to identify and provide better support for youth and their families.

To cultivate a culture of belonging, school should encourage teachers to make meaningful relationships with their students and have appropriate and effective communication and policies that make youth feel valued – such as anti-bullying policies. During our fieldwork, we saw school leaders at every level prioritizing connectivity and belonging as central goals of their school. Further, we witnessed active efforts among leaders to also get teachers to buy-in to cultivate a culture of belonging.

Despite these efforts, our research also identified three areas where the culture of belonging could be improved. First, belonging is most effective when *all* students feel like they belong; this means that all students should feel they matter and are safe, regardless of their social identities, personal challenges, skills, talents, or sociodemographic backgrounds. While this can be challenging to accomplish, it is imperative to keep in mind that students that do not fit the academic or athletic mold are at risk of feeling like they do not belong which can have serious mental health consequences (Mueller and Abrutyn 2016). Identifying these students and making sure they have trusted adults, mentors, and opportunities for inclusion is essential.

Second, many youth, school staff, and families shared stories about bullying and harassment of gender and sexual minority youth by both peers and school staff members. This was understandably painful for Lesbian, Gay, Bisexual, Transgender, and Queer + (LGBTQ+) youth and made them feel excluded from efforts at increasing cultures of belonging.

Third, schools are places where racial and ethnic minorities often face discrimination or racism—factors that also increase youth's vulnerability to suicidality. While many Latino/Hispanic students we heard from conveyed positive experiences, English Language Learner students or students whose families spoke Spanish had especially challenging experiences, sometimes being made fun of for speaking Spanish. Staff also acknowledged that incidents of racism (like racist name-calling) happened targeting Hispanic, Black, and Asian

students and that they were not corrected consistently. Working to reduce these incidents and to find ways to make all kinds of youth feel safe and welcome at school is imperative for promoting youth well-being and building a strong culture of belonging.

5. Including Mental Health in Multi-Tiered Systems of Support

Our research shows that schools can better prevent suicide and promote student well-being effectively through the highly structured Multi-Tiered System of Supports (MTSS). All WSPSD schools have some form of MTSS. MTSS is generally designed to catch kids struggling academically or behaviorally, however, they can be repurposed to also support students struggling with mental health challenges and by providing interventions to support students' mental health. These interventions and supports are also likely to improve student's abilities to learn, as happy healthy kids are kids who can learn. In doing so, suicide prevention becomes explicitly embedded within the support systems that already exist in most schools and that are already designed to identify, process, and connect youth to needed supports. Drawing on our fieldwork, interviews with staff, and interviews with youth and families, we identified seven challenges schools face to varying degrees in maximizing their current MTSS's efficacy.

First, while some schools embraced the potential power of MTSS, all schools struggled with lingering negative attitudes toward the utility of MTSS. In some cases, resistance was broad and rooted in past iterations of MTSS, while in most cases, resistance was sprinkled throughout the staff. Addressing beliefs that MTSS are impossible or useless is a major step toward harnessing MTSS effectively for mental health (and academics).

Second, the best MTSS frameworks are those that make all members of the building feel supported. This includes teachers who rely on MTSS for helping a struggling student; students and families who feel supported by interventions; and counselors who feel some of the burden of promoting mental health and preventing suicide lifted when MTSS makes it everyone's job.

Third, clear referral protocols are essential to an effective MTSS. Standardizing the referral process and making the diverse criteria for referral widely known are key.

Fourth, pursuing root causes transforms MTSS from dealing with surface-level problems like attendance or poor grades to dealing with potential causes of those observable problems, like trauma or food insecurity.

Fifth, a strong MTSS will contribute to the school's goal of preventing information loss. Preventing information loss is critical to both suicide prevention and violence prevention (Goodrum et al. 2022). Often we only receive "weak" signs that a student may be feeling suicidal or that they may be on the verge of engaging in violence (Goodrum et al. 2022). A weak signal for suicide may be that we see a student looking sad in a hallway. While we may not make much out of a single sad student, if we also knew that student had written a concerning English essay about death and that their family had recently been bereaved, connecting those dots may help us better understand the seriousness of what that student is going through. We rarely get a strong sign that student is suicidal (a strong sign would be like a Safe2Tell tip saying a student is suicidal) so we have to act on these weaker signals to be effective. Gathering as much information about student's well-being from as many different sources and collating that information in one place can really help. The MTSS team is a team that is already well positioned to do just that. As part of gathering information teams should document root causes of student's academic, behavioral, or mental health problems, making sure requested

information is collected, and synthesizing the information in a single place or team. Importantly, that information has to be shared (while also respecting student privacy with regard to specific details) so that people in the school building know to help take care of a particular struggling student.

Sixth, and related, choosing and sticking with a durable district-wide computer/software system would improve the referral and information loss processes.

Seventh, leadership buy-in is important to ensure resources are devoted to MTSS communication flows from MTSS to all staff, and to symbolically signal that MTSS is valued in the school.

As schools move towards building these stronger systems, our previous research suggests that the best MTSS programs have several aspects in common: (1) strong support from school leaders, (2) an experienced school counselor as the dedicated leader, (3) multiple Tier 2 teams that meet weekly and divide up the student body, and (4) are composed of representatives from school leadership, school counselors, school mental health professionals (when available), and teachers (Mueller et al. 2021).

6. Overcoming Communication Barriers

Since 3.4 percent of students in the district are English Language Learners, promoting mental health and preventing suicide includes providing effective supports for Spanish-speaking students and their families. Based on our observations, interviews, and surveys, we identify communication barriers with students and families. We found that many staff felt schools did not have enough resources for Spanish-speaking youth. While almost every building has bilingual staff, language barriers can affect school staff's abilities to communicate directly with students about their lives and with families about their children, particularly in a timely manner. While the district has a translation service office, we heard from many families that using this service was not always easy and often ended in frustration. In most cases, the delay in communication was annoying, but if there was a crisis at home or in school, the delay could be critical to getting the youth the support they need. Thinking through strategies to ensure that families are always able to provide or receive information about their children in a timely way is warranted.

7. Improving Trauma Responsiveness

The final way schools can engage in suicide prevention work is by recognizing and being sensitive to the traumatic experiences that many students in the district have had. Youth in the U.S. suffer from a diverse array of adverse or traumatizing experiences, including homelessness, food insecurity, or home trauma associated with poverty, abuse, neglect, alcohol/drug misuse, parental incarceration, and so forth. WSPSD school staff have demonstrated a strong desire to effectively support students who have experienced trauma, which aligns with the district and schools' commitment to the whole child and to promoting mental health and suicide prevention. Responsiveness to trauma remains an area of potential growth. Nearly every school we observed prioritized improving trauma responsiveness through trainings and professional development opportunities, which includes equipping staff with strategies to use in classrooms with students who display signs of trauma or behavioral challenges, so that they do not contribute to students' dysregulation. Building out more opportunities for training and resources can further assist staff when it comes to issues related to student trauma.

8. The Role of the District

To identify areas of growth at the district level, we review how staff feel about the current state of district policies and procedures. In general, non-mental health staff (like teachers) agree that the district has policies that facilitate their suicide prevention work and protect them from legal liability. School mental health staff (broadly defined to include school counselors, school psychologists, school social workers, and nurses) and school leaders were less confident in district policies.

We identify several ways that the district can improve how they support staff's suicide prevention work. Specifically, the district's forms are not always evidence-based. For example, when we began fieldwork, the district's **safety planning forms** were not consistent with best practices for suicide prevention. Our understanding is that after we brought this to the attention of district personnel, this was remedied, and mental health staff have been trained or will be trained in safety planning. We also strongly recommend that school leaders and school nurses/nurse's aides be trained in safety planning so that there is always someone to help support potentially suicidal children. The Colorado School Safety Resource Center is a great resource for evidence-based forms that can be adapted to local needs with the help of local experts (at the district and school levels).

We also found that the district should make sure to clarify the expectations for different staff positions. Though our survey data reveals that teachers are often clear on their role in suicide prevention – namely they are expected to help identify students who may be at risk and send them to their school counselor (or other school mental health staff, or if they are not available to school leadership) for additional support and assessment – making sure all teachers understand that this is what is expected of them may encourage more teachers to get involved in suicide prevention and feel more comfortable while doing so.

Non-teaching classroom staff or other support staff – like librarians, custodians, paraprofessionals, secretaries, etc. – often play important roles in students' lives and ensuring their school days run smoothly. Their role in suicide prevention is not always as clear to them as it is for teachers, mental health staff, and school leadership. Therefore, the district should make sure that all staff positions understand clearly what role they are expected to play in suicide prevention and how to proceed. Secretaries in particular were the unexpected stars in shaping students' school experiences. They can provide a kind word, support, guidance, and are underappreciated for their role in supporting students' well-being in schools. Given how many students trust them and talk with them (especially in middle schools), it would be ideal to ensure they have suicide prevention gatekeeper training.

Finally, the use of Colorado Crisis Services after a school mental health worker has identified a student as high risk for suicide but before taking the student to a crisis center should be discontinued. While this is not just under the control of the district, the district should advocate with the local crisis center for school mental health staff to be able to directly refer students to the local crisis center. School mental health staff are generally more trained than Colorado Crisis Services staff (who are unlikely to have graduate mental health degrees, which school counselors must have).

School counselors, school psychologists, and school social workers are mental health professionals who have the professional capacity and responsibility to assess students for risk of suicide consistent with their professional standards (including the American School

Counseling Association's professional standards). For more on this, we highly recommend Gallo and Wachter Morris (2022).[1]

Supporting Youth Well-Being Beyond the School

While our research emphasizes the role of schools in suicide prevention, schools cannot do this work alone. Suicide prevention is everyone's job, and the broader community must also help contribute to positive youth development and provide critical supports when youth inevitably encounter moments of struggle. In the final section of our report, we detail what different organizations and people in the community beyond the school can do to better support youth well-being and support schools in preventing suicide, including the role of the (1) the Community, (2) the Crisis Center, and (3) Faith Communities, and addressing (4) a Suicide Hotspot.

1. The Role of the Community

All communities have resources that can improve the well-being of their members. In our interviews, we asked staff, families, and students what recommendations they might have for reducing suicide. Many parents critiqued the limited number of activities available for youth to do in their free time, as well as the barriers associated with accessing these activities. For instance, interviewees mentioned disappointing opposition to the construction of a community center facility in one part of the community. Those opposed argued that a nearby community already had a facility, so a second facility was not necessary. This argument ignored barriers to accessing the further-away facility due to transportation and membership costs that would preclude lower socioeconomic status community members from being able to access the community facility.

The lack of sufficient activities after school for youth may lead to harmful behaviors that increase risk for suicide, such as drinking and drug use. These same inequities prevent families from taking advantage of the beautiful outdoors surrounding this community. The most serious barrier, however, was the lack of reliable, extensive public transportation. Many youth and their families reported a sense of being trapped, something that can harm well-being. Improving public transportation may not address feelings of entrapment in the community, but it may help life feel richer and increase access for mental health healthcare and to the beautiful natural spaces for youth and families in the Western Slope.

In addition, the community should work to address mental health stigma as the community's attitudes towards mental health and suicide may reduce effective help-seeking behavior and may make those struggling feel worse and more alone. While we found that families were likely to seek help for their child's mental health, our findings also indicate pervasive mental health stigma hinders help seeking behaviors among youth out of fear of shame from friends or adults. Additionally, these negative attitudes towards mental health may lead communities to unintentionally ignore persistent problems or foreclose on effective solutions. Community members must be able to feel confident that their family will not be mistreated when they seek and receive help for their psycho-social needs.

[1] This article can be freely downloaded at this link: https://trace.tennessee.edu/cgi/viewcontent.cgi?article=1246&context=tsc

2. The Role of the Crisis Center

The mental health stigma we found was further compounded by barriers to accessing mental healthcare within the Western Slope community. Valley Behavioral Health (VBH), a pseudonym, is a prominent mental health care provider and a major player in crisis care in Western Colorado, as it is one of the only mental health crisis centers in the area. While we heard some positive experiences with VBH, most staff, families, and youth shared negative experiences or stories about VBH. Importantly, nearly 89 percent of people who answered our family survey reported they were not resistant to crisis centers; however, when asked about VBH specifically, most expressed a range of hesitancies. Many parents complained about the difficulties of gaining timely support as VBH does not have walk-in services but requires a referral to gain access. Lacking walk-in services is unacceptable and goes against best practices.

Please note that since the completion of our research study, we learned that a psychiatric emergency room with walk in services opened in Western Slope. This is an incredible and hopefully positive change to mental health safety in Western Slope that we applaud.

3. The Role of Faith Communities

Research has shown that belonging to and participating in a faith community can be a powerful protective tool against poor mental health and suicidality, largely because it helps provide a safety net for families and youth. Many of the families and staff we spoke to agree with these sentiments, with several reporting that faith-based counseling had been helpful to them in the past. Despite these important benefits, both past research and our own data indicate that faith communities have the potential to harm youth well-being when the faith community itself is a source of stress or trauma. This was most obvious when the youth's socioemotional needs were at odds with their parents' faith or religion. For students in these circumstances, many struggled to get help that they needed for mental health challenges. They also experienced painful challenges navigating their sense of self in relation to the expectations of their faith community (and parents). School counselors saw this as a major challenge to students' mental health, especially for LGBTQ+ students. These students were very likely to report their faith community did not accept them, and feared their parents' anger or shame if they were to tell them about their gender or sexual identity.

Faith communities play a critical role in mental health promotion and suicide prevention. To that end, ensuring that faith community leaders are trained to identify signs of risk and to talk safely and compassionately about mental health and suicide with families and youth (in non-stigmatizing ways) would wonderfully strengthen suicide prevention in any community, including Western Slope. Faith communities should also work as communities to identify ways to support members who are struggling with their mental health, regardless of reason, so that all may benefit from membership in these meaningful communities.

4. Addressing Suicide Hotspots

A unique feature of Western Slope is its close proximity to a suicide hot spot. A suicide hotspot is defined as a "specific, accessible, and usually public site which is frequently used as a location for suicide and gains a reputation for such" (Cox et al. 2013). Given our focus on how the broader community can help improve suicide prevention, doing what we can to address this

hotspot is an important consideration. Prior research identifies four main ways to prevent suicide hotspots. First, and most recommended, is restrictions like erecting barriers that make it difficult for individuals to die by suicide. However, it is not always feasible depending on the location, available resources, or community interests. Second, encouraging help-seeking by installing telephones near the hotspot that connect people directly to crisis counseling centers and/or having signs with positive statements or contact information can also be effective. Third, training staff to be ready to respond to individuals who are in crisis may also help. Fourth, encouraging responsible media reporting of suicide may help reduce the awareness of the hotspot. Acting as a community, everyone must take care to not reinforce this particular location as a suicide hotspot.

Conclusion

Promoting mental health and preventing suicide is best done through a unified multifaceted effort. By focusing on the tangible changes presented in this report, we believe that schools, families, health professionals, faith leaders, and community members can advocate for more robust mental health safety nets and effective suicide prevention efforts. In doing so, we can actively try to make the worlds that youth inhabit safer, happier places. To that end, we offer a series of policy recommendations in the next section of this report that can help guide and focus conversations as we work together to identify concrete, actionable strategies to translate research into better lives for youth and their families in the Western Slope Community. We can all make a difference in the lives of youth if we adopt the idea that 'suicide is everyone's business.'

Resumen ejecutivo (En español)

El Estudio sobre Mundos Sociales y Bienestar Juvenil (The Social Worlds & Youth Well-Being Study) examina el impacto de los entornos sociales en la salud mental y la resiliencia de los jóvenes para identificar estrategias que mejoren la prevención del suicidio juvenil en escuelas y comunidades. Este estudio se basa en dos preguntas de investigación principales: (1) ¿Cómo podemos construir culturas de pertenencia fuertes y duraderas que fomenten la búsqueda de ayuda eficaz entre los jóvenes? y (2) ¿Cómo podemos construir mejores sistemas de seguridad de salud mental en escuelas y comunidades para ayudar a los jóvenes en dificultades y mejorar la prevención del suicidio? Este estudio surgió del deseo compartido entre el Western Slope Public School District (WSPSD) (un seudónimo) y el equipo de investigación para identificar estrategias nuevas, sostenibles, eficaces y equitativas para mejorar la prevención del suicidio en las escuelas y sus comunidades. Este resumen ejecutivo presenta nuestros hallazgos principales del estudio en un formato abreviado.

Metodología

Este informe presenta resultados obtenidos de entrevistas, trabajo de campo y encuestas, recopilados entre agosto de 2019 y septiembre de 2023. En conjunto, estos datos representan 281 entrevistas con jóvenes, personal escolar, padres y proveedores de salud mental de la comunidad, 36 meses de trabajo de campo en escuelas y en eventos escolares y comunitarios, y dos encuestas diferentes, una con familias del WSPSD (con 701 familias encuestadas) y otra con personal escolar del WSPSD (con 568 encuestados del personal).

En particular, los datos recogidos para esta investigación dejan claro que cada escuela del distrito está llena de adultos que se preocupan por el bienestar de sus alumnos. El personal escolar se preocupa por ser adultos de confianza y por prevenir el suicidio. Fuera de la escuela,

el personal del distrito y las familias locales también mostraron fuertes deseos de que las escuelas ayuden a mantener a los jóvenes felices y seguros.

Estrategias escolares para apoyar el bienestar de los jóvenes

En este informe, identificamos ocho áreas que consideramos críticas para promover el bienestar de los jóvenes y prevenir el suicidio: (1) Escuchar las voces de los jóvenes; (2) Facilitar la labor de prevención del suicidio del personal escolar; (3) Integrar a todos los niños con todos los objetivos centrales de la educación; (4) Ampliar la cultura de pertenencia; (5) Incluir la salud mental en el Sistema de Apoyo Multinivel; (6) Superar las barreras de comunicación; (7) Mejorar la respuesta al trauma; y (8) El rol del distrito. A continuación, analizamos cada uno de ellos.

9. Escuchar las voces de los jóvenes

Realizamos 47 entrevistas formales con jóvenes (aunque llegamos a conocer a unos 83 estudiantes durante nuestro trabajo de campo) y pasamos muchas horas en aulas, salas de espera, oficinas de consejeros y oficinas administrativas. La sugerencia más importante que hicieron los jóvenes para la prevención del suicidio fue que los escucharan y se tomaran en serio sus preocupaciones. Escuchar significa mostrar empatía y permitir que los jóvenes expresen su ira y ansiedad libremente. Esto incluye mostrar preocupación por lo que están luchando en el presente, en lugar de decirles que "las cosas mejorarán" en el futuro. Los jóvenes también quieren que los adultos los escuchen sin juzgarlos. Esto es esencial para que los jóvenes se sientan lo suficientemente seguros como para compartir temas difíciles con los adultos en sus vidas. Además, muchos jóvenes nos dijeron que etiquetarlos a ellos o a sus compañeros como "malos" es alienante y reduce su confianza en los adultos. Esto es algo que los jóvenes con los que hablamos experimentaron, y les hizo daño. Piden que los adultos eviten esto y tengan fe en que están haciendo lo mejor que pueden, incluso en circunstancias difíciles.

Además, los jóvenes expresaron su deseo de que se mejoren los protocolos de salud mental del distrito. En sus versiones actuales, los jóvenes creen que los protocolos reducen la disposición de los estudiantes a pedir ayuda al personal de la escuela. Los consejeros escolares, como todo el personal escolar, con frecuencia están obligados profesionalmente a compartir la información que conocen, sobre los estudiantes, con los padres o tutores de los estudiantes para garantizar la seguridad y el bienestar de los estudiantes. La mayoría de los consejeros, u otros miembros del personal, intentan hacer esto con cuidado y transparencia. La ruptura de la confidencialidad entre los jóvenes parece mejorar con dos cosas. Sugerimos que todos los miembros del personal escolar tengan en cuenta estas estrategias como mejores prácticas. Primero, es de mucha ayuda que el personal de la escuela sea lo más transparente posible con los estudiantes sobre los límites de la confidencialidad, para que los estudiantes sepan qué esperar. En segundo lugar, cuando el personal de la escuela tiene que romper la confidencialidad, los jóvenes se sienten mejor con la experiencia cuando el personal colabora con ellos en el proceso de compartir información con sus padres o tutores. En este sentido, el personal puede ofrecer a los jóvenes opciones sobre cómo estructurar la conversación con sus familias (por ejemplo, el miembro del personal puede hablar mientras el estudiante está presente o el estudiante puede hablar cuando el miembro del personal está presente). Esta estrategia puede transformar una situación estresante en una oportunidad positiva para que el personal de la escuela facilite las conversaciones entre los estudiantes y sus familias. Este enfoque colaborativo también puede fortalecer la confianza entre todas las partes: estudiantes, familias y personal de la escuela. Por lo tanto, es importante que el personal de la escuela

navegue por estas situaciones de manera reflexiva y cuidadosa, teniendo en cuenta el objetivo de generar confianza entre todas las partes.

Por último, una conclusión importante de nuestras entrevistas con los jóvenes es que *quieren* la ayuda de los adultos. No ven al personal de la escuela simplemente como figuras de autoridad, sino más bien como miembros de la comunidad escolar. En resumen, quieren confiar en los adultos. Por lo tanto, escuchar a los jóvenes es importante ya que (1) los empodera; (2) proporciona oportunidades para generar confianza y comunidad con los jóvenes; (3) fomenta la búsqueda de ayuda eficaz; y (4) crea asociaciones que fortalecen el sistema de seguridad de la salud mental.

10. Facilitar la labor de prevención del suicidio del personal escolar

De nuestros datos se desprende claramente que la prevención del suicidio está muy presente en la mentalidad del personal escolar. Más del 90 por ciento del personal escolar y las familias del WSPSD informaron en nuestras encuestas que las escuelas deben desempeñar un papel en el apoyo a la salud mental de sus estudiantes. Aunque este trabajo no siempre es fácil, las escuelas son ampliamente consideradas como uno de los lugares más importantes para la prevención del suicidio. Preparando y apoyando al personal en su labor de prevención del suicidio, se puede mejorar tanto la seguridad escolar como el sentimiento de conexión de los jóvenes. A través de nuestra investigación, hemos identificado cinco factores que pueden capacitar mejor al personal para apoyar a los estudiantes con dificultades en las escuelas.

(1) *Los líderes escolares deben dejar claro que la prevención del suicidio es parte del trabajo de cada miembro del personal.* Encontramos que los consejeros escolares y la mayoría de los administradores reconocieron la prevención del suicidio como su trabajo, pero adoptar este papel no siempre es fácil. En el caso de los consejeros escolares, a menudo les resultaba difícil equilibrar su trabajo de prevención del suicidio y de apoyo a las necesidades de salud mental de los estudiantes con sus otras obligaciones (como la programación académica, los exámenes, etc.). Los administradores escolares también tuvieron dificultades, pero generalmente porque se sentían menos preparados para poner en práctica la prevención del suicidio que el equipo de salud mental de sus centros. Los profesores fueron los menos propensos a reconocer la prevención del suicidio como parte de su trabajo, aunque la mayoría informó, que conocer aspectos como las señales de advertencia del suicidio forman parte de su trabajo. Nuestra investigación muestra que si nos aseguramos de que todo el personal escolar comprende que apoyar la salud mental de los alumnos y ayudar en la prevención del suicidio animará al personal a contribuir a esta importante labor. A medida que el distrito y la dirección de la escuela trabajen para ofrecer esta claridad, sería útil ser específicos sobre las expectativas. Por ejemplo, los profesores no tienen por qué ser terapeutas, pero deben ser capaces de identificar a los estudiantes que tengan dificultades, mantener conversaciones básicas compasivas y de apoyo con el estudiante, y asegurarse de que se pongan en contacto con un miembro del personal de salud mental para obtener apoyo adicional.

(2) *Las escuelas deberían hacer que la formación de alta calidad en prevención del suicidio sea obligatoria para todo el personal.* Descubrimos que solo el 23 % del personal había participado en una formación de prevención del suicidio de alta calidad y muchos miembros del personal nos dijeron en las entrevistas que deseaban más formación en prevención del suicidio. Contar con esta formación preparará mejor al personal para identificar, procesar y clasificar a los alumnos en dificultades. Además, una formación de alta calidad en prevención

del suicidio aumentará la confianza y la comodidad del personal a la hora de apoyar la salud mental de los alumnos y hablar de temas estigmatizados (como el suicidio y la salud mental) de forma segura, útil y compasiva.

(3) *Las escuelas también deberían facilitar capacitación al personal para comprender el trauma y el desarrollo socioemocional.* Los profesores que se sintieron seguros de entender el trauma y de saber cómo apoyar a los jóvenes que luchaban contra él, en promedio, se comprometieron más en el trabajo de prevención del suicidio que sus compañeros que tenían menos conocimientos sobre las prácticas informadas por el trauma. En general, dotar al personal escolar, pero especialmente a los profesores, de conocimientos sobre la identificación de los alumnos que muestran signos de trauma y de prácticas pedagógicas diseñadas para apoyar a los alumnos con trastorno de estrés postraumático, mejorará la comodidad del personal a la hora de trabajar con todos los alumnos en sus aulas y probablemente mejorará las experiencias y la capacidad de aprendizaje de los alumnos en las aulas.

(4*) Los líderes escolares deben afrontar las barreras que impiden al personal de la escuela realizar el trabajo de prevención del suicidio.* Afortunadamente, la mayoría del personal informó que nada les impediría preguntar a un alumno extremadamente angustiado si estaba pensando en el suicidio. Sin embargo, algunos miembros del personal informaron que el temor a la responsabilidad legal, la falta de conocimientos, la escasez de tiempo y la baja capacidad emocional les impedía preguntar a un estudiante angustiado si estaba pensando en el suicidio. La reducción de estas barreras mejorará el número de personal dispuesto y capaz de promover la salud mental y reducir el suicidio juvenil. El temor a la responsabilidad legal como barrera puede reducirse asegurando que todos los protocolos se ajustan a las mejores prácticas y -a su vez- educando al personal de la escuela en que los protocolos se ajusten a las mejores prácticas y que eso ayuda a proteger a la escuela contra litigios. Las lagunas de conocimientos pueden resolverse mediante una formación basada en datos. La escasez de tiempo puede abordarse reservando tiempo durante la jornada escolar para el trabajo relacionado con la salud mental (en lugar de exigir al personal que realice esta labor fuera del horario escolar) y asignando cuidadosamente las cargas de trabajo para no sobrecargar a ninguna categoría concreta del personal en la medida de lo posible. En ocasiones, puede resultar difícil hacer frente a la escasa capacidad emocional del personal. Es posible que los directores tengan que consultar a su personal para saber cuál es la mejor manera de hacer frente a este reto generalizado en la educación de las personas de su centro.

(5*) Por último, las escuelas deben implementar estrategias y apoyos que reduzcan la cantidad de trauma secundario que el personal puede experimentar por participar en el trabajo de prevención del suicidio.* Entre los profesores, encontramos que, en promedio, los profesores que hacen más trabajo para prevenir el suicidio y apoyar la salud mental de los estudiantes reportan niveles más altos de trauma secundario. Sin embargo, abordar las preocupaciones de los profesores sobre la responsabilidad legal, tener políticas sólidas basadas en la evidencia para la prevención del suicidio, garantizar que los profesores tengan tiempo suficiente para cumplir con todas sus responsabilidades profesionales, equipar al personal con los conocimientos necesarios para apoyar a los estudiantes que enfrentan eventos difíciles de la vida, alentar a los profesores a apoyarse mutuamente y a recurrir a los demás para obtener información, todo ello puede facilitar el bienestar del personal.

11. Integrar a todos los niños en todos los objetivos centrales de la educación

El WSPSD ha dado pasos significativos para dar prioridad a una filosofía educativa integral del niño, tanto dentro como fuera del aula, lo que contribuye positivamente a la cultura escolar y probablemente también al aprendizaje de los estudiantes. Una filosofía educativa integral reconoce que educar a los estudiantes requiere considerar no sólo las necesidades de aprendizaje académico de los estudiantes, sino también sus necesidades de desarrollo psicosocial, sus necesidades físicas y su salud mental. Nuestras conversaciones con el personal y las familias, y nuestras observaciones en las escuelas, revelaron que la filosofía educativa integral fomenta positivamente la conexión y el sentido de pertenencia de los jóvenes. Animamos a continuar con este enfoque y ampliarlo a todos los aspectos de la vida escolar en la medida de lo posible. Escuchar más las voces de los jóvenes y abordar los factores que permitirían al personal realizar mejor el trabajo de prevención del suicidio son dos ejemplos de cómo integrar más el enfoque del niño en su totalidad. Creemos que ser deliberados y creativos a la hora de expandir la cultura de pertenencia e incluir la salud mental en el Sistema de Apoyo Multinivel (MTSS) del distrito son dos pasos adicionales que los líderes escolares y del distrito pueden dar para priorizar una filosofía integral del niño.

12. Ampliar la cultura de pertenencia

El sentimiento de pertenencia es una de las protecciones más poderosas contra los pensamientos e intentos suicidas. Además, una cultura de pertenencia cultiva la confianza entre los estudiantes, el personal y las familias, lo que puede animar a los jóvenes a revelar sus problemas de salud mental a los adultos. A su vez, esto permite a las escuelas identificar y ofrecer un mejor apoyo a los jóvenes y sus familias.

Para cultivar una cultura de pertenencia, la escuela debe animar a los profesores a establecer relaciones significativas con sus alumnos y tener una comunicación adecuada y eficaz, así como políticas que hagan que los jóvenes se sientan valorados, como las políticas contra el acoso. Durante nuestro trabajo de campo, vimos que los líderes escolares de todos los niveles priorizaban la conexión y la pertenencia como objetivos centrales de su escuela. Además, observamos que los directores se esforzaban activamente por conseguir que los profesores se comprometieran a cultivar una cultura de pertenencia.

A pesar de estos esfuerzos, nuestra investigación también identificó tres áreas en las que la cultura de pertenencia podría mejorarse. En primer lugar, la pertenencia es más efectiva cuando todos los alumnos se sienten parte de ella. Esto significa que todos los alumnos deben sentir que importan y que están seguros, independientemente de sus identidades sociales, desafíos personales, habilidades, talentos o antecedentes sociodemográficos. Si bien esto puede ser difícil de lograr, es imperativo tener en cuenta que los estudiantes que no encajan en el molde académico o deportivo corren el riesgo de sentir que no pertenecen, lo que puede tener graves consecuencias para la salud mental (Mueller y Abrutyn 2016). Es esencial identificar a estos estudiantes y asegurarse de que cuenten con adultos de confianza, mentores y oportunidades de inclusión.

En segundo lugar, muchos jóvenes, personal escolar y familias compartieron historias sobre intimidación y acoso a jóvenes de minorías sexuales y de género por parte de compañeros y miembros del personal escolar. Esto fue comprensiblemente doloroso para jóvenes Lesbianas, Gays, Bisexuales, Transexuales y Queer + (LGBTQ +) y les hizo sentirse excluidos de los esfuerzos para aumentar la cultura de pertenencia.

En tercer lugar, las escuelas son lugares donde las minorías raciales y étnicas a menudo se enfrentan a la discriminación o el racismo, factores que también aumentan la vulnerabilidad de los jóvenes frente al suicidio. Aunque muchos de los estudiantes latinos/hispanos nos transmitieron experiencias positivas, los estudiantes que aprenden inglés o los estudiantes cuyas familias hablan español tuvieron experiencias especialmente difíciles, a veces se burlaban de ellos por hablar español. El personal también reconoció que se produjeron incidentes de racismo (como insultos racistas) dirigidos a estudiantes hispanos, negros y asiáticos y que no se corrigieron de forma sistemática. Trabajar para reducir estos incidentes y encontrar formas de hacer que todo tipo de jóvenes se sientan seguros y bienvenidos en la escuela es imperativo para promover el bienestar de los jóvenes y construir una sólida cultura de pertenencia.

13. Incluir la salud mental en el Sistema de Apoyo Multinivel

Nuestra investigación muestra que las escuelas pueden prevenir mejor el suicidio y promover el bienestar de los estudiantes de manera efectiva a través del altamente estructurado Sistema de Apoyo Multinivel (MTSS). Todas las escuelas del WSPSD tienen alguna forma de MTSS. El MTSS es generalmente diseñado para detectar a niños con problemas académicos o de comportamiento, sin embargo, también puede ser reutilizado para apoyar a los estudiantes que luchan con problemas de salud mental y proporcionar intervenciones para apoyar la salud mental de los estudiantes. Estas intervenciones y apoyos también pueden mejorar la capacidad de aprendizaje de los alumnos, ya que los niños sanos y felices son niños que pueden aprender. De este modo, la prevención del suicidio se integra explícitamente en los sistemas de apoyo que ya existen en la mayoría de las escuelas y que ya están diseñados para identificar, procesar y conectar a los jóvenes con los apoyos necesarios. Sobre la base de nuestro trabajo de campo, las entrevistas con el personal y las entrevistas con los jóvenes y las familias, identificamos siete desafíos que las escuelas enfrentan en diversos grados para maximizar la eficacia de su MTSS actual.

En primer lugar, mientras que algunas escuelas acogieron el poder potencial del MTSS, todas las escuelas lucharon con actitudes negativas persistentes sobre la utilidad del MTSS. En algunos casos, la resistencia era amplia y estaba arraigada en iteraciones anteriores de MTSS, mientras que, en la mayoría de los casos, la resistencia estaba dispersa entre el personal. Abordar las creencias de que los MTSS son difíciles o inútiles es un paso importante hacia el aprovechamiento eficaz de los MTSS para la salud mental (y académica).

En segundo lugar, los mejores marcos de MTSS son aquellos que hacen que todos los miembros del plantel se sientan apoyados. Esto incluye a los profesores que confían en el MTSS para ayudar a un alumno con dificultades, a los alumnos y las familias que se sienten respaldados por las intervenciones y a los orientadores que sienten que se les quita parte de la carga de promover la salud mental y prevenir el suicidio cuando el MTSS lo convierte en tarea de todos.

En tercer lugar, los protocolos de derivación claros son esenciales para un MTSS eficaz. Es fundamental estandarizar el proceso de derivación y dar a conocer ampliamente los diversos criterios de derivación.

En cuarto lugar, la búsqueda de las causas profundas transforma el MTSS, que pasa de ocuparse de problemas superficiales como la asistencia o las malas notas a ocuparse de las

causas potenciales de esos problemas observables, como los traumas o la inseguridad alimentaria.

En quinto lugar, un MTSS sólido contribuirá al objetivo de la escuela de prevenir la pérdida de información. Prevenir la pérdida de información es fundamental tanto para la prevención del suicidio como para la prevención de la violencia (Goodrum et al. 2022). A menudo solamente recibimos señales "débiles" de que un alumno puede estar sintiendo deseos de suicidarse o de que puede estar a punto de involucrarse en actos violentos (Goodrum et al. 2022). Una señal débil de suicidio puede ser ver a un alumno triste en un pasillo. Aunque puede que no saquemos mucho de un solo estudiante triste, si también supiéramos que ese estudiante ha escrito un ensayo de inglés preocupante sobre la muerte y que su familia ha sufrido recientemente, conectar esos puntos puede ayudarnos a comprender mejor la gravedad de lo que está pasando ese estudiante. Rara vez recibimos una señal fuerte de que el estudiante es suicida (una señal fuerte sería como un aviso de Safe2Tell diciendo que un estudiante es suicida) por lo que tenemos que actuar sobre estas señales más débiles para ser eficaces. Recopilar la mayor cantidad de información sobre el bienestar del estudiante de diferentes fuentes y cotejar esa información en un solo lugar puede ser realmente útil. El equipo del MTSS es un equipo que ya está bien posicionado para hacer precisamente eso. Como parte de la recopilación de información, los equipos deben documentar las causas fundamentales de los problemas académicos, de comportamiento o de salud mental del alumno, asegurándose de que se recopila la información solicitada y sintetizando la información en un único lugar o equipo. Y lo que es más importante, esa información debe compartirse (respetando al mismo tiempo la intimidad del alumno en lo que respecta a detalles específicos) para que las personas del plantel escolar sepan cómo ayudar a cuidar a un alumno con problemas concretos.

En sexto lugar, y relacionado con lo anterior, la elección y el mantenimiento de un sistema informático duradero para todo el distrito mejoraría los procesos de derivación y pérdida de información.

En séptimo lugar, la implicación de la dirección es importante para garantizar que se dediquen recursos a los flujos de comunicación del MTSS a todo el personal y para señalar simbólicamente que el MTSS se valora en la escuela.

A medida que las escuelas avanzan hacia la construcción de estos sistemas más fuertes, nuestra investigación anterior sugiere que los mejores programas de MTSS tienen varios aspectos en común: (1) un fuerte apoyo de los líderes de la escuela, (2) un consejero escolar experimentado como líder dedicado, (3) múltiples equipos de Nivel 2 que se reúnen semanalmente y dividen al alumnado y (4) están compuestos por representantes de la dirección de la escuela, consejeros escolares, profesionales de la salud mental de la escuela (cuando estén disponibles) y profesores (Mueller et al. 2021).

14. Superar las barreras de comunicación

Dado que el 3.4 por ciento de los estudiantes del distrito son estudiantes de inglés, la promoción de la salud mental y la prevención del suicidio incluye proporcionar apoyos eficaces para los estudiantes de habla hispana y sus familias. Basándonos en nuestras observaciones, entrevistas y encuestas, identificamos barreras de comunicación con los estudiantes y las familias. Encontramos que muchos miembros del personal sentían que las escuelas no tenían suficientes recursos para los jóvenes de habla hispana. Aunque casi todos los planteles

cuentan con personal bilingüe, las barreras lingüísticas pueden afectar la capacidad del personal de la escuela para comunicarse directamente con los estudiantes acerca de sus vidas y con las familias acerca de sus hijos, en particular de manera oportuna. Aunque el distrito cuenta con una oficina de servicios de traducción, muchas familias nos dijeron que utilizar este servicio no siempre era fácil y a menudo acababa en frustración. En la mayoría de los casos, el retraso en la comunicación era solo una molestia, pero si había una crisis en la casa o en la escuela, el retraso podía ser crítico para conseguir que los jóvenes recibieran el apoyo que necesitaban. Está justificado pensar en estrategias para garantizar que las familias siempre puedan proporcionar o recibir información sobre sus hijos a tiempo.

15. Mejorar la respuesta al trauma

La última manera en que las escuelas pueden participar en el trabajo de prevención del suicidio es reconociendo y siendo sensibles a las experiencias traumáticas que han tenido muchos estudiantes en el distrito. Los jóvenes en los EE.UU. sufren de una amplia gama de experiencias adversas o traumáticas, incluyendo la falta de vivienda, la inseguridad alimentaria o el trauma en el hogar asociado con la pobreza, el abuso, el abandono, el abuso de alcohol/drogas, el encarcelamiento de los padres y así sucesivamente. El personal escolar del WSPSD ha demostrado un fuerte deseo de apoyar eficazmente a los estudiantes que han experimentado traumas, lo que se alinea con el compromiso del distrito y las escuelas con el niño en su totalidad y con la promoción de la salud mental y la prevención del suicidio. La capacidad de respuesta al trauma sigue siendo un área de crecimiento potencial. Casi todas las escuelas que observamos priorizaron mejorar la respuesta al trauma a través de capacitaciones y oportunidades de desarrollo profesional, lo que incluye equipar al personal con estrategias para usar en las aulas con estudiantes que muestran signos de trauma o desafíos de comportamiento, para que no contribuyan a la alteración emocional de los estudiantes. La creación de más oportunidades de formación y recursos puede ayudar aún más al personal cuando se trata de cuestiones relacionadas con el trauma de los estudiantes.

16. El rol del distrito

Para identificar las áreas de crecimiento a nivel de distrito, revisamos cómo se siente el personal sobre el estado actual de las políticas y procedimientos del distrito. En general, el personal no relacionado con la salud mental (como los profesores) está de acuerdo en que el distrito tiene políticas que facilitan su trabajo de prevención del suicidio y les protegen de la responsabilidad legal. El personal de salud mental de la escuela (definido ampliamente para incluir consejeros escolares, psicólogos escolares, trabajadores sociales escolares y enfermeras) y los líderes escolares, tenían menos confianza en las políticas del distrito.

Identificamos varias formas en que el distrito puede mejorar la forma en que apoya el trabajo de prevención del suicidio con el personal. Concretamente, los formularios del distrito no siempre se basan en la evidencia. Por ejemplo, cuando comenzamos el trabajo de campo, los **formularios de planificación de la seguridad** del distrito no eran coherentes con las mejores prácticas para la prevención del suicidio. Entendemos que, después de que llamáramos la atención del personal del distrito sobre este asunto, se puso remedio, y el personal de salud mental ha recibido o recibirá formación sobre planificación de la seguridad. También recomendamos encarecidamente que los líderes escolares y las enfermeras escolares/auxiliares de enfermería reciban formación en planificación de la seguridad para que siempre haya alguien que ayude a apoyar a los niños potencialmente suicidas. El Centro de

Recursos de Seguridad Escolar de Colorado es un gran recurso para los formularios basados en la evidencia que pueden adaptarse a las necesidades locales con la ayuda de expertos locales (a nivel de distrito y de la escuela).

También descubrimos que el distrito debe asegurarse de aclarar las expectativas para los diferentes puestos del personal. Aunque los datos de nuestra encuesta revelan que los profesores suelen tener claro su papel en la prevención del suicidio, -es decir, se espera que ayuden a identificar a los estudiantes que puedan estar en riesgo y los envíen a su consejero escolar (o a otro personal de salud mental de la escuela, o si estos no están disponibles, a la dirección de la escuela) para recibir apoyo y evaluación adicionales- asegurarse de que todos los profesores entiendan que esto es lo que se espera de ellos, y puede animar a más profesores a involucrarse en la prevención del suicidio y a sentirse más cómodos mientras lo hacen.

El personal no docente u otro personal de apoyo, como bibliotecarios, conserjes, paraprofesionales, secretarias, etc., suele desempeñar un papel importante en la vida de los alumnos. A menudo desempeñan un papel importante en la vida de los alumnos y en el buen desarrollo de su jornada escolar. Su papel en la prevención del suicidio no siempre está tan claro para ellos como lo está para los profesores, el personal de salud mental y la dirección del centro. Por lo tanto, el distrito debería asegurarse de que todos los cargos del personal entienden claramente qué papel se espera que desempeñen en la prevención del suicidio y cómo proceder. Las secretarias, en particular, son las estrellas inesperadas en la configuración de las experiencias escolares de los alumnos. Pueden proporcionar una palabra amable, apoyo, orientación y son poco apreciadas por su papel en el apoyo al bienestar de los estudiantes en las escuelas. Teniendo en cuenta cuántos alumnos confían en ellas y hablan con ellas (especialmente en los centros de enseñanza media), sería ideal asegurarse de que recibieran formación como guardianes de la prevención del suicidio.

Por último, el uso de los Servicios de Crisis de Colorado después de que un trabajador de salud mental de la escuela ha identificado a un estudiante como de alto riesgo de suicidio, pero antes de llevar al estudiante a un centro de crisis debe ser descontinuado. Aunque esto no solo está bajo el control del distrito, éste debería abogar ante el centro de crisis local para que el personal de salud mental de la escuela pueda derivar directamente a los estudiantes al centro de crisis local. El personal de salud mental escolar suele estar más capacitado que el personal de los Servicios de Crisis de Colorado (que probablemente no tengan títulos de posgrado en salud mental, que sí deben tener los consejeros escolares).

Los consejeros escolares, los psicólogos escolares y los trabajadores sociales escolares son profesionales de la salud mental que tienen la capacidad profesional y la responsabilidad de evaluar a los estudiantes para detectar el riesgo de suicidio de acuerdo con sus normas profesionales (incluidas las normas profesionales de la American School Counseling Association). Para obtener más información sobre este tema, recomendamos encarecidamente Gallo y Wachter Morris (2022). [2]

[2] Este artículo puede descargarse gratuitamente en este enlace: https://trace.tennessee.edu/cgi/viewcontent.cgi?article=1246&context=tsc

Apoyar el bienestar de los jóvenes más allá de la escuela

Aunque nuestra investigación enfatiza el rol de las escuelas en la prevención del suicidio, las escuelas no pueden hacer este trabajo solas. La prevención del suicidio es tarea de todos y la comunidad en general también debe contribuir al desarrollo positivo de los jóvenes y proporcionarles un apoyo fundamental cuando inevitablemente se enfrentan a momentos difíciles. En la sección final de nuestro informe, detallamos lo que las diferentes organizaciones y personas de la comunidad, fuera de la escuela, pueden hacer para mejorar su apoyo al bienestar de los jóvenes y apoyar a las escuelas en la prevención del suicidio, incluyendo el papel de (1) La comunidad, (2) El centro de crisis y (3) Las comunidades de fe, y abordaremos (4) Un sitio crítico para el suicidio

5. El rol de la comunidad

Todas las comunidades tienen recursos que pueden mejorar el bienestar de sus miembros. En nuestras entrevistas, preguntamos al personal, a las familias y a los alumnos qué recomendaciones podían hacer para reducir el suicidio. Muchos padres criticaron el limitado número de actividades disponibles para los jóvenes en su tiempo libre, así como las barreras asociadas al acceso a estas actividades. Por ejemplo, los entrevistados mencionaron la decepcionante oposición a la construcción de un centro comunitario en una parte de la comunidad. Los que se oponían argumentaban que una comunidad cercana ya disponía de una instalación similar, por lo que no era necesaria una segunda. Este argumento ignoraba las barreras para acceder a la instalación más lejana debido a los costes de transporte y de afiliación que impedirían a los miembros de la comunidad con un estatus socioeconómico más bajo poder acceder a la instalación comunitaria.

La falta de suficientes actividades extraescolares para los jóvenes puede conducir a comportamientos nocivos que aumentan el riesgo de suicidio, como el consumo de alcohol y drogas. Estas mismas desigualdades impiden a las familias aprovechar los hermosos espacios al aire libre que rodean esta comunidad. Sin embargo, el obstáculo más grave era la falta de un transporte público fiable y amplio. Muchos de los jóvenes y sus familias manifestaron sentirse atrapados, algo que puede perjudicar su bienestar. Es posible que la mejora del transporte público no solucione la sensación de estar atrapado a la comunidad, pero puede ayudar a que la vida sea más enriquecedora y a aumentar el acceso de los jóvenes y las familias en Western Slope a la atención sanitaria en salud mental y a los bellos espacios naturales.

Además, la comunidad debe trabajar para abordar el estigma de la salud mental, ya que las actitudes de la comunidad hacia la salud mental y el suicidio pueden reducir el comportamiento eficaz de búsqueda de ayuda y pueden hacer que los que luchan se sientan peor y más solos. Aunque descubrimos que era probable que las familias buscaran ayuda para la salud mental de sus hijos, nuestros hallazgos también indican que el estigma generalizado de la salud mental dificulta los comportamientos de búsqueda de ayuda entre los jóvenes, por miedo a la vergüenza frente a sus amigos o adultos. Además, estas actitudes negativas hacia la salud mental pueden llevar a las comunidades a ignorar involuntariamente los problemas persistentes o a descartar soluciones eficaces. Los miembros de la comunidad deben poder sentirse seguros de que su familia no será maltratada cuando busquen y reciban ayuda para sus necesidades psicosociales.

6. El rol de los centros de crisis

El estigma de la salud mental que encontramos se vio agravado por las barreras para acceder a la atención sanitaria mental dentro de la comunidad de Western Slope. El Valley Behavioral Health (VBH), un seudónimo, es un prominente proveedor de atención de salud mental y un actor importante en la atención de crisis en el oeste de Colorado, ya que es uno de los únicos centros de crisis de salud mental en la zona. Aunque escuchamos algunas experiencias positivas con el VBH, la mayoría del personal, las familias, y los jóvenes compartieron experiencias negativas o historias sobre el VBH. Algo importante es que casi el 89 por ciento de las personas que respondieron a nuestra encuesta de familias reportaron que no se oponían a los centros de crisis. Sin embargo, cuando se les preguntó acerca del VBH específicamente, la mayoría expresaron una serie de dudas. Muchos padres se quejaron de las dificultades de obtener apoyo a tiempo ya que el VBH no provee servicios sin cita previa, sino que requiere una remisión para obtener acceso. La falta de servicios sin cita previa es inaceptable y va en contra de las mejores prácticas.

Por favor, tenga en cuenta que desde la finalización de nuestro proyecto de investigación, supimos que abrió una sala de emergencias psiquiátrica con servicios de atención sin cita previa. Este es un cambio muy importante que aplaudimos y, que esperamos, sea positivo para la salud mental en Western Slope. La sala de emergencias psiquiátrica tiene personas que hablan español.

7. El rol de las comunidades religiosas

La investigación ha demostrado que pertenecer a una comunidad religiosa y participar en ella puede ser una poderosa herramienta de protección contra la mala salud mental y el suicidio, en gran parte porque ayuda a proporcionar una red de seguridad para las familias y los jóvenes. Muchas de las familias y el personal con los que hablamos están de acuerdo con estos sentimientos y varios de ellos informaron de que el asesoramiento basado en la fe les había sido útil en el pasado. A pesar de estos importantes beneficios, tanto las investigaciones anteriores como nuestros propios datos indican que las comunidades religiosas tienen el potencial de perjudicar el bienestar de los jóvenes cuando la propia comunidad religiosa es una fuente de estrés o trauma. Esto era más evidente cuando las necesidades socioemocionales de los jóvenes estaban en desacuerdo con la fe o la religión de sus padres. De los estudiantes en estas circunstancias, muchos tuvieron dificultades para obtener la ayuda que necesitaban para sus problemas de salud mental. También experimentaron dolorosos desafíos para navegar por su sentido de sí mismos en relación con las expectativas de su comunidad religiosa (y de sus padres). Los consejeros escolares consideraron que se trataba de un problema importante para la salud mental de los estudiantes, especialmente para los estudiantes LGBTQ+. Estos estudiantes eran muy propensos a informar que su comunidad religiosa no los aceptaba y temían el enfado o la vergüenza de sus padres si les hablaban de su identidad sexual o de género.

Las comunidades religiosas desempeñan un papel fundamental en la promoción de la salud mental y la prevención del suicidio. Para ello, garantizar que los líderes de las comunidades religiosas reciban formación para identificar los signos de riesgo y para hablar de forma segura y compasiva sobre salud mental y suicidio con las familias y los jóvenes (de forma no estigmatizadora), reforzaría maravillosamente la prevención del suicidio en cualquier comunidad, incluyendo Western Slope. Las comunidades religiosas también deben trabajar

como comunidades para identificar formas de apoyar a los miembros que están luchando con su salud mental, independientemente de la razón, para que todos puedan beneficiarse de la pertenencia a estas importantes comunidades.

8. Abordar los sitios críticos para el suicidio

Una característica única de Western Slope es su proximidad a un sitio crítico para el suicidio. Un sitio crítico para el suicidio se define como un "sitio específico, accesible y generalmente público que se utiliza con frecuencia como un lugar para el suicidio y se gana una reputación por ello" (Cox et al. 2013). Dado nuestro enfoque en cómo la comunidad en general puede ayudar a mejorar la prevención del suicidio, hacer lo que podamos para hacer frente a este sitio crítico es una consideración importante. Investigaciones previas identifican cuatro formas principales de prevenir los sitios críticos para el suicidio. La primera, y más recomendada, son las restricciones, como erigir barreras que dificulten la muerte por suicidio. Sin embargo, no siempre es factible dependiendo de la ubicación, los recursos disponibles o los intereses de la comunidad. En segundo lugar, también puede ser eficaz fomentar la búsqueda de ayuda instalando teléfonos cerca del punto de acceso que conecten directamente con centros de asesoramiento en crisis y/o colocando carteles con frases positivas o información de contacto. En tercer lugar, formar al personal para que esté preparado para responder a las personas en crisis también puede ayudar. En cuarto lugar, fomentar una información responsable sobre el suicidio en los medios de comunicación puede ayudar a reducir la conciencia sobre el sitio. Actuando como una comunidad, todos deben tener cuidado de no reforzar este lugar en particular como un sitio crítico para el suicidio.

Conclusión

La mejor manera de promover la salud mental y prevenir el suicidio es mediante un esfuerzo multifacético unificado. Al enfocarnos en los cambios tangibles presentados en este informe, creemos que las escuelas, las familias, los profesionales de la salud, los líderes religiosos y los miembros de la comunidad, pueden promover redes de seguridad de salud mental más sólidas y esfuerzos efectivos de prevención del suicidio. Al hacerlo, podemos intentar activamente que los mundos que habitan los jóvenes sean lugares más seguros y felices. Para ello, ofrecemos una serie de recomendaciones sobre las políticas en la siguiente sección de este informe, que pueden ayudar a guiar y centrar las conversaciones a medida que trabajamos juntos para identificar estrategias concretas y viables para traducir la investigación en mejores vidas para los jóvenes y sus familias en la Comunidad de Western Slope. Todos podemos marcar la diferencia en la vida de los jóvenes si adoptamos la idea de que "el suicidio es responsabilidad de todos".

Policy Recommendations

Determining how to better prevent youth suicide in schools and communities is a challenging but important public health goal. While recognizing that the causes of suicide are complex and that preventing all suicide deaths may not be possible, there are strategies to build a world worth living in for youth and a world where youth and families can access mental health supports when times inevitably get tough. We believe that making many small changes – that nudge youth to get help when needed, make it easier and safer for school staff to ask students if they are doing okay, and enable communities to foster positive youth development – are what is going to make the difference.

With that in mind, we offer the following policy recommendations to help guide and focus conversations as we work together – school staff, community members, and suicide prevention researchers – to develop policies and practices that will accomplish our shared goal of diminishing youth suicide in Western Slope. We believe that the best policies are those that are science informed but also responsive to local needs. This is in part because we know that some of our recommendations (e.g., having in-person school psychologists) may be difficult or impossible in the local environment. Thus, it is only through collaboration in the coming months and years that we will be able to identify and implement the best strategies to improve youth suicide prevention in Western Slope.

Please note, we have no conflicts of interest and receive no financial incentives from any of the following trainings or resources that we recommend. They are simply the best resources in our professional opinions. Often they are resources we ourselves use to train our research team or in our own classrooms.

Recommendations for the Schools and District

Recommendations for Youth Voices

1. The district and school leaders should identify ways to include youth voices in developing strategies to improve well-being in district schools. One way to do this may be to have youth advisory boards at the district and school levels;

Recommendations for Building a Strong Foundation

2. District and school leadership should continue to encourage staff to use a whole child educational philosophy to guide their daily work supporting and educating students;
3. District and school leadership should continue to cultivate cultures of belonging in school buildings, paying particular attention to ensure that students with marginalized or minoritized social identities also feel welcome and safe;
4. District and school leadership should improve the Multi-Tiered System of Supports (MTSS) program so that it reflects the district's whole child educational philosophy by including mental health in MTSS procedures and outcomes. Efforts to prevent information loss through MTSS are also likely to improve both suicide prevention and school safety;
5. District and school leadership should provide more opportunities for staff to learn about using trauma responsive pedagogy and strategies to manage students' behaviors in classrooms;
    a. Specifically, we recommend www.TrepEducator.org and *Trauma Responsive Educational Practices: Helping Students Cope & Learn* by Dr. Micere Keels (2023; ISBN 13: 978-1416631736) for its practical hands-on guidance for teachers and school staff.

Recommendations Regarding Resource Allocation

6. The district should increase the number of mental health staff (defined as school counselors, school psychologists, school social workers, and nurses) in school buildings to ensure schools have the capacity to support students' mental health needs, including having in-person school psychologists and increasing the number of school mental health therapists whenever possible;
7. While we did not overly focus on the health clinic offered in one high school, our data suggests that this clinic strengthened mental healthcare for youth in the community (see Mueller, Abrutyn, and Diefendorf [2022]). The clinic also helped reduce the burden on the school's mental health workers. Therefore, we recommend expanding health clinics when possible. They improve access to both mental and physical healthcare for youth;
8. School psychologists should not be exempt from suicide risk reviews;
9. The district should work to expand the number of independent therapists who offer students therapy in the school building (with parental consent);

Recommendations for Training School Staff

10. The district should ensure that mental health staff receive LivingWorks ASIST training before they begin working with students. They should retake this training at least every 3 years;
    a. We suspect that CAMS training may be validated for use in schools in the near future. In that case, we suggest that it be accepted as a substitute for training when mental health staff need to re-up their suicide prevention training (i.e., after they have taken ASIST).
    b. The Office of Suicide Prevention in the Colorado Department of Public Health and the Environment can also provide recommendations for high-quality evidence-based trainings (as time progresses and things change).
11. To address the knowledge gaps that concern staff and thwart their ability to engage in suicide prevention, the district should ensure that non-mental health school staff (teachers, librarians, custodians, paraprofessionals, etc.) complete a suicide gatekeeper training before they begin working with students;
    a. A non-exhaustive list of acceptable trainings include QPR (Question, Persuade, & Respond), LivingWorks Start (what our research team uses), LivingWorks SafeTALK; Mental Health First Aid, etc..
    b. It is essential that the training provide some practice in talking about suicide to meet minimal quality standards.
    c. The Office of Suicide Prevention in the Colorado Department of Public Health and the Environment can also provide recommendations for high-quality evidence-based trainings (as time progresses and things change).
12. The district should ensure that anyone who is involved in Spanish-language translation for schools has completed a suicide prevention gatekeeper training to ensure that they do not inadvertently introduce stigmatizing language during the process of translation. Such mistakes are common and so it must be guarded against;
13. While we did not focus on crisis response in this report, we are aware of district strategies and recommend the district continue its current protocols for crisis response. In particular, crisis response teams should continue to be PREPaRE trained prior to engaging in crisis response;

Recommendations for Improving Suicide Prevention Protocols

14. The district should ensure that all suicide prevention and postvention protocols are evidence-based and consistent with professional best practices;
15. Since staff consider worries about legal liability as a barrier to engaging in suicide prevention work, we encourage the district to make it clear to staff how district protocols protect them, emphasizing what is known about legal liability and the importance of documentation and communicating with parents as major protectors against legal liability (see Erbacher, Singer, and Poland [2014]; Gallo and Wachter Morris [2022] for reviews of legal liability and how it pertains to suicide prevention in schools);
16. The district should make clear that all school based mental health staff can be called upon to complete an evidence-based suicide risk review and that no category of mental health worker is exempt from this work;
    a. This is particularly relevant to school psychologists, who were the group with the least role clarity with regard to suicide prevention during our fieldwork.
17. The district should clarify expectations for teachers and all non-mental health staff with regard to suicide prevention. Namely that they are expected to help identify struggling students and refer them to the school counselor or other mental health staff and, if they are not available, to the school leadership. What is not expected should also be clarified;
    a. The district should also inform non-mental health staff what follow up will look like so they have confidence that if they identify a student in need they will be connected to appropriate care.
18. District forms, for example for safety planning, should match evidence-based protocols in order to both reduce district liability and to reduce staff's concerns about legal liability (a barrier staff identified to engaging in suicide prevention work);
    a. For safety planning, we recommend the district follow the Stanley Brown Safety Plan, same as the Colorado School Safety Resource Center recommends (we also use this protocol ourselves).
19. The district should develop protocols for following up with students who have experienced suicidality to ensure that they continue to get the support they need and feel cared about;

Recommendation for Improving Staff Well-Being

20. District and school leadership should identify strategies to help teachers and school staff form supportive relationships with each other to ensure that staff have the social connections that help them avoid secondary trauma from the sometimes difficult work they have to do during the school day.

Recommendations for the Community

1. The community should develop more activities and places for youth, like community recreation centers;
2. The community should improve public transportation with an emphasis towards increasing equitable access to the beautiful natural areas around the community, to mental (and physical) healthcare centers, and to places where youth can hang out with some supervision (like recreation centers);
3. The community should address prevalent mental health stigma through positive public health messaging campaigns that encourage mental health help-seeking and diminish shame around needing supportive resources;
4. The community needs an effective and accessible walk-in crisis center which it lacked during our fieldwork. This was a massive and pressing gap in the mental health safety net

that we understand has been addressed thanks to the newly opened psychiatric emergency room.

5. The community should support district efforts to expand the number of health clinics in the schools, and increase the number of both school mental health staff and mental health therapists that work in the schools;
6. Faith communities can play a positive and important role in supporting youth mental health, particularly when they are welcoming and supportive spaces. Therefore, ensuring faith communities are ready and trained to play a role in suicide prevention will strengthen the supports that families and youth experience particularly during difficult times;
    a. LivingWorks has a training that specifically targets faith communities that these communities can use to be better prepared to prevent suicide in their congregants;
7. The community should support any efforts to address the suicide hotspot that is in the community. For more details on this, please reach out to us privately.

Building Schools & Communities that Prevent Youth Suicide:

The Final Report of the Social Worlds & Youth Well-Being Study, Western Slope, Colorado

I. Introduction

Since 1999, the suicide rate for youth in the U.S. has increased dramatically (Curtin, Warner, and Hedegaard 2016), as have reports of suicide clusters in schools (Rosin 2015). A major barrier to reversing trends in youth suicide is that suicide's complexity makes it nearly impossible to accurately predict which youth with risk factors for suicide will attempt or die by suicide (Cha et al. 2018; Franklin et al. 2017). This frustrating and frankly painful reality has caused researchers to call for more of an emphasis on upstream suicide prevention – which means identifying effective strategies to improve youth well-being and facilitate help-seeking *before* a youth's psychological pain becomes a crisis resulting in suicide. This report contributes to such efforts by identifying ways to improve suicide prevention in schools and their surrounding communities.

Western Slope Public School District (or WSPSD—all names and places are pseudonyms) recognizes suicide as a major public health concern, both in their schools and in the broader community. According to reports from the county's public health department, the county's overall suicide rate continues to exceed both the suicide rates of Colorado and the United States at large. While the rate of youth suicide is thankfully too small to make comparisons by county within Colorado possible, youth in Western Slope County (aged 10-19) are at the highest risk of suicide attempts and suicidal ideation (e.g., suicidal thoughts) of any age group. It is not uncommon for suicidal thoughts or attempts to be more prevalent among youth than adults. What is clear is that suicide across all age groups is a major concern in Western Slope. The concern about the elevated suicide rate extends to the youth population. As a result, like in many communities around the United States, there has been an increased effort locally to prioritize youth suicide prevention—an effort we hope to contribute to with this report.

Why Schools Matter

As we shift emphasis to upstream prevention, schools have been increasingly emphasized as one of the most important organizations for suicide prevention (Joe and Bryant 2007; Singer 2017; Wyman 2014). The reason for this is multifaceted. First, youth spend most of their waking hours in school buildings, making schools the primary social context of their lives. Beyond family members who live with youth, school staff have the second greatest opportunity to notice early signs of psychological pain or distress that could escalate to suicide if unaddressed. Second, schools are communities that generally try to cultivate a sense of pride and membership in their students. As a result, youth's identities – how they see and define themselves and what they value – are often tied to their school. This can amplify the importance of relationships with friends, peers, counselors, teachers, and trusted adults at school. It can also increase the importance of fitting in at school to youth's psychological well-being. As a result of those two factors, what we do in schools regarding promoting mental health and suicide prevention can have critical repercussions for youth's lives.

And yet, despite the importance of schools, many schools struggle to effectively prevent suicide and sustain evidence-based strategies over the long-run (Singer, Erbacher, and Rosen 2019). This is likely because existing strategies require significant time, labor, and financial commitments (Shankland and Rosset 2017). Additionally, few existing strategies are designed to be incorporated seamlessly into school's existing safety nets or operational strategies. Finally, empirical research examining the best ways to prevent suicide in schools is extremely limited. This dearth leaves considerable gaps in our understanding of how evidence-based strategies work on the ground during the day to day work of schools and what we may be missing when it comes to strengthening suicide prevention, crisis response, and post-suicide interventions (or "postventions") in schools and their communities.

Communities Matter, Too

While we recognize schools as a key location for suicide prevention, we also acknowledge that schools are deeply dependent on the social contexts in which they are embedded – particularly at the district, community, and state levels. These additional social contexts shape both youth psycho-social development (Bronfenbrenner 1979; Spencer 2007) and the social environment of the school (Calarco 2020; Hallett 2010; Spillane, Parise, and Sherer 2011), including in ways that are known to be relevant to the environmental risk of youth suicide (Mueller and Abrutyn 2016). Additionally, schools' suicide prevention strategies are facilitated or constrained through the community's wrap-around resources and complementary supports, such as psychiatric hospital beds, 24/7 crisis counseling services, psychiatrists, therapists, and pediatricians with behavioral health training (Bridge et al. 2014). Thus, to understand how schools prevent suicide and promote mental health, it is also necessary to examine the communities that surround them.

The Social Worlds & Youth Well-Being Study

The Social Worlds & Youth Well-Being Study grew out of a shared desire between two school districts – "Front Range" and "Western Slope" – and the research team to better understand how youth experience their schools and how schools go about the daily work of preventing suicide, responding to crises, and promoting well-being in their students. Our shared goal is to identify new, sustainable, effective, and equitable strategies to improve suicide prevention in schools and their surrounding communities. This study is guided by two primary research questions: (1) How can we build connectedness in schools and communities that facilitates a sense of belonging and effective help-seeking among youth?; and (2) How can we build mental health safety systems in schools and communities to better help youth who are struggling and to improve suicide prevention?

While two school districts are participating in the larger Social Worlds & Youth Well-being Study, this report focuses on our findings from our collaboration with our Western Slope school district. For the purposes of this report, we will call this district "Western Slope Public School District" (WSPSD), a pseudonym. WSPSD volunteered to collaborate with researchers as part of this study after hearing a principal investigator, Dr. Anna S. Mueller of Indiana University Bloomington, give a keynote address featuring her research on youth suicide and suicide clusters at an annual conference hosted by the Colorado School Safety Resource Center in 2018.

Expressing Our Gratitude

One barrier to improving strategies to prevent suicide in schools is that schools and districts are rarely eager to allow researchers to examine their procedures and protocols to identify limitations or gaps. For that alone, we are deeply grateful to the district, school leaders, school staff, and community families for trusting us to do this work. We are grateful to the many people who invested tremendous time and effort to share their insights with us, opened up their homes or schools to us, organized focus groups for us, or allowed us to follow them around all day as they went about their jobs. We also recognize that some families, schools, and youth in this community have lost loved ones to suicide, making this a deeply personal and potentially painful topic of discussion. We are especially grateful to suicide loss survivors who shared their stories with us and helped us better understand their and their loved one's experiences.

We believe that this work will provide an important benefit for WSPSD, school districts around the U.S., and for the scientific understanding of suicide and suicide pre- and postvention in schools. Additionally, we look forward to collaborating with the district, schools, and community to translate the findings shared in this report into new strategies to improve youth's lives and strengthen school and community mental health safety nets.

On Blame, Change, and Suicide

During our time in Western Slope, we witnessed media coverage and community discussions that ultimately can be characterized as discussions about who or what was at fault – be it schools, substance use, families, etc. – for youth suicides. Following a collective trauma like a suicide loss, it is very human to search for something or someone to blame to help us make sense of why something terrible happened. As we engage in this fault-finding process, our intention is often to discover ways to prevent the trauma from happening again. Unfortunately, fault-finding often goes hand-in-hand with blaming and shaming. This is problematic because a focus on who is to blame undermines our ability to make the changes needed across the multiple levels of social life to make a difference in youth's lives and improve our ability to prevent suicide.

In the suicide prevention world, we often say, 'suicide is everyone's business' because it will take all of us to reduce youth suicide. Every school we studied had strengths and weaknesses, strategies we could learn from, and strategies that could be shifted to reduce gaps in mental health safety nets. We also provide insights into how the community writ large, including the many faith communities, families, and medical offices, can better support the schools and WSPSD's work. We encourage readers to absorb this content with an eye towards "what can *I* do to improve the lives of youth?" "what can *I* do to strengthen mental health safety nets?" and "how can *I* support or encourage other organizations – from schools to doctors' offices to faith communities – to improve their contribution to suicide prevention and make kids' lives worth living?" We hope that by working together we can actually make changes that diminish suicide in this community – but it will take us all.

Methodology in Brief

To answer the two overarching questions that drive this work, we utilized three different research tools to collect data: (1) interviews, (2) in-person and online fieldwork, and (3) surveys. The data in this report were collected between August 2019-September 2023, and combined, represent 281 interviews (broken into 48 youth, 164 school staff, 69 parents, and 12 community mental health providers interviews) with 36 months of fieldwork in four high schools and two

middle schools in addition to district and community meetings and events, and two different surveys—one with WSPSD families (with 701 family respondents) and one with WSPSD school staff (with 568 staff respondents). It is important to note that Mueller and Ortiz speak Spanish fluently, which allowed us to offer interviews in Spanish as well as offer the survey in Spanish.

At the beginning of each semester, the district and school principals sent out letters informing families about our research and presence in the schools. Parents were given the opportunity to opt out of the study. All fieldworkers were required to memorize this list of students whose parents had withdrawn consent and to ensure their names and identifying characteristics are absent from the data and report. All interviews were conducted only with individuals who volunteered for them. For adults who volunteered, a consent form was sent through email prior to the interview and then verbal consent was obtained prior to the beginning of the interview. Mueller and Ortiz were able to provide and obtain informed consent in Spanish for Spanish-speaking families or youth. For youth under 18 years old, a consent form was sent to a parent or guardian and when it was returned with their signature, a member of our research team contacted the parent to ensure consent was granted. The youth was also given an assent form and prior to the interview beginning, assent was obtained after discussing the form. All interviews were given the option of a $40 gift card to Amazon or Starbucks, even if they did not finish the interview.

Questions that begin with "how" or "why" are usually best answered by qualitative research methods, which is why we center the data collected via interviews alongside the data collected from our fieldwork observations in this report. The survey data elicited broad views of both family and staff opinions and experiences that, very importantly, allowed us to confirm or challenge the themes present in our interview and fieldwork data. For more details on our methodology and our analytic strategy, please review Appendix A: Methodology.

Overview of the Report

With this report, Section II sets the stage by sharing the opinions and experiences of youth themselves. Youth want adults to listen to them without judgement or being labeled; they also want to be involved with improving mental health and suicide prevention protocols. Lastly, youth desire more accessible local activities. Their thoughts are invaluable for this research.

Next, Section III discusses why schools are being called on to engage in suicide prevention, before discussing staff, family, and community attitudes towards schools playing a role in suicide prevention. We then reveal just how often teachers, administrators, and mental health staff (broadly defined to include school counselors, school psychologists, school social workers, and nurses) in schools are called on to engage in a variety of work related to suicide prevention and student well-being. In short, this is work that staff engage in, regardless of their position, with frankly surprising frequency.

Section IV examines how staff understand and feel about their work to prevent suicide and support student mental health. We also identify what factors enable or discourage staff's engagement in suicide prevention work, with special attention paid to the role of suicide prevention training and to barriers to asking the critically important question "are you thinking about suicide?" We conclude by examining staff's well-being and specifically the relationship between engaging in suicide prevention work and experiencing symptoms of secondary trauma. This work can be stressful, but we also identify things that improve staff well-being and resilience.

Having established the landscape of suicide prevention in schools, in Section V, we turn to discussing how schools do this work through the educational philosophy that guides all staff's daily work and building school cultures that support the needs of all students and that make all students feel welcome and safe. As we discuss school cultures, we are also attentive to the special needs of certain student groups, like English language learners, students with families that do not speak English, sexual and gender minority students, etc. Finally, we examine the systems that schools have built to support students, identifying what system-level factors help suicide prevention (and violence prevention) and which need adjusting.

Section VI details how the district can support the work in schools through clear, evidence-based protocols, while Section VII details efforts beyond the school district that are crucial to supporting youth suicide prevention. These include community resources, an effective, accessible crisis center, the importance of faith communities, and how to build safety in suicide hotspots.

Finally, our appendices offer a detailed question by question look at the staff and family surveys as well as an in-depth review of our methodology.

II. Youth's Insights into Improving Suicide Prevention

We begin the empirical portion of this report by sharing insights from youth about how their families, schools, and community can better support their mental health and well-being and in so doing help prevent suicide. We largely draw on 47 interviews that we conducted with youth alongside our observations of youth life in schools (the total number of youth we got to know to some extent is 83).

Listen to Youth

One of the first things youth in Western Slope (and incidentally also youth in our other research studies [Mueller, Abrutyn, and Diefendorf 2022]) made clear is that it is essential adults hear them and take their concerns seriously. Many youth recognize the world they inhabit today is different from that of their parents and, consequently, adults do not always understand what it is like to grow up in the 21st century. Listening to youth requires adults avoid saying things like "Everyone goes through this" or "Just wait, it will get better when you're older." For instance, when Daria (a pseudonym—henceforth, all names will be pseudonyms) sat down with us for an interview (with parental consent), she expressed that during the time of her struggle with self-harm, she wished she had "somebody to talk through [her] shit [with], without having to sugarcoat everything and lie to them" about herself and her circumstances.

What youth want most is empathy and, sometimes, a safe space for expressing anger, fear, and concern. Telling youth that it will get better in the future can feel patronizing or, worse, like we as adults just expect them to endure suffering for an indefinite period. What they want instead is for adults to care about what is going on with them now and try to make the *present* better for them and their peers. When making the present better is beyond an adult's control – because of course not all problems have simple solutions – youth also acknowledged that just listening and empathizing is helpful as it lends credence to youths' experiences. It also signals that adults agree: the world should be better for our children.

Youth made it clear that adults can express care in various ways. Listening without judgment is a major thing that youth desire from adults, be it family members, mentors, or

school staff. Sometimes they even welcome advice from a "parental point of view" or an unbiased place. Sometimes a hug really helps, as does telling youth "I understand."

Youth that did not have someone to listen to them learned to mask their emotional struggles while navigating their day-to-day. Some students even expressed that "I've always been on my own for everything." Neither of these is good for youth well-being or their psycho-social development, but for some youth this is their reality. This can amplify the importance of school staff working to be trusted adults for their students. Some teens may have no one else in their lives.

Listening to youth also goes beyond listening in one-on-one conversations. Youth also want to be included in efforts to make their schools and communities positive, safe places. They want to be consulted when deciding how best to prevent suicide or when developing suicide prevention policies. They want to collaborate with adults in building a world worth living in. This is particularly important since, as we will discuss shortly, youth do not always feel safe using mental health services controlled and designed by adults. Thus, partnering with youth should be an important goal in the community and schools as it builds trust between adults and youth and helps ensure that mental health supports are ones that youth are willing to use.

Don't Judge Me

The second major theme that came out of our conversations with youth is that youth do not want to be judged for their experiences or for their experiences to be diminished or dismissed. Youth expressed fear that they would be ignored if they shared their concerns and that their voices would be met with judgment from adults. Youth reported many responses to sharing their troubles with parents and guardians that felt extremely dismissive. Comments like "you are just dramatic," or "there [is] nothing to be sad about" because "it's not as hard as what [we, their parents] went through." Youth experience these comments as not only frustrating but also hurtful. Laura, a teenager, for example, felt that her family made fun of her suicide attempt and her emotional distress. This led her to feel even worse about herself. Of course, parents can change and can do better. This was thankfully part of Laura's story, as Laura also conveyed her appreciation for her parents "trying to open up…a little bit more," and talking about what Laura was struggling with. "[That] makes me happy," Laura shared. Laura's happiness is a reminder that no matter how independent teens may seem, they still need their parents and guardians and how feeling accepted and cared for is critical to their happiness.

Youth felt that these kinds of responses, or even just the fear that this is how adults may respond, reduced the likelihood they would turn to adults for help. Alexis, a teenager, explained that her parent grew up in "a really hard situation," e.g., exposed to drug abuse. She continued, "I think my mom was kind of just always expecting [me] to get over [my own struggles] and move on with the situation. So, I've always had trouble talking with her about my struggles...If I'm really struggling and I need to talk to her, I will." But it took a lot for Alexis to feel comfortable talking with her mom. The situation had to be really serious before she would take the chance of talking with her mom. Alexis was not alone in her concern about help-seeking from adults. When we spoke with Sarah, a teenager, she shared that her peers worried about "what [would] happen" if they talked to their parents about their mental health struggles. "I don't wanna get my parents angry at me for that," Sarah recounted.

Listening without judgment is critical to suicide prevention because youth need trusted adults that they can turn to if or when they need mental health help (King and Merchant 2008;

Whitlock, Wyman, and Moore 2014). This is considered one of the most important pieces in the suicide prevention puzzle. When parents do listen without judgment, it helps bridge potential gaps between youth and adults.

Don't Label Kids as "Bad"

In addition to not being judged for their experiences, youth felt that forgiveness for not being perfect all the time would make their lives better. In the U.S., schooling is often a high-stakes, high-stress game. Competition is often the norm instead of cooperation. Getting into universities has become increasingly difficult and requires far more extracurricular activities than before. Students' time and attention are stretched thin. Additionally, many youth in Western Slope are not just navigating adolescence and stiff academic pressures, but also things like childhood trauma, food insecurity/poverty, family instability, or mental health challenges. As a result, students may not always have the capacity to behave like the perfect student, but they often still feel as though they must.

This general concern expressed by many youth we got to know also took on a specific form among youth who had at one point or another been labeled as "troublemakers" or "bad." Tony, for example, craved adults who could understand who he was in all his complexity. This meant understanding "I can't be a hundred percent, but I feel they're just like, oh, he is a bad kid, whatever…[they] kind of didn't really care…to try and actually get to know me or help me out in any way." Tony, who had not had the easiest life, felt that adults were quick to label him as "bad" and that they used that to justify denying him care and help. This is unfortunate because having a teacher or mentor or faith leader – anyone – who can look past students' histories of troubling behavior, imperfect grades, or substantial absences, and have faith that they can "make it"—that they can graduate and they can make something of themselves is often what students need to turn their academic trajectories (and possibly their lives) around.

Jake, who successfully graduated from high school, shared with us a story about his middle school teacher who "took time to actually…understand students for what they are outside of their shell." Jake explained that "you may think they're a horrible kid due to behavior—that's just a shell of something, that's their pain showing in certain people, their emotions showing in others." Kayla was another student who shared with us that an adult at school saw her potential despite her feeling like most adults perceived her as a "menace to society." She did not listen to him initially, but the staff member's persistence in telling her how much he believed in her eventually got through to her. Last time we spoke, she was on track to graduate.

Students benefit greatly from having adults in their lives that believe in them. Students in Western Slope are no different. It hurts when they perceive staff as seeing them as "bad" kids and it helps when staff have faith that they can make something of themselves.

Develop Better School Mental Health Protocols

The final theme that emerged from our conversations with youth is that many youth experienced their school and district's mental health protocols as *barriers* to help-seeking rather than evidence-based protocols designed to support students. Youth's main concern with existing protocols was their worry that their conversations with counselors (or other staff members) will be shared involuntarily with parents or, worse, other authorities. Students often did not see sharing information with parents or guardians as helpful or as something that would improve suicide prevention. In one case, Chloe, a high school student, shared that she felt that

the school's suicide prevention protocol to communicate everything with parents was "making everything chaotic." She recalled that when her friend used suicidal language at school, she got reported to counseling. The end result was that a counselor called her parents. Chloe believed that "it made her [friend's] situation worse," because her friend's situation was then no longer a private issue. This was upsetting because Chloe felt that the friend's situation was temporary and not that serious, and that having the counselor talk to her parents escalated rather than helped the situation. Chloe expressed frustration that the situation had gone badly. "[If youth] don't get that [mental health] help from the one place where it is free and readily accessible [their school], they don't get any help." Vincent, who shared similar views with Chloe, felt like whether talking to staff would result in actual help was a serious gamble.

The risk in these situations is that students will simply stop sharing things with school staff if they feel that staff will immediately tell their parents. This happened with several students we met. For example, Gabriela's counselor called her parent after she shared her struggles with dating and a family tragedy. Gabriela's response was to stop sharing certain things with her counselor. "It's just scary," she told us, "because I never know what I can share with them [school counselors] [and at what] point will they have to contact my parents." Thus, there may be a cost to breaking student's confidentiality: students may become far less likely to trust or confide in school staff, which can in turn have consequences for suicide prevention.

It is worth inserting our own voices in here for a moment to acknowledge how important Chloe and her peers' perceptions are, while also recognizing that schools have a different obligation to share information with parents and guardians than therapists or clinicians working in other settings (Gallo and Wachter Morris 2022). Therapists would generally only break confidentiality when there is a serious threat to self or others or when mandatory reporting guidelines are triggered. Particularly in the case of conversations with a student who may be vulnerable to suicide, school counselors will have to notify parents or guardians with what they have learned and help guide parents or guardians through next steps (which sometimes may include communicating with other professionals). The purpose for sharing with parents and guardians is important to suicide prevention itself –to integrate information between parents or guardians and school staff (parents/guardians may know things school staff doesn't know, and the reverse that may change the risk evaluation of the situation). Sharing information ensures that the student's safety is improved across places where they spend time (school and home). Thus, the best thing for suicide prevention may not be honoring youth's desire for confidentiality at all costs, at least not in school settings. But schools still need to balance student's desire for confidentiality with staff's professional imperative to disclose things to parents or guardians.

One solution to this conundrum is to do everything possible to (ideally) obtain youth's permission before breaking confidentiality in non-emergency or non-life threatening situations (in emergency or life threatening situations, preserving life has to come first with little regard for confidentiality). If full permission is not possible or likely, then staff should work to include youth in the conversation with their parents or guardians so that they feel like they have as much control and agency over their information and what is happening to them as possible. Most school counselors and other school mental health staff that we met advocate for this approach. And we found it can work. For example, one student that we spoke with, Kayla, had her counselor break confidentiality, but with her collaboration. Even stories where confidentiality is broken can have happy endings: Kayla expressed love and gratitude for her school counselor and she felt *increased trust* in her counselor because of how the counselor navigated telling

Kayla's parents about her struggles. In Kayla's case, her counselor found out that Kayla was engaging in non-suicidal self-injurious behaviors (an example of which is cutting one's skin to alleviate psychological pain). Self-injurious behaviors are distinct from suicidal behaviors in that there is no intent to die, though they are indicative of psychological pain that warrants care, concern, and support. However, non-suicidal self-injurious behaviors generally do not trigger a mandatory report *outside* of a school setting, for example in a therapist's office (unless the student needs medical attention for the injury). Kayla's counselor (according to Kayla) encouraged her to share what she was experiencing with her parents. This staff member asked Kayla to text her parent first and then made a phone call to that parent with Kayla in the room. Kayla appreciated that she could hear what the counselor was saying to her parent and shared with us, "No other teacher or counselor has ever done that for me." The counselor ended up communicating their care for Kayla both by listening to what was going on in her life and by providing the incredible service of helping Kayla begin a difficult conversation with her parents. Youth sometimes find it challenging to initiate difficult conversations with their parents or guardians on their own, suggesting that in this instance the counselor did an amazing job helping Kayla and her family.

It's important to remember that youth want – and deserve – to be treated with dignity and respect by adults. They also need safe spaces to talk with adults, they need access to information about healthy coping strategies, and they need to feel some semblance of control over their lives (perhaps especially when they are in psychological pain). As one student told us:

> [Adults need] the plain understanding of, alright, "I know what you're going [through]," like, "I understand that you're having a really hard time and that you're suffering with this mountain of a problem. Let's just have some time just to sit down and think about it and talk, and we'll set you up with some resources that you need and set you up with healthy cope, healthy coping skills and ways to make you feel like you are in control."

This student's imagination of what an adult would sound like when a student seeks help from them is on point and insightful.

Ultimately, the big take away from students' critiques of the school's mental health protocols centered on issues of confidentiality. Violating the confidentiality of students imperils trust between students and school staff and in the worst case, even endanger youth who may face abuse at home. This, in turn, can diminish students' willingness to seek help at school. While in an ideal world, students could seek help directly from their parents and guardians (and we encourage parents and guardians to form relationships with their children that enable that), there will also be moments when students want to talk to someone else. This is in many ways a normal part of adolescent development where youth are beginning to cultivate independence (a necessary skill for the transition to adulthood) (Giordano 1995). Prior research shows that having a "trusted adult" that students can turn to in order to discuss anything, including mental health and suicidality, is extremely important to preventing suicide attempts and deaths (Pisani et al. 2013). The more trusted adults a youth has, the better. We as adults never know which person is the one youth will feel comfortable seeking help from – the most important thing being that they seek and receive help from someone. Because youth spend the majority of their waking hours outside of their homes in schools, it is critical that some of those trusted adults be at school. Thus, this difficult issue around breaking confidentiality is one that deserves some attention.

One additional solution to the confidentiality issue is to make sure that there are community spaces – like therapist's offices or pediatrician/family medicine practices – where youth can access needed supports while having a higher threshold for maintaining confidentiality. Ensuring the community has these spaces and that they are accessible to youth would help alleviate an important piece of the suicide prevention puzzle without requiring school staff to break their professional ethical guidelines.

Finally, in our own work, when youth have wanted something that actually was contrary to suicide prevention best practices (such as a permanent memorial at school to honor a student who died by suicide, something we and all suicide prevention scientists discourage), we found that having serious conversations with youth where we explain our concerns, explain existing research, while also trying to work with them to find alternative ways to meet their psycho-social-developmental needs (in our case to grieve and honor someone's memory) works very well. It honors student's need to be heard and have control over their lives. And once scientific insights are shared, youth often are willing and excited to engage existing knowledge and contribute their own – a pathway we feel confident will lead to stronger suicide prevention. Youth can then also help their fellow students understand the intricacies of the issue. They are often far more effective public health ambassadors than adults in these situations. In such schools and communities that are heavily impacted by suicide and mental health struggles, school administrators could consider developing programs in which interested students become trained to be these public health ambassadors and help to improve the culture around mental health in their school.

Give Us Stuff to Do

One issue youth in Western Slope face is a lack of access to activities to do during their free time. One student replied to the question "What is it like to grow up here?" with, "I guess there's not really a lot to do. It's kind of boring until you get older." Similarly, a former student we spoke with said, "There's not a lot of things to do when you're in high school there. There's not a lot of park and rec centers …There [were] no places to hang out with your friends, and there was a lot of drug consumption and alcohol use … because kids there felt like that's the only thing they could do." Thus, youth in Western Slope have relatively few options for ways to spend time. These limited options may contribute to the emergence of self-destructive behaviors.

Furthermore, the activities that are available in Western Slope are not very diverse: they primarily involve physical or outdoor activities. Given the size and diversity of Western Slope, outdoor activities may be suitable for many, but not for all. The issue some students told us is there is a strong cultural expectation that you will enjoy an active lifestyle, which may make those who do not engage in outdoor or physical recreation feel like they do not fit in. They may pursue riskier avenues for leisure and entertainment. A current student we spoke with echoed these sentiments:

> There's just so much for you to do and if you don't want to do any of that stuff, then you're not in the right place. If you don't want to be an active person, this is not the place because being active is a huge part of everyone's lifestyle. People are walking their dogs all the time, walking downtown, riding their bikes and if that's just not your lifestyle, then you're just not going to...you may fit in and be able to do other things, but it's going to be harder to have an active social life.

This student's comments demonstrate the pressure placed on youth in Western Slope to enjoy certain activities and the implicit disapproval of others. Without alternatives, youth may struggle to find safe, enjoyable uses of their time.

Additionally, many of the activities in Western Slope are expensive, which given the broader socioeconomic trends in the community, makes access to them inequitable. In some cases, athletic programs offer scholarships for lower-income families to address this gap in access. However, the competition for a scarce number of spots and a range of hidden costs beyond just team fees or dues makes free or reduced-cost access more theoretical than practical. Many people we talked with spoke about local transportation as further complicating the issue of lack of activities (a topic we delve into in depth in Section VII).

While there are various downsides to limited or expensive activities, youth we spoke with drew a direct line between the small number of activities and the relatively high rates of suicide in Western Slope. One current high school student told us:

> Why we've got so many suicides? It's just a small area in my opinion…it's just too small. There's so many kids and they want to do so much stuff but it's a pretty limited town…there's no experiences…We don't have anything cool here so they're just tired. And it's the same people, same faces, same stuff. And it's just dreary to them.

This student describes how the lack of options for things to do in the area could contribute to feeling down or depressed, in addition to not providing healthy outlets for making connections with other youth and channeling their energy in positive ways.

Summary

In short, youth in Western Slope want adults to listen to them and include them in big decisions that affect their lives. They also want adults' help. They want advice, they want guidance, but they do not want to be judged. They also do not want to be labeled as simply "bad"; like adults, youth are complex beings, and they desire to be seen as such. When adults have faith in kids that can be a powerful catalyst for change – even helping get students back on track academically and destined for graduation. Additionally, students really want better suicide prevention protocols that do not involve inherently breaking their confidentiality. They need adults they can talk to, and they do not always want that to be their parents. When school counselors can be trusted adults, they can be powerful game changers for youth—still, youth need to feel some sense of control over what happens to information about them. While there will be times when school staff must break confidentiality, doing so with the permission of the student and while including the student may go a long way towards producing better outcomes for the student. Furthermore, school staff should be aware that protocols that require frequent breaking of student confidentiality will simply discourage students from turning to school staff for help. Discouraging help seeking is a grave concern for suicide prevention. Finally, students want more activities to do. Youth find it difficult to channel their energy in a positive way due to the narrow local expectations of what counts as enjoyable activities and the inaccessibility of diverse things for them to do and places for them to be during their free time.

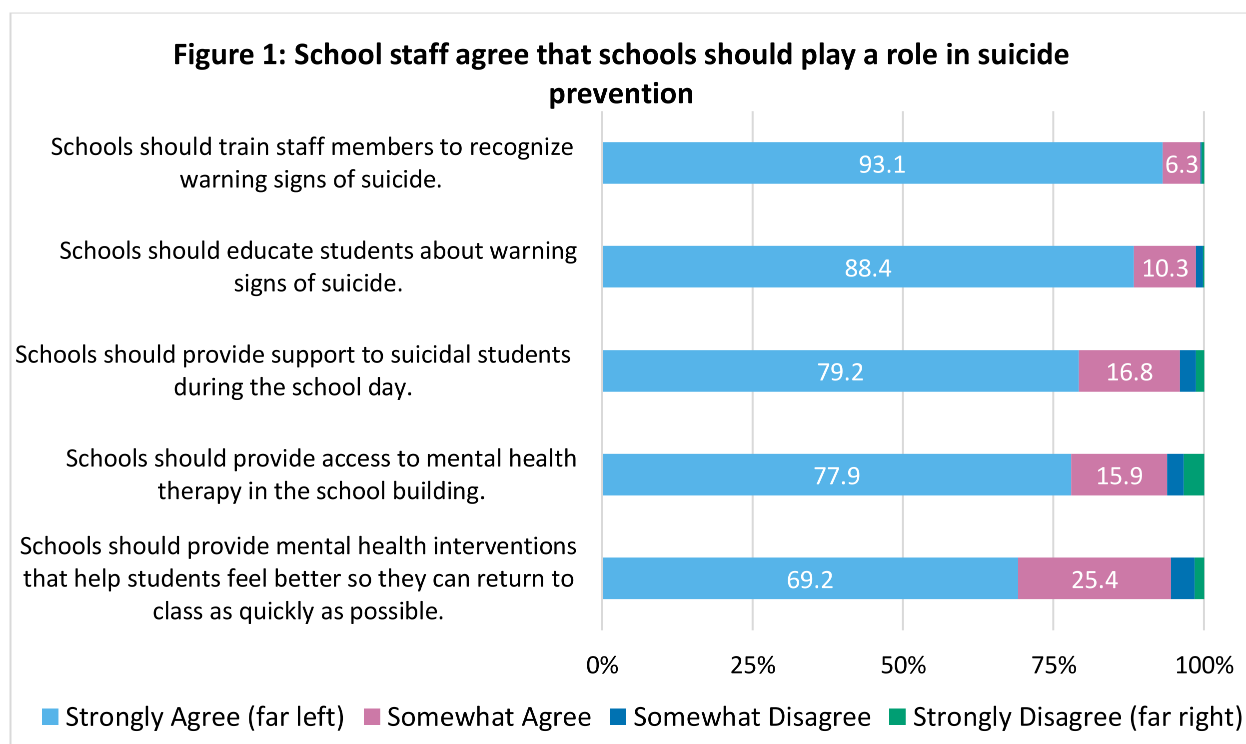
III. The Role of Schools in Youth Suicide Prevention

As communities begin the difficult work of improving youth suicide prevention, an important but often overlooked place to start is what school staff and families believe about the

role of schools in suicide prevention. What staff and the broader community believe about the school's role in suicide prevention matters to how successful any school can be at preventing suicide or promoting mental health. It is also helpful to set policy agendas to understand staff and community expectations of schools. Thus, we start by analyzing what staff believe before turning to family perspectives on the role of schools in suicide prevention.

Staff's Perspective on the Role of Schools in Suicide Prevention

It is clear from our data that suicide prevention is very much on the minds of school staff. "In all my years in education," a school leader we call Tammy shared with us, "I never worried that my students might die, but now every night. Every. Night. I say to myself, 'Please just let everyone live another day.'" Tammy's school has lost a tragic—and disproportionately high—number of youth to suicide, motivating her fears and concerns; concerns that are shared by many school and district staff members we got to know during our time in Western Slope. Unprecedented rates of youth suicide in the United States mean that schools must increasingly be prepared to triage youth in crisis, prevent suicide, and, if necessary, effectively respond after deaths occur, all while continuing to educate youth.



Results from the staff survey show that *over 90 percent of school staff* — comprised of teachers, administrators, mental health staff, and other staff members — agree that schools should play a role in supporting the mental health of their students. As Figure 1 (above) illustrates, significant majorities of school staff believe schools should (1) educate staff and students about the warning signs of suicide, (2) provide access to mental health therapy in the building, (3) support suicidal students during the school day, and (4) make available mental health supports that help get students back to class as soon as possible. Notably, this general pattern is substantively similar among teachers, administrators, mental health staff, and other staff.

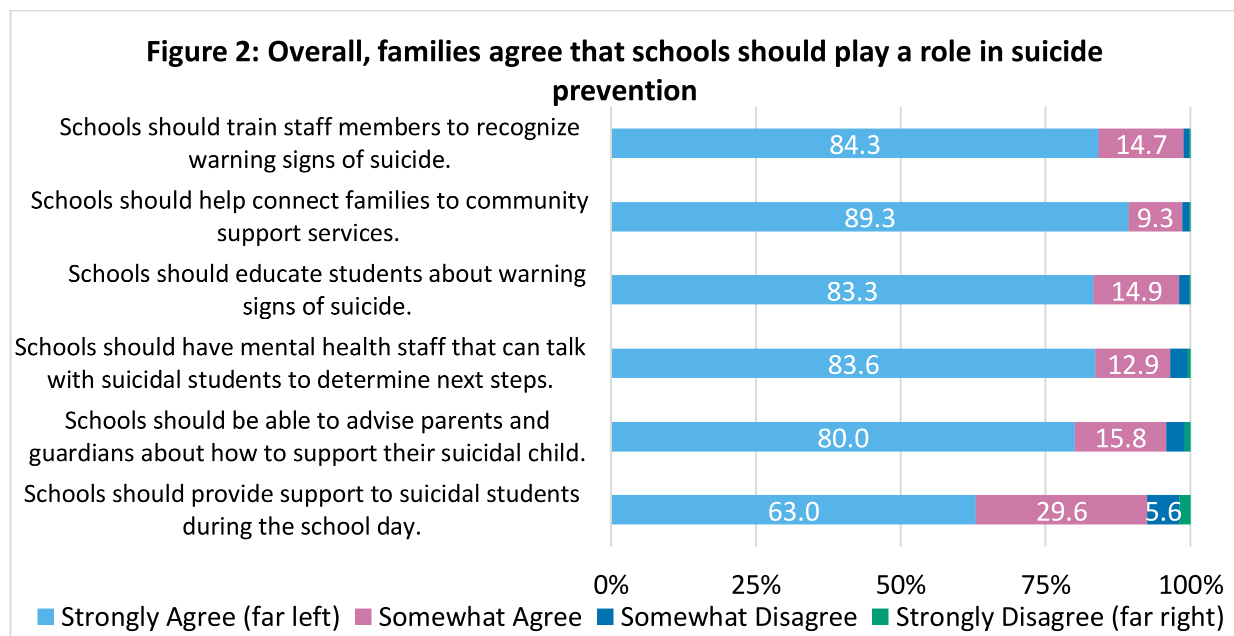
In interviews, school staff members provided several reasons why schools should play an active role in student mental health. One common refrain is that providing mental health

support contributes to the primary school goal of academic achievement. One mental health staff worker said, “If we can help eliminate some of those barriers, they’re going to come to school more ready to learn.” Similarly, a teacher asked rhetorically, “If a kid’s not in a good mental state, how are they going to learn in your class?” Many other staff felt that mental health struggles were significant barriers to learning that schools should be focused on mitigating.

Consequently, some staff members even view mental health as part of the curricula they hope to teach. One teacher said they aimed to “support work-based learning skills: some of the soft skills, social-emotional kinds of things that help people retain, find and retain work.” These sentiments align with what educators call a “whole child philosophy,” or the belief that schools need to treat the student as a complete person and not just as an academic product. As one administrator remarked: “Education has to be holistic; social-emotional has to be intentional...it’s a skill.” According to this perspective, students need to learn social-emotional skills to be successful in life, just as they need to know how to read or write. Our observations show that staff do not see traditional academic goals as competing against or superior to mental health and suicide prevention. Instead, they see these two goals as intertwined and mutually reinforcing.

Family Perspectives on the Role of Schools in Suicide Prevention

Like school staff, *over 90 percent* of family members surveyed agreed that schools should play a role in supporting the mental health of their students (Figure 2, below). The majority of families agreed that schools should (1) train staff and students to recognize the signs of suicide and (2) support suicidal students during the school day. In addition, families strongly felt schools should also (3) have mental health staff talk with suicidal students, (4) advise parents about how to support their suicidal children, and (5) help connect families to community support services (see Figure 2). These findings show families generally believe schools should play an active role in mental health.



The most common justification for folding mental health into the school’s role was that students spend a disproportionate amount of their day at school, which provides school staff with a unique opportunity and responsibility to identify distressed students and intervene whenever possible. As one parent told us, the school’s role in mental health support is “a huge

role because they're with the kids. My kid's in school eight hours a day. Maybe the counselor sees something. I want them to pick up on it." Another parent felt similarly:

> I feel like schools have a huge role in [mental health]. I feel like that's where the kids are most of the day…In our [area] we have a high suicide rate here…If you get a kid that's in middle school that you feel is struggling with mental health, I feel like you should be able to step in somehow and start helping with that child or supporting that child more; more so than just not really doing much until there's a suicide…So, I do feel like it is a very important thing for the schools to do, just because the kids spend so much time there.

Importantly, this parent is not just pointing to the duration of the school day as a reason for schools to promote mental health, but also because youth suicide is prevalent in the community. Other parents recognized that the suicide rate was a problem, but also noted that youth in the district had all sorts of struggles they were dealing with that made it a critical job of schools to promote mental health and prevent suicide. One parent confided, "I don't think we should underestimate the amount of support they need…I don't think that excluding anybody from helping support a kid deal with that is a good idea. I think schools need to do what they can."

In short, the overwhelming consensus from both families and school staff is that schools should be engaged in suicide prevention and in supporting the mental health of students.

Challenges to Schools Prioritizing Suicide Prevention

Despite overwhelming consensus that schools should play a role in suicide prevention, some school staff pointed to challenges that came from prioritizing youth mental health over academic success. For instance, a school leader felt that balancing the academic goals of the school with the socioemotional needs of students was not always easy:

> I get real frustrated with it because I feel like our responsibility to these kids has grown so much just in my time in education that I'll look and there are like 10 kids in the hall waiting to talk to the counselor...Then I have to go out and be the bad guy and say, "Get back to class. Get back to class. Get back to class"…I'm telling the counselors, you can't have this. We're not therapists. You're not a therapist…That's not our role here…We're still needing to teach them how to read and write and do math.

Staff like this school leader sympathize with the goal of working with students' mental health struggles, but also see time spent supporting students' mental health as potentially distracting from the school's role in teaching students skills and academic standards. Since meeting state and national academic standards are required for schools to receive funding, many school staff stayed focused on getting students back to class as quickly as possible even when they were concerned about the student's psychological well-being.

Another common concern from school staff is that schools face mounting pressure from parents and the community to provide services that they wish would come from other sources, given how overburdened school staff often feel with their existing responsibilities. This pressure was most common at schools with a substantial number of high-needs students (which can include disabled students, ELLs, students from low-income families, neurodiverse students, students who have experienced trauma, and students from minoritized communities). One high school mental health staff member, Brea, described this as "not sustainable":

> The expectation from our community is that we're taking full care of their kids and that we're parenting them and feeding them and clothing them and taking care of their medical and mental health stuff…The pressure I think has increased…we've enabled this belief that school should be everything to everyone, and that is just not sustainable.

Like many staff members in schools with high-needs students, this staff member feels that the problem with the intense and increasing expectations schools are facing is that schools lack sufficient resources to take care of their academic needs. This leaves less resources for the more complex socioemotional or health dilemmas students bring to school stemming from food insecurity, trauma, poverty, and beyond. Brea's sentiment speaks to a larger, pressing need for more support from and active partnership with community organizations to provide holistic student support that focuses on *both* education and mental health. That said, as public health scholars, it is unlikely that we are going to find alternative organizations that have the same accessibility and presence in youth and families' lives that schools typically have. Youth spend the majority of their time in schools (second only to their homes) and typically have guaranteed transportation to school, making schools critically important organizations for access to all kinds of social services. Thus, while this was not the view of this particular staff member, we argue that states should increase school funding to enable schools to meet the societal demands we are placing on them without causing them to sacrifice their important academic mission.

How schools allocate precious resources was also central to the hesitation some parents and guardians expressed in terms of schools focusing on mental health or suicide prevention. One parent, for example, worried that her child's school's focus on mental health might detract from education: "The amount of social services being handled through the school system is becoming overbearing, overburdensome and inhibitive to education…The school should be for education." Another parent shared similar sentiments, when she told us, "I don't think [the school] should be the main source of supports…You also don't want to allocate so much resources to it that it's no longer an educational facility, it's more of a mental health facility." In both cases, these parents believe that schools' first goal should be education, and they worry that supporting mental health might make it harder for schools to achieve this goal.

Importantly, parents did not take a hard stance in their resistance towards or concern over schools prioritizing mental health. Generally speaking, parents and guardians were aware that the community itself needed to do a better job of taking some of the burden off of the schools. A mother remarked:

> I feel that the schools have become the one-stop shop for social services for students. I believe that's unfortunate. In an ideal world for me, there would be some basic help and services available at the school, but the mental health issues would be handled through a different organization than the school... There needs to be support, outside organizations, community, civic, government, whatever resources available that the educational institution can then support, and hand those students off, to get the accredited professional help that needs to happen there...If I were going to redesign it…the schools would be identifiers and help to facilitate the communication with those organizations.

In this sense, many parents are aligned with school staff like Brea (whom we quoted above) in their belief that schools *shouldn't have to be* the primary or only organization supporting youth mental health. Instead, schools should identify struggling students and refer them to external

community organizations that have more resources to help youth. Again, community members and staff members both see that there needs to be more cross-organizational collaboration to adequately support students.

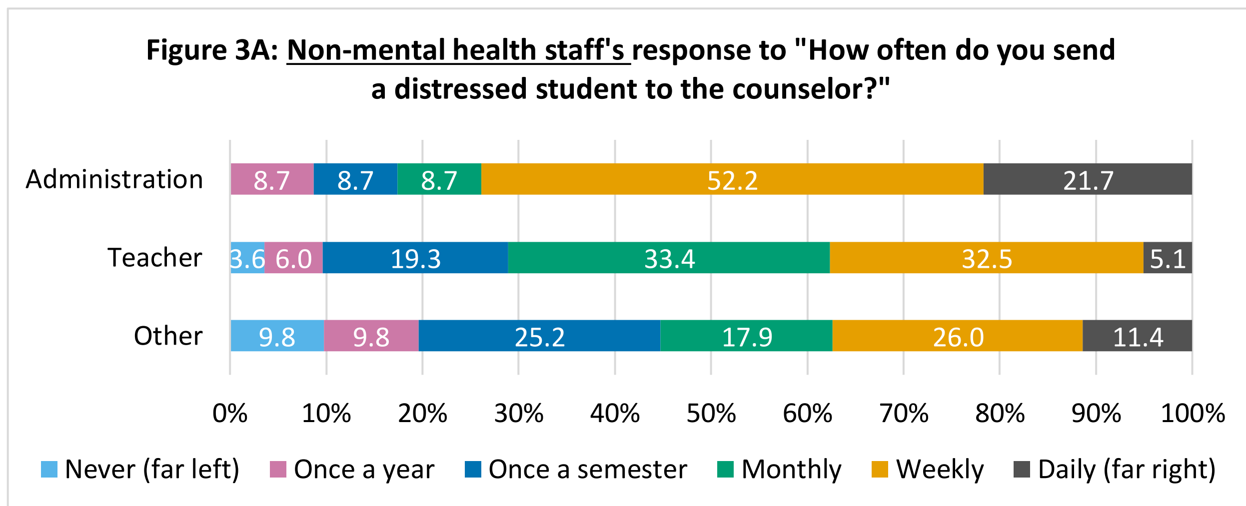
In short, staff and families generally believe schools are in the business of preventing suicide and promoting youth mental health. They both agree that schools should provide mental health supports in-school and should also be trained in knowing the risks of suicide, as well as how to respond in a crisis situation. Parents especially feel like schools should partner with families by connecting them to community resources, teaching them how to help their kids, and by educating their students about the signs of suicide. These beliefs underline a commitment to keeping kids safe and promoting their well-being. Additionally, while there are some staff and parents in the minority that are concerned with the school's role in suicide prevention, many of these folks are worried about the school's capacity to manage both academic and socioemotional goals without failing at both.

Prevalence of Suicide Prevention Work in Schools

That staff members embrace suicide prevention as part of their work is reflected in the frequency with which they engage in suicide prevention and mental health promotion during their day-to-day jobs. To date, no data has ever been collected that reveals how often school staff are called on to engage in suicide prevention work, an important gap in the literature that we address with this study. Not surprisingly, given what we have shared thus far, we found that staff do this work with startling frequency. In what follows, we share results from each of the questions that we asked in the staff survey, showing how often teachers, administration, mental health staff (a category that includes school counselors, social workers, psychologists, and nurses), and other school staff all engage in this work.

Prevalence of Sending Distressed Students for Support

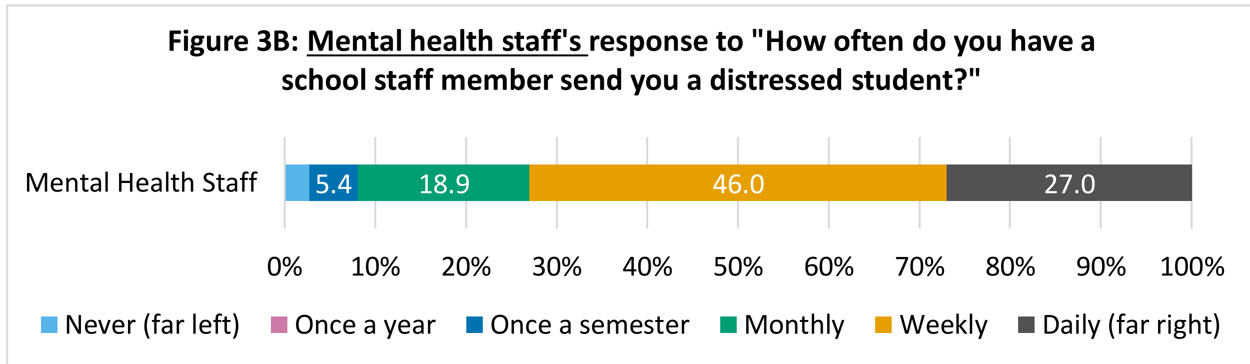
Figure 3A (below) shows how often non-mental health staff – meaning administrators, teachers, and other staff (e.g., paraprofessionals, librarians, etc.) – send a distressed student to the counselor, and Figure 3B (below) shows how often mental health staff receive distressed students.



As Figure 3A (above) illustrates, 83 percent of administrators and 71 percent of teachers report sending a distressed student to their school counselor at least monthly, if not more often. This matches our observations of how teachers work with students as well as information teachers shared in interviews. For example, one middle school teacher said "[Suicide

prevention] is everybody's job. And teachers are always on the lookout [for struggling kids], and thy know how to report if there's an issue. Every teacher knows to do that…[it's our job] to at least notice things and report them."

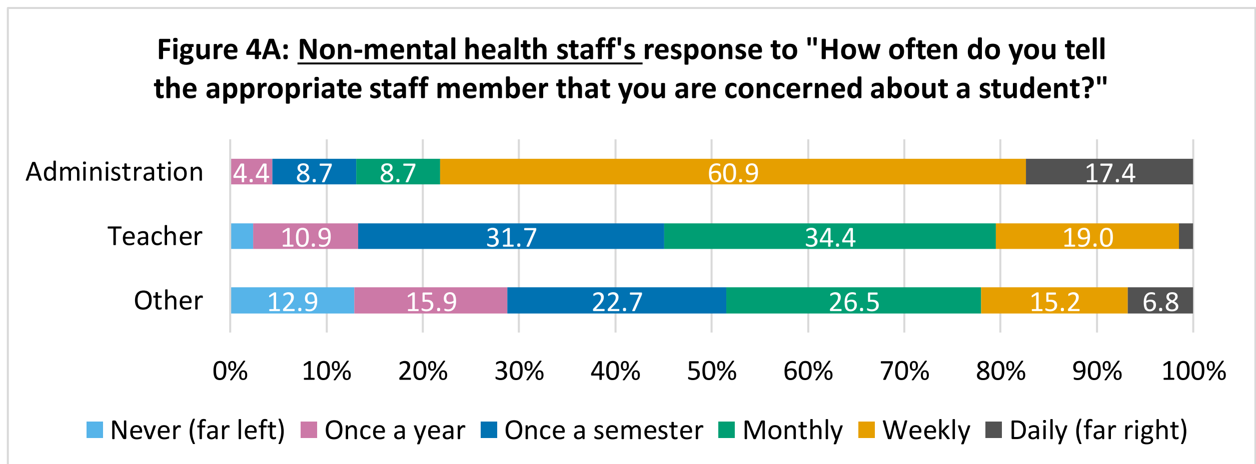
Unsurprisingly, 92 percent of school mental health staff report having school staff send them a distressed student at least monthly (if not more often). In fact, for 27 percent of school mental health workers, having a distressed student sent to them is a daily occurrence. Another 46 percent report having staff send them a distressed student weekly (see Figure 3B below).



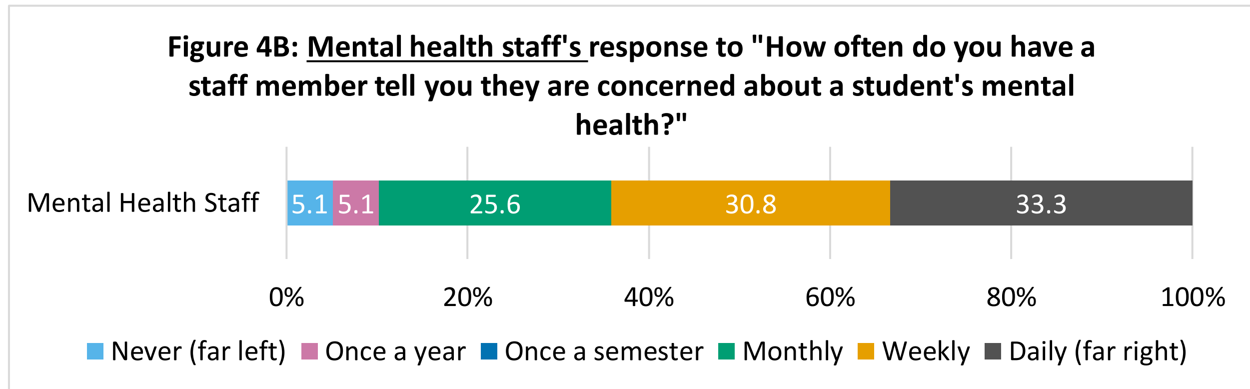
In short, schools in WSPSD are actively working to support a high number of distressed students on a daily basis.

Prevalence of Communicating Concern about a Student's Mental Health

This pattern of frequent engagement in student mental health was also apparent when we asked staff how often they tell an appropriate staff member that they are concerned about a student's mental health (see Figure 4A below). In this district, the appropriate staff member is generally a school counselor. Again, a significant number of administrators (87 percent) report that they tell the appropriate staff member that they are concerned about a student's mental health monthly or more frequently.



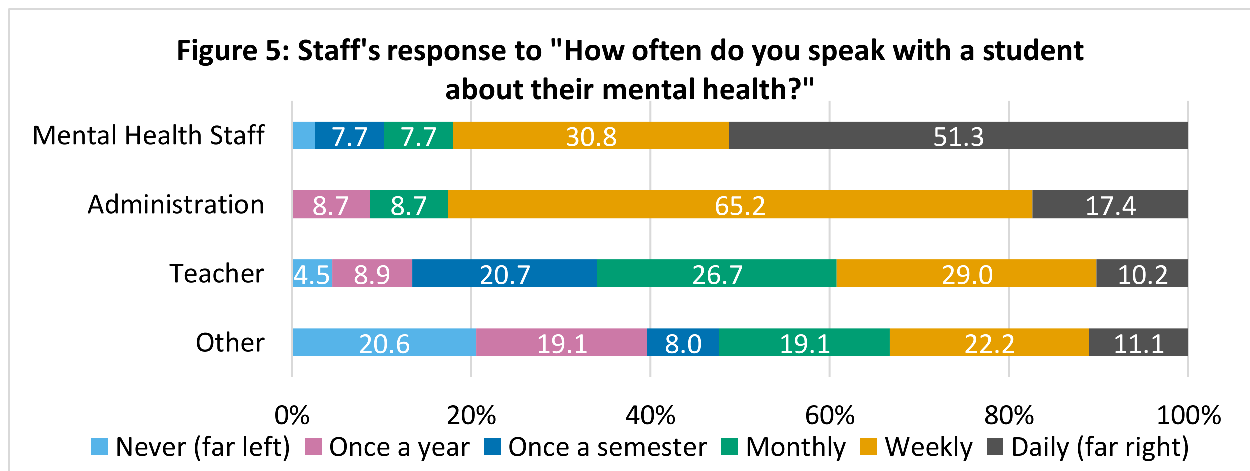
Teachers, however, report concerns about students with less frequency than administrators, with 55 percent informing someone about a student at least monthly. It is important to note that nearly 32 percent of teachers report telling an appropriate staff member they are concerned about a student's mental health at least once a semester. This means that approximately 90 percent of teachers report concerns about a student at least once a semester.



Illustrative of the frequency of supporting struggling students, Figure 4B (above) shows that nearly 90 percent of mental health staff report that they have a staff member share concerns with them about a student's mental health monthly or more frequently, of which over 30 percent report this as a daily occurrence.

Prevalence of Speaking with Students About their Mental Health

The prevalence of processing and triaging distressed students is further elaborated on in Figure 5 (below), where we found that nearly 90 percent of mental health staff speak with a student about their mental health monthly or more, with over 50 percent doing so daily. As is the general trend, mental health staff play a primary role in supporting youth, however Figure 5 shows nearly 91 percent of administrators and 66 percent of teachers also report speaking to students about their mental health monthly or more often. These findings underline just how much youth mental health is a part of a school's job across all staff members, and not just mental health workers. This effort was evident in our qualitative data.

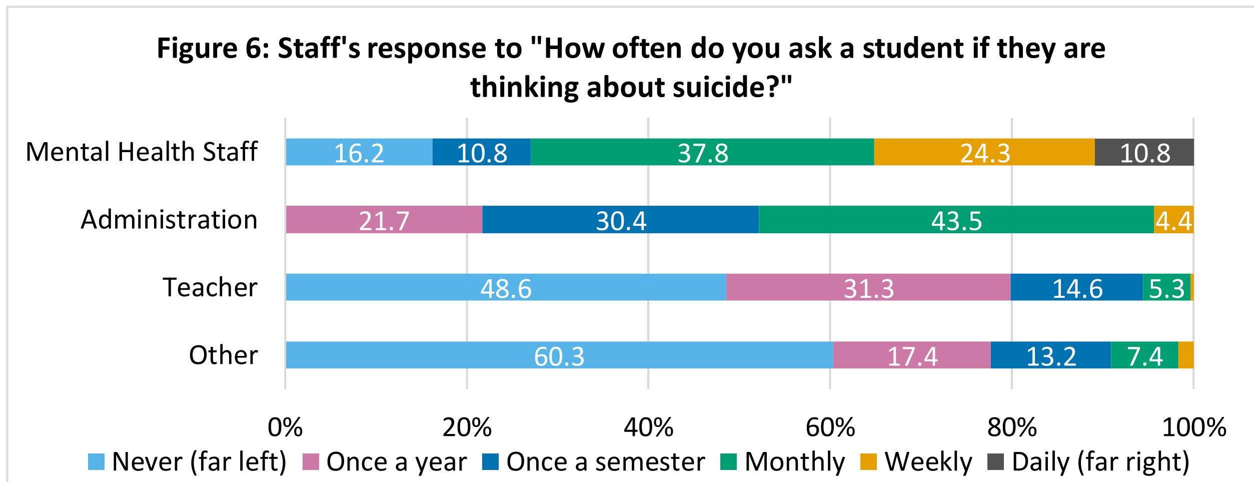


For instance, when talking with one administrator, they mentioned how they make sure to regularly check in on struggling students: "We are…incredibly sensitive to suicide ideation. Any

inkling of it. I'll talk to a kid. I'm worried about you, worried you are thinking about killing yourself...The human connected piece is so important, we believe in it so much."

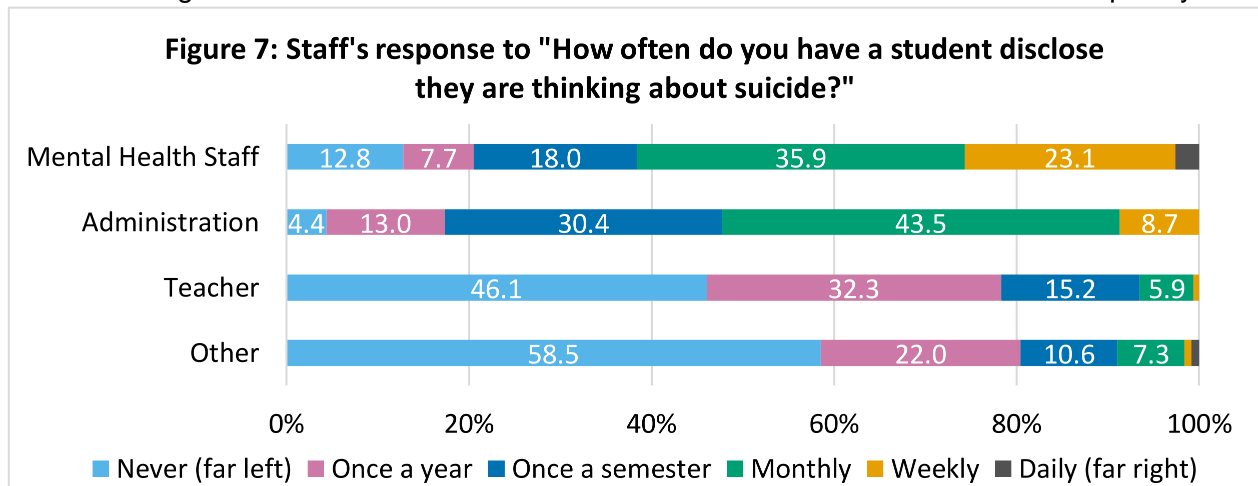
Prevalence of Asking Students if they are Thinking about Suicide

In Figure 6 (below), we shift from mental health generally to suicidality specifically. The findings are similar between prevalence of discussing mental health and suicide. Mental health staff do this work most frequently (73 percent), with more than **one-third** asking weekly or daily. However, we found that asking youth if they are thinking about suicide was not limited to counselors or other mental health staff members. Every administrator in our survey reported asking a student at least once a year if they were considering suicide, while 78 percent reported asking monthly or more frequently. Notably, teachers are far less likely to directly ask a student about suicide, though a sizeable percent still ask. Just over 50 percent report asking once a year or more. Teachers are often the front-line safety net for suicide prevention. That almost 49 percent report never asking is a place for improvement, given that this is a safe and helpful suicide prevention behavior.



Prevalence of Students Disclosing They are Suicidal to School Staff

Conversations about mental health and suicide are not always instigated by school staff. Figure 7 (below) provides insight into how often school staff have a student disclose they have been thinking about suicide. Mental health staff are the staff members who most frequently have

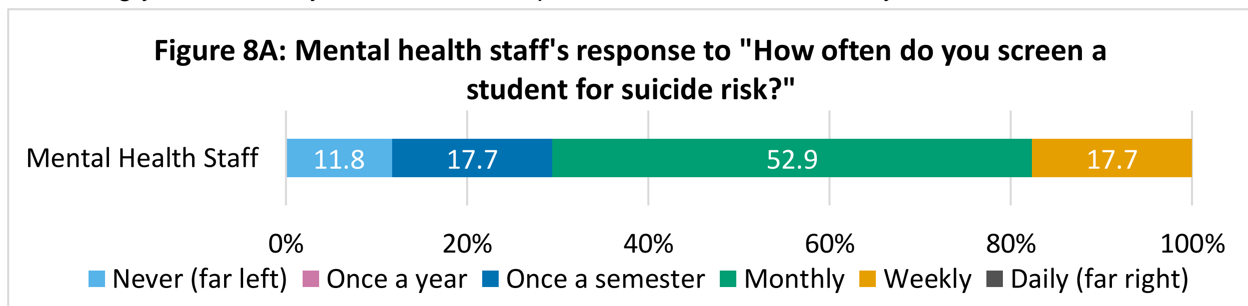


students disclose they are feeling suicidal, with nearly 60 percent reporting experiencing student disclosures at least monthly, if not more often. Still, trusted adults are all types of staff members, and the data reflects that. Ninety-five percent of administrators have had a student disclose their suicidality at least once a year, and 52 percent experienced this monthly or more frequently. Teachers also play their role: 54 percent have a student disclose they are feeling suicidal at least once a year.

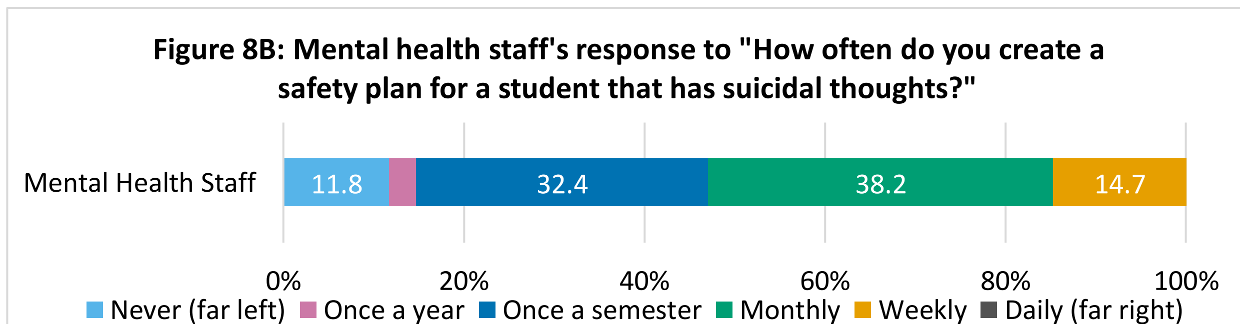
Prevalence of Suicide Prevention Interventions by School Mental Health Staff

School mental health staff are also tasked with delivering evidence-based suicide prevention interventions. The following three figures (Figures 8A, B, and C) reveal the frequency of mental health staffs' suicide prevention work.

The first figure (8A, below) asks how often mental health staff screen youth for suicide risk. The purpose of conducting a suicide risk review with a student is to determine whether they need a clinical intervention or other forms of clinical support beyond what schools can generally offer. Clinical supports can span speaking with a therapist, going to a crisis center, or even being hospitalized for suicidality (in the most extreme case). While these screeners are imperfect – in part because youth do not always feel safe and supported enough to tell the truth about how they are feeling (an issue we discuss later on in this report) – these screeners are a necessary first step in supporting youth mental health in schools. The policy in WSPSD is for parents and guardians to be told when their child has been screened for suicide risk, the results of the screener, and next steps (which is decided on together. These screeners are only done by mental health staff (though anyone can be trained to complete a screener with fidelity). Among mental health staff, we find that almost 53 percent of mental health staff report screening youth monthly, while about 18 percent do this weekly.



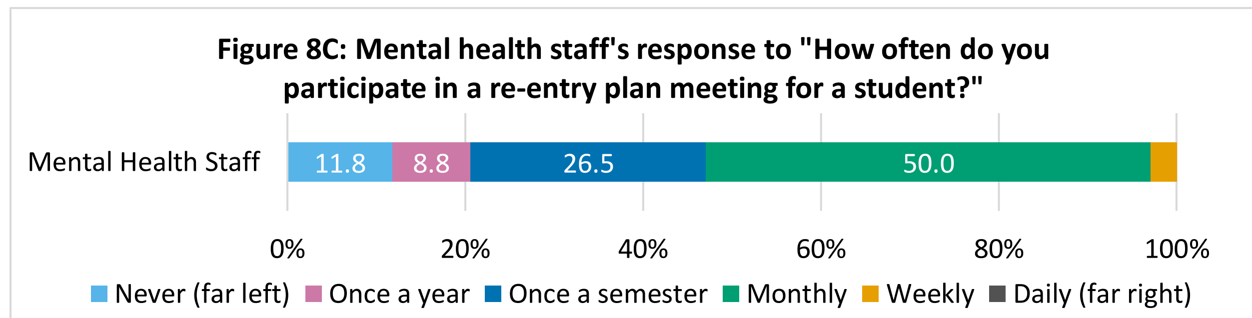
The second figure (8B, below) asks how often school mental health staff create a safety plan for a student. Safety plans are an excellent evidence-based suicide prevention intervention that staff can use to increase a student's resilience against suicide. It involves helping youth identify the feelings and situations that generate emotions that trigger their suicidal thoughts and coming up with a list of coping and help-seeking strategies. Safety planning is one of the best



tools that any clinician, doctor, therapist, or parent has to help a child cope with suicidal thoughts and should be used in all schools (Erbacher, Singer, and Poland 2014), particularly since this intervention is free. For more on safety planning, see https://suicidesafetyplan.com/.

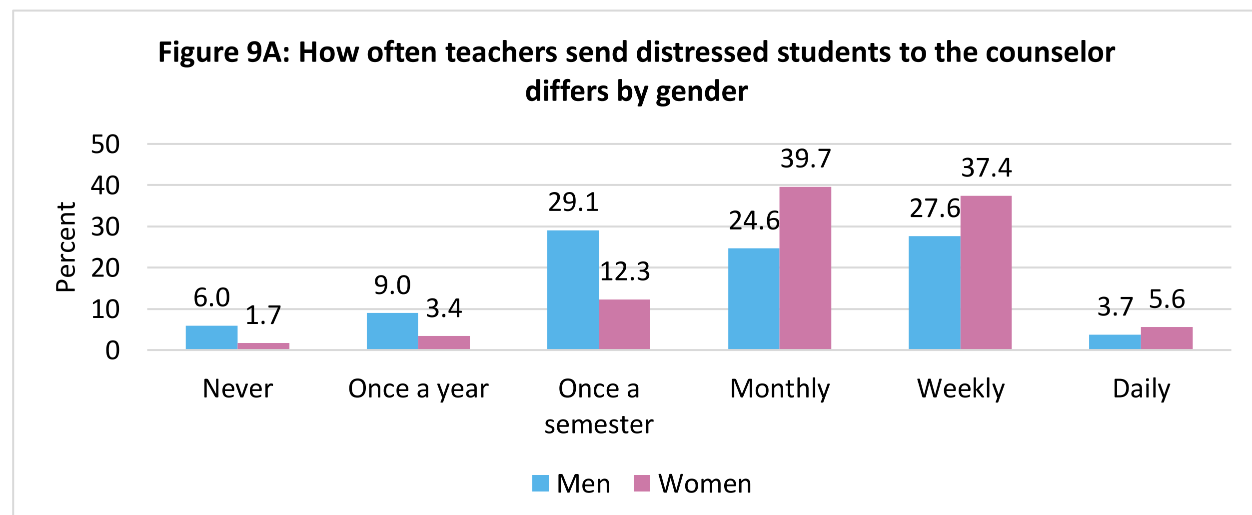
The good news is that school mental health staff report using safety plans frequently. Almost 15 percent create safety plans for students weekly; 38 percent create plans monthly; and only 11 percent never create safety plans. Since safety planning can only help students, it's a good idea to ensure that all staff feel comfortable and are well trained to complete evidence-based safety plans with students.

In Figure 8C (below), mental health staff report similarly high levels of engaging in re-entry planning, another important effort to support suicidal youth. Re-entry planning generally happens when a student is coming back to school after being removed from the school context. A solid re-entry plan is particularly important when a student is returning to school after a hospitalization for suicidal thoughts or an attempt (and should be used in combination with a safety plan). Again, fortunately, mental health staff are using re-entry planning to help support students through these crucial and potentially stressful transitions back to school. Fifty percent report engaging in re-entry planning and almost 40 percent report engaging in it monthly.

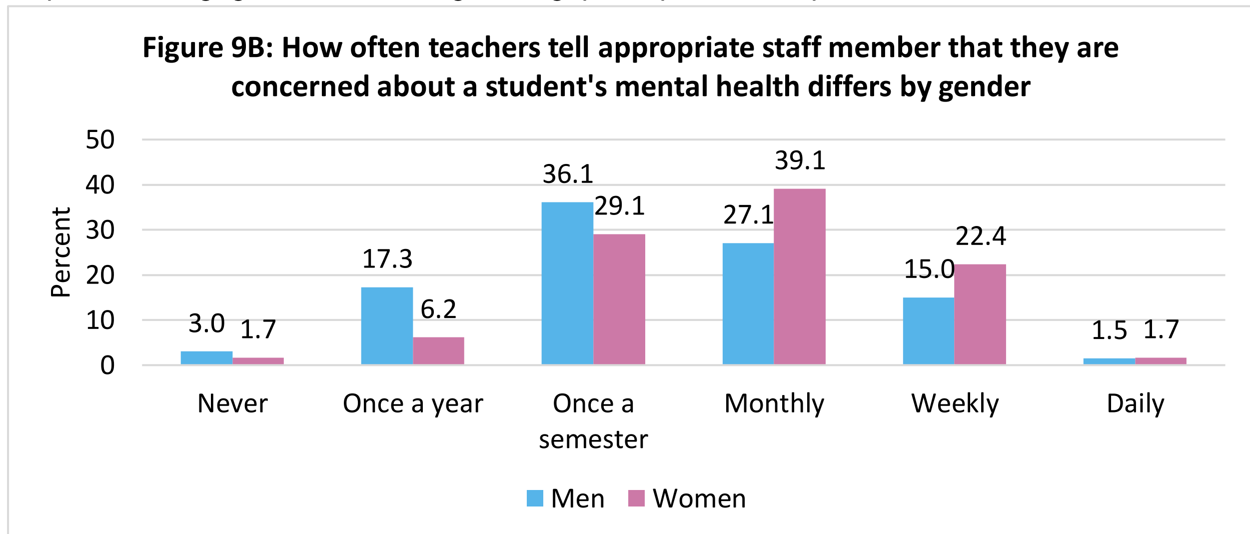


Demographic Differences in Who Does Mental Health Work in Schools

We found that the main difference in who engages in suicide prevention work is by gender. Figures 9A and 9B (below) illustrate these findings. In general, we find female teachers are much more likely to engage in suicide prevention work than their male counterparts, especially when it comes to (1) sending distressed students to the counselor; and (2) telling the appropriate staff members they are concerned about a student's mental health.



As Figure 9A (above) illustrates, male teachers are significantly more likely to have *never* sent or *rarely* send distressed youth to a counselor, which is in many ways the most basic kind of suicide prevention work. Female teachers are far more likely than their men colleagues to send a student to their counselor for support monthly or more. Figure 9B (below) shows a similar gender discrepancy when it comes to sharing concerns about a student's mental health with an appropriate staff member. Again, a higher proportion of male teachers do this just once a year or once a semester, while a higher proportion of female teachers do this monthly or weekly. Though women do this work more often than men, it is still true that over 50 percent of male and female teachers report sending youth to counselors for emotional support – a respectable engagement. But this gender gap is a place for improvement.



These findings also were present in multivariate regression models predicting the frequency of engaging in suicide prevention work while holding constant other important controls, like race/ethnicity, whether they work at a middle school or high school, and correcting for the clustered nature of our data (correcting standard errors for clustering by school in our staff survey). In short, across all forms of suicide prevention, on average, female teachers do this work more often than male teachers.

We explored other demographic differences, such as differences by race/ethnicity, by political ideology, and by frequency of religious attendance. We found no significant differences in how often school staff engage in suicide prevention work on the basis of race/ethnicity or the frequency with which they attend religious services.

We did find that staff that identify as politically conservative, on average, engage in this work less often than their colleagues who identify as liberal, moderate, or who preferred not to disclose their political orientation. The difference in the frequency in engaging in suicide prevention work by political orientation is not large, and it was explained by mental health beliefs. Specifically, when we include whether people agree with one of the following statements "Not all distressed youth are suicidal" or "I am not comfortable with the topic [of suicide]", the difference between conservatives and liberals disappears. This suggests that these beliefs, which could likely be addressed by offering suicide prevention training, may create a barrier for some members of the school staff to engage in suicide prevention.

Summary

Our data reveals that school staff members support students' mental health more generally and support suicidal students more specifically. Almost 90 percent of school mental health staff report speaking with a student about their mental health at least weekly, and 35 percent report asking a student if they are thinking about suicide at least weekly. Screening students for their risk of suicide is also a monthly task for the majority of school mental health workers, as is having a student disclose they are thinking about suicide (if not something they do more often than monthly). Teachers and administrators are also doing significant labor to support students at risk of suicide. For example, over 50 percent of teachers in our sample report having at least one student disclose to them that they feel suicidal during the school year and 40 percent of teachers speak with students about mental health weekly. We found minimal demographic differences in which staff engage in suicide prevention work; the one robust demographic difference that we found was that, on average, women staff members engaged in this work more frequently than men.

IV. Factors that Enable Staff's Suicide Prevention Work

In this section, we examine what factors encourage teachers, counselors, and other school staff to engage in work to prevent suicide. We begin by drawing on our survey, ethnographic, and interview data to examine the importance of understanding that suicide prevention is part of school staff's professional responsibilities – whether they are a teacher, secretary, school counselor, or beyond. We find this understanding provides a necessary foundation for this work. We then turn to our survey data to analyze demographic differences in who does this work in addition to what factors encourage and discourage engagement in this work. To thoroughly assess this, we performed statistical tests—specifically, we examined both bivariate relationships using frequency crosstabulations (with Chi-Square tests of significance)—or tests that allow us to look at the variation between two things, before conducting a series of multivariate regressions—or tests that allow us to consider the effects other variables may have on the bivariate relationship. For the multivariate models, we created a single measure (our dependent variable) that captures the various ways that staff work to prevent suicide, including: sending distressed students to the counselor, communicating concern about a student to an appropriate staff member, asking students if they are thinking about suicide, and having students disclose they are suicidal to a staff member ($\alpha=0.85$). We then examined what attitudes and personal attributes encourage or discourage staff from engaging in suicide prevention work. Unfortunately, we did not have sufficient sample size for a reliable examination of demographic differences among mental health staff, so we limit our examination of demographic differences to non-mental health staff.

Clarity that Suicide Prevention is Staff's Professional Responsibility

In our multivariate analyses predicting engagement in suicide prevention work, one of the most important factors that encourages staff to engage in this work is understanding that suicide prevention *is part of their job responsibilities*. For example, teachers who reported that knowing the warning signs for suicide is a part of their job were engaged in suicide prevention work significantly more often than staff who felt it was not their job or not the school's job. Similarly, if teachers reported believing that they have a professional responsibility to understand and work to support students' mental health needs, they engaged in more suicide prevention work than their colleagues. On the other hand, teachers who believe that schools should leave mental health in the hands of parents, on average, reported engaging in suicide

prevention work less frequently than staff who disagree with that statement. Thus, the beliefs about whether suicide prevention is part of a staff member's professional responsibilities and part of the school's job is fundamentally important to whether staff engage in this work. The benefits of communicating this expectation of school staff members and providing that "professional role clarity" was obvious in both our quantitative and qualitative data.

Given its importance, it is fantastic that school-based mental health workers – meaning school counselors, school psychologists, school social workers, etc. – clearly understood suicide prevention as a part of their job. Specifically, about 99 percent of school mental health workers indicated that asking a distressed student if they are thinking about suicide or talking to a student if there is concern the student may be suicidal is a part of their job (note, 100 percent of middle school mental health workers endorsed these sentiments). All mental health staff reported that knowing the warning signs for suicide was a part of their job. School counselors and their mental health colleagues credited this role clarity with making it easier for them to be effective at suicide prevention.

While school mental health workers embraced suicide prevention, school counselors in particular experienced barriers to doing this work well. These barriers have also been established by prior research (Blake 2020, 2023; Fox and Harding 2005). Namely, school counselors have many diverse obligations that include course scheduling, college applications, testing, recess duty (for middle schools), substitute teaching (when necessary), and beyond. Most counselors told us that they feel overburdened by the diversity of tasks that they are responsible for, which a common issue and not unique to this district. One counselor even noted they wished there was a counselor responsible just for academic issues like scheduling so as to take some of the time strain off of them. Counselors felt stretched thin way too often; something we also observed first-hand. So, while counselors were clear about their critical role in suicide prevention, this role clarity was undermined by the ambiguity that was introduced by the reality of their typical workday. Suicide prevention and taking care of students' mental health sometimes fell by the wayside under the pressure of all their other obligations.

School administrators – meaning principals, assistant principals, deans of students, etc. – were also clear that suicide prevention was part of the school's job. One hundred percent of school administrators reported agreeing that the following statements reflect what is a part of their job: knowing the warning signs for suicide is a part of my job; talking to a student who I'm concerned is suicidal; telling a counselor I'm concerned a student may be suicidal; and asking a distressed student if they are thinking about suicide. This is outstanding and represents a serious strength for suicide prevention in this district. School administrators are more likely to defer to their mental health colleagues when it comes to screening students for suicide risk, though a majority (78 percent) still viewed this as part of their job. Administrators were similarly less confident about their role in designing a safety plan for a student; only 65 percent said that this was part of their job, though 100 percent acknowledged that ensuring students' safety plans are followed is a part of their job.

If school administrators receive high quality suicide prevention gatekeeper training (i.e., suicide prevention training intended for anyone who is not a clinician but may still encounter at-risk individuals [Hawgood et al. 2022]) and safety planning training, they can be capable and qualified to determine whether a student is at risk of suicide and work with a student on completing a safety plan (these are considered skills that any adult can master with training;

training such as ASIST covers this skill). Several administrators directly cited a lack of training as the reason they preferred to send students to their mental health colleagues. Their lack of training raised concerns for them about legal liability. For instance, when discussing how they would respond to a suicidal student, one administrator stated, "our main office, we aren't certified in that area, so we'll always take [the student] down to the counseling office." While it is appropriate for administrators to respond to a potentially suicidal student by referring them to school-based mental health staff, it would still be wise to train administrators to be suicide gatekeepers, particularly given how overworked school mental health staff can be. It will only increase their skill and comfort with this part of their jobs and strengthen school-based suicide prevention; things that administrators clearly care deeply about.

Compared to counselors and administrators, the role of teachers and other non-mental health and non-administrator staff in suicide prevention is much more ambiguous. Many school staff acknowledged that teachers are critical to identifying students exhibiting concerning behaviors and engaging in warm hand-offs with counselors (e.g., walking students in crisis to the counseling office). Teachers agreed. About 96 percent of teachers in the district believe that they should know the warning signs for suicide and nearly 100 percent consider informing a counselor of concerns regarding a possibly suicidal student a part of their jobs. Still, in our survey findings, teachers express some uncertainty regarding how their roles relate to suicide prevention. For example, only about 70 percent of teachers believe that asking a distressed student if they were thinking about suicide was part of their job. Additionally, only about 75 percent of teachers report that their duties include ensuring that students follow their safety plans.

Since students spend most of their time in class, teachers need to be aware of and ready to support students' safety needs. Teachers themselves often shared that they were afraid that they might respond improperly to a student with suicidal ideation, and that this contributes to their inaction (a topic we discuss in more length below). For example, one teacher shared:

> I think the biggest thing is educating teachers on the right way to address suicide, because…We're really scared. I mean, nobody wants to think that one of our students could kill themselves...Complete suicide. And I think that we're really, really afraid to talk about it with them because there are some of those myths still out there, like, 'If I bring this up to you that means that you're going to go do it.' And I think just giving us more education and more trainings and spending the time to really help us have the tools to be comfortable talking with students who may come to us or we may notice things about.

Like administrators, teachers wanted more training in suicide prevention and specifically in what to do when they encounter a potentially suicidal student so that they could feel more confidence that they were doing the right thing.

The Role of Suicide Prevention ("Gatekeeper") Training

Given the explicit requests for more training from administrators and teachers, we collected and analyzed data on how participating in a suicide prevention gatekeeper training

impacts staff's willingness to engage in suicide prevention. Training is not prevalent in this district. Only 23 percent of staff had participated in a high-quality suicide prevention training like LivingWorks SafeTALK, ASIST, or QPR. We qualify these trainings as high quality because they include time to practice talking with a potentially suicidal person, something that is considered crucial to rendering these trainings effective. Participating in a high-quality training was slightly higher among administrators – 30 percent – and school mental health workers – 64 percent. But it is worth noting that ALL mental health staff need to have a high-quality suicide prevention training at least every three years. Every clinician we have consulted agrees that LivingWorks ASIST training is the appropriate training for school-based mental health workers.

More staff participated in Signs of Suicide training than what we are calling "higher quality" trainings (though Signs of Suicide is still an evidence-based training). About 21 percent of school staff participated in Signs of Suicide. Additionally, almost 40 percent of administrators, 15 percent of mental health staff, and 24 percent of teachers participated in Signs of Suicide.

Finally, 27 percent of staff respondents had no suicide prevention training whatsoever, and 21 percent had only a low-quality suicide prevention training. Among those who reported having no training on suicide prevention, 15 percent were mental health staff, 17 percent were administrators, and 28 percent were teachers. It is important to note that all mental health staff who reported no suicide prevention training were nurses or nurse's assistants; not core school mental health workers. However, nurses can and should contribute (and we in fact observed them contributing) to suicide prevention, indicating that they should receive training. While the low rates of high-quality suicide prevention training may seem surprising, we find this is actually the norm in school districts around the United States. It certainly warrants additional research and concern as it is likely to contribute to gaps in mental health safety nets around the United States.

We did find that teachers who had a high-quality or higher quality suicide prevention gatekeeper training (Signs of Suicide, SafeTALK, ASIST, etc.) were on average more likely to report doing some suicide prevention work at least once a year compared to never. Interestingly, training only made a difference among these individuals who are reporting the lowest levels of suicide prevention work by frequency. Training seems to nudge people who are never doing this work to do it at least once a year, and while that is still infrequent, it is better than never. Training did not make much difference to staff who did this work more often, at least in terms of the frequency with which they did the work.

Training may of course matter to the quality with which the work was done. We were unable to assess this with our survey data, though staff clearly want this training. Additionally, when we spoke to mental health staff before and after receiving suicide prevention training, all appreciated the training and felt it improved their ability to support students. Clearly, more research is warranted to fully understand the role of gatekeeper training in willingness to engage in, comfort with, and efficacy with suicide prevention work.

The Importance of Knowledge

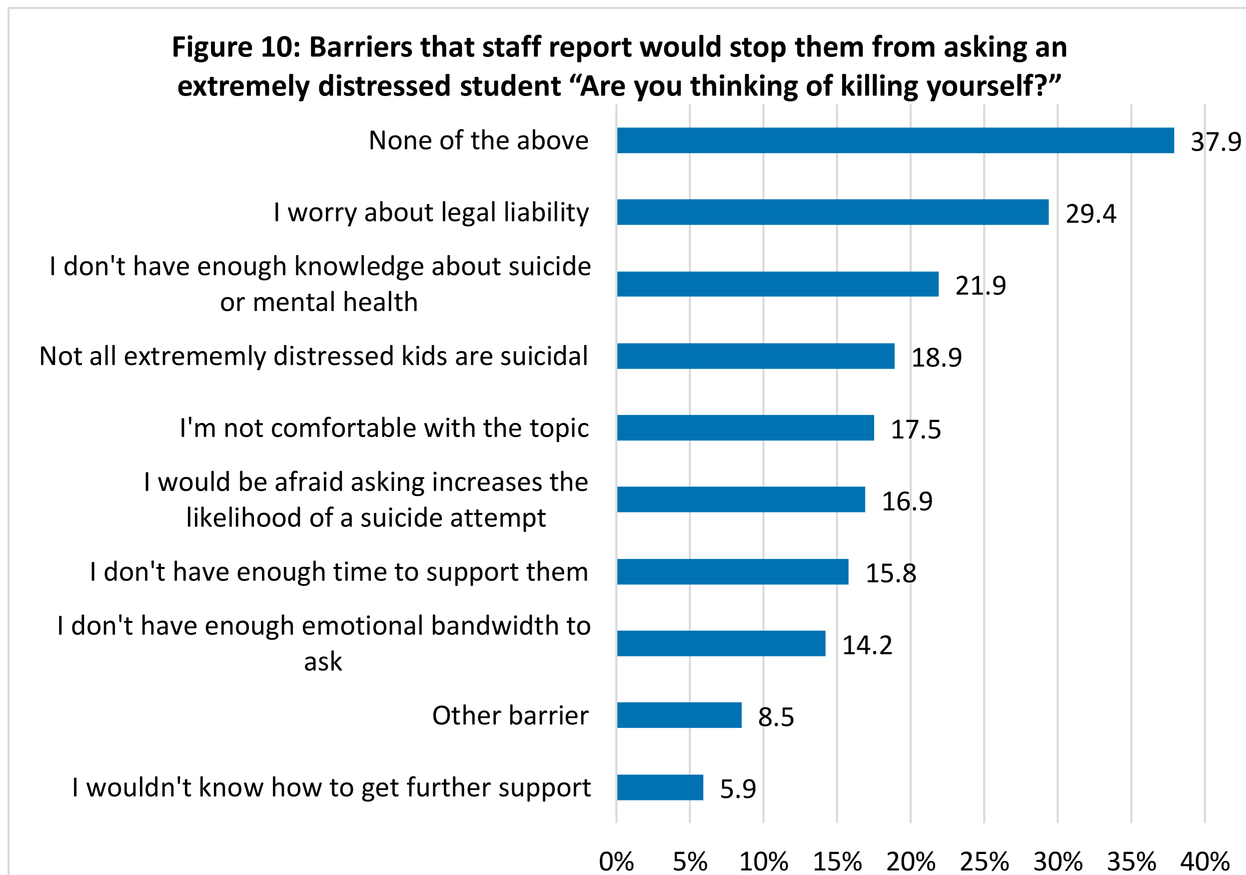
Another reason that investing in suicide prevention training, along with training staff in understanding trauma or social emotional development, may be worthwhile is that our data suggest that understanding these difficult topics makes it easier for staff to engage in this work. For example, teachers who felt confident that they understand trauma and how to support youth struggling with trauma, on average, engaged in more suicide prevention work than their less

confident peers. Additionally, teachers who are uncomfortable with the topic of suicide prevention or who feel afraid to ask students if they are thinking about suicide (because they fear it would cause the student to attempt suicide, a common myth) did suicide prevention work less frequently. As we discussed above, teachers also made it clear in interviews that more information about suicide was something that they desired. Not having adequate training, they felt, creates confusion and increases anxiety about how to best support students.

Barriers to Asking a Distressed Student "Are you thinking about suicide?"

The hesitance some school staff, especially teachers, feel in talking to or asking a student about suicide is not unique to WSPSD. In a survey by the American Foundation for Suicide Prevention (2020), 24 percent of U.S. adults worried that talking directly about suicide – such as asking the question 'are you thinking about suicide?' – would increase the likelihood that someone would attempt or die by suicide. This is a pervasive myth about suicide. Research has shown that asking someone if they are thinking about suicide generally *reduces* their risk of suicide (Joiner 2005; O'Connor 2022). This makes asking about suicide one of the most important things school staff (and community adults) can do in order to improve suicide prevention in schools and their communities. Because being willing to ask this kind of question is so important to suicide prevention, we asked school staff (in our staff survey) what might stop them from asking an extremely distressed student 'are you thinking about suicide?' These findings are summarized in Figure 10 (below).

Figure 10: Barriers that staff report would stop them from asking an extremely distressed student "Are you thinking of killing yourself?"



Nothing Would Stop Me

The good news is that the most common response was that nothing would stop staff from asking an extremely distressed student if they were thinking about suicide. Importantly, staff could write in their own barrier if one of the pre-written barriers did not fit their concerns, which makes it clear that no barriers, means exactly that: nothing would stop them. Specifically, 38 percent of school staff said that nothing would stop them from asking an extremely distressed student whether they were thinking about suicide (see Figure 10, above). This matches the commitment to taking care of students, and thus to suicide prevention, that we observed regularly in school staff. This pattern was also evident in our 2021 school staff survey, where we did not offer a response option that matched 'nothing would stop me.' The majority of staff wrote in using the "other" option that nothing would stop them.

Fears of Legal Liability

The second most frequent response to "what would stop you from asking an extremely distressed student if they are thinking about suicide" was concerns about legal liability (Figure 10, above). Almost 30 percent of school staff reported that liability concerns are a barrier for them to asking this question. Concerns about liability were more prevalent among teachers (34 percent endorsed this as a barrier), than among administrators and school mental health staff (13 percent and 8 percent respectively endorsed this barrier). However, while this barrier was more prevalent among teachers than mental health workers, it is potentially more consequential when it is present for mental health workers. One counselor told us in an interview that fears of liability were "huge" for her and other staff. But unlike teachers, most counselors saw this as just a cost of the job. "If I think too much about it, I worry about things like we can be sued for all manner of things," she reflected, "and sometimes it's not within our control."

We **did not** find that concerns about legal liability changed how most counselors worked with students who were obviously in crisis. If anything, for most counselors it pushed them to follow district suicide screening protocols as closely as possible. This is a good thing for the student, the counselor, and the district because following evidence-based protocols and documenting all that has been done to support a student is one of the best ways to protect against legal liability (Erbacher, Singer, and Poland 2014). Additionally, regardless of counselors' beliefs, we found that students in crisis always had prompt access to suicide risk reviews in our 2-plus years of observations. However, we did find that among counselors who disliked doing this work, they tended to avoid "going there" with students – meaning they would be less likely to ask questions that encourage open conversations about mental health. Additionally, we identified limited cases where counselors preferred that one of their colleagues be responsible for triaging potentially suicidal students – even when the student was technically on their caseload. Generally speaking, counselors did not seem to mind supporting each other in this way, though it does create a disproportionate workload.

Concerns about legal liability are understandable, particularly in a state that has already eroded some of the governmental immunity that schools are generally protected by through the Claire Davis School Safety Act (CRS 24-10-106.3). However, they undermine schools' abilities to effectively prevent suicide. Instead, with these concerns looming, staff hesitate to ask extremely distressed students if they are thinking about suicide. Educating staff in how to protect themselves from legal liability through strong clear evidence-based protocols for identifying and supporting potentially suicidal students that are appropriate to their role in a school building is an important intervention to improving suicide prevention in schools.

Knowledge Gaps

Figure 10 (above) also reveals that mental health knowledge gaps are an important barrier that would prevent school staff from asking a distressed student if they were thinking about suicide. The third most common barrier acknowledged by about one in five school staff members (22 percent) was "I don't have enough knowledge about suicide or mental health." This barrier was more common among non-mental health staff like teachers, secretaries, librarians, paraprofessionals, etc., than administrators (only 9 percent selected this barrier) and mental health staff (8 percent). Almost 18 percent of staff noted "I'm not comfortable with the topic" as a barrier, though no administrators and only one mental health staff member endorsed this barrier. Thankfully, only 6 percent of staff—or about one in every 20 staff members—reported that they wouldn't ask an extremely distressed student if they are thinking about suicide because they "wouldn't know how to get further support for the student." While this represents a minority, knowing how to connect students to further support is fundamental to suicide prevention and school safety. It is vital that every school staff member knows what to do when encountering distressed students. To help build this knowledge, we can share that the appropriate response in this district is that when in doubt, take the student to the counseling office and if a counselor is not available, take them to the principal or assistant principal. These individuals will have the knowledge and tools to ensure the student gets the support they need speedily.

In the survey, about 19 percent of staff believed that extreme distress in students does not always indicate suicidal thoughts and that this belief would stop them from asking extremely distressed students about suicide. While it is true that extreme distress does not always indicate suicidal despair, this belief should not prevent staff from asking directly about suicidal thoughts in extremely distressed students. It is crucial to ask since it is impossible to discern if a student's distress is a sign of suicidal despair from outward appearances alone. This does not imply that all distressed students should be asked about suicidal intentions, but it is advisable to do so in cases of extreme distress, in order to ensure that we are supporting students in the best possible ways. Almost no mental health staff endorsed this belief as a barrier. Instead, this knowledge gap was more common among administrators and teachers.

Finally, 17 percent of school staff endorsed the erroneous belief we discussed above – that asking a student about suicide increases their likelihood of attempting suicide. This 17 percent is made up almost exclusively of teachers, paraprofessionals, secretaries, and other non-mental health and non-leadership staff members. It indicates an important opportunity to close a knowledge gap.

Collectively, these barriers relate to knowledge gaps that could be reduced by providing access to high-quality suicide prevention training as well as clear protocols for what to do when encountering distressed students. Knowledge gaps are particularly important to close given the role they play, as we discussed above in how frequently staff engage in a set of suicide prevention behaviors, including things beyond directly asking students if they are thinking about suicide (like sending students to counselors for support).

Time Scarcity and Emotional Bandwidth

Beyond fears of legal liability and knowledge gaps, we found that many staff felt they do not have the time to support students adequately. Specifically, almost 16 percent of staff reported that they would be disinclined to ask an extremely distressed student if they are thinking about suicide because they would not have time to support them. We did not find that

this prevalence varied significantly across the different staff roles. Whether they were mental health staff, administrator, or teacher, time stress was a real barrier to suicide prevention. In part, this sense of time constraint was founded on schools never having the resources they need to accomplish all they are entrusted with for our children. This time stress was amplified by clear staff shortages. For instance, not every school had a full-time in-person school psychologist. One school psychologist, Chelsea, reported that she was currently “half time at two schools” and “spread really thin.” School psychologists have many tasks related to supporting students with disabilities and identifying and addressing students’ individual educational needs. When present and well-integrated into the school’s academic and social-emotional safety nets they can make a serious difference to the school’s ability to meet the diverse needs of students. Chelsea also highlighted the fact that many schools relied on grant-funding that added staff. While those additional staff strengthen the school’s safety nets, relying on grant-funding creates challenges for building stable systems.

In addition to staff shortages, staff generally felt overwhelmed by the tasks they were assigned. For counselors, they often felt that they were really “spread out doing different things” and, as one counselor felt, “I think we’d be more effective in creating those relationships and connections that I feel strongly about with kids” if they were not so spread out in their job responsibilities. In one middle school, for example, we observed that counselors were often tasked with lunch and recess duty. Counselors often enjoyed this informal opportunity to chat with students (often checking in with them quickly); however, it also meant that during times when students were not in class learning, their counselor was not available for private one-on-one meetings. Instead, students who needed to meet with their counselor would have to leave class to do so. Counselors also did not have these periods to accomplish their many work obligations, such as documentation, adding to their sense of time pressure.

The final barrier worth noting is some staff (14 percent) noted that not having the emotional bandwidth was a barrier for them to asking an extremely distressed student if they were thinking about suicide. This was significantly more common a response among teachers, compared to school mental health staff and administrators. Almost one in five teachers reported feeling that their emotional bandwidth was a barrier (compared to no school mental health staff and one administrator). While suicide prevention work is crucial, it can be stressful. As such, considering strategies to boost the well-being of teachers so that they have the energy for suicide prevention and taking care of the whole child in front of them is crucial to effective, compassionate suicide prevention.

Examining the Well-Being of Teachers

While school staff report a lot of pride and joy in their work at school, the job can be challenging, particularly when staff find themselves regularly supporting students who are struggling with trauma, mental health issues, or suicidality. For that reason, we used an established scale of secondary trauma (used with permission from the Trauma Responsive Educational Practices [TREP] Project) to examine the relationship between supporting student mental health and staff’s own well-being. Secondary trauma is defined as experiencing psychological distress as a result of exposure to another person’s trauma. The measure asked school staff to indicate how frequently they experienced certain things in the past 7 days that are associated with secondary trauma. Answers ranged from “never” to “very often.” The statements included “I had disturbing dreams about my work with students;” “My heart started pounding when I thought about my work with students;” “It seemed as if I was reliving the

traumas experienced by my students" (among others in a similar vein). As expected, the scale performed well (α=0.89). Higher values indicate higher levels of secondary trauma reported by the staff member.

Part of our motivation for examining the well-being of teachers was the frequent mention of burnout in our qualitative data collection. Many staff spoke about how difficult it can be to work in schools where many students were struggling, academically and emotionally. As one teacher, Jessica, said, "I actually worry about our staff in particular, about burnout….People are just at the end of their ropes." She went on to note that this directly impacts teachers' abilities to play their important role in suicide prevention: "They're not going to notice stuff" – meaning things going on with students – "as much" when they are so burned out and exhausted. "They just don't have the emotional capacity to even recognize changes in behavior unless they are extreme. So, kids are going to fall through the cracks and only the very loudest child is going to get any attention." Jessica concluded by sharing that this is actually her own experience:

> I do not have the emotional capacity to be like, "Hey student, you haven't even spoken to me in the last 3 days, because I'm really glad that I don't have to deal with you because I've got 6 other kids who are screaming at me." And I don't have the time because I also have to do all this paperwork. My classes are bigger. It's overwhelming.

For these reasons, we felt it was important to understand the well-being of teachers, not only to ensure they have the emotional capacity to teach students and thrive in their jobs, but also to ensure that they have the capacity to play their crucially important role in suicide prevention.

<u>The Impact of Suicide Prevention Work on Teachers</u>

Among teachers, we found that, on average, teachers who do more work to prevent suicide and support student mental health report higher levels of secondary trauma. We are not able to establish the cause and effect in this relationship – this is merely an association. We did not find a similar pattern among school-based mental health workers (school counselors, school psychologists, etc.). Our sample size for school mental health workers is small (N=39). It is potentially too small to detect moderate effect sizes. Future research should continue to examine this important issue for school mental health workers.

<u>Factors that Increase Teacher's Experiences of Secondary Trauma</u>

Beyond engaging in suicide prevention work, a number of other workplace experiences and beliefs were associated with higher levels of secondary trauma among teachers. These factors include:

- Worrying about legal liability;
- Giving up knowing why students are struggling because the teacher did not know how to help;
- Believing that schools should leave mental health in the hands of parents;
- Feeling that there is a high degree of mental health stigma in the community;
- Agreeing that their job requires they spend more time supporting student mental health than they want;
- Feeling they don't have enough emotional bandwidth to engage in suicide prevention work;

- Feeling that if they focus on student mental health that they can't fulfill their other work responsibilities;
- Feeling they don't have enough time to support students' mental health.

It is important to note that our survey is cross-sectional, meaning that we only offered one survey at one point in our time, so our data cannot speak to changes over time. Thus, we cannot make cause-and-effect claims—we can, however, describe associations or correlations between two variables. To explain further, we cannot claim that worrying about legal liability *causes* secondary trauma—only that they are correlated.

Factors that Decrease Teacher's Experiences of Secondary Trauma

We also identified a number of things that help teachers cope with stressful events at work and thus lower their levels of secondary trauma. District protocols help. Teachers who reported feeling that district protocols protect them from liability and believing that district protocols for supporting suicidal students help keep students safe, on average, reported lower levels of secondary trauma. Additionally, understanding trauma and how to support traumatized students was associated with lower levels of secondary trauma among teachers. Finally, having colleagues who staff can turn to for support and information and who they in turn offer support to was very protective against secondary trauma.

Summary

Collectively, these findings point to strategies to encourage and empower all school staff to engage in suicide prevention work. Namely, making it clear that staff are expected to do this work and equipping them with accurate, factual information about suicide and how to support distressed students can increase the frequency with which staff connect students to potentially lifesaving care and reduce barriers to staff engaging in this work. However, to improve the role school staff play in suicide prevention, the district and schools must also understand how doing this work affects school staff. We did find evidence that staff sometimes experience signs of secondary trauma from their work supporting students at work, including from engaging in suicide prevention work. Still, we also identified things that school districts can do to help disrupt this distress. Addressing teachers' concerns about legal liability, having strong evidence-informed policies for suicide prevention, and ensuring teachers have enough time to meet all of their professional responsibilities is important for teacher well-being. Equipping staff with the knowledge needed to support students facing difficult life events is similarly vital. Additionally, and perhaps most importantly, encouraging teachers to support each other and to turn to each other for information and support is a powerful protective factor.

V. Building Effective Suicide Prevention Strategies in Schools

Having established (1) how important schools are to suicide prevention, (2) how frequently school staff are called on to do this work, and (3) how doing suicide prevention work can impact staff well-being, we now turn to discussing how to build effective suicide prevention strategies in schools. We begin by highlighting the foundation that schools must have for suicide prevention to be robust and effective before discussing the systems that schools can build to prevent suicide through teamwork.

The Foundation

We identified two critical foundational elements that enable suicide prevention in schools. The first concerns the educational philosophy that school and district leaders enact to guide the everyday work of school personnel. The second concerns student cultures of belonging. We discuss each in turn below.

Whole Child Education

WSPSD has taken significant strides to prioritize a whole child approach, in and outside of the classroom as an integral part of the schools' culture. A whole child educational philosophy recognizes that educating students requires considering not just students' academic learning needs, but also their psycho-social-developmental needs and their physical and mental well-being. This philosophy encourages being trauma-informed and understanding that many students may carry emotional burdens stemming from their life outside of the classroom that directly affect students' abilities to be present at school. Administrators, teachers, and support staff alike consider teaching emotional regulation skills to be an essential part of their job. One district staff member described this as:

> [What's] most important...is that students are in an emotional place where they can learn...And if they're not in that place emotionally, it doesn't matter what type of academic systems you have in place, it's not going to make a better difference. So, I think first and foremost, we have to understand and appreciate that the kids have to be in an emotional state where they're ready to receive the instruction.

By weaving the whole child approach into the school staff's culture, WSPSD empowers its staff members to support students by understanding their unique circumstances and by including teaching students how to cope with their complex situations. Both of these are vital to fostering student well-being and can be considered "upstream" suicide prevention strategies.

WSPSD's whole child educational philosophy also recognizes the critical role that the community and family play in a student's educational journey. The challenges that students face at home, which range from important familial responsibilities to painful traumatic experiences, are acknowledged and considered when shaping staff's approach to providing learning opportunities in classrooms and support in counseling offices. One teacher shared, "I take the temperature of my classroom every morning when I walk in the door. And just by looking at someone, I know if it's a good day or bad day, I know if we need to start slow. I need to see if it sounds bad." The emphasis on building one-on-one relationships between students and school staff is a common theme that emerged from interviews. This approach aims to ensure that every student has a trusted person within the school who can provide emotional support and guidance, aligning perfectly with the whole-child model. An impressive 99 percent of school staff reported on the staff survey that they value being a trusted adult for students in their school district.

Teachers sought to tailor their teaching to each individual student by providing opportunities to learn regardless of barriers. One teacher described their responsibilities as teaching children "how to navigate the world, advocate for themselves, be a kind human, to support others, how to read a room, and how to know when they need time out or self-help." This commitment to the whole child also appeared in how staff thought about their own continuing education and commitment to supporting student mental health. About 97 percent of

school staff felt that they have a professional responsibility to promote the mental health of students. About 96 percent of school staff agreed that they have a professional responsibility to continue to learn about the most effective ways to support children who are experiencing behavioral and emotional problems.

School staff recognize that, for many of their students, their internal world is in a state of survival. Staff strive to create safe environments where students can confide in educators who genuinely care and respect them; something we also observed during our time in schools. School staff not only talk the talk but walk the walk in this regard. In this district, administrators, teachers, and staff are in near unanimous agreement that social-emotional learning takes precedence, ensuring that students receive the holistic support they need for a successful and emotionally healthy future as adults – and so that they can take full advantage of the critical learning opportunities that these schools offer. This commitment to a whole child approach provides the strong foundation that staff need to enact effective suicide prevention in schools. Many of the small behavioral issues that staff are attentive to in classrooms or when speaking to students (1) help staff notice when students are experiencing psychological distress and (2) help make school a safer place for students who lack experiences of safety in other places in their lives.

Indeed, building a culture that honors students and makes them feel safe and welcome in school buildings is another critical foundational element to strong school-based suicide prevention. Something we discuss next.

Culture of Belonging

Feeling like you belong is a powerful protection against suicidal thoughts and attempts (Olcoń, Kim, and Gulbas 2017). Research shows that a sense of belonging also fosters greater trust between students, staff, and parents. This in turn encourages disclosures of mental health struggles (Fisher et al. 2015; Pisani et al. 2013), which is the gold standard for suicide prevention. School staff often have to go to great lengths to build a culture in which all students feel they belong to the school community. In our research, effective cultures of belonging include communication and policies designed to make a youth feel valued and to intervene when students are not being kind to each other. Importantly, a culture of belonging is only protective when it makes all students feel they matter and are safe at school, regardless of their social identities, personal challenges, skills, talents, or sociodemographic backgrounds. In addition, positive cultures place a premium on student voices and concerns, intentionally designing space for students to have their needs, experiences, and struggles addressed. Importantly, a culture of belonging supplements and supports an educational philosophy that emphasizes the mental health and well-being of students alongside their academic successes.

One of WSPSD's most positive qualities is its awareness of the function of a culture of belonging and the district's intentional effort to cultivate this culture in every building. Bolstered by the Panorama Survey (a survey that allows school leaders to assess school climate and progress towards school goals) and the implementation of Capturing Kids' Hearts intervention, all of which encourage school leaders to set benchmarks for connectedness that shape policies, every school we observed had set improving the sense of belonging as one of two primary goals in the 2022-23 school year. In what follows, we detail how schools worked to achieve greater connection and highlight areas for continued growth.

Cultivating a Culture of Belonging

Nearly every school leader felt that building a culture of belonging begins with teachers, who were the staff members in most frequent contact with youth. In at least one building, for instance, school leaders asked all teachers to remain outside of their classroom doors for five minutes before class began to greet students as they walked by. “I believe, with every fiber of who we are, that the three things that make a high school successful are: relationship, relationship, relationship,” a school leader in one of these buildings told us. When teachers are not inherently equipped with ideas about how to build relationships, “you can operationalize relationship building [to provide help] for those teachers,” the leader continued. These purposive policies came to life through concrete interactional strategies—be it from teachers’ own innovations or from teachers’ efforts to implement strategies proposed by their leadership.

School leaders actively used Panorama data to understand what interventions actually impact students’ lives in the school building:

> We’ve asked kids, “What is it about certain teachers that makes [them a trusted adult]?” [Kids tell us] “It’s really just, they actually seem like they like us. They seem like they like their job and they’re funny.” That’s basically it, but you'll have teachers be, “I think it’s because of how he decorates his room” or, “I think it’s because of this.” If you could quantify what it is so that teachers could just go, “Oh, I just need to do this, this, and this,” that’s all [students] want.

This quote highlights the need for teachers who “really try to connect with kids on an emotional level, not just academics,” as a counselor believed. It also calls for school leadership to provide help to teachers who may need that guidance on how to best build meaningful relationships and positive classroom experiences with students. The more teachers show this extra level of attention and concern, the more youth and in turn their parents feel supported. As one parent observed:

> [The teachers] work hard. They work hard, and they show kindness. Every one of them, when I went to [parent-teacher] conferences, every one of [the teachers] knew exactly who my kid is. I mean, how many kids do they teach in a day? They knew who he was [and] they knew where he was at with specific things that would not be a general for everybody in the class. And to me that shows that they have a real vested interest in actual students in their class. So that just felt good. It really did because we’ve not had that all the way along.

When a school creates this sort of trust with families, word of mouth helps strengthen these feelings. The mom told us, “I have heard nothing bad about [my son’s school]. And I think now I’m starting to understand why. The people that are there really want to be there and want to make a difference and help the kids. And the kids are their number one thing. So that is wonderful. I love that.” Families feel at ease when they know that their children are cared for and valued at school.

Most students felt the same way, if not more strongly. Consider one student’s experience with a teacher they had the previous year. He told us:

> Even if I don’t have that class this year, I still have that connection with that teacher from last year. I still see my teachers from last year. They ask me how I’m doing in the hallway and everything...I’ve noticed that they reach out and

> they try and get to know everybody. All of my teachers this year still are good at that a lot. I have a good relationship with most of [my teachers].

When students have this kind of relationship with their teachers, it communicates to them that they matter, that they are a valuable member of the school community, and therefore increases the sense of belonging students have at school.

In addition to mobilizing teachers to build relationships with their students, we saw several policies in place designed to explicitly foster a sense of belonging for all students. For instance, in one middle school, teachers could nominate a student every week that they felt had been trying hard or who had begun to shine. Importantly, the criteria were not just academic; instead, this recognition served as a way to recognize youth's efforts to achieve and be better students no matter their specific area of growth (be it behavioral, academic, kindness, etc.). In another school, a student-led lunch program was put in place with staff support that aimed to ensure no students ate alone. More conventionally, nearly every school encouraged the creation of student clubs for just about any interest youth might have, an important strategy for ensuring students find peers with common interests, something that has been shown to help students find friends (Frank, Muller, and Mueller 2013).

Finally, school leaders in every building were conscious of the detrimental effects of bullying and had explicit anti-bullying policies that staff worked to enforce. A high school parent told us that her child's school does not "tolerate [bullying]. Everything's about inclusion, and I think the schools are going a really good job of trying to instill that value in our kids." Another parent felt these anti-bullying policies extended beyond standing against bullying, but also promoted other values, "like just respecting other students and speaking up and trying to be really open with the kids and talk about things, which is good." Despite their commitment, no school perfectly prevented all cases of bullying – unfortunately it is an all-too-common occurrence in youth culture. All school staff were strongly committed to anti-bullying efforts.

Why Cultures of Belonging Matter

Building trust contributes to creating stronger relationships between youth, parents, and staff, which in turn allows more communication to happen between all of these concerned parties. One parent who had children who went to several schools found that only some "schools have cultural environments that are more accepting." These schools, in her experience, were "easier to navigate" because she found that the school's culture of accepting special needs kids, students of color, and LGBTQ+ youth went beyond just how they treated these kids—it spread to all facets of the way school staff see their role and responsibilities in building communities.

Cultures of belonging matter seriously to suicide prevention primarily because a student that feels connected to and supported by their teachers is more likely to feel they have a trusted adult that they confide in if they are struggling with academics, home life, and mental health. Students are not inherently likely to reach out to school staff (or any adult) for help navigating challenges they are facing. Existing research as well as our own data from WSPSD demonstrates that youth are more likely to reach out to peers than adults (Pisani et al. 2013). One teenager told us that she regularly hides her emotions from adults. "[I've] learned to manipulate my face, my eyes, my stature. I put on a mask, so people won't worry," she shared. Another youth we spoke with used similar language, telling us that he deals with his problems

by “just keeping my head down in class.” Students learn from past experiences, which makes building a culture of belonging even more imperative. One teenage boy explained:

> It’s really hard when the teachers you’re in the class with and you’re trying to understand the lesson and they just expect you to understand and know what you’re doing on the assignment but you don’t. And so you ask for help and they are right there and say you should know and not ask for help and instead just get it done, but how can that happen when I don’t know what I’m doing?

Little moments like this – in a classroom with a struggling student – matter deeply to students generalized understanding of whether they matter to school staff. Students often find it challenging to ask for academic help under ordinary circumstances. That situation becomes exacerbated when the response to their help-seeking is “You should know” rather than the teacher meeting them where they are. Being free to ask whatever question, however frustrating for the teachers, is important for conveying to students that they matter and thus belong.

Teachers and other school staff can also convey painful messages that students don’t belong when students come back to class after a long hiatus. This was a challenge that we observed multiple times in district schools. A typical example was when school counselors worked diligently to encourage a truant student to return to school and classes, only for the student to encounter snide and discouraging remarks from a teacher. The student was crushed by the discouraging teacher and stopped attending school again. The student’s school counselor was also disappointed; their work to support the students return was undone by a casual negative remark. The counselor explained to us that sometimes teachers need to understand that just being in the school building and in class is a major victory for some students, even if they have no chance of passing the class that semester. Often, students have to take small steps, such as coming back to class, before they can tackle larger problems, like meeting graduation requirements. These moments are also critical moments of exclusion. This is the opposite of the culture of belonging this school was deliberately attempting to cultivate. Importantly, when we say that belonging matters, we also mean that it should matter for *all* students, including students who struggle to meet academic standards. It is crucial to building cultures of belonging that facilitate learning and social-emotional well-being for students.

Ensuring Everyone Belongs

A culture of belonging is only as good as its’ ability to make *all* students, and not just those that fit the model of an ideal student at their school, feel welcome and safe. Students that do not fit the mold are often aware that they are perceived as less than those star students or star athletes, which often translates into their feeling less deserving of attention from adults. If they feel like adults care more about high achievers, athletes, or other “ideal” kids, they may feel left out. As one parent explained about her child’s previous school:

> They’re very sports oriented. I feel like the kids who play sports, that they might not even be great academically, but they tend to make it far because they’re in sports. But the same doesn’t apply, for example, to theater kids. You could be really good academically and do really good in theater, you’re not going to get the same passes that you will if you are scoring at the football game, if that makes sense.

Contrast this with her child’s current school where, she shared:

> There are a lot of extracurricular activities. So, I feel like kids who maybe don't have mentors in their own life can at least get mentors through those supports. They do have quite a few programs for people who can't participate financially, where you can apply for like scholarships. They will help you that way so that your kids can still participate and be included. They also do a lot of like food distribution for people who have food insecurity. I know a few of the schools do like... Food banks will come to the parking lots on weekends, and you can just come get food. No questions asked.

Schools must expand what kinds of activities youth can participate in and make sure all activities are valued by school leaders. An important barrier to belonging in WSPSD is not just the traditional social identities that may lead to a feeling of exclusion, but also challenges occurring beyond the walls of the school. For these kids, feeling connected carries extra meaning and weight. As a teacher told us:

> If you really dive into those kids, they love being at school…It's a safe place for them. Home's not always safe for a good chunk of our population. And not necessarily because parents are not good parents, but because they're just impoverished or mom is working three jobs to try to make ends meet, or mom is depressed, or dad is out of the picture, or dad is depressed, whatever.

For some youth, school can be the primary place for forming meaningful connections and experiencing belonging. The consequences for failing to build a warm, supportive culture are clear. Consider this interaction we observed with a student, Alex:

> Alex (student): I have been told I was a failure, that I was not going to do shit, that was from my [former] teacher.
>
> [A school leader in the room expressed sympathy and apologized, and asked how often it happened].
>
> Alex (student): This specific one in middle school [said] it a few times a month. Other teachers in middle school said the same things, that I was a failure and nothing and stuff.

Perhaps the difference for the student in the above example was that in "that whole school, [I liked] only one teacher." Alex went on to share, "He supported [me]. He would sit down and actually help me. He didn't call me names. He was just nicer and treated me like nicer." What this example demonstrates is that while district schools place great emphasis on creating cultures of caring and belonging, there is always room for improvement. Teachers are sometimes going to have bad days (though some behavior should not be tolerated). It's important staff orient toward cultivating a culture of belonging and caring. One teacher felt his building does a good job of catching kids when they struggle. He said, "There's always kids that slip through the cracks [even though] we are literally on the lookout for those kids." The more staff we have contributing to being "on the lookout," the better off students will be.

Thus, even when schools are doing their best, finding ways to create a sense of belonging and connection for more students can go a long way towards building trust. What we observed was school staff who cared a great deal about belonging. We observed countless meetings between staff and with staff and students that highlighted the amount of consideration

that goes into producing connectedness, building trust, and finding ways for all youth to fit in. However, as with other sections in our report, there are places for improvement. When it came to building cultures of belonging, we found several distinct groups of students struggled more than other in feeling they mattered to their school communities. One district staff member told us she worries "about [those kids] that don't fit the mold." We turn to discussing these groups next. Specifically, we highlight the unique needs of gender and sexual minorities, racialized minorities (particularly Latino/a/e or Hispanic minorities) and, more, broadly how the schools interact with Hispanic families. By being deliberate in shaping policy around these three different groups, schools can further strengthen their safety net.

Gender and Sexual Minority Students

It is important to note that questions around inclusivity with gender and sexual identity continue to present challenges across the U.S. that are not unique to the district. While acknowledging school leaders work hard to support all students, some school and district leaders recognized that efforts to support "Trans[gender] kids [has been] slow." We found that the district and the schools have not always been sure what the best practices for conforming to state laws and the needs of students are, especially when novel situations arise that require creativity.

These things matter to suicide prevention. Public health research shows that Lesbian, Gay, Bisexual, Transgender, and Queer + (LGBTQ+) youth are especially vulnerable to mental health struggles and suicide. For example, the Trevor Project's most recent National Survey on the Mental Health of LGBTQ+ Young People found that 46 percent of LGBTQ+ youth aged 13-17 considered suicide and 17 percent of LGBTQ+ youth aged 13-17 attempted suicide in the last year (2023). We found evidence suggesting that this trend holds true in Western Slope. Local community mental health workers shared that LGBTQ+ students are overrepresented as patients in local mental health crisis centers. A community mental health professional shared: "queer youth and youth with mental health crises overlap a lot…I can't think of a single time [at the hospital I worked where] we didn't have at least one or two queer kids in the hospital."

There are many ways identified by existing research that schools can create more positive school climates for LGBTQ+ students. They can (1) have gender-sexuality alliances (GSAs), or other school clubs that provide community and support for LGBTQ+ students; (2) encourage educators to be supportive of these students and build relationships with them; (3) incorporate LGBTQ+ inclusive curriculum; (4) have inclusive and enumerated school policies protecting LGBTQ+ students; and (5) have signs on doors noting that the person inside considers themselves a "safe space" for LGBTQ+ youth (Kosciw et al. 2020). When schools have a GSA in place, generally, LGBTQ+ students experience less homophobic remarks and victimization and have lower fears for their own safety (Marx and Kettrey 2016). During our fieldwork, we observed many of these supports in place, including student clubs, positive signage and messages around schools, supportive educators, and protective policies.

Despite these supports, we also observed areas with potential for growth. For instance, we found evidence that LGBTQ+ youth were targets of bullying and harassment. On our staff survey, we asked an open-ended question about whether staff had observed instances of bullying and harassment of federally protected classes, which means students belonging to gender, sexuality, or racialized minorities (among other social categories). One major theme in responses involved stories about LGBTQ+ students who were bullied for their identity. For example, one staff member shared, "In my classroom, I do occasionally see

bullying/harassment related to sexual orientation or gender identity. I very strongly defend the student on the receiving end of the bullying, but it feels frustrating because I think my words fall on deaf ears." Another staff member echoed these remarks, "There is often harassment of LGBTQ+ students and when I can, I will address these in the classroom." Notably, these staff members said they make a point to address these issues when they arise.

LGBTQ+ students also sometimes experience invalidation of their identities by school staff members, which can make them feel less accepted. At one school, we had an opportunity to observe a GSA meeting in which a school counselor came to talk to and learn from the students. During this meeting, one student shared, "I tell the teachers my name and then they revert back to the name that's on their list and I don't want to correct them all the time, but they don't even try to correct themselves and sometimes they don't even say that name right." This interaction is important in two ways. On the one hand, the attendance of the school counselor at this meeting shows how much school staff value building better relationships with students and is evidence of staff taking care with LGBTQ+ students. On the other hand, the story the student shared is a serious negative experience that may make them trust adults less and feel more unsafe or alienated at school.

This issue around students' preferred names or correct pronouns came up repeatedly in multiple schools. In several cases, school staff declined or refused to use the preferred name or pronoun for students, even when the preferred name and pronoun were documented in the student's official school record (which requires parental consent). Going against parents' wishes for their children and children's wishes is inconsistent with school policies and state laws. This is problematic because the intentional use of the wrong name and pronoun has been shown in prior research to be harmful to LGBTQ+ student's mental health (Earnshaw et al. 2020; McLemore 2018).

It is worth noting that students do not expect school staff to be perfect, but they do expect school staff to try to use their preferred name and pronoun. One student at the GSA meeting mentioned previously shared with the school counselor, "…Some teachers don't get [pronouns right] but like [they] at least *try*…I very clearly let teachers know in the beginning of school year [my preferred pronouns]. One of my teachers tries and I appreciate it, but the rest don't care." Importantly, this student does not have a problem with the teacher who tries but is imperfect; their problem is with the teachers who "don't care."

The final challenge we encountered for LGBTQ+ students concerned participation in GSAs, which is generally supposed to be a protective and positive experience. Unfortunately, GSAs at several schools were targeted for bullying or discrimination during our fieldwork. This undermines the protective benefits of that safe space for LGBTQ+ students. Multiple staff members responded to our survey describing instances in which GSA clubs in this district were not able to adequately serve their students because of harassment. For example, one staff member shared:

> [GSA club] posters were torn down from bulletin boards all over school last semester, and they were never replaced. No [GSA] club has been formed this year. A student tore down 'safe space' rainbow stickers from 8-10 classroom doors/windows this week, and all the LGBTQ+ students definitely noticed…Queer students do not feel safe at this school and cannot be their true selves because they fear for their safety and mental health.

Another staff member explained, “Students are worried and afraid to join GSA because of how others perceive them and treat them when their sexual orientation is revealed. They are often called names, threatened, and teased. Even when they are not open about their sexual orientation, the idea of being gay, etc. is used to bully and intimidate.” Not being able to be your true authentic self or not feeling safe from bullying at school is not good for youth mental health. It is also at odds with a whole child educational philosophy and indicates a less-than-effective culture of belonging for students in these schools.

Racial Minority Students

Despite the district’s efforts to create a culture of belonging, it is important to be cognizant that schools are places where racial/ethnic minority students can face racism or discrimination—two factors linked to elevated suicide-related risks (Gomez, Miranda, and Polanco 2011) as well as thwarted academic opportunities. In the last decade, rates of suicide, suicidal behaviors, and suicidal thoughts among Latino/Hispanic youth have increased nationwide (Fortuna et al. 2007). Given that Latino/Hispanic students are the largest racial/ethnic minority group served by the district, we highlight their experiences in the district’s schools first and discuss the implications for belonging. We then highlight the experiences of other racial/ethnic minority students.

Latino/Hispanic Students: When asked what it is like as a minority student in school and in the community, some Latino students shared positive experiences. For instance, one Latina girl shared, “I don’t feel like a minority here.” Another Latino boy mentioned, “With my sister’s friends, they are all Americans, they invited my mom to this thing. She doesn’t speak English. They don’t treat her bad. My mom even wrote recipes for them.” These students’ positive experiences demonstrate that while they are a numerical minority, Latino students do not always feel alienated in their daily lives. Instead, these students feel comfortable and safe to share their culture with others.

Despite these positive experiences, we also encountered some Latino students who reported negative experiences. For example, one student recounted an experience his family had at a school soccer game: “Four years ago, [my] mom was yelling in Spanish at [my] sister’s soccer game, [and] these two [students] in front of us said, ‘If you want to speak another language, you might as well speak French.’” The student interpreted this comment as hostile (particularly since a fair number of people speak Spanish in Western Slope). Latino students were also aware that they could be perceived as “different” because of cultural differences. One Latina student summarizes this perspective, stating, “Some actions or attitudes among the Mexican community [are] normal [for us], but others find [it] strange or unusual. Because of some experiences, I’m less open about cultural expressions and hide it.” Any time students feel a need to “hide” a part of themselves, particularly when it is a part as fundamental as their ethnic heritage, it harms their sense of belonging in the school community. For students who are more comfortable speaking Spanish (and in the context of WSPSD, who are often recent immigrants), the barriers in communication and the potential bias associated with these barriers can matter greatly to their sense of belonging. This group of students is generally referred to in the education literature as English Language Learners (ELL) — students whose English is deemed not proficient based on a standardized tests (but who often are conversant in English). One ELL student told us in English, “Sometimes people think I am slow because I don’t speak English.” As we mentioned before, any time a student feels they cannot “be themselves,” their mental health is put at risk.

Staff also mentioned witnessing racism and discrimination specifically targeting Latino/Hispanic students. Indeed, the second major theme in the open-ended question on our staff survey that we mentioned above (where staff were invited to share information about incidents they witnessed of students bullying or harassing protected classes of students at their school) concerned racialized discrimination and bullying. One staff member wrote in, "Some students have experienced microaggressions, discrimination, and bullying amongst some of their peers based on language, heritage, and skin color." Other staff members cited specific instances of bullying or racism targeting Latino/Hispanic students, such as using the word "'Mexican'…in a derogatory way." Another staff member noted, "There have been occasions where white students have told Hispanic students to 'go back to your country' or 'speak English' or other [prejudicial] statements." One staff member reflected that discrimination may be worse for ELL students: "There can also be racial discrimination towards Hispanic/Latino people, especially if they speak little to no English." Unfortunately, these incidents may trickle down to affect not only the student's sense of belonging, but also whether families believe they are full-fledged members of the school community.

Other Racialized Minorities: Though Latino students were the predominant ethnic or racial minority in Western Slope schools, staff also witnessed bullying and discrimination targeting Asian and Black students. In response to our open-ended survey question, one teacher wrote, "I have heard of many instances of racist comments outside of the classroom. In particular, one of my students…had to deal with Asian racial slurs, inaccurate to boot, a couple of years ago…I hear that that is far from atypical." Another teacher recalled a specific experience of an Asian boy who was bullied in front of the whole class:

> I've had 2 incidents that stick out in my mind. One student said loudly to the whole class to an Asian student, "[Student name], does your dad eat dogs?" And he went on to say that people in Asian countries eat dogs, then other kids in the class chimed in, some saying "That's a stupid thing to say, shut up," and some started discussing which Asian countries eat dogs. The Asian boy was very upset and I told the offending boy to stop talking, but he has trouble controlling his mouth so he kept on for a few more comments. I finally threatened to write him up.

What this incident shows, again, is that staff are likely to care and show as much. The teacher in this case intervened, which hopefully made the student feel like they had an adult ally in their corner and, at worst ameliorated a bad situation. Comments like this one have the potential to create a hostile environment for other Asian students who may have either witnessed or heard about the event.

Staff also reported incidents on the survey with regard to racism against Black students. Specifically, one staff member wrote, "Black students get called the N-word all the time. Rarely does anything happen to the bully." Another staff member reported, "From experience at this school…I know that many African American students do not feel welcome here. This community often displays racial ignorance and is never taught to know any better." These two accounts suggest that racial degradation or exclusion including racial epithets are not treated as important issues to be resolved or prevented in the community.

Taken as a whole, these first-hand staff accounts suggest that racial minority students may have negative experiences in schools. Like with gender or sexual minorities, we observed

sincere and serious efforts across staff to prevent these incidents from happening. However, they do continue to happen, which suggests the school and district may need to continue to design and implement new policies while enforcing existing ones to address this gap in the culture of belonging. While struggling with racialized bullying and racism in schools is by no means unique to this district or this historical moment, these experiences have significant potential to harm youth well-being and are even associated with elevated suicide risk. Any comprehensive strategy for suicide prevention must include attention to racism, discrimination, and bullying, particularly for minoritized groups.

VI. Building Systems to Support Suicide Prevention

Having established the philosophical and cultural elements that provide a strong foundation for suicide prevention and mental health promotion in schools, we now turn to discussing how schools can effectively build systems to accomplish the everyday work of supporting youth well-being in school buildings. As we've shown in earlier sections of this report, this work is best done in teams – both to increase its effectiveness for supporting youth mental health and to ensure that school staff are not overwhelmed by the sometimes high needs they encounter in students.

Multi-Tiered Systems of Support

Most schools across the U.S. have existing systems to support students' academic growth. In Western Slope, the majority of the schools use a well-established intervention promoted by the Colorado Department of Education called Multi-Tiered System of Supports, or MTSS (CDE 2023b) to support students struggling with academic or behavioral challenges.[3] As an evidence-based educational intervention, MTSS emphasizes using data and shared-decision making through teams and group decisions to support student needs. It is a 3-tiered intervention model, where Tier 1 supports are available for all students, but Tier 2 and Tier 3 are restricted to students who are more "at risk" and thus more in need of intensive supports. This stratified support system ensures that all students get access to some (Tier 1) supports (e.g., having a school counselor), while more intensive supports are reserved for students who most need them. Importantly, most schools do the majority of their MTSS Tier 2 and Tier 3 work through a small team of school staff that tends to include a mix of teachers, school counselors, school psychologists, school social workers, and administrators. It also sometimes includes intervention specialists (who are generally expert teachers with deep knowledge of how to help struggling students learn).

While MTSS is traditionally an educational intervention, it is a flexible system, and schools are encouraged to define the support goals for their MTSS locally. In our research, we have found that the most effective MTSS systems are those that include mental health in their considerations and as a support goal. This matters for two reasons. First, sometimes the root cause of a student's academic challenges is not academic, but rather related to their well-being more broadly. For example, an effective intervention for a student who is struggling in math because they have knowledge gaps that need to be remediated is going to be very different from an effective intervention for a student who is struggling in math because they are experiencing stressful family conflict at home or having severe anxiety. Understanding the root cause of student struggles is critical to providing appropriate and effective support and is

[3] For more on MTSS in Colorado and this definition visit: https://www.cde.state.co.us/mtss

consistent with the whole child educational philosophy embraced by the district. The second reason including mental health in the MTSS framework is important is because school staff have high workloads. This means that it is important that systems are efficient and that we do not duplicate systems. Additionally, it is important to have a mechanism that promotes mental health and suicide prevention that teachers and other non-mental health school staff can participate in, with the support of mental health staff. This is both because teachers spend the most time with students on a daily basis and because supporting students effectively requires interventions that work in classrooms – the place where students spend the most time in schools. MTSS provides this system without requiring the creation of a separate safety system for mental health struggles which would further amplify the workload of staff rather than consolidate it.

In our observations, we identified seven challenges that school staff encounter that prevent students and staff from fully benefitting from the potential of this intervention. We discuss the challenges below, before offering a better vision that would harness MTSS for both academic and more social-emotional student support.

Challenges to MTSS

Challenge #1. Differing Attitudes towards the Efficacy of MTSS

The overarching challenge we observed in most schools was the lack of clarity in the purpose and goals of MTSS. We noticed that school staff (including school leaders) often referred to "Tier 1" intervention when what they actually meant was "Tier 2" interventions, or more specialized interventions designed for "at risk" youth. We also identified a lack of understanding of what MTSS even is. As one counselor confided, "I feel like with MTSS, we can say that word a lot, but if you were to ask 99 percent of the people in this building, they would have no idea what that meant, what that should even look like." We found that there was confusion of what a Tier 2 intervention is, as opposed to just being flexible with a particular student. "This is my fifth year at this school, and we don't really have defined interventions," another counselor told us. "I don't know if staff even knows the difference between an intervention and an extension of time. If I don't know what kind of interventions [there are] for kids, then we are kind of a sinking ship."

These sentiments matched the fragmented design of MTSS in many of the schools we observed. MTSS was often separated from the other teams in the building (e.g., the counseling team, the administration team) with little information sharing, planning, or collaboration among teams (beyond [over]relying on school counselors, which we will discuss below). Additionally, many MTSS teams lacked a coherent set of priorities, goals, and protocols to guide MTSS staff's work to identify at-risk students, determine their needs, provide effective interventions, and assess the success of these interventions at defined intervals. Consequently, school leaders and counselors felt there was a pervasive lack of understanding among many staff about why MTSS matters and why it works. A school leader at one high school told us that "we need a common understanding of universal interventions and the responsibilities of all as it fits into an MTSS structure." They continued:

> The idea, and there is some unlearning we need to do, the MTSS is not a place, but a structure that supports all students through a continuum of supports. Often, not always, a teacher will skip the MTSS because they are frustrated or concerned and not sure what to do. They need somebody or something to be done with this kid. So, what are we doing universally? And

> that is a bigger discussion, and difficult, and why MTSS is a heavy lift in big schools because they are diverse and complicated. My vision would be: one that we have a real clear understanding across the boards. What's the universal supports that are available.

This particular challenge was one we observed primarily in the high schools, as opposed to the middle schools. Middle school staff tend to focus on a specific grade-level as opposed to high school staff, who are often responsible for teaching multiple grades and a larger population. These organizational differences led many school leaders in the high schools to worry about the effectiveness of MTSS in such a diverse and complex environment. One school leader argued that "MTSS...does not work well at the high school level because of volume and the way that we are structured." They went on to explain that "in elementary and middle [schools] there are naturally groups. Once you get to high school, we don't have that [which makes implementing] MTSS the way the district [wants, impossible.]" We disagree with this take and have observed MTSS serve as a critically important tool in high schools (for both academics and mental health). However, this belief – that MTSS was too challenging or impossible to do well – undermined the utility of MTSS in these buildings. Without a clear understanding, staff (and sometimes leadership and counselors) felt that MTSS was more burdensome than beneficial. It felt like another team they had to participate in and another meeting they had to attend, a sentiment which reduced staff's buy-in to the system.

This issue is salient when considering the time-pressure that many staff felt. We observed that school staff are stretched thin and feel less-than prepared to handle youth mental health challenges. At one high school, a school leader told us that "Staff will not fill out [an MTSS] form. They will not continue to document things whether you tell them it's the law." This implied that these actions were perceived as a burden on staff without faith that doing the work would result in better supports for students. This greatly undermines both the academic and mental health safety nets of the schools. Sharing information about students who are struggling is paramount to the identification, processing, and triage of youth at risk.

Despite these challenges to the utility of MTSS, we have observed in WSPSD and our broader research that MTSS can and does work as both an effective academic and mental health safety net. Thus, it adds a layer to efforts at suicide prevention. When well-structured, they provide clear consistent protocol for identifying students who are at risk and give staff, like teachers, an easily accessible support system. **Addressing the beliefs that MTSS is impossible or not worth the effort and providing concrete guidance about how to effectively build high school level MTSS is a critical first step to harnessing MTSS systems for mental health, as well as improving its use for supporting academic needs.**

<u>Challenge #2. Making Support Everyone's Job, Not Just the Counselors</u>

An ideal MTSS system is one that helps everyone feel supported in the school building; one that teachers feel helps them support students, that students and families feel improves their child's learning opportunities and life chances, that school leaders feel helps accomplish their organizational goals and meet Colorado's performance frameworks, and that allows school support staff (like academic interventionists and mental health staff) feel empowered to be proactive rather than reactionary.

Despite this ideal, we found an overreliance on individual staff members, particularly school counselors, when assessing and accomplishing these intervention needs. Multiple

school leaders commented that “referring [students] to the counselors” is the first step in any intervention process. While that is fine – and indeed school counselors are a core Tier 1 intervention in any MTSS – counselors should not be the primary Tier 2 or 3 source of interventions, particularly not without additional supports. More importantly, the attitude that the counselors **are** the MTSS was something we encountered frequently, particularly in the high schools. For example, one school mental health worker shared that “our counselors are our best MTSS…I wish [the MTSS] were better, but it meets the needs of most of our students…We try to do a good job, we try to get support, but it’s tough.” This is not a strong foundation for an MTSS system that effectively supports students and teachers, families, etc.

While we found incredibly effective school counselors throughout the district, overreliance on counselors will ultimately weaken MTSS’s efficacy. This is because the entire strength of MTSS as an intervention is in team-based decision making and brainstorming to identify how to best support students. As one counselor put it, working “kid by kid, teacher by teacher” is “a mess.” They continued, “[We’re] putting out fires, instead of working with groups…Everyone is just trying to keep their head above water [and it’s] not good for the kids.” When staff are overburdened, their work tends to move towards reactionary – “putting out fires” – rather than proactive and preventative. Relying on individual staff, no matter how excellent they are, is more likely to produce reactionary rather than proactive support systems. Additionally, school counselors are some of the primary individuals providing socio-emotional support and conducting suicide risk reviews. Overburdening school counselors with intense obligations without a team of support behind them is more likely to increase burnout and reduce their ability to effectively carry out their critically important job obligations.

Challenge #3. Creating Clear MTSS Referral Protocols

Referrals to Tier 2 (and 3) MTSS supports are an important and defining aspect of any MTSS system. Clear protocols for who to refer to MTSS are essential to processing concerns about mental health and preventing suicide, and contribute to integrating MTSS effectively. While a few schools did have clear referral processes, most struggled to implement them consistently. Many school leaders and counselors felt teachers did not know how or who to refer to MTSS.

Expanding referrals beyond academic indicators of a student at risk is an important first step towards effectively harnessing MTSS for suicide prevention while likely also improving its ability to support students’ academic needs. In virtually all cases we observed, students were referred to MTSS on the basis of low attendance and/or grades, and occasionally for behavioral issues. Almost never were students referred for identified mental health issues, even though mental health issues often cause academic or behavioral issues (Needham, Crosnoe, and Muller 2004; McLeod, Uemera, and Rohrman 2012). As MTSS puts more students on their radar, one counselor felt as though it increases the odds of “identifying [their unique concerns and challenges] a little bit earlier, [which] would help the team” in the long run. Another way of understanding this insight is that identifying students’ needs earlier will allow the system to be more proactive rather than reactive. One way to increase the likelihood that earlier identification happens is to expand the factors that can land a student in MTSS, while also having the added benefit of strengthening suicide prevention.

Challenge #4. Pursuing Root Causes

Not only should criteria for referrals expand beyond the traditional academic or behavioral issues, but the protocols for processing students once referred to MTSS should also

purposefully include the search for root causes of issues. The middle schools in WSPSD did this particularly well. For example, in one MTSS at the middle school level that we observed, every student that was discussed by the Tier 2 intervention team received a thorough review of all challenges the student was experiencing. Team members dug into their mental health history when possible, discussed their home and outside-of-school life, and so forth. When staff found gaps in records or things that they didn't know but thought might be instructive, they sought out additional information through conversations with the student, parents, and teachers. While this was the normal procedure in the middle schools, this was not what we observed in the high schools.

While pursuing root causes was rare in the high schools, it was a popular idea that school leaders acknowledged would be beneficial. For example, one school leader commented that "[we always] need to figure out what's going on with kids and what's going on is rarely simple." A second school leader envisioned a better MTSS would be one that is "doing root cause analysis." They continued, "we need to be better about [identifying] root causes [of students' problems while] broadening our stakeholders; it's not just kids, but families too." Indeed, families often hold critically important information about the struggles, challenges, and strengths in their children's lives. Encouraging families to share this information with school staff and to work with school staff to effectively support students would strengthen MTSS systems. But this requires building greater trust between schools and kids. As one school leader acknowledged, too many families "have had negative experiences with schools and are leery about being engaged with schools."

Challenge #5. Preventing Information Loss

Perhaps the most important job of an MTSS system is to prevent information loss about students. Preventing information loss is important for both preventing suicide and rampage-style school shootings (Fox and Harding 2006; Goodrum et al. 2022). We observed systematic challenges with capturing important information about students' lives (inside and out of school) in our time in district schools. Information loss takes two important forms.

First, information loss can happen when MTSS teams do not pursue and document the full picture – the root causes – of problems that a student is experiencing. In that sense, MTSS should supplement conventional data, like data on grades or attendance, with reports from teachers, other staff, and, importantly, the student and their parents about broader challenges from diverse perspectives that the student is experiencing (regardless of what issue brought them to the attention of MTSS). These reports should aim to provide a holistic view of the child, including their socioemotional needs, academic history, academic and occupation aspirations, what they like or hate about school, their mental health history, and past interventions and their success or failure.

Second, information loss can happen when staff do not provide requested information to the MTSS team to help them identify interventions or do not provide documentation of how a student is progressing as interventions are implemented. In one school, a member of the leadership team explained the costs they faced with information loss. While they had a clear flow-chart for referring kids to Tier 1 to get them on the radar of MTSS, he said that "the biggest hurdle I saw was getting teachers to document those tier 1 interventions," which often led to later problems when those same teachers would refer kids for a "Tier 1 intervention and we're like doing Tier 2 and 3 interventions."

Closing some of these information gaps will help build teachers' faith in MTSS's efficacy. This can then increase their willingness to engage in MTSS processes (such as responding to requests to provide information about how a student is doing). The consequences of information loss create challenges for helping youth and reducing the burden on staff. Because MTSS is only as effective as the knowledge staff have about the referral process, including whom they can and should refer, MTSS can only gather some data if staff are committed to providing it.

Challenge #6. Issues with Technology

While we are aware that the district could not always control the need to change computer systems, we would be remiss if we did not discuss the strain frequent changes of district software and computer systems puts on documentation. As one school leader noted: "you have to document it in X, oh wait, now you have to document it in Y software, and now you have to document it in EduClimber. It's another new thing to learn. And then it turns out it is the same as Alpine." Having a stable system for documentation will make this job much easier on school staff.

Challenge #7. Securing Leadership Buy-In

Fundamental to effective MTSS systems is buy-in from school leadership. In one building, where MTSS was fragmented, a school leader named Mike was exasperated when asked to describe the system, or lack thereof:

> It's not good. [We] have had 10 people in charge of it and [they] all tried to create something that isn't so cumbersome, but it is…I was in charge of it at one point [and] it's a struggle in my mind [because] at the high school levels you're looking [at so many] kids...[If a]s a student, you're doing well, [w]e incentivize playing hoops for 45 minutes. But when we [have to] refer [a student to MTSS,] it's a three-month process and by the time it's [resolved] the quarter is over and they're in another class. So, it makes direct intervention difficult.

A counselor named Ashley, who works in the same building, expressed a similar defeated sentiment. This was not because she lacked faith in MTSS, but because she felt leadership was not supportive:

> I've been the MTSS coordinator in every building I've been. There is a defined process on paper, but there is not one in reality [in this building]. For instance, we have a large number of kids on READ plans, but I couldn't tell you who they are or if they are receiving services to help close that achievement gap.

When asked why this was, Ashley replied "It's administrative…In this building, no one wants to be on it because it's not valued. Valued as a process, an understanding. *It's not that they don't want to help kids. They don't realize that if they had a strong systemic plan it would help with attendance, mental health, discipline, changing schedules*." One consequence of leadership's resistance, as highlighted by Ashley, is that staff are less inclined to buy in. Another school's MTSS was ineffective because, as the school leader explained, "Staff will not fill out [an MTSS] form. They will not continue to document things whether you tell them it's the law." In the same conversation, the school leader we spoke with, Mike, felt it was an impossible task to reorganize MTSS:

> So, if we're thinking that's where we're going to be able to start [MTSS up again], we've already shot ourselves in the foot. This is just me but we need to be very honest about what we can do and what we can't, and what we can't do is focus on getting people called into us. We can pull data. We cannot fix them all. We need to triage and find those that we can help and help them. We cannot save them all. So, we need to focus on those we can save.

We found schools that typified the opposite sentiment, where leadership had a vested interest in MTSS. In one high school, a different school leader, Manty, had been tasked with revamping the whole system. For a time, he led the Student Support Team that dealt with Tier-2 and Tier-3 students, which consisted of two counselors, an in-school mental health professional, and seven teachers. This extensive group had built a process that made referral easy, captured information in a single Excel file that combined the fact-finding data collected from parents, youth, and teachers, and had a protocol for following up with youth and teachers. What is important to note is that this school's MTSS program, like all MTSS programs, faced challenges, particularly being visible on teacher's radars for referral. School leadership adapted to this challenge by putting a teacher in charge of the MTSS group, while having the school leader responsible for MTSS remain a vital member. Manty explained: "Just because we have this doesn't mean every teacher knows about it. That's our black hole. But the reason I feel good about MTSS is that I used to run it all but it's not sustainable for admin to run it all. Giving it over to the teacher running it means he can circle around other teachers and do the follow up that I don't always have the time for." In every case that MTSS was effective at achieving both its academic and mental health goals, there was synergy between leadership and MTSS. This smoothed the path for expanding MTSS from a set of interventions for some kids to a system designed to make the school a safer, happier community.

Towards a Stronger MTSS

While we identified many challenges to MTSS in WSPSD, they are all possible to address. The first step is to change staff's attitude towards MTSS, particularly school leadership. School staff must have confidence that investing time, energy, and resources in MTSS actually will help students and importantly help staff do a better, more efficient job at student support. We suspect that the best way to do this is to train school and MTSS leaders in how to build effective MTSS systems. In our research, the best MTSS system that we observed had (1) strong support from the school's administration; (2) a dedicated leader who was an experienced school counselor; (3) four different Tier 2 teams that met weekly; (5) each Tier 2 team included representatives of school leadership, school counselors, school psychologists, teachers, and intervention specialists. This diverse participation is crucial to creative problem solving and building a system that works for all staff members of the school community. The MTSS system also had (6) diverse ways that students could be identified for Tier 2 supports (self-referral, teacher referral, parent referral, counselor referral) and (7) diverse reasons for referral (academic, behavioral, engagement, mental health, disability, etc.).

The culture of the successful MTSS Tier 2 team also emphasized pursuing root causes for the student's support needs no matter what reason students were referred to the Tier 2 Team. This translated to offering diverse interventions that met the student's needs (e.g., mental health, academic, social-emotional, etc.). The Tier 2 teams also had many established systems for collecting data about student needs. One of the most powerful of these was something they called "Learner Surveys" which were brief surveys the student, teachers, and other staff

members could fill out. The goal of these surveys was to understand what the student liked and hated about school, what worked to help the student meet school expectations, and the student's goals in high schools and their future plans and dreams (work, postsecondary education, etc.). They used this information to design individual plans to address the student's challenges. Finally, there were strategies to follow up and determine if interventions were working as needed.

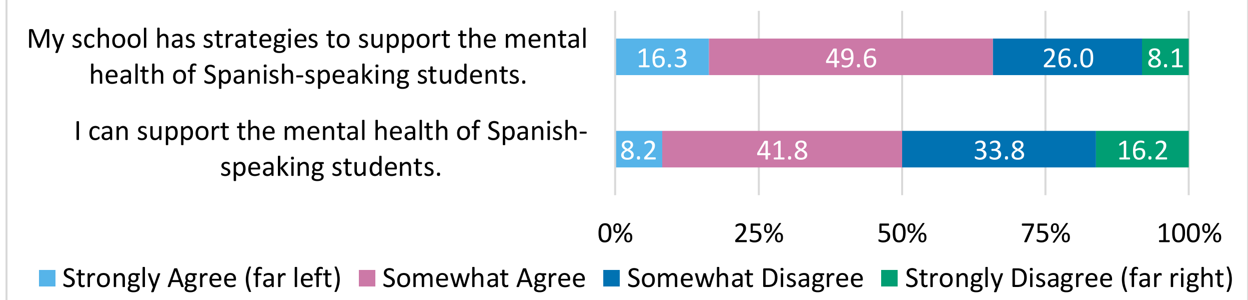
In addition to ensuring that systems are robust and effective, it is important to ensure that systems work equitably for all students. One major gap on this front that we identified is in school's abilities to communicate with Spanish-speaking students and their families. Strengthening suicide prevention in this culturally and linguistically diverse community will require strategies to ensure that families and school staff know how to communicate effectively with each other, particularly in moments of crisis.

Overcoming Communication Barriers

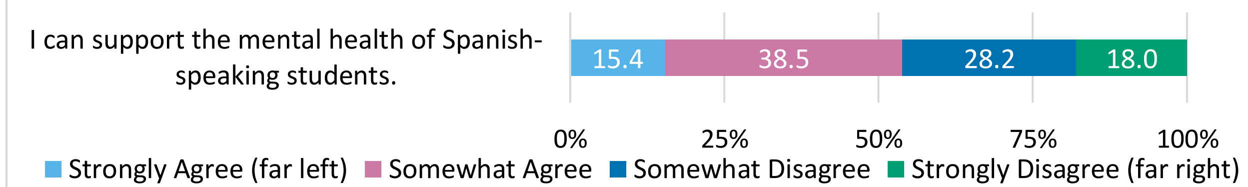
For school systems to effectively work for all students, we must ensure that they can effectively support Spanish-speaking students and their families in the district. Given that out of the 21,000 students in the district, 25 percent are Latino/Hispanic and 3.4 percent are English Language Learners (with likely a higher percentage of Spanish-speaking parents and guardians), ensuring that support systems work for these demographic groups is important. While we also understand that some families and students speak languages other than Spanish and English, we unfortunately only had English and Spanish-speaking students and their families participate in our study. This allows us to comment on some of the unique challenges Spanish-speaking families faced that are relevant to suicide prevention on in Western Slope. However, we recognize that families that speak less represented languages will likely be even more marginalized than Spanish-speaking families in this community since there are Spanish-speaking school staff and community organizations in Western Slope. While this is a limitation of our research, we hope that by sharing the experiences of Spanish-speaking families and students we can highlight barriers and problems in the system that can inform how to support any language minority youth or family in the Western Slope community. We identify barriers to support below.

Communicating with Spanish-Speaking Students

In general, school staff recognized that there were gaps when it came to supporting the mental health of Spanish-speaking students. The district has staff prepared to translate materials in English into Spanish when needed for schools and every school had at least some bilingual staff who were sometimes available to translate for students and families. That being said, results from the staff survey show that 35 percent of staff do not think their schools have strategies to support the mental health of Spanish-speaking students (Figure 11, below). Furthermore, 50 percent of school staff doubt their individual ability to support the mental health of Spanish-speaking students.



Being able to speak Spanish was not prevalent among mental health staff in most schools. As a result, it is not surprising that almost 46 percent of mental health staff in the district doubt their *own* ability to support the mental health of Spanish-speaking students (Figure 12, below). This is troubling given the key role mental health staff play in mental health support and suicide prevention.



In our conversations with school staff, they also expressed concern about their inability to support ELL students emotionally and academically. For instance, one teacher recalled the experience of teaching an ELL student who spoke no English:

> We had a girl who showed up from Central America and she spoke no English. None. And she looked like a deer in headlights. And there are no other Spanish-speaking kids [to translate for her] and I can use Google Translate for documents, but it's really isolating for her. So, we tried switching her to a different level class with a teacher who can provide some language support…but now that teacher has to teach in two languages.

The academic and social obstacles described by this teacher are obstacles that many ELL students face within the district and highlight the challenges in supporting them. This example also highlights a common strategy schools employ to support ELL students: they place them in classrooms with teachers who are bilingual. This, of course, means, as the teacher above acknowledged, that these teachers now have added duties and must deliver content in English and Spanish. Students also are placed in classes whose level is not a match for their academic performance or preparation. Their language needs potentially eclipse their learning needs (though they are not unrelated).

Unsurprisingly, given this scenario and the prevalence of ELLs, many school staff would like additional district assistance with serving ELL students. One English teacher felt like the

“district doesn’t offer much support for ELLs. The district acts like our high school doesn’t have language learners.” A school leader echoed this teacher’s point, stating, “For years, we have struggled in our office to get direction from the…district. When we turn to [the district], I have struggled to get clear direction, clear support, and then that’s frustrating for me when a student has tested out [of the ELL program] but still needs some support.” Supporting ELL students and balancing when they should leave the program with their need for services is a challenge school districts face around the U.S. and not at all unique to this school district. Still, it is important to highlight these equity concerns.

While these language barriers can impact students’ general ability to participate in learning opportunities, for our purposes, we are concerned with their implications for mental health supports and suicide prevention. School staff are very aware that many of their ELL students came to the United States through difficult circumstances. ELL students, according to school leaders we spoke with, also noted that these students often have heightened challenges with their home lives that can increase their socioemotional needs at school. One school leader said:

> Our ELL kids are not moving here because they are doing great…Things in their family life at home are not always easy…and we aren’t given any discretion, no local control, in how we support them…this isn’t new. It's been like this for years and years and years.

The school leader implied that there are several factors that resulted in ELL students immigrating to the community. We heard about students who may be refugees fleeing violence or may have been impacted by a natural disaster.

Children of Latino immigrants noted challenges relating to cultural differences and cultural expectations that impacted their mental health. We interviewed one Latina student whose parents are immigrants and she emphasized:

> Personally, and from other people that I know, people who are kids of immigrant parents, it's really hard to talk about mental illness or that you're struggling because they mentioned the fact that [parents] had it a lot harder…immigrant parents expect you to make them proud…It’s a really big pressure for students that you have to get the best grades, be the best you can, like succeed in order to make your parents prouder in order for them to have had a reason to immigrate here.

For this student, it was sometimes more difficult to talk about mental health because of the dramatic differences between her own life experience and the life experiences of her parents. Additionally, her parents’ expectations of her created additional pressure.

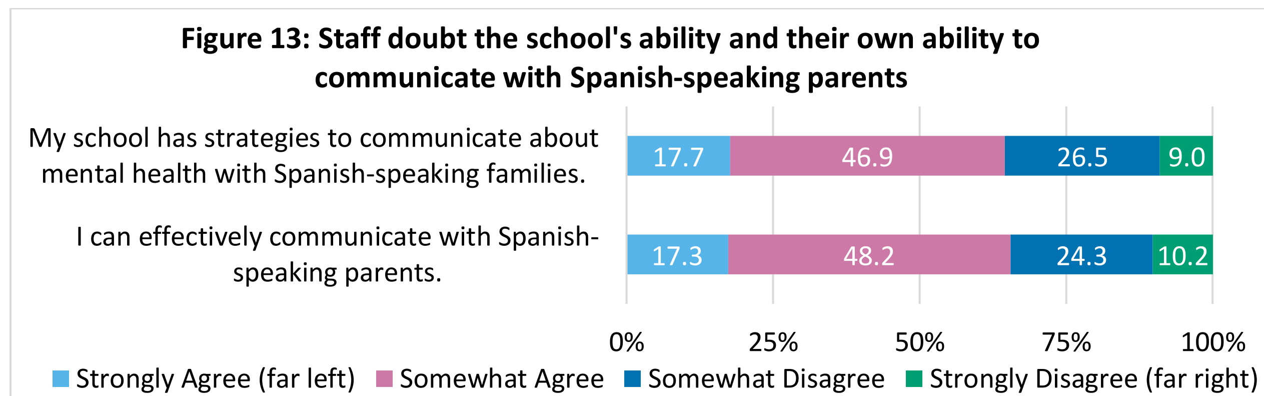
These students have gone through difficult experiences, are facing economic insecurity, or simply are coping with high parental expectations. Such cultural differences highlight the importance of ensuring that school mental health safety nets work for these students. In short, ELL and second-generation students require academic support *and* emotional support — supports that schools are sometimes struggling to provide. While the bullying and challenges to cultures of belonging outlined earlier in the report are barriers to connectivity, so too is the lack of fluent trusted adults. This is especially important when we consider that Latino students’ families may be facing similar or worse discrimination in addition to expected struggles in

adjusting to a new place. The school is a key point of integration in American life for immigrants, and subsequently, the same support students need extends to their families as well.

Communicating with Spanish-Speaking Families

Just as speaking with Spanish-speaking students is challenging, communicating effectively and promptly with Spanish-speaking families can be as well. Although only 3.4 percent of students are English Language Learners (ELL), many non-ELL Latino students have immigrant parents who speak little to no English. School staff are aware that they serve a large Latino/Spanish-speaking community that has its own culture, language, and values.

Results from our staff survey show that staff have concerns about their ability to communicate with Spanish-speaking families. Over 30 percent of school staff, including teachers, administrators, and mental health staff, do not think their school has strategies to communicate about mental health with Spanish-speaking parents (Figure 13, below). Furthermore, about 35 percent of staff doubt their own ability to effectively communicate with Spanish-speaking parents. Overall, these results illustrate the lack of confidence school staff have in their ability to connect with Spanish-speaking families.



These concerns also appeared in our conversations with school staff. For example, in one interview when we asked whether there were a lot of staff capable of speaking enough Spanish to convey concerns about a student's academic or socioemotional struggles, the staff member replied, "No. Just the Spanish teachers. Our staff does not match our population. We desperately need more teachers who match our population. We need some more diversity in this building; in that area." Diversity among staff would bring positive benefits to ethnic students and families: they would serve as important role models, mentors, cultural translators, and, in some cases, literal translators for Spanish-speaking students (Redding 2019).

Despite these concerns, the district does have established strategies to facilitate communication with families that do not speak English. The district has a translation services office with bilingual staff. Still, we found instances where these services were insufficient in enabling Spanish-speaking families to easily access their child while they were at school. For example, in an interview conducted in Spanish, a mother named Fernanda recalled a time when she tried to call the school to check her child out early and she was unable to accomplish this simple goal:

> There are times, I don't know why, but bilingual staff don't last long in schools, and I'll call because my son has appointments and I want to go pick him up. I call and say, "Spanish" and they say, "One moment" and then send me to an

> answering machine. They say they are bilingual, but it is an answering machine. I need them to respond to me at the moment, not leave a message. I need someone to respond to me at that moment because my son is about to have an appointment. I need to go pick him up.

Unfortunately, experiencing these barriers is not an isolated incident. Fernanda went on to explain how similar issues are frequently discussed among other Spanish-speaking Latinos in the community:

> [Other Latinos and I] also [talk about] how we need more bilingual people [in schools] because sometimes we will go with a problem or we will call and, well, we have to have our child translate. And, the child will tell the school whatever they want. And, well, no. We need someone who is genuine in the situation so they can interpret correctly.

For most parents, this delay in communication is an annoyance, but one that makes their ability to be actively a part of their child's school life and school community harder than it needs to be. Still, we observed instances where English-speaking parents needed to get immediately in touch with school staff because they learned that their child was in a suicidal crisis on school grounds. It is not clear how a Spanish-speaking family would immediately reach school staff in the same situation. Simply put, communication is imperative to student safety and should not be treated as an annoyance. As a different Spanish-speaking mother, Martina, shared:

> I can tell you that my kids are healthy, my kids are alive, but there are times where if we're not informed about that stuff [by the school]...how will we help them? How will we know what to do? So, we need to be informed so we can know how to help…it's something very, very…well worrisome for us as parents.

The district has taken multiple, commendable measures to serve Spanish-speaking families, which include a district translation office, as well as Spanish-speaking staff at every school who communicate with parents. We recommend continuing to expand on these efforts. However, as illustrated by the Spanish-speaking families that we got to know, these measures are not foolproof and do not entirely ameliorate obstacles to establishing the open lines of communication that are key to supporting student safety and mental health.

Efforts to be Trauma-Responsive

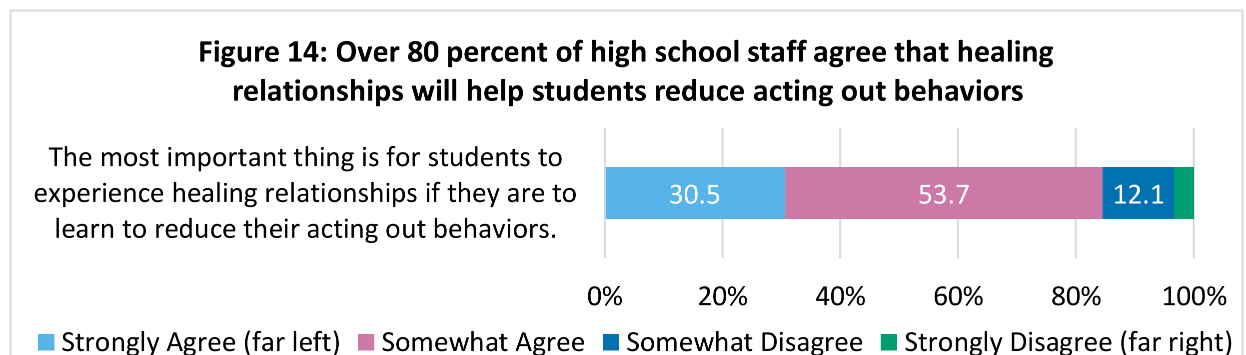
The final way schools engage in suicide prevention work is by working to be sensitive to the traumatic experiences impacting many students in the district. Youth across the U.S. suffer a wide range of potential adverse or traumatic experiences, including homelessness, food insecurity, or trauma associated with poverty, abuse, neglect, or alcohol/drug misuse, and so forth. More than two-thirds of youth aged 16 and younger have experienced at least one traumatic event in their lifetimes (Finkelhor et al. 2015). Trauma can influence a student's behavior, academic progress, relationships with adults and friends, as well as their mental and physical health. WSPSD school staff clearly demonstrated their desire to effectively support students who have experienced trauma. This further underlines the district and individual schools' commitment to the whole child and to promoting mental health and suicide prevention.

School leaders were very aware of the trauma that their students were bringing with them to school. One school leader shared with us:

> The trauma that so many of our kids have gone through...I think poverty is one of the traumas...We have so many kids that have been sexually assaulted or molested or abused. We have so many kids who have really horrific home lives with divorced parents, or…they have 90 days before they're going to get evicted...There's so much horror that they face outside of our walls that I always just tell them, *I want you to feel safe or safer here than you do in your living room*.

This awareness also informed staff's strategies regarding how to best help students. Some staff have snacks in their rooms for students who may be hungry; some schools have clothing and personal hygiene products available as well; and one school had an in-house wellness clinic that provided a range of supports that may be difficult to obtain elsewhere, including medical services.

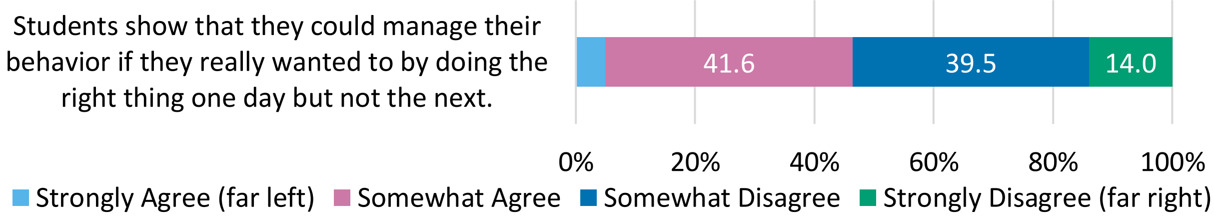
School staff especially emphasized the importance of building relationships with students as central to providing effective support for students who had experienced trauma. For example, Figure 14 below shows that over 30 percent of high school staff strongly agree that healing relationships are crucial to helping students reduce acting-out behaviors that teachers often experience in classrooms.



While these efforts to connect were related to the culture of belonging discussed in an earlier section of the report, there was also an explicit awareness that being sensitive to students' trauma histories mattered a great deal. For example, when discussing a struggling student, one counselor explained that the student had "some heavy trauma anniversaries coming up" and had previously been in crisis. To respond to the situation, he discussed how he had built a good relationship with her parents, making it a "no brainer to call the parents" and check in to make sure the student was doing okay with the impending anniversaries. Involving families in their child's mental health journey and recovery from trauma supported students both at home and at school and may be appropriate for most students. This can allow staff members to work together with families and triangulate information on how to best support the child.

As with all successful efforts at preventing suicide, trauma response remains an area of potential growth. Our staff survey revealed that a substantial percentage of staff hold incorrect beliefs about trauma. Figure 15 (below) reveals that 47 percent of staff agree that students could manage their behavior better if they really wanted to since some days they behave well and some days they don't. This is considered an incorrect belief because something could have happened in a child's life to change their behavior one day or the next (one example was raised above – an anniversary approaching). Healing from grief and trauma is not a linear process, and students may experience setbacks.

Figure 15: About 47 percent of high school staff agree that students show they can manage their behavior if they really wanted to by doing the right thing one day but not the next



A substantial minority of high school staff also felt that students' trauma was used as an excuse for avoiding holding students accountable for their actions. While schools cannot function without boundaries around acceptable behavior and discipline to enforce those boundaries, trauma should be considered when disciplining students and teaching them to be accountable. Otherwise, the lesson will be lost. Additionally, using trauma-responsive disciplinary practices, like restorative justice (which is in use in many schools) can be more effective to teach accountability to students with a history of trauma. Unfortunately, in both the middle and high schools, staff acknowledged that their school relies heavily on consequence-based discipline (detention, suspension, and other punishments). This applied to about 49 percent in high schools as reported by staff. On the positive side, 80 percent of high school staff and about 81 percent of middle school staff agreed that they know how to adjust their teaching practices to support students who have experienced trauma. We recommend supporting these teachers with evidence-based training.

One school mental health worker shared that while they think Capturing Kids' Hearts is a great surface level training and a great start for WSPSD, schools need further training. For example, about 35 percent of high school staff and about 20 percent of middle school staff reported that they still did not have a strong understanding of the symptoms traumatized students display. Additionally, when asked if they knew the next steps to take if they suspect a student has experienced trauma, about 40 percent of high school staff and about 38 percent of middle school staff reported not knowing what to do. School staff also reported struggling to know about or access appropriate resources to support students outside of school when taking those next steps, particularly when it came to students' difficulties at home. Interestingly, staff seem clearer on what to do if they encounter a suicidal student and less clear on what to do if they encountered a student experiencing trauma at home. This is surprising because in many ways, the protocol is the same – tell the school counselor or a school administrator (and complete any obligations with regard to mandatory reporting).

One similarity with suicide prevention was that staff reported that some of their hesitancy with responding to student's traumas was linked to their discomfort with trauma-related topics. Here, one school mental health worker noted:

> I had a really awesome opportunity a couple of weeks ago to do a two-and-a-half-hour in-service for my staff...I had them do the ACE questionnaire. I had them reflect on their own privilege and their own trauma histories and that resonated. When it got to making the connection about how [social emotional

learning] in the classroom can help move us in that direction, I hit a lot of resistance because it's really outside their comfort zone.

School staff also reported struggling to know about or access appropriate resources for students outside of school, particularly when it came to students' home lives. One teacher shared, "I would love to have just some at-your-fingertips resources, even if you could program five numbers into your phone, the homeless, suicide, whatever, and just put them in and be able to call." Providing all school staff with an easy to access list of these resources would be a great starting point.

To summarize, school staff often recognize that various forms of trauma show up in the school and classroom. They use strategies like forming relationships with students and families, as well as school resources, to support them in effectively responding to students' needs. However, many staff need more education in trauma and its effects on children (especially their behavior and ability to control their behavior). Perhaps most importantly, equipping staff with strategies to use in classrooms with students who display signs of trauma or even just behavioral challenges would help them avoid contributing to student's dysregulation. Building out more opportunities for training and resources can further assist staff when it comes to issues related to trauma.

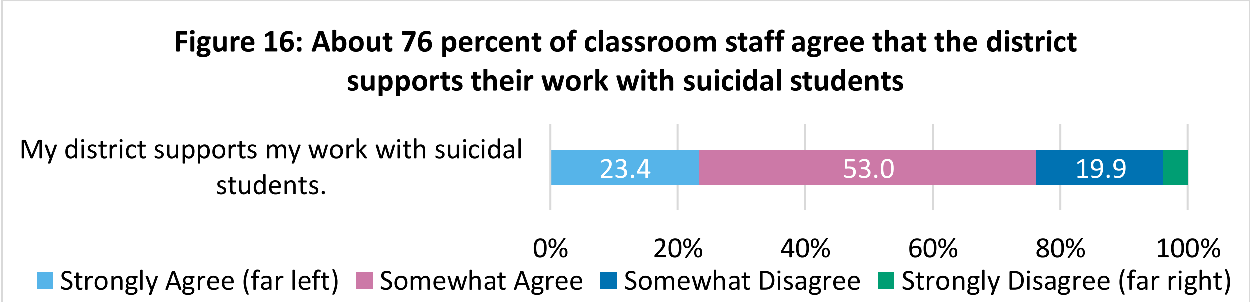
The District's Role

Much of the daily work to support student's mental health and prevent suicide happens in schools. The school district plays a crucial role in developing evidence-based protocols that conform to current best practices and support the work of school-level staff. As we saw earlier in the report (in Section IV), strong and clear district policies are associated with staff well-being. Staff feel better when they believe the district is protecting them and students. The district also has opportunities to develop protocols and policies that address some of the barriers that discourage staff from engaging in suicide prevention work – like legal liability and knowledge gaps (see Section IV).

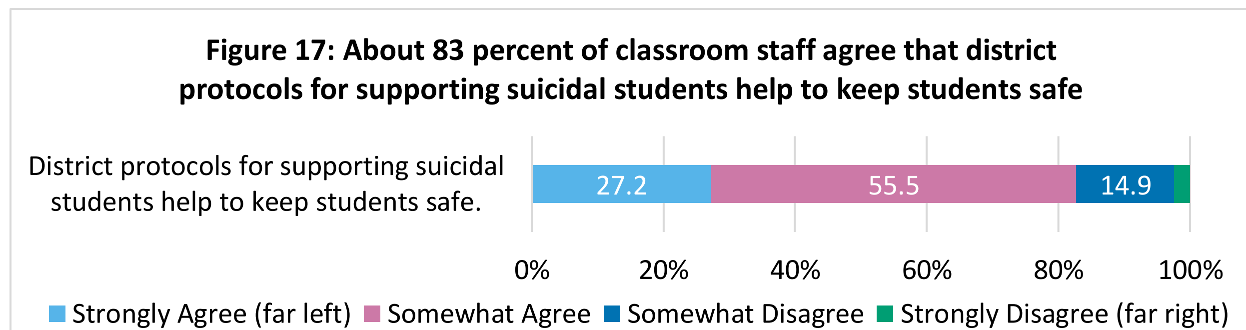
Classroom Staff's Opinions Regarding District Policies

To identify areas of growth at the district level, we begin by reviewing how staff feel about the current state of district policies and procedures. We begin by assessing how staff who are **not** in mental health staff or school leadership positions (which we will refer to as "classroom staff" for brevity) feel about the district. Figure 16 (below) summarizes how classroom and student support staff feel about whether the district supports their work with suicidal students. The good news is that the majority (76 percent) feel that the district does support their work, though only 23 percent strongly agree. Additionally, this does leave a sizable portion of staff reporting that they feel unsupported (24 percent).

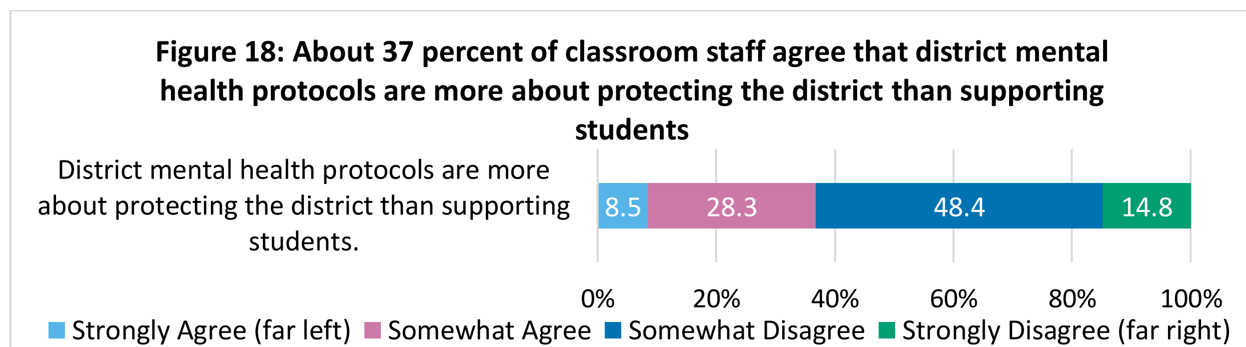
Figure 16: About 76 percent of classroom staff agree that the district supports their work with suicidal students



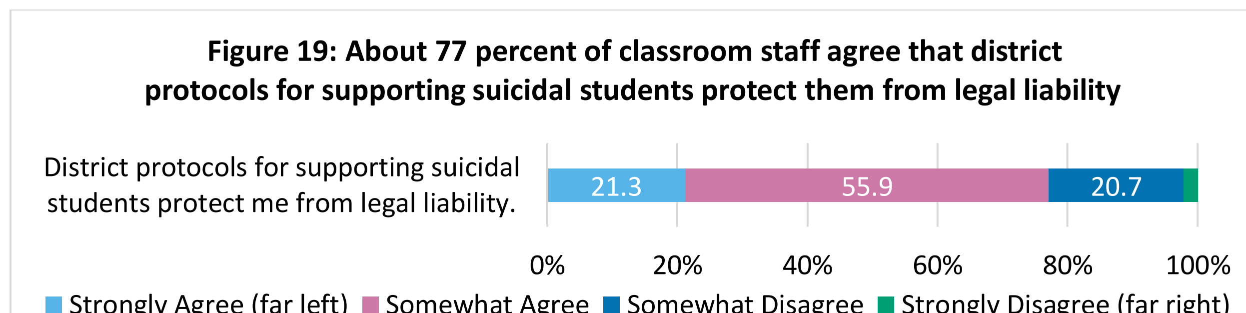
A majority of classroom staff also agree that the district's protocols for supporting suicidal students help to keep students safe. Once again, only 27 percent strongly agree and about 17 percent do not agree, indicating some room for improvement (Figure 17, below).



When we ask classroom staff the question differently – whether district mental health protocols are more about protecting the district than supporting students – we find similar patterns (Figure 18, below). Only 9 percent of classroom staff strongly agree with this statement, though another 28 percent somewhat agree. The majority disagree, with 48 percent somewhat disagreeing and almost 15 percent strongly disagreeing. The district does need to protect itself from legal liability in the current litigious climate, but in an ideal scenario this need would not undermine the district's abilities to support students and those students would be prioritized.

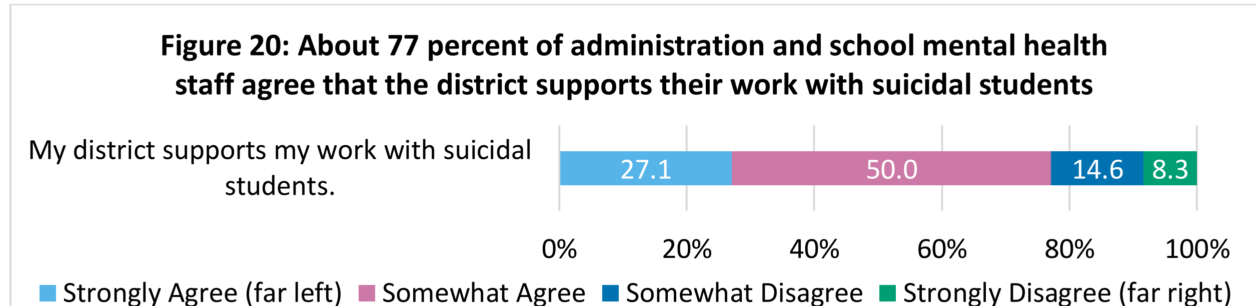


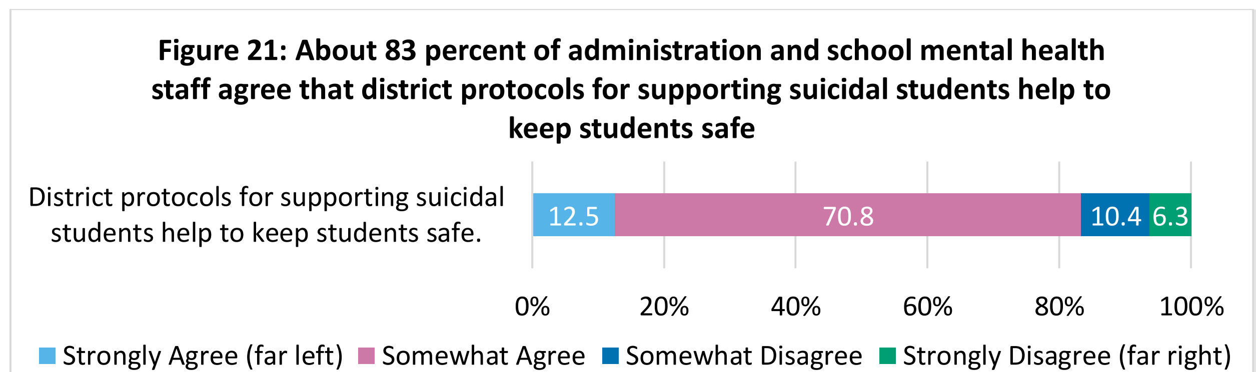
Finally, we asked classroom staff about legal liability directly. Importantly, 77 percent of classroom staff feel that the district's protocols protect them from legal liability, which is a major barrier to staff engaging in suicide prevention work (Figure 19, below). Though once again those who strongly agree are a minority (21 percent) and are almost evenly matched with those who disagree (21 percent). Thankfully, those who strongly disagree are a very small minority (about 2 percent).



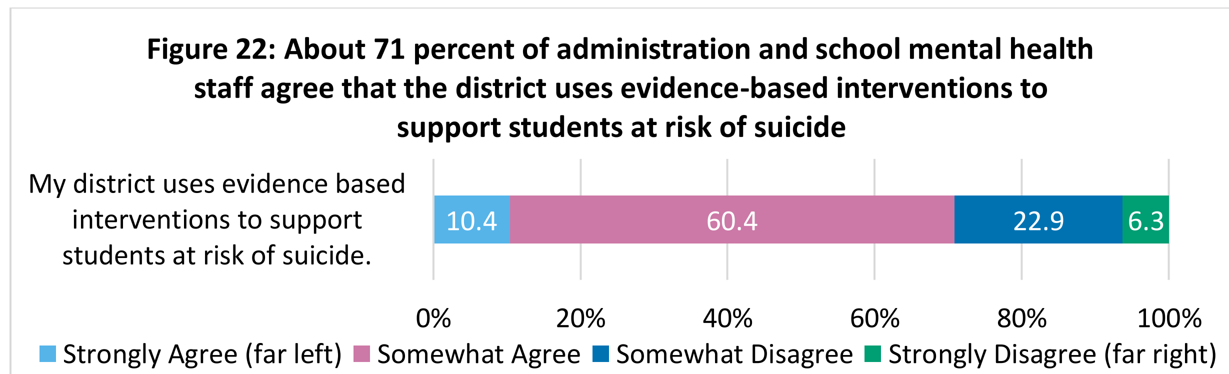
Mental Health Staff and School Leadership's Opinions Regarding District Policies

We asked the same questions to the school's mental health staff and leadership to assess how they feel about district mental health policies. Similar to classroom staff, 77 percent of administrators and school mental health staff agree that the district supports the work they do with suicidal students, though 15 percent somewhat disagree, and 8 percent strongly disagree (Figure 20, below). When asked whether district protocols keep potentially suicidal students safe (Figure 21, below), the majority once again agree with 13 percent strongly agreeing and 71 percent agreeing somewhat – a fairly strong endorsement of district policy. Still almost 17 percent disagree (either strongly or somewhat) that district policy helps keep students safe.

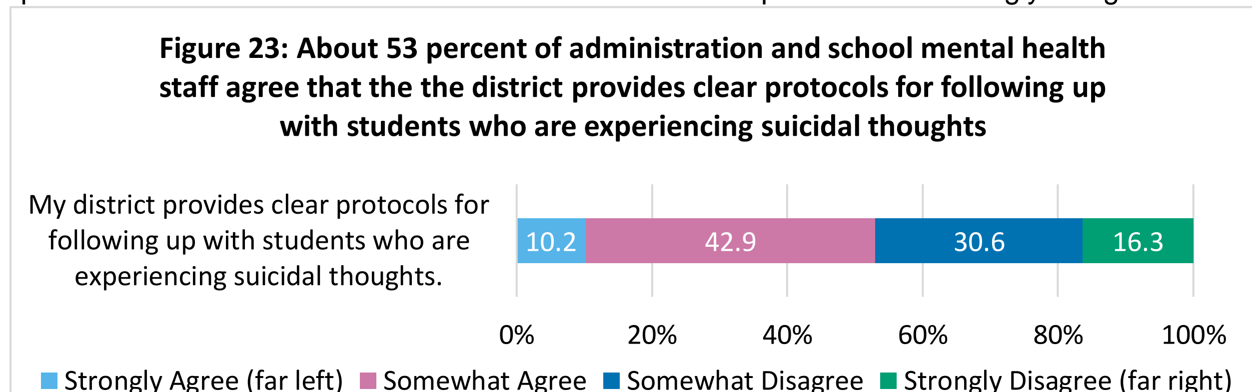




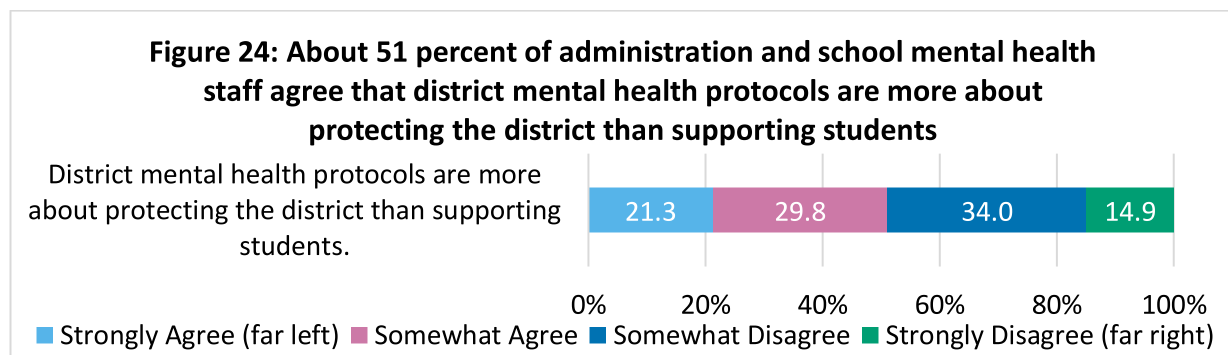
Unfortunately, we did not follow up with staff to understand their specific concerns with district policy, though we did assess their opinions on two specific district policies (that we did not ask classroom staff about since they are generally not involved in these tasks). In Figure 22 (below), we asked mental health staff and school leaders whether they agree that the district uses evidence-based interventions to support students at risk of suicide. Ten percent strongly agree that the district does and an additional 60 percent somewhat agreed. Still, 23 percent somewhat disagreed, though only 6 percent disagreed strongly.



Follow-up supports for suicidal students was a theme that mental health staff in particular let us know they were concerned about in our conversations with them. Follow-up is important as suicidality can be chronic or take time to resolve (Binnix et al. 2018) and when staff do not follow up with students they know are distressed (whether suicidal or not) it can exacerbate that student's pain and even discourage them from seeking help a second time (Mueller and Abrutyn Forthcoming). For that reason, we asked whether the district offered clear protocols for following up with suicidal students (Figure 23, below). More members of the mental health and administration teams disagreed that these protocols are strong, matching our qualitative conversations with mental health staff. Sixteen percent even strongly disagreed.

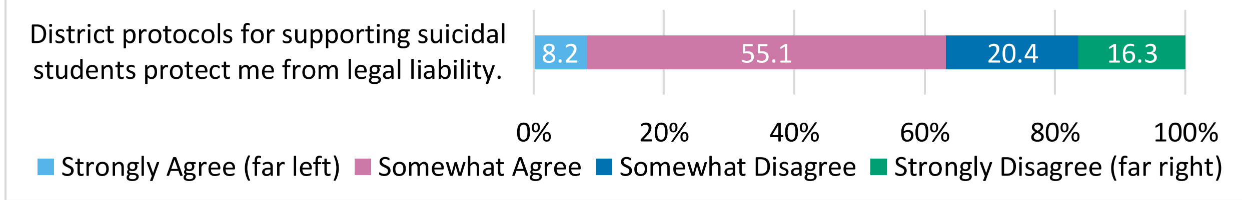


Next, we asked whether members of school leadership or school mental health teams felt that district mental health protocols are more about protecting the district than supporting students (Figure 24, below). Mental health and leadership staff are less confident than classroom staff in this regard. While only 9 percent of classroom staff strongly agree with this statement, 21 percent of mental health and leadership staff strongly agree. Additionally, more mental health and leadership team members somewhat disagree (34 percent) compared to classroom staff (48 percent, recall Figure 18 discussed above).



Finally, we asked mental health and leadership staff specifically about whether district protocols for supporting suicidal students protect them from legal liability (Figure 25, below). Only 8 percent of school mental health staff and administrators strongly agree that district protocols for supporting suicidal students protect them from legal liability. Another 55 percent of these staff somewhat agree that the protocols are protective. This is significantly lower than among classroom staff, 21 percent of whom strongly agreed with this statement (recall Figure 19 above). This finding is particularly important since legal liability is a major concern for mental health staff and school leaders.

Figure 25: About 63 percent of administration and school mental health staff agree that the district protocols for supporting suicidal students protects them from legal liability



Assessing District Policies

In general, district policies with regard to suicide prevention follow best practices, though there is a constant and evolving need to stay up to date with the current literature. It is critical that the district has a qualified mental health professional to help them with this task. This is not something that someone without mental health expertise can easily do. Our research does suggest some areas that can be improved.

The Need for Evidence-Based Forms

While the district's policies are often evidence-based, their forms are not always consistent with evidence-based best practices. For example, when we began fieldwork, the district's **safety planning forms** were not consistent with best practices for suicide prevention and instead were understood by most staff as worthless and oriented towards "CYA" (which they sheepishly explained meant 'Cover Your Ass'). Our understanding is that after we brought this to the attention of district personnel, this was remedied, and that mental health staff have been trained or will be trained in safety planning. We also strongly recommend that school leaders and school nurses/nurses aids be trained in safety planning if possible so that there is always someone to help support potentially suicidal youth.

Importantly, safety planning is very different than a no-suicide contract which should **not** be used and is **not** considered an evidence-based practice (in fact, no-suicide contracts may do harm) (see Gallo and Wachter Morris [2022] for an excellent discussion and up-to-date review that is consistent with the American School Counseling Association's ethical standards and principals). In general, all school forms must be consistent with evidence-based best practices. The Colorado School Safety Resource Center is a great resource for evidence-based forms that can be adapted to local needs with the help of local experts (at the district and school levels).

The Need for Role Clarity

Though our survey data reveals that teachers are often clear on their role in suicide prevention – namely they are expected to help identify students who may be at risk and send them to their school counselor (or other school mental health staff, or if they are not available to school leadership) for additional support and assessment. Making sure all teachers understand that this is what is expected of them may encourage more teachers to get involved in suicide prevention and feel comfortable while doing it if this expectation was made clear.

Non-teaching classroom or other support staff – like librarians, custodians, paraprofessionals, secretaries, etc. – often do play important roles in students' lives and making their school days run smoothly, but their role in suicide prevention is not always as clear to them as it is for teachers, mental health staff, and school leadership. We found this was particularly

true for school secretaries, who often were the people who greeted students as they walked in the door and who helped students access resources (e.g., seeing the school nurse or sometimes a counselor). Secretaries often know every student in the building. For some parents, especially Spanish-speaking parents, Spanish-speaking secretaries may also be their primary point of contact and communication with the school. And yet, it can be easy to overlook these critical team members when thinking about suicide prevention protocols. Thus, it is essential that these staff understand their role and how to play it. Based on our fieldwork, many of them will embrace supporting students in this way. As one secretary told us, "I'm like the mother of the school." And kids respond to their warmth and support as such. Therefore, the district should make sure that all staff positions understand clearly what role they are expected to play in suicide prevention and how to play it.

Direct Referral to Crisis Centers (No Colorado Crisis Services)

During fieldwork we learned that if a student is considered at a high risk of suicide, Colorado Crisis Services will be called to repeat the suicide risk assessment and refer the student to a local crisis center. This procedure does not make sense if our goal is to keep students safe. It may make sense if our goal is to protect the district from legal liability or if this is the **only** way for a student to gain access to the local crisis center which we call Valley Behavioral Health (we discuss this crisis center further in the next section). The most important thing to be clear about is that this procedure does **not** help students. Research has shown that suicide risk assessments are not designed to be repeated; a second screener is likely to be less valid. Once one screener has been administered and shown a student is higher risk for suicide, steps should immediately be taken to triage that student to a higher level of care. Waiting for Colorado Crisis Services to repeat the procedure before granting the student access to the local crisis center is **not** okay. It delays care, puts the student through additional stress, and serves only as a barrier to care. While we understand that this policy is less tied to the district than to the crisis center, the district would serve youth well by objecting to this procedure. Specifically, the district should advocate with the local crisis center for school mental health staff to be able to directly refer students to the local crisis center.

School counselors, school psychologists, and school social workers are mental health professionals who have the professional capacity and responsibility to assess students for risk of suicide consistent with their professional standards (including the American School Counseling Associations professional standards). For more on this, we highly recommend that all read Gallo and Wachter Morris (2022).[4] Importantly, there is a guarantee that school mental health staff are highly trained mental health professionals with master's degrees. There is no such guarantee with Colorado Crisis Services, though they will be trained in completing suicide risk assessments, but there is no guarantee they have a mental health degree or certification.

VII. Beyond the School District

While our research emphasizes the role of schools in suicide prevention, schools cannot do this labor alone. Suicide prevention is everyone's job, and it takes a community to change the world for youth. In the following section we examine how people and organizations beyond

[4] This article can be freely downloaded at this link: https://trace.tennessee.edu/cgi/viewcontent.cgi?article=1246&context=tsc

the school and school district can better support youth well-being and support schools in preventing suicide.

We begin by discussing the broader community and how community resources matter. We then discuss the crisis center and barriers to accessing it that should be removed to improve suicide prevention in Western Slope. This discussion is followed by a review of how faith communities can help promote healthy, happy childhoods. Finally, we conclude by discussing strategies to transform a suicide hotspot – or a location where a disproportionate number of people go to die by suicide – into a safer space.

Community Resources

All communities have resources that can improve the well-being of their members even though the quality, number, and accessibility of these resources is sometimes limited by factors beyond the community's control. When we asked staff, families, and students what recommendations they had for reducing suicide, they identified several ways the community might focus its resources to improve the well-being of youth. In particular, community members discussed the lack of activities for youth as well as barriers that reduced their ability to access existing activities. In addition, many felt that the school, families, and youth could benefit from leveraging the beautiful natural environment surrounding Western Slope. Finally, we also heard about the stigmatizing attitudes people believed the community held about mental health, and how this too might be an area that the community could find creative means to improving.

Limited Activities

One issue youth in Western Slope face is a lack of access to recreational activities or spaces during their free time. As we heard previously (in Section II) students took issue with the lack of activities and places for them to gather. They felt that this made too many kids turn to unhealthy behaviors (like drinking or using drugs) and even exacerbated their risk of suicide. A "third place" for youth to be besides home and school can be greatly beneficial in expanding youths' options for their free time (Abbott-Chapman and Robertson 2015). Parents agreed with this assessment, noting that the limited extracurricular activities presented a challenge for healthy adolescent development. For instance, we asked, "Why do you think that Western Slope has a higher [suicide] rate, especially for youth?" One parent felt, "We're very limited on resources for the kids to have any sort of activities…There's just not a resource to keep kids occupied in a positive activity." Another parent said, "This community knows that our suicide rates are higher than other areas of the state…A lot of people will say, 'There's nothing for kids to do here. What do you expect?' Basically, there's no support for them. There's nothing for them to do."

Importantly, parents also shared that when youth had access to recreation and community centers, their effect was positive. One parent we spoke with saw the benefits of one such recreation center for her son: "In [our area], they do have a rec center, which is huge. My son, my oldest, he used that a lot as a youth…It's kind of a place where youth can just be, which is nice."

Unfortunately, other parts of Western Slope (which is a fairly spread-out community), have struggled to build community centers for youth. A parent we spoke with told us:

> They tried to get a community center here and not enough people supported it. People would be like..."What do we need one in [Western Slope] for?

> There's one in [a different part of the county]." That's a 25-minute drive and not everyone has a car. And, if you're at work, how are you going to get your kid to [out there] to go to the community center?

Other community members – some in leadership positions – confirmed that efforts to build community centers, particularly in the less affluent areas of the community, had not been successful despite a community desire for them. Addressing this may be beneficial to both youth well-being and to equity in access to resources in the community.

While increasing access to activities is important, parents and guardians also noted that even when extracurricular activities existed, like those that related to sports, the costs could be prohibitive, particularly for lower income community members. One parent said that there are not "many after-school activities [and those that we do have], they're expensive. So there's lots of youth that can't afford them." In some cases, athletic programs offer scholarships for lower-income families to address this gap in access. However, the competition for a scarce number of spots and a range of hidden costs beyond just team fees or dues makes free or reduced-cost access more theoretical than practical. As one parent described, "If you can't do all the things those teams require you to do, you're not going to make the team." Consequently, because she sees these opportunities as essential for her child's development, she sends her child to out-of-town sports camps that cost thousands of dollars. It takes extra time to drive her child there and back. Inequality in access to extracurricular activities may persist despite efforts to improve equity.

School staff were also aware of inequalities in students' and families' abilities to take advantage of the local environment. For example, a school staff member told us, "I started an outdoor club, and it was just mind blowing to me how many kids had never been to [the local nature fixture], never been to [the nearby national parks], never been to the river, and so we started trying to get kids doing that and it was just really eye-opening to me."

A mental health professional said:

> [Western Slope] is a mecca for outdoor activities. So, we've got the rivers, we've got the mountains, we've got the canyons, we've got the beautiful red rock. We have wonderful outdoor options, but access to those options for a lot of people is super limited. You can take a cab if you don't have a car. But if you don't have money, you can't take a cab. Our public transportation is really limited. It doesn't go to the [state park]. It doesn't go to [hiking and biking trails]. So those things, the things that a lot of us utilize in this area to protect our mental health, a lot of our lower income families don't have access to that.

It's true that spending time outdoors, in nature (Beyer, Szabo, and Nattinger 2016; Bratman et al. 2019), as well as getting physical exercise are protective for mental health, including for youth (Bélanger et al. 2019). Research has shown that spending time in outdoor environments can have positive effects on heart rate, blood pressure, and self-reported measures of health (Kondo, Jacoby, and South 2018). Natural environments are also uniquely restoring to people's well-being – they are different from taking a walk in an urban environment (Berman, Jonides, and Kaplan 2008). Thus, any way to facilitate access to the outdoors in Western Slope is likely

to be beneficial to mental health. However, the community should also consider issues with transportation, a topic we turn to next.

<u>Geography and Transportation</u>

Part of Western Slope's appeal is its geographic location and the open space it provides in contrast to more crowded major metropolitan areas. However, the downside to this geography is that the community is quite spread out, generating a need for reliable, consistent transportation. A parent summarized the difficulties families face when she told us that there is "this crunch around transportation and carpooling and figuring out ways to shuffle kids back and forth. Because there's not a good bus system here, and things are [too] far apart as far as biking [goes]." Parents and guardians frequently mentioned the stress of trying to arrange transportation for their children. Another parent described the lack of options because of the spread-out nature of Western Slope: "where we live, there are no buses, there is no train. I mean, I guess technically my kids could start Uber-ing, but I mean, there's not even anything close enough to where I live…There's not even a convenience store…[Kids] have to rely on you to take them to whatever." In addition to causing parental stress, the lack of available transportation curtails youths' independence.

This lack of transportation options may contribute to feelings of trapped. Another parent aptly labeled Western Slope a "treadmill town" where "kids feel boxed in [and]…trapped." She elaborated, saying:

> We are physically boxed in…Nothing is close. It's not like you can hop in your car, like in [a city]…[in those areas] if you wanted to really do something better with your life, you could drive down to the beach in 30 minutes. You could go to a mountain in 30 minutes, you could go explore another part of the desert in 30 minutes. It's not the same here. Everywhere you go costs extraordinary amounts of money. You have to have snow tires, you have to have permission to drive, you have to be safe. You have to have the money to get there. There's just nothing for these kids to do. Nothing to do but drink and be bored and eat Taco Bell.

This quote indicates that Western Slope's physical isolation may further decrease the activities available to youth. A former student described living in Western Slope:

> [It] feels like nothing else happens in the world except for in that town, so it is very close and very suffocating…Obviously, the culture there is the part to play and it's just, you feel stuck, and you are stuck, physically and mentally.

He attributed feeling stuck to his own experience with suicidality when he was in high school. Previous research shows that feeling like there is no escape from one's current situation or that one's options for making social connections are limited based on proximity is dangerous for mental health (Abrutyn and Mueller 2016; Baumeiester 1990). It seems this risk is heightened when the feeling of being stuck is a feature of the culture of the place. We learned that this feeling of being stuck is exemplified in a so-called curse that we learned about from parents and young adults. One parent explained, "Anyone that tries to leave is not going to be able to leave really forever. Like they'll always come back. They'll always come back unless you take the dirt from these four locations." True or not, the persistence of a legend like this speaks to the pervasive feeling of entrapment.

Improving public transportation may not address feelings of entrapment in the community or the so-called curse, but it may increase opportunities for youth and families in Western Slope. For example, accessible, frequent public transportation would make the existing community center more accessible to youth who live in other parts of the community, while also giving youth greater autonomy and independence to travel to other places.

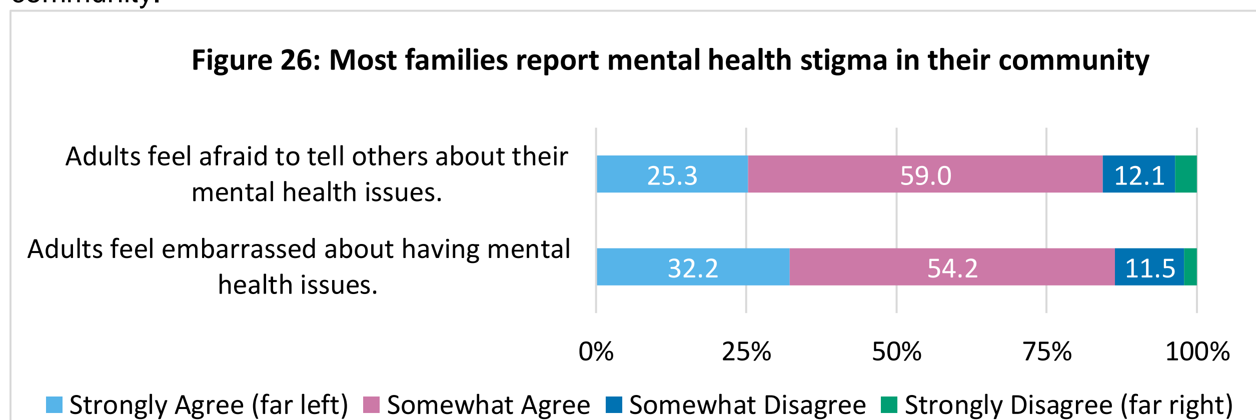
Improving transportation would also have the effect of improving access to mental and physical healthcare in the community more broadly. Nearly 10 percent of the families that took our family survey reported that they did not always have reliable means of transporting their child to mental healthcare appointments. These appointments are critical to suicide prevention.

Better transportation options may also allow a greater number of Western Slope families to use the abundant wealth of outdoor activities. Thus, improving transportation options is a great way to increase the added value of existing community resources, improving community mental health.

Community Attitudes toward Mental Health

Research on attitudes towards mental health in the U.S. consistently show that many stigmas persist. Where mental health is stigmatized, people are less likely to actively seek help for fear of being shamed by friends or neighbors. This stigma may also lead communities to ignore lingering problems and effective solutions. We found evidence that mental health is stigmatized in Western Slope. Another opportunity to improve the promotion of youth mental health and suicide prevention involves addressing mental health stigma.

According to our interviews and surveys with family members, many parents and guardians acknowledge that mental health is stigmatized in the community. For example, one parent said that the "general community atmosphere is, 'I've got this car, I've got this house, I've got these things and so I'm doing good' even though…everyone's mental health is not what it appears to be. It's not encouraged to talk out here, [and] you can't not be okay here." In our survey data, we find significant support for this parent's beliefs. Almost 85 percent of families agree that adults are embarrassed to have mental health issues (Figure 26, below). Similarly, about 86 percent of families agree that adults are afraid to talk about mental health issues in the community.



These fears are amplified when parents feel pressure to raise children without needing external support, like mental healthcare or resources that promote family security which is a critical building block of well-being for parents and kids. A parent lamented, "It is not highly

looked upon if you're a parent who has to seek out alternate resources. It's kind of that pull yourself up mentality. I do feel like there's a lot of stigma and shame if you're somebody who has to utilize and live off those resources." She gave an example of a community food pantry program in schools that many parents felt too ashamed to utilize. Parents' perceptions of stigma can thus hinder the support they can give their kids. This issue can also arise when children have mental health concerns. This mother also shared:

> I feel like that's one of the hardest things to navigate is even say you have a kid who gets a [mental health] diagnosis, it's really hard to even find like a support group of other parents coming together to talk about those things. Thank God for the internet, because if I didn't have even telehealth, being able to reach out beyond our community, I wouldn't have the support I do.

Fortunately, our survey also revealed that families tended to seek help for their kids' mental health challenges despite their fears of judgment. Unfortunately, they often felt alone in this pursuit of support, as they preferred to keep their family's business private. For example, one parent shared, "[My child's mental health and suicidal ideation] is not really something you just want to share with everybody…I don't want people looking at him differently because then it will just make it worse on him." At times these fears could impede help-seeking, making it all the more necessary to address mental health stigma in the community. Parents need to be able to seek help for their kids' mental health needs without worrying that others will mistreat their children.

Accessing Care During Mental Health Crises

Please note, the following section summarizes findings from our data collection efforts which ended in May 2023. Since the end of our data collection, we understand that a psychiatric emergency room with walk-in services has opened in Western Slope and that Valley Behavioral Health (a pseudonym) is under new management. The new management is aware of many of the issues we raise below and is actively working to address many of them, including ensuring sufficient Spanish-speaking mental health staff, expanding access to mental healthcare, working on issues related to continuity of care, building trust with Western Slope residents, and restoring VBH's reputation. While we have not and cannot assess these efforts, as our data collection has ended, the opening of the psychiatric emergency room is an incredible first step that we applaud. Given VBH's importance to suicide prevention, we welcome these changes and are hopeful that they signal better things to come.

The mental health stigma was further compounded by barriers to accessing mental healthcare that we identified within the Western Slope community. These barriers were most egregious when families sought crisis care. Valley Behavioral Health (VBH) (a pseudonym) is a prominent mental health care provider and major player in crisis care in Western Colorado. In fact, it is one of the very few mental health crisis centers in the area. While we observed and heard of some positive experiences with VBH, most people had negative experiences or stories about VBH. For instance, one student stated, "it's helped a couple people I know, but other times I think it gets a bit of a reputation for not doing very much, or being harmful, actually." Overall, staff, families, and students were critical of VBH. A school mental health staff confided, "I'm being honest, [Valley Behavioral Health] is worthless." Another school staff member said,

> I don't feel comfortable sending kids to [Valley Behavioral Health]. I feel like that's not somewhere I would send my own child, so I don't feel comfortable referring families to

> them. If this kid is immediately in a position where they're talking of committing [sic] suicide, the options would be [Valley Behavioral Health] or [major hospital].

That the hospital's emergency room is not simply the preferred option over a crisis center, but perceived by a mental health professional as the only option is concerning (though this emergency room is equipped to assess youth risk of suicide and triage them to care). Even if VBH provided excellent care, its negative reputation will limit the likelihood that community members will see it as a viable option for support and safety.

It is notable that our family survey found that community members are not resistant to crisis centers in general. More than 89 percent reported they were likely go to a crisis center if their child was experiencing a crisis. However, when asking about VBH specifically, most community members expressed a range of concerns about VBH's therapeutic or crisis intervention services. One community member told us she has tried for years, to no avail, to steer families to VBH. She noted:

> I think the hardest thing with [Valley Behavioral Health]...first of all, their reputation's terrible to the point that nobody even considers it a viable option. There used to be a really great peer specialist there that I was really good friends with and I would tell patients like, "Oh, you have to go see [her]. She'll change your life." And they were like, "Great, yeah. Where do I see her?" And I'm like, "She runs groups at [Valley Behavioral Health]," and they're like, "Oh yeah, we're not doing that." Parents would say, "I'm not doing that." Kids would say, "I'm not doing that." Their reputation is so bad that even if they have the services, no one wants to take them up on it.

Some of these negative reputational claims were tied to experiences. Nearly every school mental health staff we spoke with relayed one or more stories about the poor response, communication, and quality of services their students experienced after they were referred to VBH. Families had similar experiences. For instance, many parents we interviewed commented on their difficulties gaining timely support, as VBH requires potential patients to first call a 1-800 number to gain access to their services. **The lack of walk-in crisis services at a crisis clinic was described as problematic. When we discussed this situation with the clinicians who serve as formal consultants on our research project, they stated unequivocally that lacking a walk-in crisis center was unacceptable. The only reason for VBH to require a referral before entry was to limit the number of people they were in-taking. Also, it is important to note that this is NOT the case with other crisis centers in Colorado. On the Front Range, school counselors, parents, or youth themselves can walk into a crisis center and gain access to services. This is a severe gap in the mental health safety net in Western Slope.**

The issues continued when families gained access to services from VBH. These issues included lengthy wait times, too few providers, and general disorganization or miscommunications among VBH staff. For instance, one parent recounted their experience at VBH while their daughter was in crisis:

> I ended up putting her in the car, taking her to [Valley Behavioral Health]. They just put us in a room with this buzzing fluorescent light. We were there for, I

> bet, two hours. One person had come in, and asked a few questions, and then just made us wait. It was just no one was coming in.

Many crisis centers and mental healthcare facilities struggle with wait times and sufficient staffing (there is a shortage of mental health providers in the U.S.). Many parents also have negative experiences with crisis centers because of the nature of mental health crises. There is no way to fix them quickly. Instead, a crisis center's main job is to stabilize a young person, keep them safe while the worst of the suicidal crisis passes, and coordinate longer term care – whether that is inpatient hospitalization or outpatient therapeutic resources. These are very stressful moments in a family's story. Still, crisis centers should do all they can to address wait times and other barriers that make the experience of seeking crisis help negative for families and children.

A key concern, given the sizable Latino population in Western Slope, is the lack of accessibility for some families because VBH does not always have a Spanish-speaking translator on staff. One former employee could not recall "a single time we have a non-English speaking patient who I felt got everything we could have given them." A school staff member provided a similar story about a student's grandparent who tried to access VBH services during the granddaughter's suicide attempt. In that case, the grandparent reported that she waited several hours to be connected with a Spanish-speaking provider who could conduct a safety plan over the phone (as VBH reported they were at capacity on-site)[5]. Even more concerning, when the grandparent requested additional in-person options, she discussed how VBH offered one sister facility as an alternative – even though it was four hours away and did not have Spanish-speaking services. Additionally, the VBH website offers very limited information for non-English speakers, outside of listing one phone number specifically for Spanish speakers. This issue of limited Spanish-speaking services conflicts with the fact that nearly 70 percent of Hispanic family members (admittedly only some of which were non-English speakers) we surveyed (N=75) indicated that they would be very likely to contact a crisis center to support their child. Thus, VBH, along with the local emergency rooms, must be ready to serve the local Spanish-speaking population. Given the many issues prevalent to VBH, along with its poor reputation, strengthening timely and linguistically competent access to crisis services are critical to supporting this community.

Faith Communities

Research has shown that participating in a faith community can be a powerful protective tool against poor mental health and suicidality. This is largely because it helps provide a safety net for families and youth, access to resources, and can help families navigate stress (Schieman, Bierman, and Ellison 2013). In the family survey, around 74 percent of families agreed that faith in God can relieve mental health struggles. As one staff member explained, "If a person were to ask me…'What is the role of faith or God in a person's mental state or health,' I think a lot. There are many scriptures in the Bible that can uplift your spirits per se. Your mood, or your mental state, or your perspective of yourself." While religious beliefs may provide one source of positive mental health, it is also the relationships and connections people build with their faith communities that can serve as support systems. Unsurprisingly, approximately 66 percent of families in our survey agreed that religious leaders can help relieve mental health struggles. Additionally, overall, almost 20 percent of families who had actually experienced a

[5] As an aside, this is an intervention that could have been offered by the school.

mental health crisis with one of their children turned to their religious leader for help. Of those who turned to their faith leader, almost 60 percent rated that person as "very helpful" and no one rated them "not at all helpful." Indeed, of all the people families turned to, their religious leader was the category that had the second highest ratings for helpfulness (second only to mental health professionals).

When we asked a school staff member what their church would do if someone came in asking to discuss their mental health, they said, "We are very caring, very accepting, and we would probably flood you with a lot of support from the Bible and whatever else we can provide. Counseling, not a formal counseling, but giving advice." As one school mental health worker summarized, "I think the faith community is a source of strength for people and families. Definitely. Honestly, in the families that I've worked with, sometimes they look to their faith community for counseling or support in that way." Faith can be a source of comfort for many individuals.

Some families and students we spoke with felt that there were benefits to faith-based counseling. Current research highlights how important it can be to integrate a patient's religious faith or spirituality into the provision of psychological services (Currier et al. 2023). This is part of current movements in clinical psychology to be more aware of individuals' intersectional identities and unique cultural needs. A student said, "[My counselor] gives good advice in a non-secular way, which means that it also fits and it correlates to my religious beliefs," making the therapy more useful for them. Having therapy and counseling embedded in faith communities, which is a resource that people already trust and value, can be a powerful way to make therapy accessible and acceptable. For some, they may find support in counseling that is not explicitly faith-based, but still ties into their religious beliefs. For instance, a parent shared:

> It's such a wonderful thing to realize how much God loves me and that he wants me to be healthy. So that helps me want to pursue therapy because I want to get to be my best self. And people who love you and accept you, no matter what state you're in, I find those people in my church and I find it in my best friend, and I find it in my spouse, and I find it in my kids.

While this individual's therapy is not faith-based, their faith is what drives them to go to therapy. Thus, secular counseling and faith-based counseling (and faith in general) can work in tandem to lift up those who may be suffering, especially when secular therapists are respectful and interested in their client's faith.

Despite the positives of faith communities, existing research and our own data also recognizes that faith communities can harm youth's well-being when they are a source of stress (Schieman, Bierman, and Ellison 2013) or trauma (Ellis et al. 2022). In the Western Slope, this was most obvious when youth's socioemotional needs were in conflict with their parents' religious faith. This caused students to struggle to seek help and to reconcile who they were with who their faith communities expected them to be. Counselors in schools also saw this as a challenge to students' mental health. They noted that this was especially true for LGBTQ+ students. Not only did LGBTQ+ youth frequently report that their faith communities were not accepting of them, but they feared their parents' anger if they were to tell them about their gender or sexual identity. Counselors, even more so than with non-LGBTQ+ students, continued to search for solutions to balancing the needs and well-being of the student with the religious beliefs of their parents and faith communities. Many staff, families, and students

reported dissatisfaction with their church's stance on sexuality and gender, and cited this position as reason for leaving their faith communities altogether.

Thus, while religiosity can help protect against suicidality by promoting feelings of belonging (Pescosolido and Georgianna 1989), this may not be the case for LGBTQ+ individuals in the Western Slope – something that existing research has also found (Blosnich et al. 2020). This finding is particularly relevant given our earlier discussion of the unique needs of LGBTQ+ youth. They are at higher risk of suicide than heterosexual youth in part because of family and community rejection and feelings of shame (Haas et al. 2010). To better support everyone in the community, especially those at a higher risk of suicidality, we encourage faith communities to prioritize unconditional support, inclusion, and openness, which in turn, can foster suicide prevention.

Preventing Suicide at a Hotspot

A unique feature of Western Slope is that it has relatively close proximity to a suicide hotspot. A suicide hotspot is defined as a "specific, accessible, and usually public site which is frequently used as a location for suicide and gains a reputation for such" (Cox et al. 2013). Given our focus on how the broader community can help improve suicide prevention, doing what we can to address this hotspot is an important community consideration.

Prior research identifies four main ways of preventing suicide at suicide hotspots. The first, and evidentially strongest method, is restricting access to means. For instance, a bridge that is commonly used for suicide could be fitted with barriers, like fences or screens, which make it more difficult for individuals to jump and die by suicide. Barriers also work by increasing the amount of time an individual experiences between arriving in a place and engaging in an act that could end their life. This can allow space and time for an individual to reconsider their decision to die by suicide and is one important way that means restriction works (Cox et al. 2013). The second method of suicide prevention at suicide hotspots is encouraging help-seeking. This can include installing telephones near the hotspot that connect individuals to crisis counseling centers (like 988 or Colorado Crisis Services). Another option is signs with positive statements and contact information for crisis centers. Third, training staff to be ready to respond to individuals who are in crisis and increasing the likelihood of third parties (like staff) encountering someone at the hotspot can also help. These latter options are especially important where restricting access to the means is difficult or impossible, or when something like a structural barrier is cost prohibitive — even though the price of the impact of a suicide cannot be calculated (Pirkis et al. 2015).

The fourth and final method for preventing suicide is encouraging responsible media reporting of suicide. Experts have created guidelines for media reporting of suicide. Some of these guidelines include reporting suicide as a public health issue; providing help-seeking resources and factual information about suicide in the article; using appropriate non-stigmatizing language; and emphasizing getting help, accentuating that things can change, and being hopeful. Specific information can be found at https://reportingonsuicide.org/. Proper reporting is essential, as studies have found that in places where media reporting on suicide is not done with care, suicide rates may stay the same (Hamilton, Metcalfe, and Gunnell 2011). However, when the media follows the guidelines responsibly, suicides rates can decline and sometimes even remain low (Etzersdorfer and Sonneck 1998).

Finally, we will note that we have shared additional site-specific insights with appropriate individuals. We are happy to share this additional information with limited community leaders by request, but we must take care to not reinforce this particular location as a suicide hotspot. This concern has shaped our decision to withhold some site-specific strategies and details (like the location itself).

VIII. Limitations

While this study provides an unprecedented and comprehensive view of how schools, districts, and their communities work to prevent youth suicide, it is not without limitations. Our first limitation is that our in-person data collection was interrupted by the COVID-19 Global Pandemic. In many ways, the pandemic has heightened concerns about mental health and revealed how stable (or unstable) school support systems are. It also meant that our initial fieldwork in 2019 was interrupted for nearly a year before we were able to return to observing in schools. While a break in continuity did not affect our ability to collect rich data, it does represent a break in community and school continuity, and the impact may not be fully understood for years. Regardless, we are grateful that the district and all of the schools stuck with the project and worked tirelessly to include us in the everyday happenings of schools.

Our second limitation results from the fact that we only included two middle schools in our study compared to all high schools in this school district. This limits our abilities to make comparisons or understand what may be different in those two schools compared to other middle schools in the district. Still, we are confident that the insights and the policy recommendations that we have provided in this report are a strong starting point for improving suicide prevention in any school in the community and beyond.

Our third limitation is related. While our school leaders worked hard to help us recruit family participants for our family survey, our response rate still remained quite low. We were able to include insights from and the voices of almost 700 families. We would have benefitted from a representative sample. Thankfully, our survey responses were quite diverse, suggesting that some families from all major demographic groups are represented, as were a wide range of families from different political orientations, religious faiths, and beyond.

Our fourth limitation is that while we highlight a substantial amount of insights from the data we collected, time limitations mean that we are still leaving some stones unturned. If staff or families have particular questions, we encourage them to reach out to us to see if we may be able to leverage our data to answer them. We also strongly encourage readers to review the family survey report and the staff survey report (found in Appendix X [to come]). There are additional details around the questions we asked on surveys that may be of interest. We recognize that this is not ideal, and we regret that a full report would be impossible to create and difficult to read and absorb. We do believe we have highlighted the most important findings we learned and emphasized which have direct relevance on practical efforts to promote mental health and prevent suicide.

Despite these limitations, we feel that the rich, multifaceted data that we present in this report provides important and robust insights into suicide prevention in schools. Insights that we can leverage to improve suicide prevention and mental health promotion.

IX. Conclusions

Given rising rates of youth suicide in the U.S., identifying new strategies to improve suicide prevention and to promote the well-being of youth is critical. With this research report, we identify several ways to improve suicide prevention in schools, families, medical offices, faith communities, and beyond. In times of crisis, youth and their families do not just turn to one person or one organization for help. This further illustrates how important we all are to suicide prevention. Some of the changes our research suggests may be necessary to improve our collective capacity to prevent suicide may feel daunting; for example, changing organizational cultures to place higher priority on mental health or shifting our expectations for excellence for youth. However, there are existing interventions and resources that we can use to help us build a happier and healthier world for youth, their families, and ultimately their community. We offer more specific policy recommendations and guidance in the Policy Recommendations section on page xv.

Appendix 1. Comprehensive Findings from the Family Survey

Family Views on Mental Health Promotion and Suicide Prevention on Colorado's Western Slope

By

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Detailed Methodology for the Family Survey

This report presents the findings from a survey of parents and legal guardians administered in Winter 2023. The purpose of the survey was to assess families' attitudes towards suicide prevention and mental health promotion in schools. This report provides the responses to nearly every survey item asked (for a more synthesized report of our findings with policy implications, please see our primary report [Abrutyn, Mueller, et al. 2024]).

All high schools in Western Slope Public School District (WSPSD, a pseudonym) and two middle schools (selected by the school district) were invited to participate in the survey. All parents and legal guardians who have emails on file with their children's schools were sent an email from their school principal with an invitation to participate. Approximately 678 family members began the survey; over 81 percent of the 678 finished the survey.

The survey was offered in Spanish and English. Family members could switch between languages on any question of the survey. The survey was administered online using Qualtrics (an online survey software), though families could also take the survey by phone or on paper by request. We had no requests for a paper or phone survey.

Prior to beginning the survey, family members reviewed an informed consent document and provided active informed consent prior to beginning the survey. Family members who completed the survey and were willing to provide an email address received a $20 e-gift certificate to Amazon.com.

More women (76 percent) than men (19 percent) responded to the survey. The over-participation of mothers and female legal guardians is typical of surveys targeting parents and legal guardians.

Fourteen percent of respondents self-identified as Latino/a, Hispanic, or Spanish origin (with the largest subgroup at almost 8 percent identifying as Mexican or Mexican American). Approximately 2 percent of respondents identified as Black or African American; 2 percent as Asian or Asian American; and 3 percent as American Indian or Alaska Native (per our funders regulations we used Census categories to measure race/ethnicity and our language matches the language used in those questions).

About 53 percent of our sample had a college degree or higher. An additional 14 percent had an associate's degree.

Only 20 percent of respondents reported that they had no religious affiliation and most religious respondents identified as Christian. Their specific denomination varied from non-denominational, the Church of Jesus Christ of Latter-day Saints, Catholic, to Protestant (which encompasses Lutheran, Episcopalian, Methodist, and beyond).

Families held a wide range of political views. More families who identify as conservative responded to the survey than families who identify as liberal. Specifically, 36.2 percent of respondents identified as either "slightly conservative," "conservative," or "extremely conservative." About 26.7 percent of family respondents identified as "slightly liberal," "liberal," or "extremely liberal." The extreme ends of the political belief spectrum (like extremely liberal or extremely conservative) were rare with 2.2 percent of parents or guardians identifying as extremely liberal, and 3.9 percent identifying as extremely conservative. Table 1 (below) summarizes respondents' political beliefs. In short, families with a wide range of political beliefs

responded to our survey. Additionally, having more conservative than liberal respondents matches the political beliefs in the local community, which helps ensure that our survey is accurately representing beliefs about mental health and suicide prevention in the community.

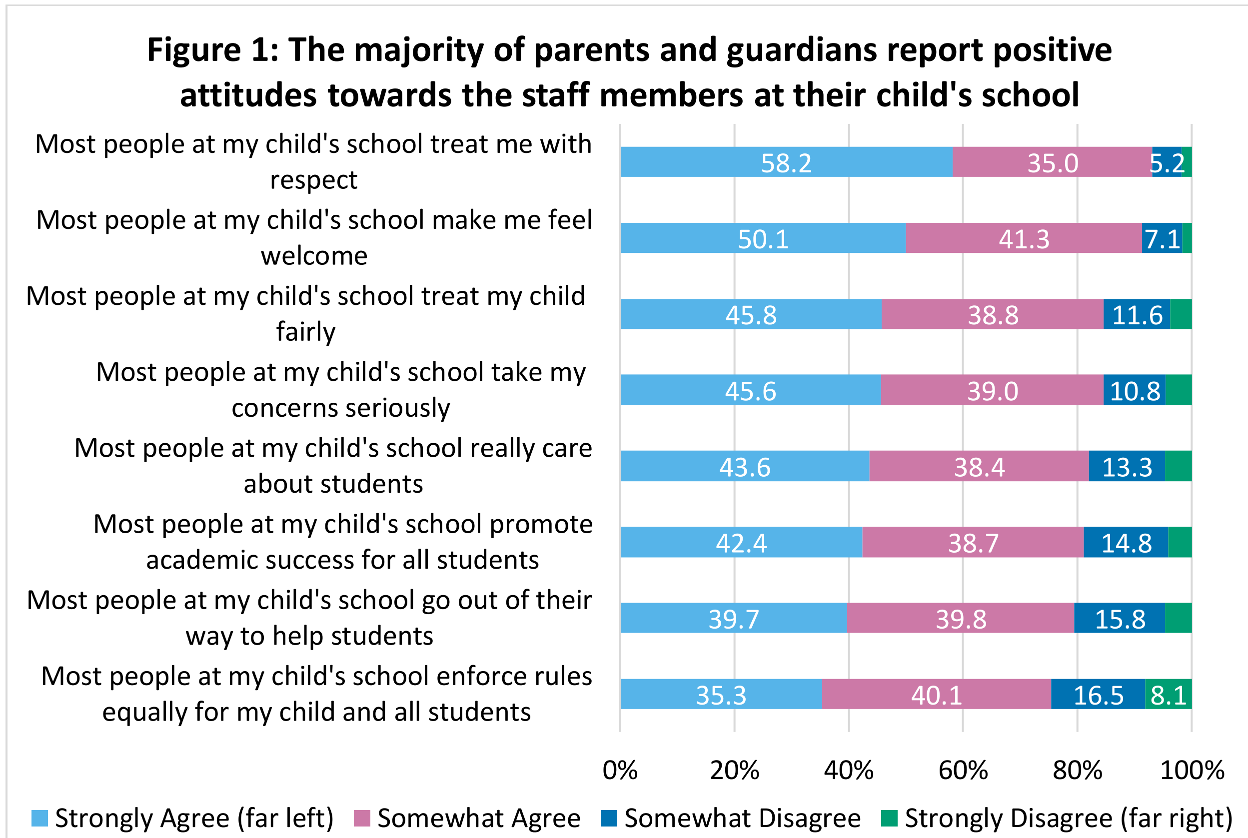
Table 1. Family Respondents' Political Beliefs

	N	Percent	Percent
Extremely liberal	12	2.2	
Liberal	81	14.5	26.7
Slightly liberal	56	10.0	
Moderate/middle of road	109	19.5	19.5
Slightly conservative	54	9.7	
Conservative	126	22.6	36.2
Extremely conservative	22	3.9	
Haven't thought about	22	3.9	3.9
Don’t know	17	3.0	3.0
Prefer not to answer	59	10.6	10.6

Almost 95 percent of respondents speak English in their homes, though 9.3 percent speak Spanish in their homes (some, in addition to English). Families also reported other foreign languages in their homes, like German, American Sign Language, Hebrew, Mandarin, and beyond. Twenty-three respondents rely on their children to help with English language translation. Importantly, for our purposes, this is representative of percent of English Language Learners in the school district.

The majority of family respondents filled out the survey while thinking of the high school their child attended, while 13.5 percent filled out the survey while thinking of a middle school (because families can have multiple students in a school, we asked parents and legal guardians to let us know which school they would focus on with their responses).

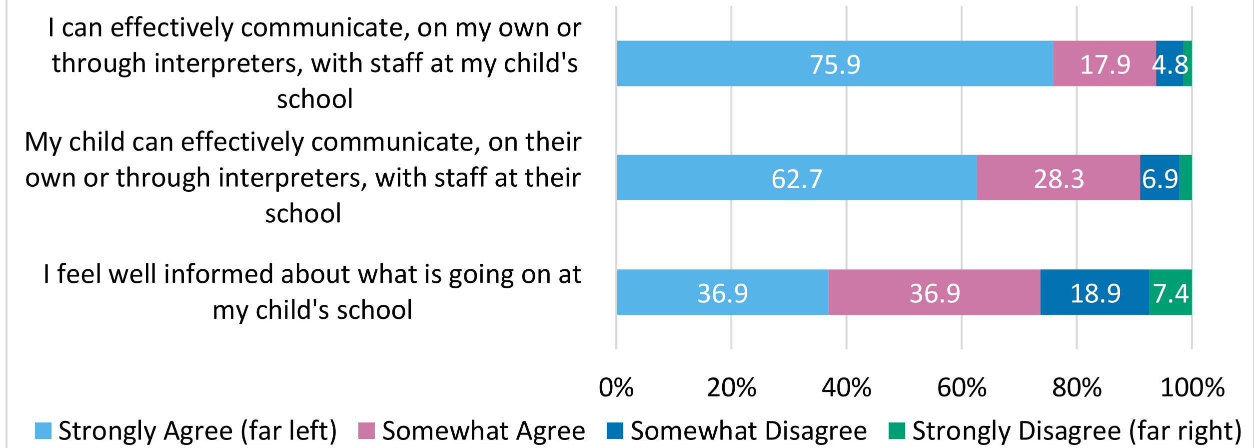
Families' Attitudes Towards their Child's School



Key Findings:

- Over 93 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that most people at their child's school treat them with respect.
- Over 90 percent of parents and legal guardians AGREE that most people at their child's school make them feel welcome.
- Nearly 85 percent of parents and legal guardians AGREE that most people at their child's school treat their child fairly.
- Nearly 85 percent of parents and legal guardians AGREE that most people at their child's school take their concerns seriously.
- Around 82 percent of parents and legal guardians AGREE that most people at their child's school really care about students.
- Around 81 percent of parents and legal guardians AGREE that most people at their child's school promote academic success for all students.
- Nearly 80 percent of parents and legal guardians AGREE that most people at their child's school go out of their way to help students.
- Around 75 percent of parents and legal guardians AGREE that most people at their child's school enforce rules equally for their child and all students.

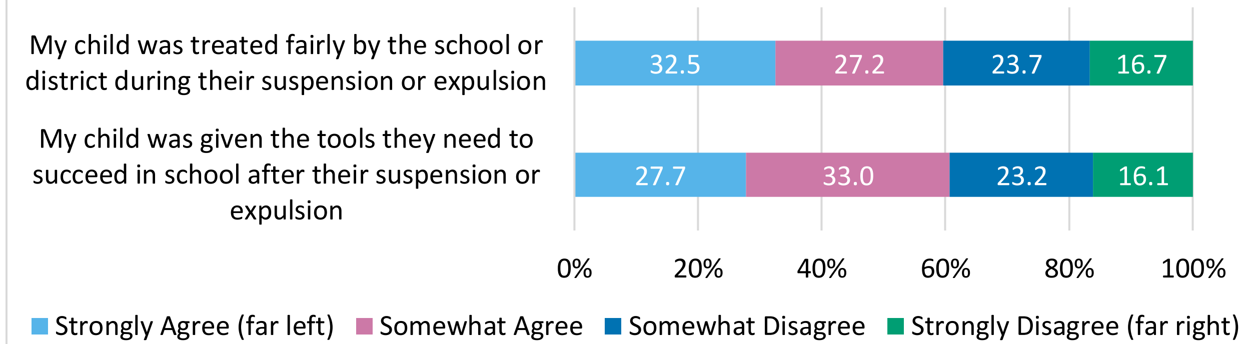
Communication between Families and their Schools



Key Findings:

- Nearly 94 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that they can effectively communicate, either on their own or through interpreters, with staff at their child's school.
- About 91 percent of parents and legal guardians AGREE that their child can effectively communicate, either on their own or through interpreters, with the staff at their school.
- About 74 percent of parents and legal guardians AGREE that they feel informed about what is going on in their child's school.

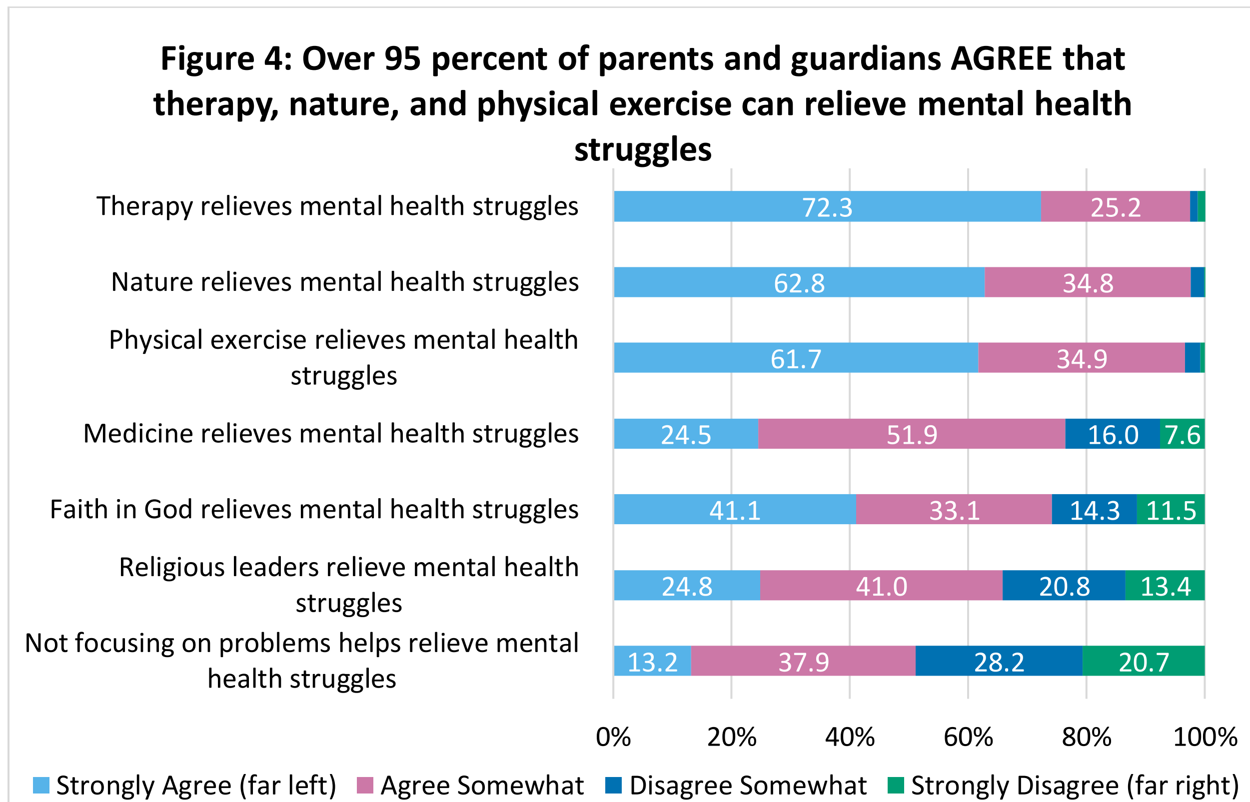
Families' Experiences with School Discipline



Key Findings (from Figure 3, above):

- Nearly 60 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that their child was treated fairly by the school or the district during their suspension or expulsion.
- Nearly 60 percent of parents and legal guardians AGREE that their child was given the tools that they needed to succeed after their suspension or expulsion.

Families' Attitudes on What Relieves Mental Health Struggles



Key Findings:

- Over 97 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that therapy relieves mental health struggles.
- Over 97 percent of parents and legal guardians AGREE that nature relieves mental health struggles.
- Nearly 97 percent of parents and legal guardians AGREE that physical exercise relieves mental health struggles.
- Around 76 percent of parents and legal guardians AGREE that medicine relieves mental health struggles.
- Around 74 percent of parents and legal guardians AGREE faith in God relieves mental health struggles.
- Nearly 66 percent of parents and legal guardians AGREE that religious leaders relieve mental health struggles.
- Around 51 percent of parents and legal guardians AGREE that not focusing on one's problems helps relieve mental health struggles.

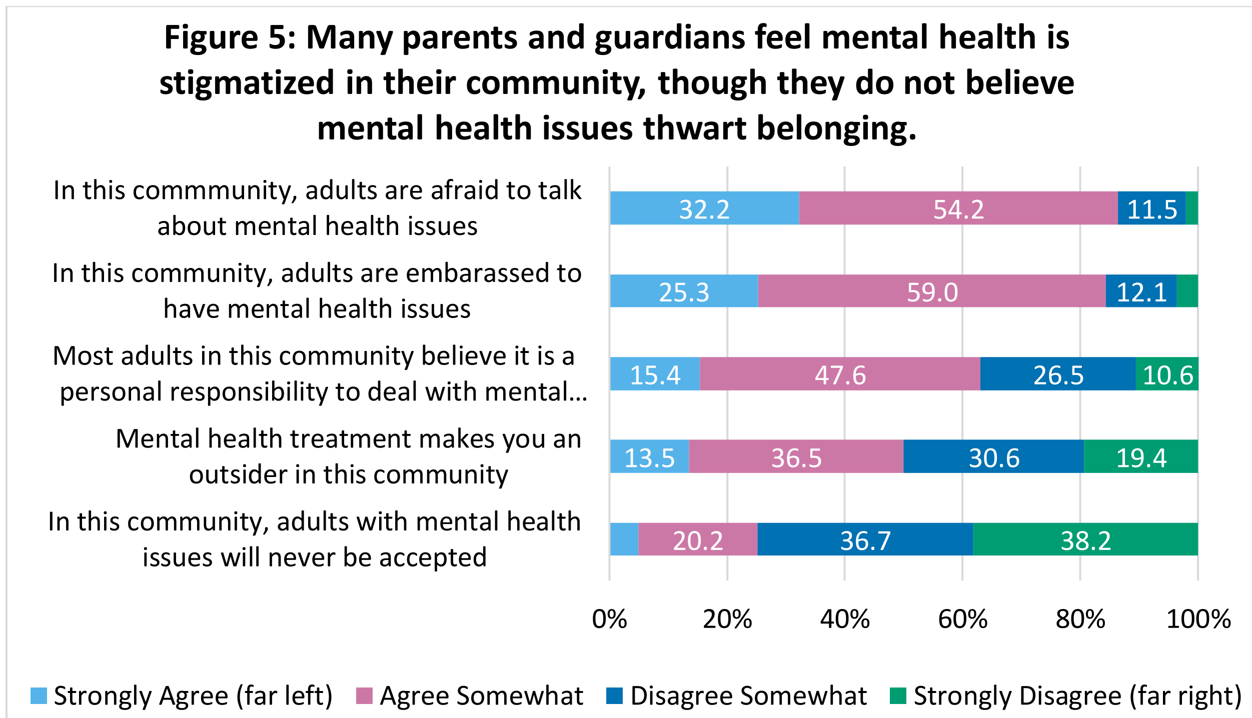
Reponses to the "Other: Please write in" option:

- When asked what other things people who are struggling with mental health would find relief from, 111 respondents wrote in answers.
- Fifty-seven responses, or half of the 111 responses, were related to communication and connection with others. Fifteen of these 57 responses explicitly mention family support.

Other examples of these 57 responses describe connection with friends and/or peers; connections with trusted adults and community; and involvement in group hobbies (e.g., sports teams, volunteering) and clubs.

- Nineteen responses were about mindfulness, meditation, and other self-improvement methods (including bettering sleep and diet).
- Nine responses had to do with bettering the school environment. Two of these responses mentioned safety concerns at school.
- Six responses surrounded getting at the root of the issue, e.g., “I feel 80% of all problems come from the kids upbringing.” and “Get a deep understanding on where the issues come from”.
- Five responses described minimizing use of technology and/or social media.
- Four responses mentioned turning to religion for relief.
- Three responses described explicitly seeking “professional” help.
- Four responses did not fit with the other categories:
    - One response said, “You should have a don't know answer.”
    - One response said, “While you have to face your problems I do not believe that it should be your only focus.”
    - One response said, “Being challenged and held accountable for behavior.”
    - One response said, “Not being immersed in woke ideology”.

Families’ Perceptions of Mental Health Stigma in the Community

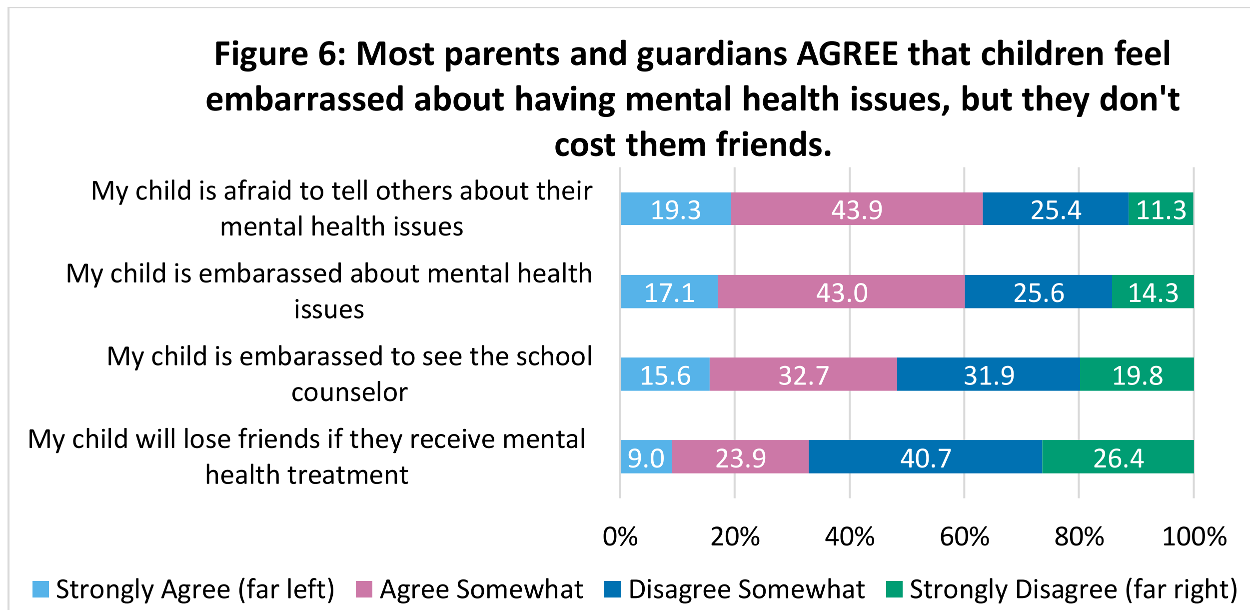


Key Findings (from Figure 5, above):

- Over 86 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that in their community, adults are afraid to talk about mental health issues.

- Over 84 percent of parents and legal guardians AGREE that in their community, adults are embarrassed to have mental health issues.
- About 63 percent of parents and legal guardians AGREE that most adults in their community believe that it is a personal responsibility to deal with mental health struggles.
- About 50 percent of parents and legal guardians AGREE that in their community, mental health treatment makes you an outsider.
- Only 25 percent of parents and legal guardians AGREE that in their community, adults with mental health issues will never be accepted.

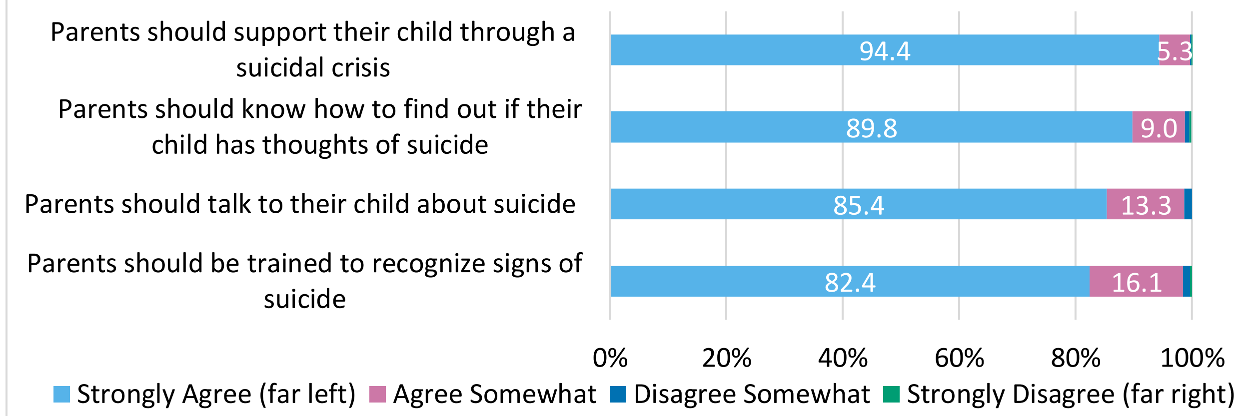
Families' Perceptions of Children's Feelings of Mental Health Stigma



Key Findings:

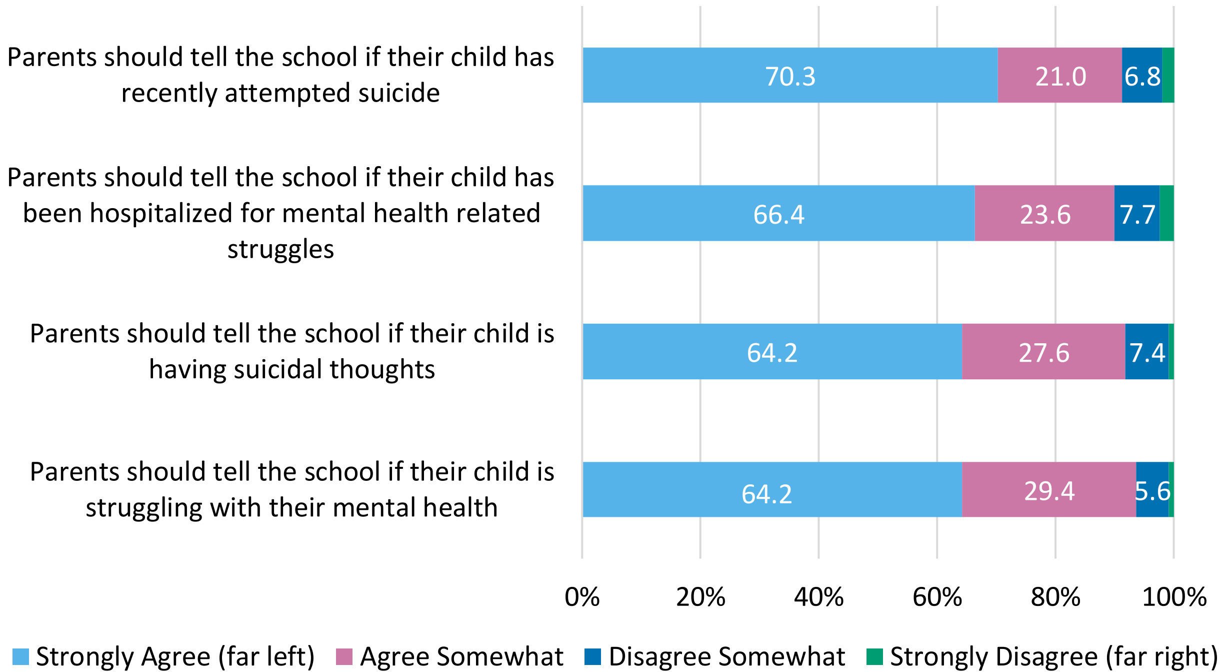
- Over 63 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that their child is afraid to tell others about their mental health issues.
- Around 60 percent of parents and legal guardians AGREE that their child is embarrassed about mental health issues.
- Around 48 percent of parents and legal guardians AGREE that their child is embarrassed to see the school counselor.
- Nearly 33 percent of parents and legal guardians AGREE that their child will lose friends if they receive mental health treatment.

Families' Views regarding their Role in their Child's Mental Health



Key Findings:

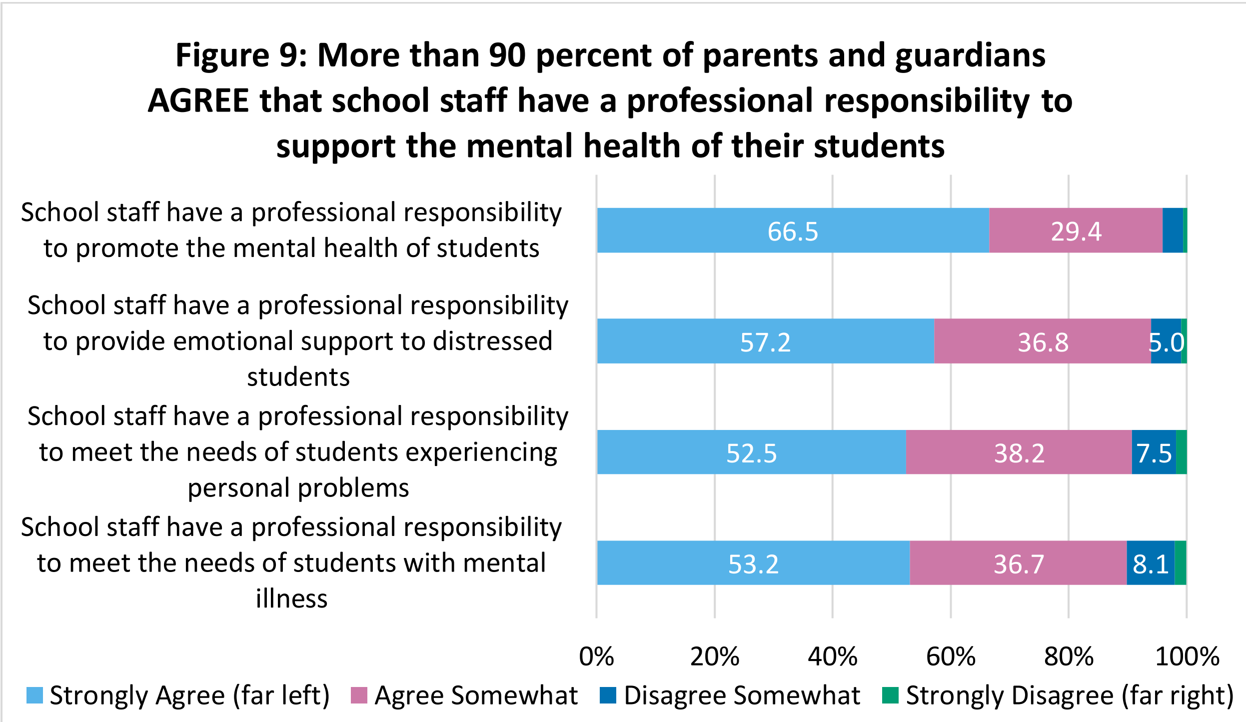
- Over 99 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that parents and legal guardians should support their child through a suicidal crisis.
- Nearly 99 percent of parents and legal guardians AGREE that parents and legal guardians should know how to find out if their child has thoughts of suicide.
- Nearly 99 percent of parents and legal guardians AGREE that parents and legal guardians should talk to their child about suicide.
- Over 98 percent of parents and legal guardians AGREE that parents and legal guardians should be trained to recognize the signs of suicide.



Key Findings:

- Around 91 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that parents and legal guardians should tell the school if their child has recently attempted suicide.
- Around 90 percent of parents and legal guardians AGREE that parents and legal guardians should tell the school if their child has been hospitalized for mental health related struggles.
- Nearly 92 percent of parents and legal guardians AGREE that parents and legal guardians should tell the school if their child is having suicidal thoughts.
- Nearly 94 percent of parents and legal guardians AGREE that parents and legal guardians should tell the school if their child is struggling with their mental health.

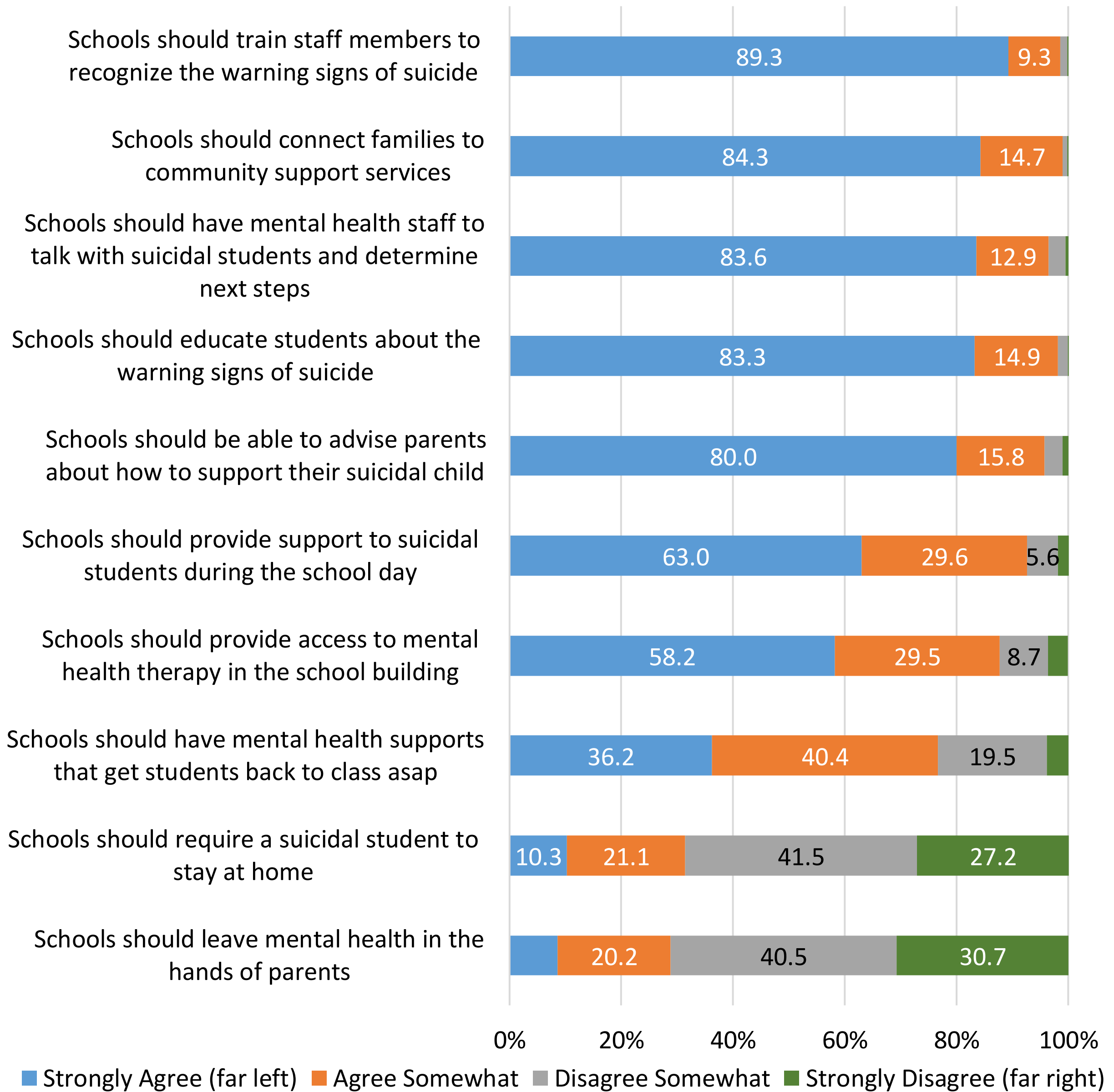
Families’ Attitudes towards Staff’s Professional Responsibility regarding Mental Health



Key Findings:

- Nearly 96 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that school staff have a professional responsibility to promote the mental health of students.
- About 94 percent of parents and legal guardians AGREE that school staff have a professional responsibility to provide emotional support to distressed students.
- Nearly 91 percent of parents and legal guardians AGREE that school staff have a professional responsibility to meet the needs of students experiencing personal problems.
- Nearly 90 percent of parents and legal guardians AGREE that school staff have a professional responsibility to meet the needs of students with mental illness.

Families’ Attitudes Concerning the Role of Schools in Supporting Students’ Mental Health

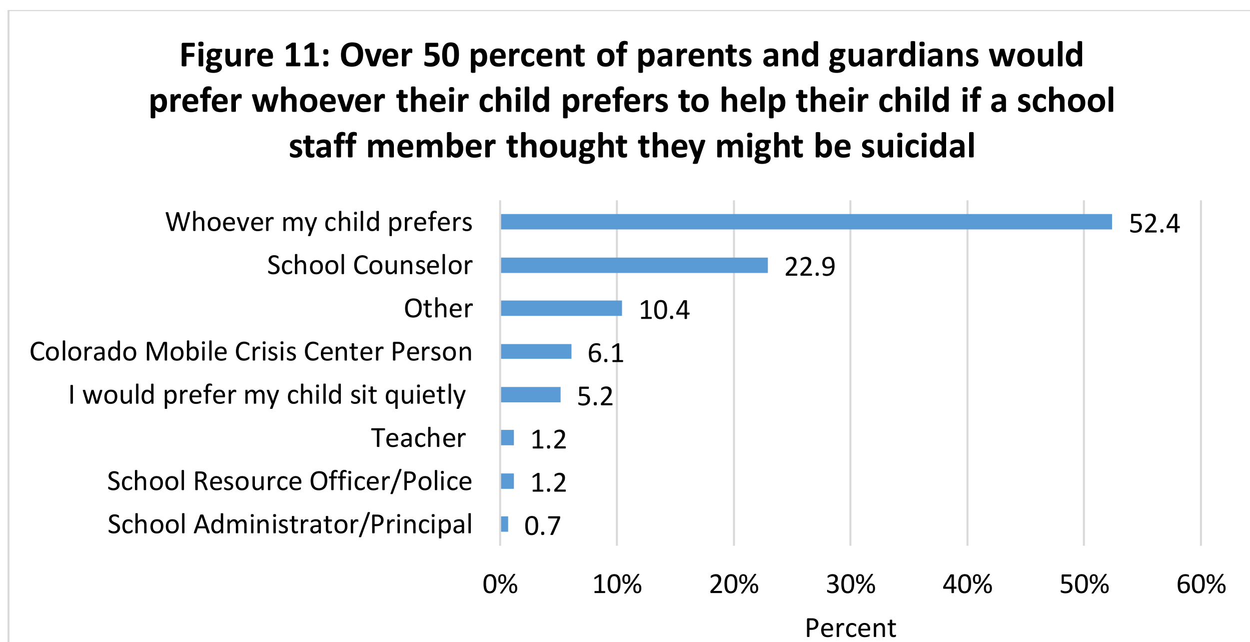


Key Findings:

- Nearly 99 percent of parents and legal guardians AGREE (either strongly agree or somewhat agree) that schools should train staff members to recognize the warning signs of suicide.
- Around 99 percent of parents and legal guardians AGREE that schools should connect families to community support services.

- Over 96 percent of parents and legal guardians AGREE that schools should have mental health staff to talk with suicidal students and determine next steps.
- Over 98 percent of parents and legal guardians AGREE that schools should educate students about the warning signs of suicide.
- Nearly 96 percent of parents and legal guardians AGREE that schools should be able to advise parents and legal guardians about how to support their suicidal child.
- Nearly 93 percent of parents and legal guardians AGREE that schools should provide support to suicidal students during the school day.
- Nearly 88 percent of parents and legal guardians AGREE that schools should provide access to mental health therapy in the school building.
- Nearly 77 percent of parents and legal guardians AGREE that schools should have mental health supports that get students back to class as soon as possible.
- Around 31 percent of parents and legal guardians AGREE that schools should require a suicidal student to stay home from school.
- Nearly 29 percent of parents and legal guardians AGREE that schools should leave mental health in the hands of parents.

Families' Opinions on who Should Help Their Child if They Have a Mental Health Crisis at School



Key Findings:

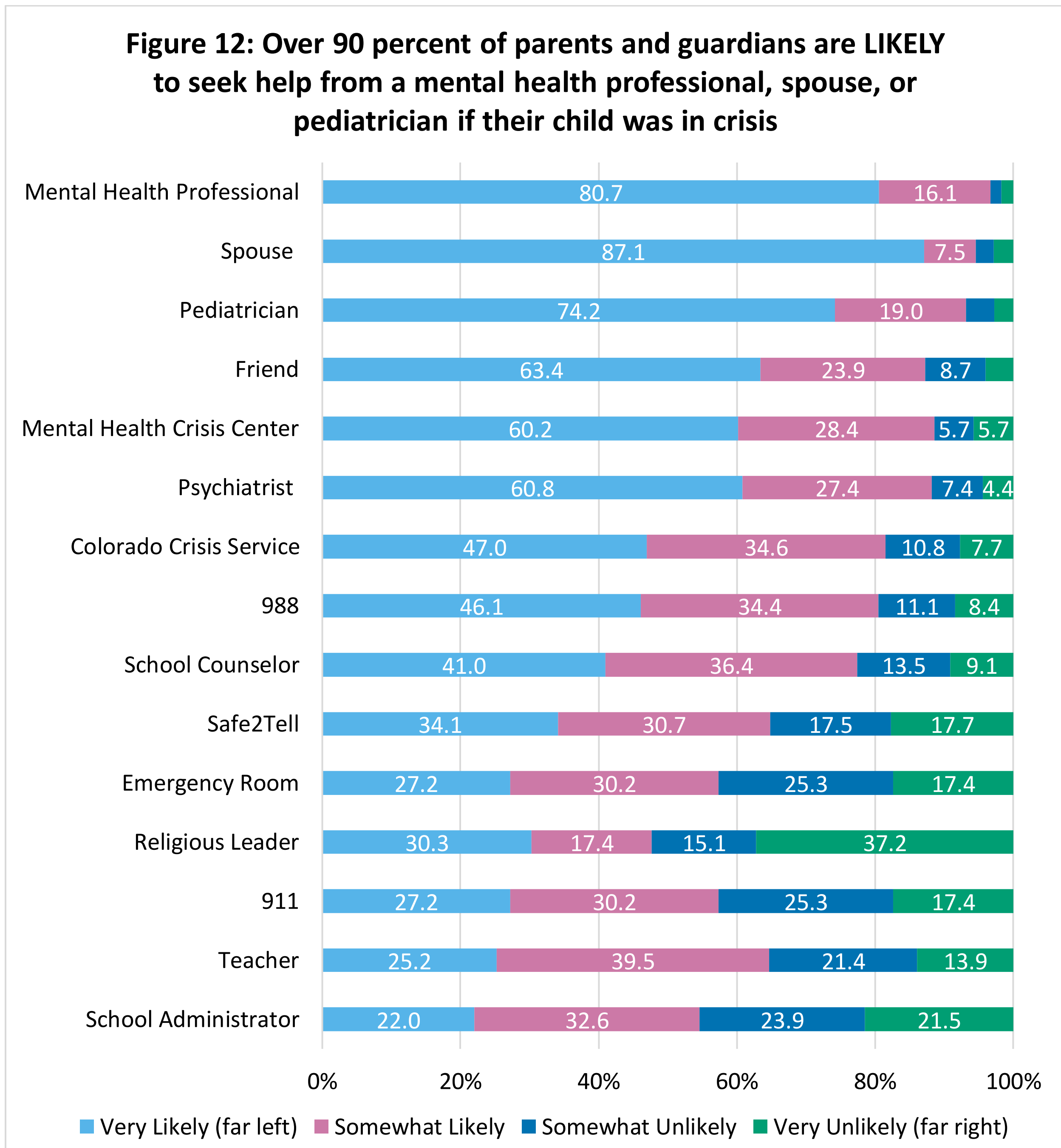
- Around 52 percent of parents and legal guardians would prefer that **whoever their child** prefers helps their child if a school staff member was worried their child might be suicidal.
- Nearly 23 percent of parents and legal guardians would prefer that a **school counselor** helps their child if a school staff member was worried their child might be suicidal.

- About 6 percent of parents and legal guardians would prefer that a representative from **the Colorado Mobile Crisis Center** helps their child if a school staff member was worried that their child might be suicidal.
- Over 5 percent of parents and legal guardians would prefer that **their child sits quietly** until they can get to the school if a school staff member was worried that their child might be suicidal.
- Around 1 percent of parents and legal guardians would prefer that a **teacher** helps their child if a school staff member was worried that their child might be suicidal.
- Around 1 percent of parents and legal guardians would prefer that a **school resource officer or police officer** helps their child if a school staff member was worried that their child might be suicidal.
- Less than 1 percent of parents and legal guardians would prefer a **school administrator or principal** helps their child if a school staff member was worried that their child might be suicidal.

Reponses to the "Other: Please write in" option:

- Of the 62 responses who selected "Other," 36 responses listed and/or expressed desiring more than one source of support for their child ("Counselor for initial help then proceeding to specialists as needed"; "Anyone and everyone. It takes a village.").
- Slightly over half of the respondents (32 of the 62) explicitly wanted parent involvement.
- Twenty-three of these 32 responses described wanting someone to help their child until they, the parent, got there ("Whoever my child prefers until I can get there"; "Contact me and talk to a counselor at school until I get there"). The remaining 9 responses do not mention help other than parents and include answers like "Call me" and "I would go get my child from school."
- Twenty-one of the 62 responses described preferring help for their child from whoever their child preferred, or their child's safe and trusted adult. Fifteen of the 62 responses described preferring help for their child from someone at school, like a school counselor or the school clinic. Fourteen of the 62 responses described preferring help for their child from a mental health professional, like their child's therapist.
- Five responses said they would want anyone and everyone to help their child.
- One response stated, "Not the school or any affiliate."

Families' Hypothetical Strategies for Help-Seeking if Their Child was Experiencing a Mental Health Crisis



Key Findings:

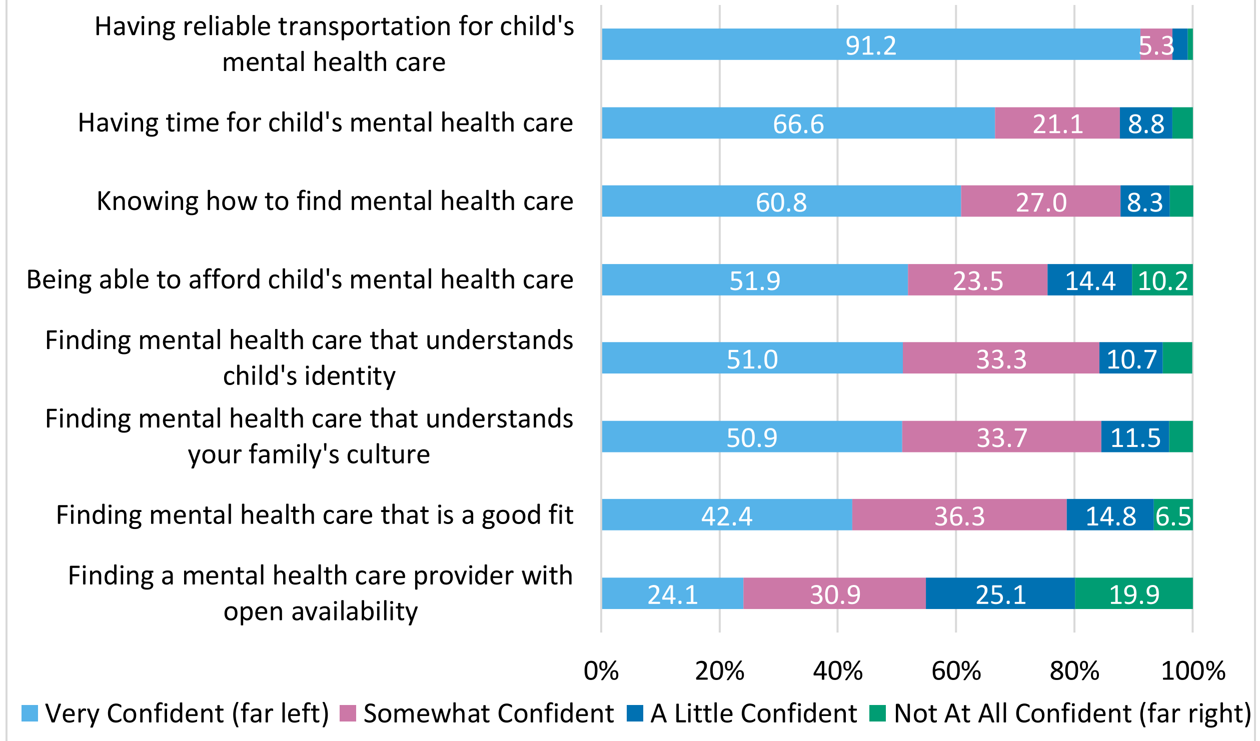
- Nearly 97 percent of parents and legal guardians are LIKELY (either very likely or somewhat likely) to seek help from a mental health professional if their child was having a mental health crisis.

- Nearly 95 percent of parents and legal guardians are LIKELY to seek help from their spouse if their child was having a mental health crisis.
- Around 93 percent of parents and legal guardians are LIKELY to seek help from their pediatrician if their child was having a mental health crisis.
- Around 87 percent of parents and legal guardians are LIKELY to seek help from a friend if their child was having a mental health crisis.
- Nearly 89 percent of parents and legal guardians are LIKELY to seek help from a mental health crisis center if their child was having a mental health crisis.
- Around 88 percent of parents and legal guardians are LIKELY to seek help from a psychiatrist if their child was having a mental health crisis.
- Nearly 82 percent of parents and legal guardians are LIKELY to seek help from the Colorado Crisis Service if their child was having a mental health crisis.
- Around 80 percent of parents and legal guardians are LIKELY to seek help from 988, the national suicide hotline, if their child was having a mental health crisis.
- Over 77 percent of parents and legal guardians are LIKELY to seek help from their child's school counselor if their child was having a mental health crisis.
- Nearly 65 percent of parents and legal guardians are LIKELY to seek help from Safe2Tell if their child was having a mental health crisis.
- Around 57 percent of parents and legal guardians are LIKELY to seek help from the emergency room if their child was having a mental health crisis.
- Nearly 48 percent of parents and legal guardians are LIKELY to seek help from a religious leader if their child was having a mental health crisis.
- Around 57 of parents and legal guardians are LIKELY to seek help from 911 if their child was having a mental health crisis.
- Nearly 65 percent of parents and legal guardians are LIKELY to seek help from their child's teacher if their child was having a mental health crisis.
- Nearly 55 percent of parents and legal guardians are LIKELY to seek help from a school administrator if their child was having a mental health crisis.

Reponses to the "Other: Please write in" option:

- When asked if there was anyone else who was not represented on the list of people or services families might turn to if their child was having a mental health crisis, 17 respondents wrote in answers.
- Of the 17 text responses for people or services not listed, five participants mentioned family broadly, or cited specific family members. Two participants said, "Myself." Additionally, two people described religious entities. Two people cited their child's trusted adult ("Whoever my child felt most comfortable with"). Two people described mental health professionals.
- Finally, there were four other responses that could not be grouped together thematically:
    - One person said, "I would see out anyone to benefit my child."
    - One person said, "Online communities."
    - One person said, "ANYONE - even the guy in the ditch - if they were NOT pushing the WOKE demonic agenda!"
    - One person said, "No".

Challenges with Accessing Mental Health Care for Families

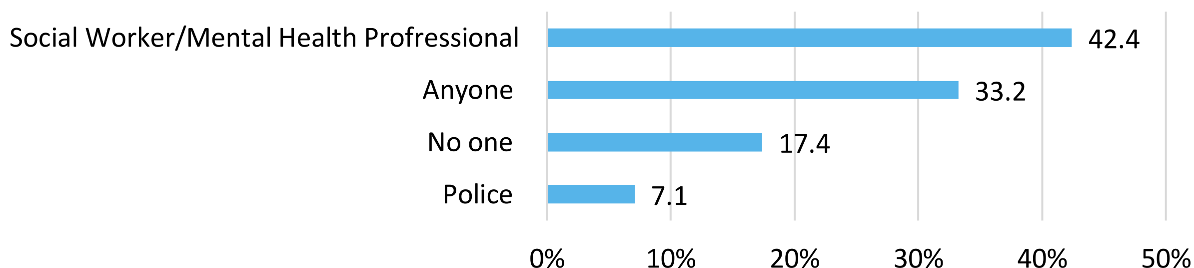


Key Findings:

- Around 91 percent of parents and legal guardians are VERY confident that they would have reliable transportation for their child's mental health care.
- Nearly 67 percent of parents and legal guardians are VERY confident that they would have time for their child's mental health care.
- Nearly 61 percent of parents and legal guardians are VERY confident that they would know how to find mental health care for their child.
- Nearly 52 percent of parents and legal guardians are VERY confident that they would be able to afford mental health care for their child.
- About 51 percent of parents and legal guardians are VERY confident that they could find mental health care that understands their child's identity.
- About 51 percent of parents and legal guardians are VERY confident that they could find mental health care that understands their family's culture.
- Around 42 percent of parents and legal guardians are VERY confident that they could find mental health care that is a good fit for their child.
- Only 24 percent of parents and legal guardians are VERY confident that they could find a mental health care provider with open availability.

Families’ Preferences for Crisis Responders to an After-Hours Wellness Check

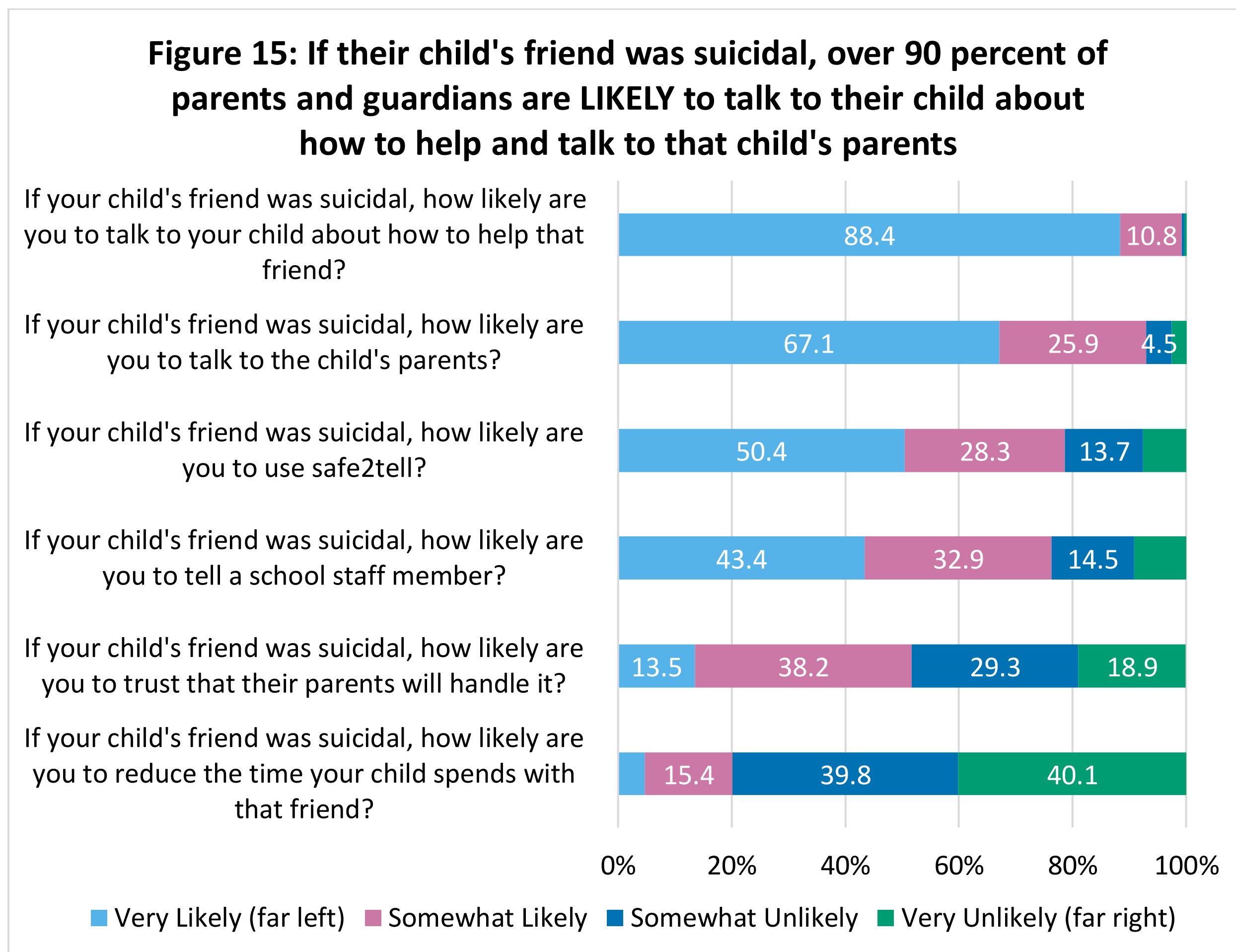
Figure 14: Most parents and guardians prefer a mental health professional be the person who responds if the school receives information that their child may be in crisis after school hours.



Key Findings:

- Around 42 percent of parents and legal guardians would prefer that a **social worker or mental health professional** would come to their house to check on their child’s well-being if the school received information suggesting their child may be in crisis after hours.
- Around 33 percent of parents and legal guardians would prefer that **anyone** would come to their house to check on their child’s well-being if the school received information suggesting their child may be in crisis after hours.
- Around 17 percent of parents and legal guardians would prefer that **no one** would come to their house to check on their child’s well-being if the school received information suggesting their child may be in crisis after hours.
- Around 7 percent of parents and legal guardians would prefer that a **police officer** would come to their house to check on their child’s well-being if the school received information suggesting their child may be in crisis after hours.

Families' Responses to their Child's Friend Having a Hypothetical Suicidal Crisis



Key Points:

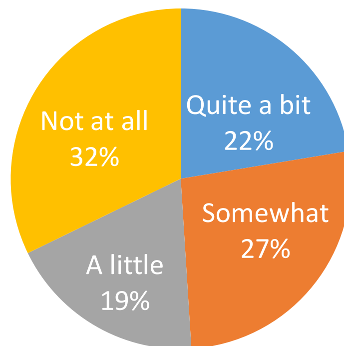
- If their child's friend was suicidal, over 99 percent of parents and legal guardians are LIKELY (either very likely or somewhat likely) to talk to their child about how to help their friend.
- If their child's friend was suicidal, around 93 percent of parents and legal guardians are LIKELY to talk to that child's parents or legal guardians.
- If their child's friend was suicidal, nearly 79 percent of parents and legal guardians are LIKELY to use Safe2Tell.
- If their child's friend was suicidal, around 76 percent of parents and legal guardians are LIKELY to tell a school staff member.
- If their child's friend was suicidal, nearly 52 percent of parents and legal guardians are LIKELY to trust that their parents or legal guardians would handle it.
- If their child's friend was suicidal, around 20 percent of parents and legal guardians would reduce the time their child spends with their friend.

Reponses to the "Other: Please write in" option:

- When asked what respondents would do if their child's friend was suicidal, 19 respondents wrote in answers.
- Sixteen expressed that they would help in some way. The specific ways respondents would help varied and included responses like "Ask my child's friend if they would like my help", "Refer them to a trusted Christian leader who can help", "Call th [sp] school counselor" and "24/7 supervision".
- Three respondents expressed that what they did would depend on how well they or their child knew the suicidal friend.
- Three respondents gave other answers:
  - "Safe2 tell has been used to prank, embarrass kids and parents as it is anoumous [sp] with no accountability."
    - Note from Dr. Mueller: According to Safe2Tell's 2022-2023 Legislative Annual Report (https://safe2tell.org/wp-content/uploads/2023/11/Safe2Tell-2022-23-Annual-Report.pdf) only 2.8 percent of Safe2Tell reports are false reports created with "intent to harm, injure, or bully another person." Of course, if this rare event happens to your child, how rare it is does not change the potential impact on a family.
  - "Family"

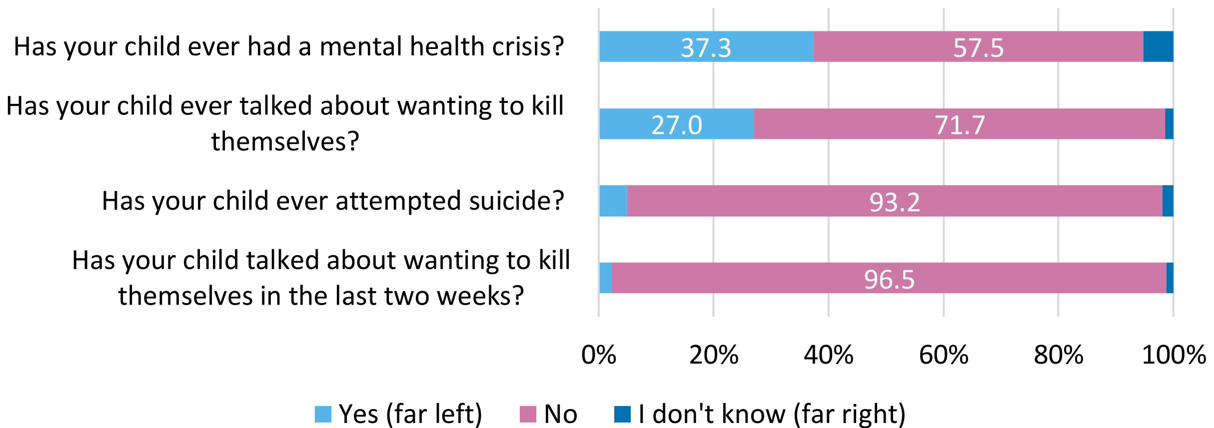
The Frequency of Child Mental Health Concerns and Crises in the Community

Figure 16: Most parents and guardians are worried about their child's mental health



Key Point:

- About 68 percent of parents and legal guardians are worried about their child's mental health to some degree.

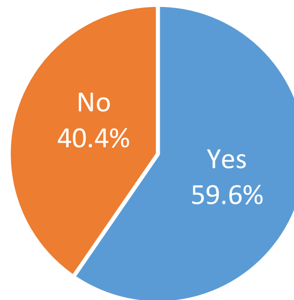


Key Points:

- About 37 percent of parents and legal guardians report that their child has had a mental health crisis.
- About 27 percent of parents and legal guardians report that their child has ever talked about wanting to kill themselves.
- About 5 percent of parents and legal guardians report that their child has had a suicide attempt.
- Over 2 percent of parents and legal guardians report that their child has talked about wanting to kill themselves in the last two weeks.

Percent of Parents and Guardians who Told the School about Their Child's Mental Health Struggles

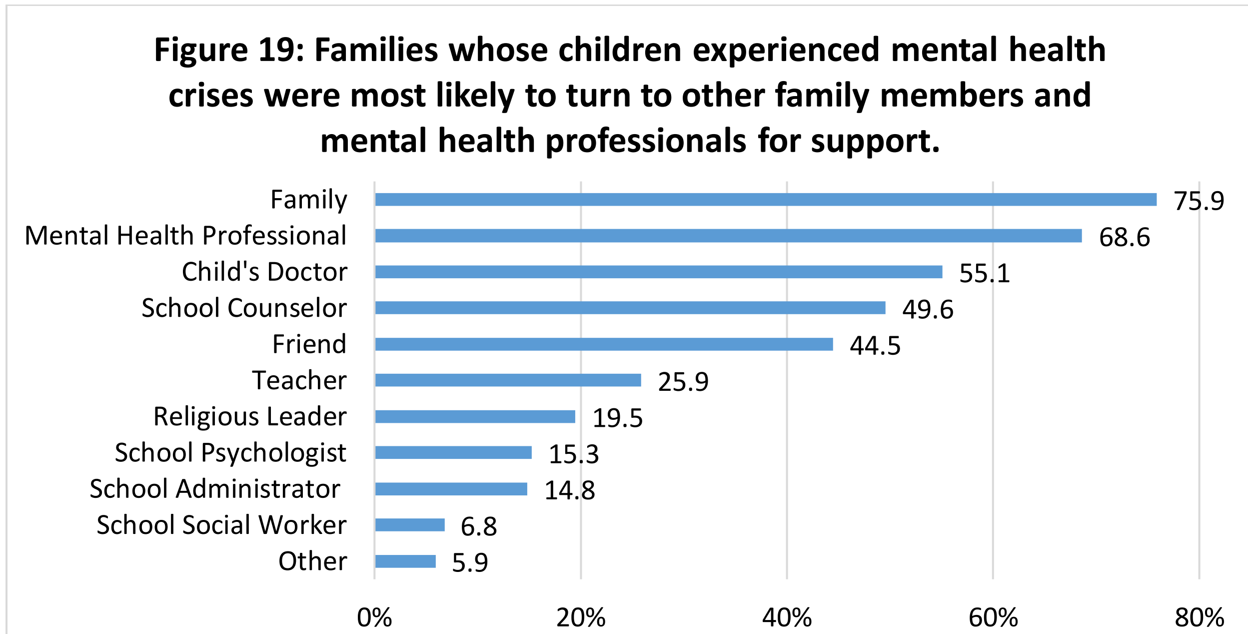
Figure 18: Forty percent of parents and guardians did NOT tell the school that their child had had a recent mental health crisis.



Key Point:

- Nearly 60 percent of parents and legal guardians report telling the school their child was struggling when they experienced a crisis.
- It would be better for suicide prevention if more families shared this information with school staff so that school staff can contribute to their child's safety and well-being while at school.

Families' Strategies to Seek Help During an Actual Mental Health Crisis



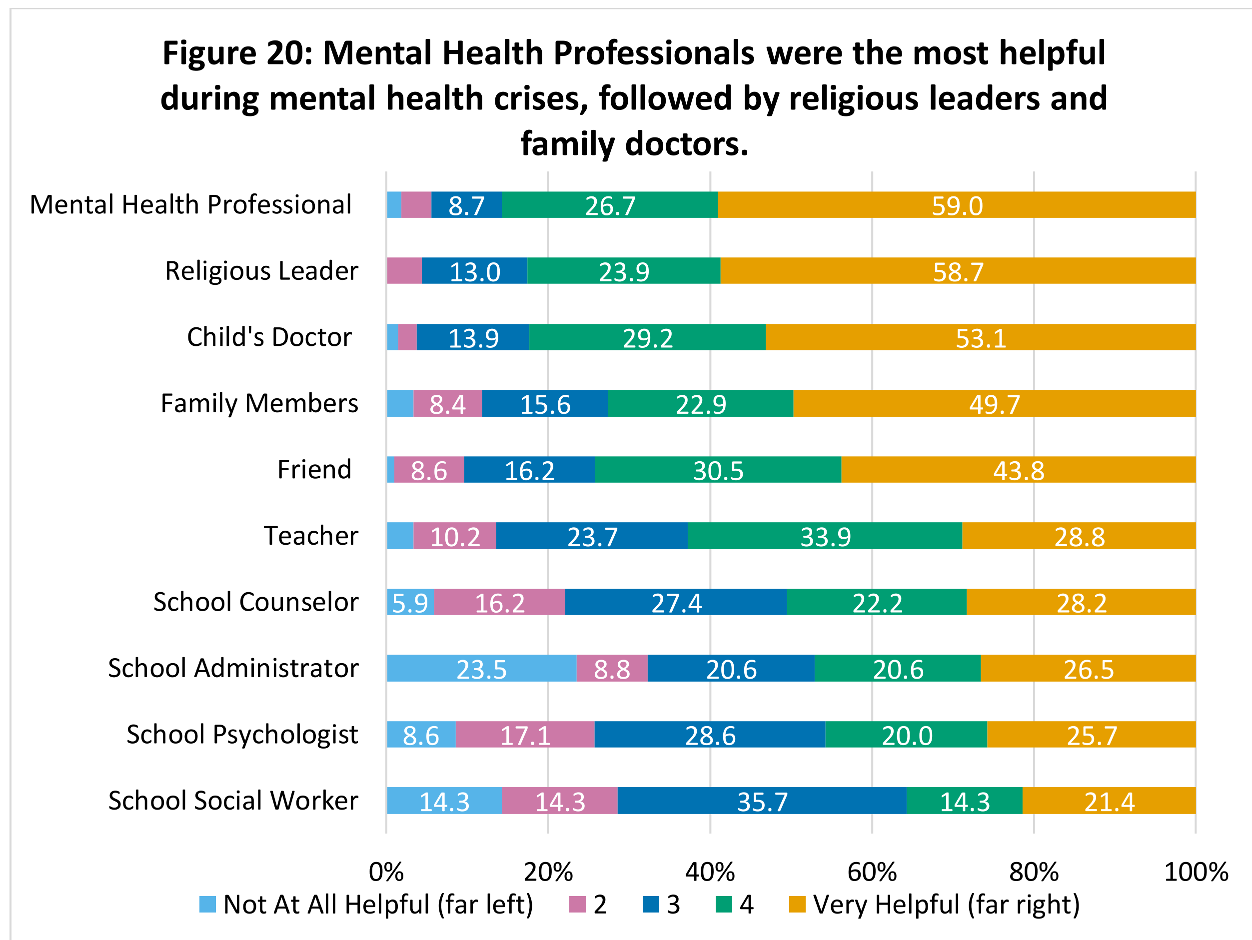
Key Points:

- Note: these questions were only asked to parents and guardians whose children had an actual mental health crisis.
- Nearly 76 percent of parents and guardians report turning to their family during their child's crisis.
- Nearly 69 percent of parents and guardians report turning to a mental health profession during their child's crisis.
- Around 55 percent of parents and guardians report turning to their child's doctor during their child's crisis.
- Nearly 50 percent of parents and guardians report turning to a school counselor during their child's crisis.
- Nearly 45 percent of parents and guardians report turning to a friend during their child's crisis.
- Nearly 26 percent of parents and guardians report turning to a teacher during their child's crisis.
- Nearly 20 percent of parents and guardians report turning to a religious leader during their child's crisis.
- About 15 percent of parents and guardians report turning to a school psychologist during their child's crisis.
- About 15 percent of parents and guardians report turning to a school administrator during their child's crisis.
- About 7 percent of parents and guardians report turning to a school social worker during their child's crisis.

Reponses to the “Other: Please write in” option:

- There were 11 respondents who selected the “Other: please write in” option to this question. The write in responses listed that were something other than the original options include:
- “Online communities”; “Emergency room”; “Mental Health Hospital”; “Behavioral mentor and caseworkers”; “Coach”; “Cops”; “School officers”; “Crisis Hotline”; “Local law enforcement”

Families’ Ratings of How Helpful Different Kinds of People were During Their Child’s Mental Health Crisis



Key Points:

- Among school staff, teachers and school counselors were deemed the most helpful.
- About 59 percent of parents and legal guardians report that a mental health professional was VERY HELPFUL during their child’s crisis.
- Nearly 59 percent of parents and legal guardians report that a religious leader was VERY HELPFUL during their child’s crisis.
- Around 53 percent of parents and legal guardians report that their child’s doctor was VERY HELPFUL during their child’s crisis.

- About 50 percent of parents and legal guardians report that their family was VERY HELPFUL during their child's crisis.
- About 44 percent of parents and legal guardians report that their friend was VERY HELPFUL during their child's crisis.
- Nearly 29 percent of parents and legal guardians report that a teacher was VERY HELPFUL during their child's crisis.
- Around 28 percent of parents and legal guardians report that a school counselor was VERY HELPFUL during their child's crisis.
- About 27 percent of parents and legal guardians report that a school administrator was VERY HELPFUL during their child's crisis.
- About 26 percent of parents and legal guardians report that a school psychologist was VERY HELPFUL during their child's crisis.
- Around 21 percent of parents and legal guardians report that a school social worker was VERY HELPFUL during their child's crisis.

Appendix 2. Comprehensive Findings from the High School Staff Survey

School Staff's Views on Mental Health Promotion and Suicide Prevention on Colorado's Western Slope

By

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High School Staff Survey Methodology

This report presents the findings from a school staff survey administered in Winter 2023. The purpose of the staff survey was to assess strengths and vulnerabilities in school staff's approaches to supporting student mental health and suicide prevention. This report provides the responses to nearly every survey item asked (for a more synthesized report of our findings with policy implications, please see our primary report [Abrutyn, Mueller, et al. 2024]).

All school staff at all high schools in Western Slope Public School District (WSPSD, a pseudonym) were invited to participate in the survey. Approximately 456 high school staff members responded to the survey. Our estimated response rate for the entire staff survey is 75 percent, meaning that 75 percent of school staff who were invited to participate did so. This is an exceptionally high response rate that indicates we can draw meaningful conclusions about staff attitudes towards suicide prevention and mental health promotion in this school district.

The survey was administered during a teacher in-service day. Principals generously allowed their staff 20-30 minutes to complete the survey during a staff meeting (the survey required approximately 20 minutes to complete). Prior to completing the survey, school staff who attended the staff meeting (which is disproportionately teachers and school counselors) attended a brief presentation by either Drs. Mueller, Abrutyn, Zhang or Ms. Olivia DeCrane. The presentation explained the importance and purpose of the survey. Staff then had an opportunity to ask the researchers questions about the purpose or intent of the survey.

Prior to beginning the survey, staff reviewed an informed consent document and provided active informed consent prior to participation. Staff who completed the survey and were willing to provide an email address received a $20 e-gift certificate to Amazon.com.

Staff who completed the survey reported diverse roles in their school including classroom teachers, principals and other administrators, school counselors, school psychologists, social workers, secretaries, paraprofessionals, school nurses, and beyond. We refer to school counselors, school psychologists, school social workers, school mental health therapists, school nurses, and nurses' aids as "mental health staff" to protect their identities. We refer to school principals, assistant principals, deans of students, and athletic directors as "school administrators." We do not identify groups of people with less than 5 in a particular category to protect people's identities.

Ninety-seven percent of respondents work full time for their schools. Fifty four percent have more than 10 years working as in schools or as educators. Thirteen percent were in their first year in their career in schools.

Community Attitudes towards Mental Health

Figure 1: About 60 percent of school staff AGREE that most adults in this community believe you should pull yourself together instead of calling on a mental health professional when you're struggling

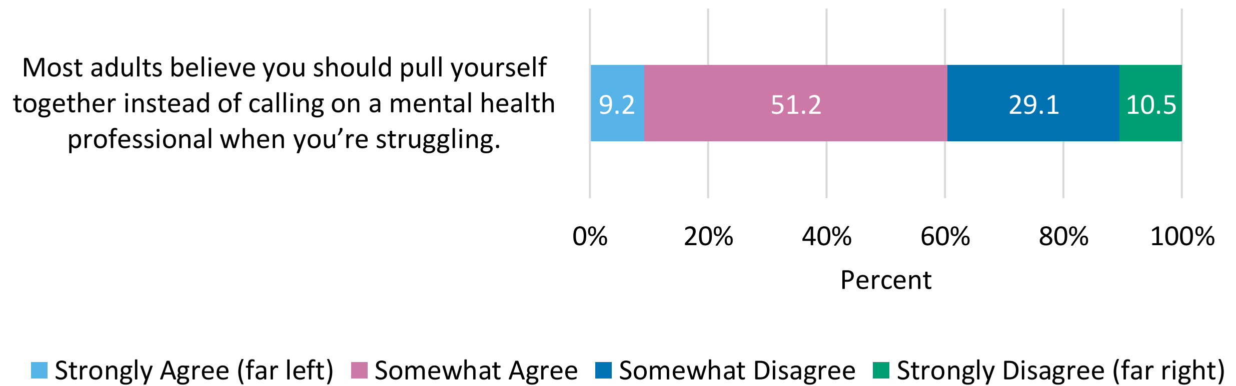
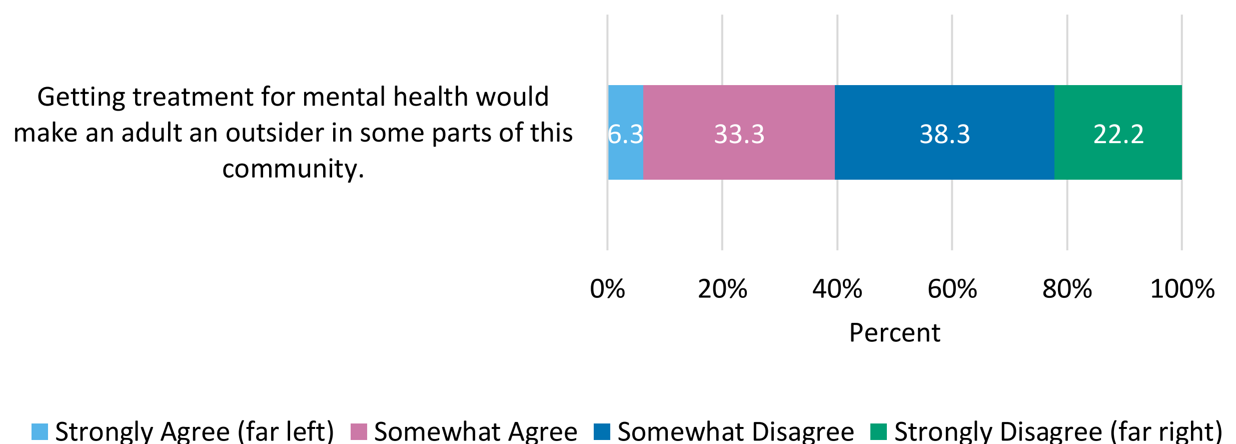


Figure 2: About 40 percent of school staff AGREE that getting treatment for mental health would make an adult an outsider in some parts of this community



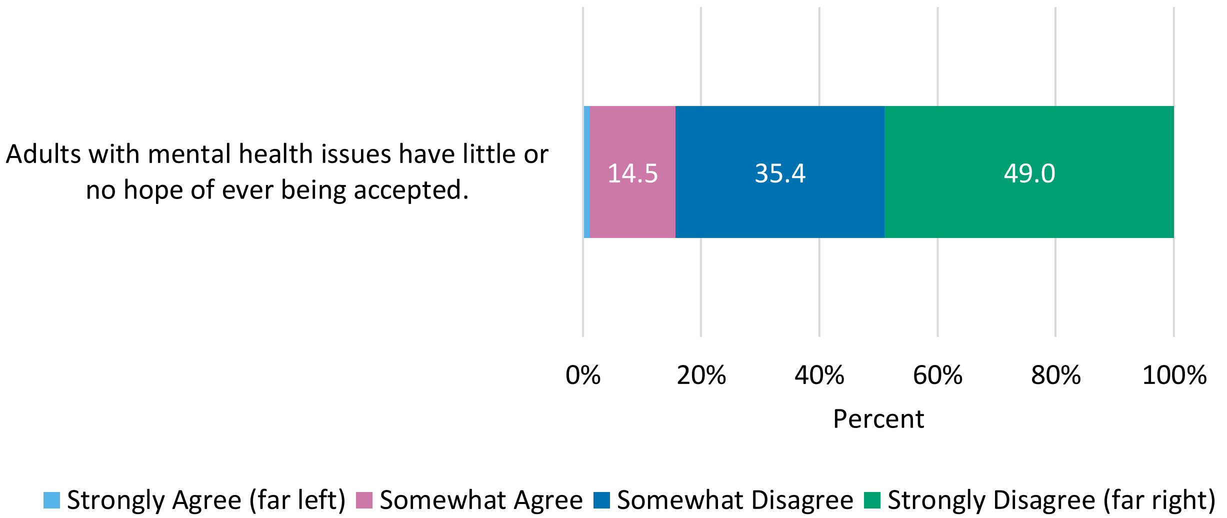


Figure 3: Only 15 percent of school staff AGREE that adults with mental health issues have little or no hope of ever being accepted in this community
Adults with mental health issues have little or no hope of ever being accepted.
14.5
35.4
49.0
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

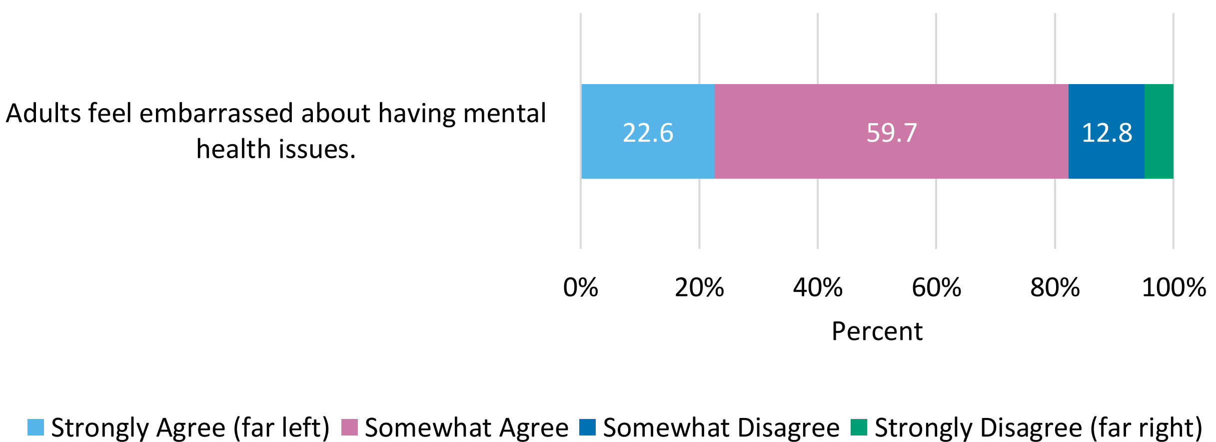


Figure 4: About 82 percent of school staff AGREE that adults feel embarrassed about having mental health issues in this community
Adults feel embarrassed about having mental health issues.
22.6
59.7
12.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

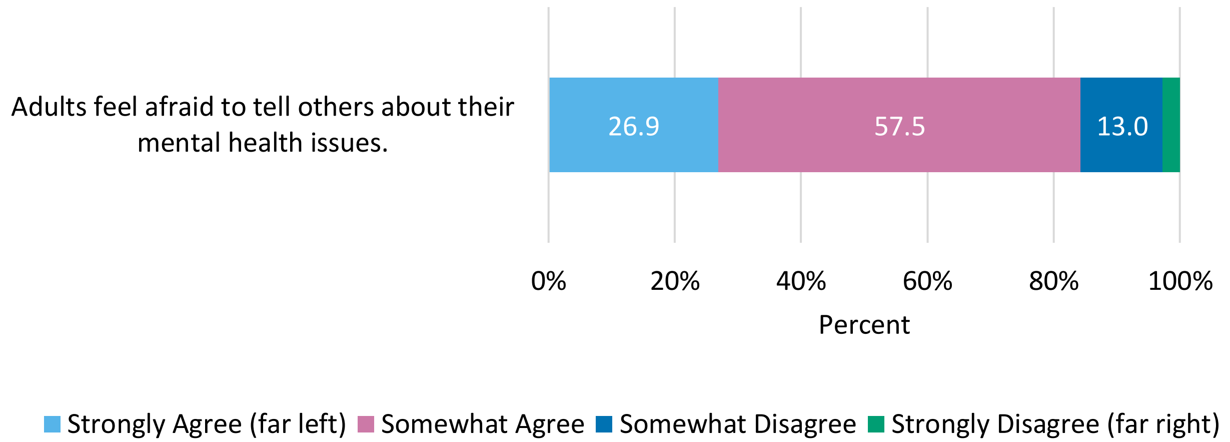


Figure 5: About 85 percent of school staff AGREE that adults in this community feel afraid to tell others about their mental health issues
Adults feel afraid to tell others about their mental health issues.
26.9
57.5
13.0
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

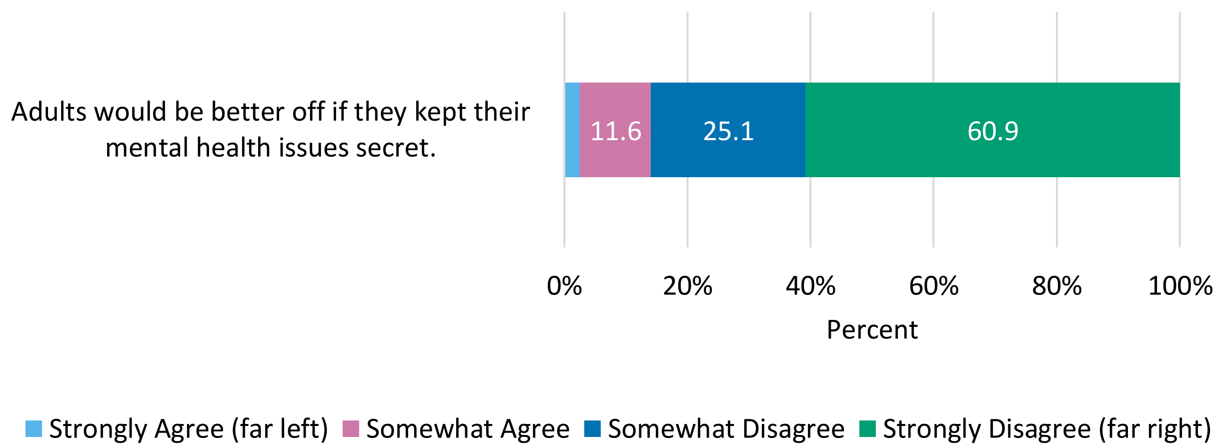
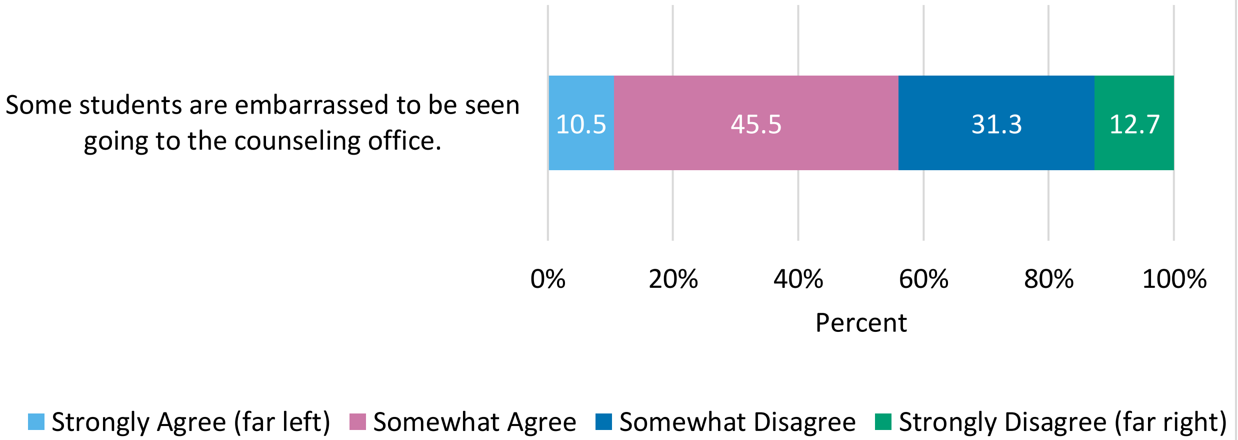
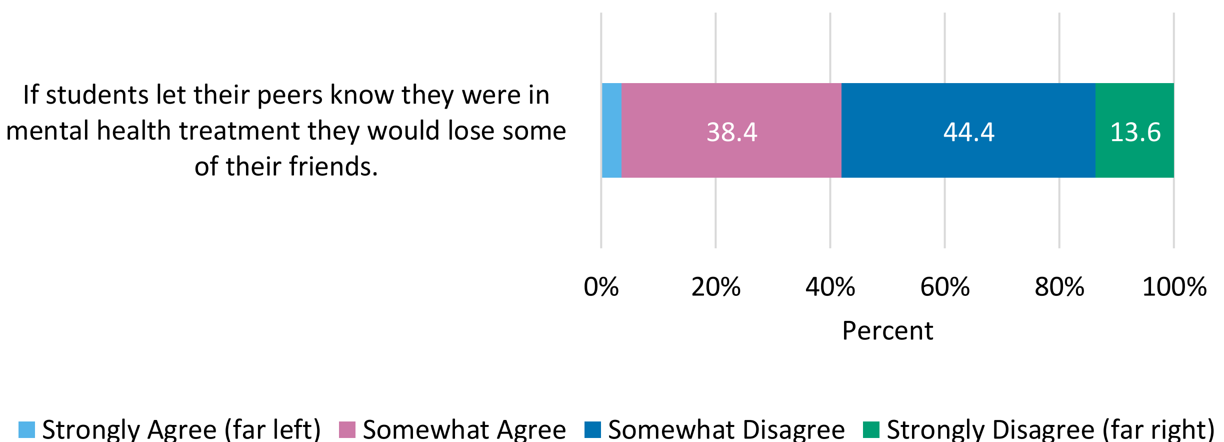


Figure 6: Only 14 percent of school staff AGREE that adults in this community would be better off if they kept their mental health issues secret
Adults would be better off if they kept their mental health issues secret.
11.6
25.1
60.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Staff's Perceptions of Student Attitudes towards Mental Health





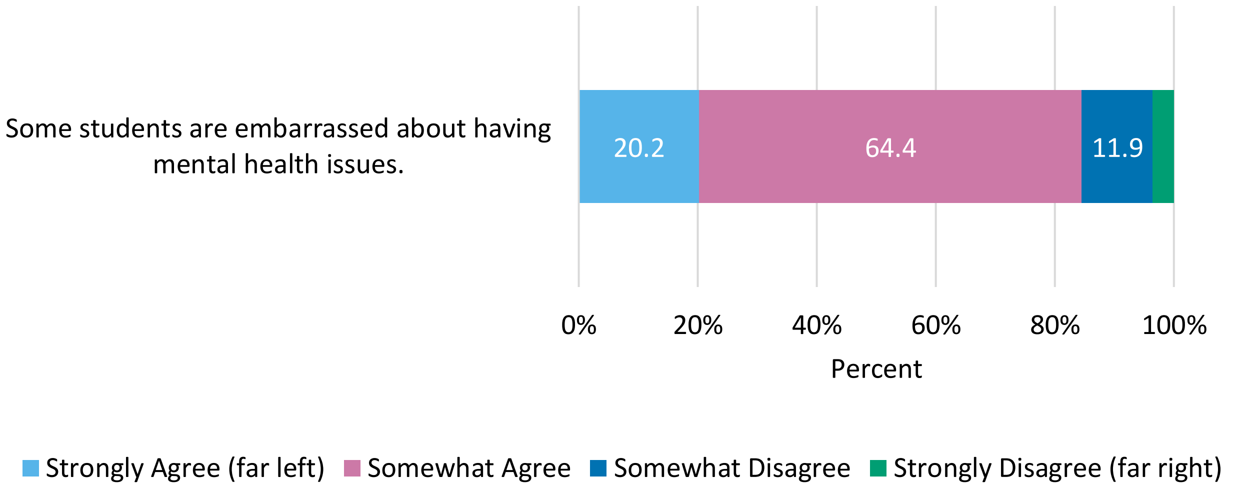


Figure 9: About 85 percent of school staff AGREE that some students are embarrassed about having mental health issues
Some students are embarrassed about having mental health issues.
20.2
64.4
11.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

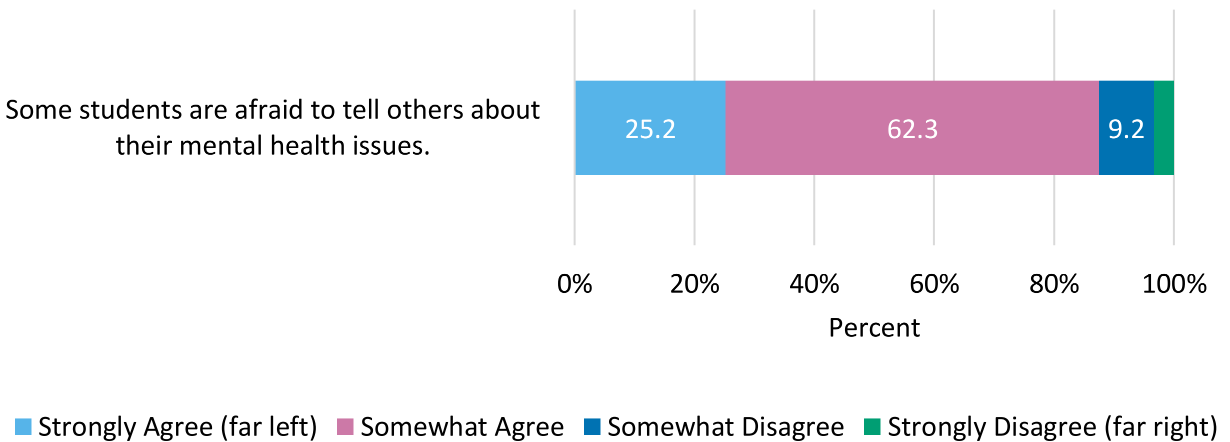


Figure 10: About 88 percent of school staff AGREE that some students are afraid to tell others about their mental health issues
Some students are afraid to tell others about their mental health issues.
25.2
62.3
9.2
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

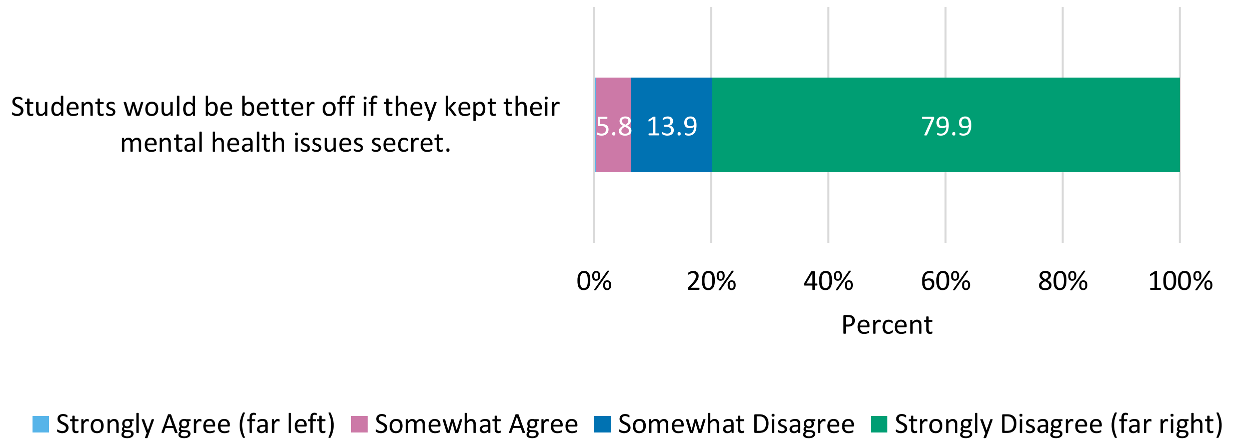


Figure 11: Only 6 percent of school staff AGREE that students would be better off if they kept their mental health issues secret
Students would be better off if they kept their mental health issues secret.
5.8
13.9
79.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

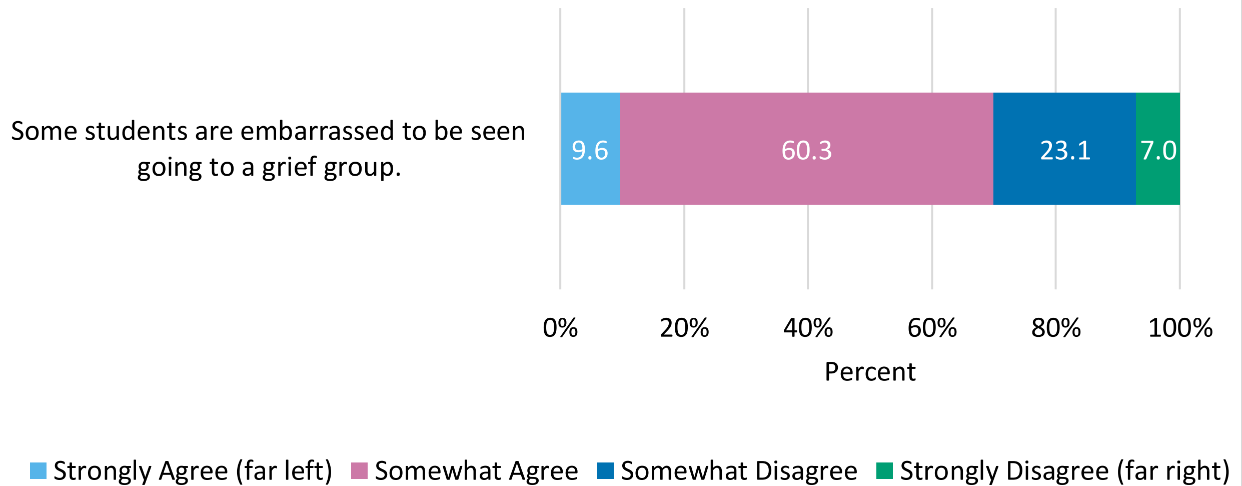


Figure 12: About 70 percent of school staff AGREE that some students are embarrassed to be seen going to a grief group
Some students are embarrassed to be seen going to a grief group.
9.6
60.3
23.1
7.0
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

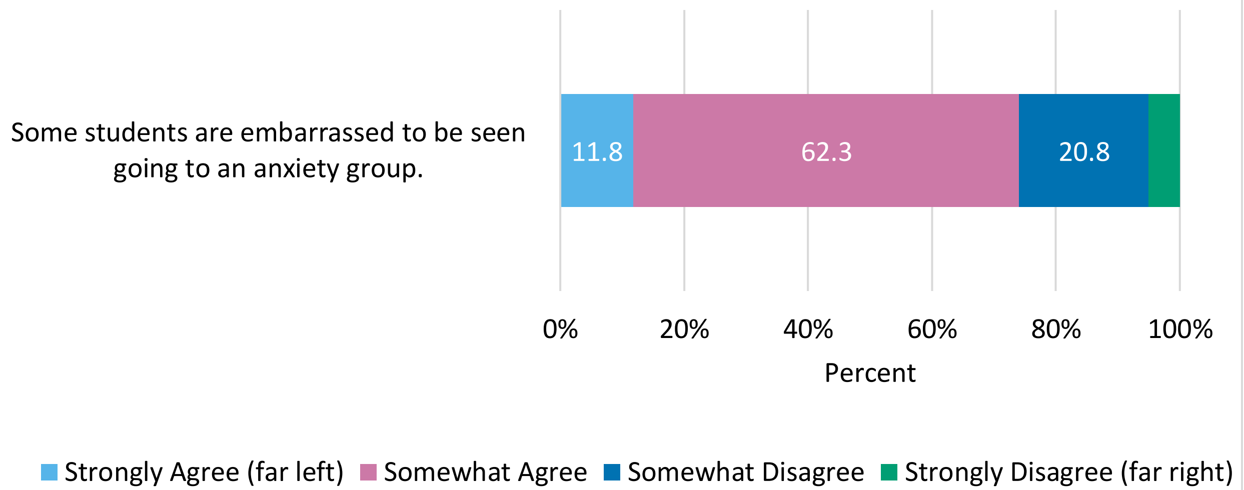


Figure 13: About 75 percent of school staff AGREE that some students are embarrassed to be seen going to an anxiety group
Some students are embarrassed to be seen going to an anxiety group.
11.8
62.3
20.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

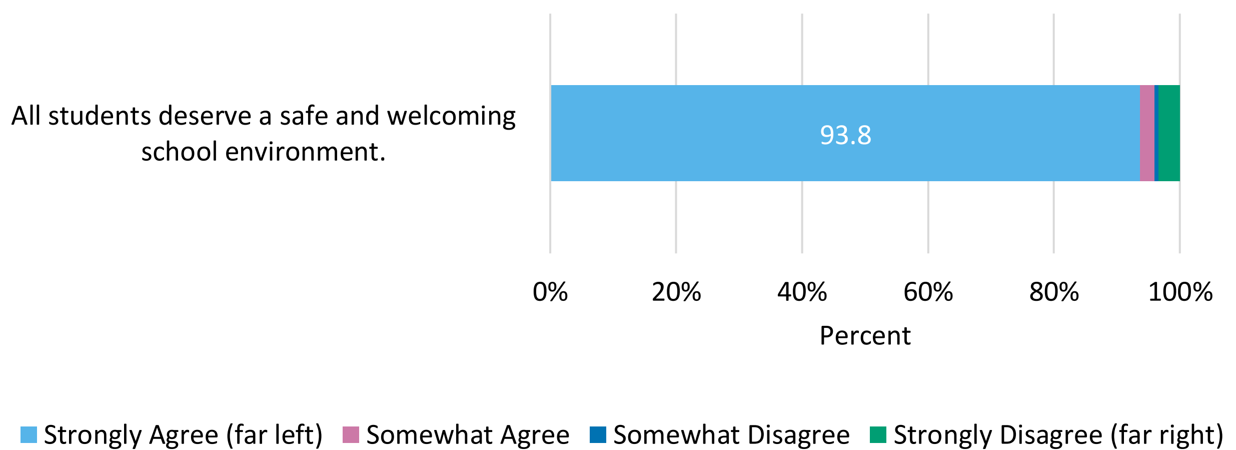
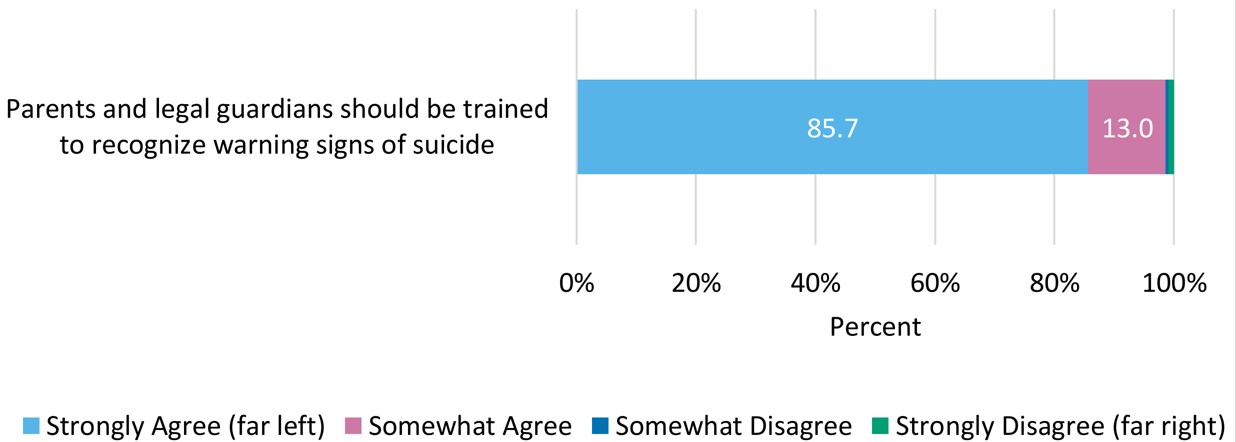
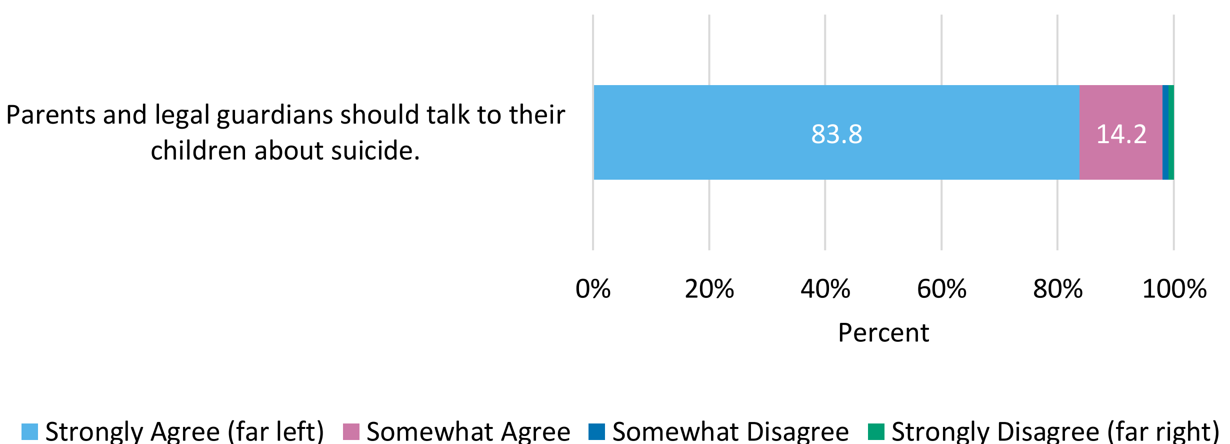


Figure 14: Ninety-six percent of school staff overwhelmingly AGREE that all students deserve a safe and welcoming school environment
All students deserve a safe and welcoming school environment.
93.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Staff's Opinions about Family's Roles in Mental Health & Suicide Prevention





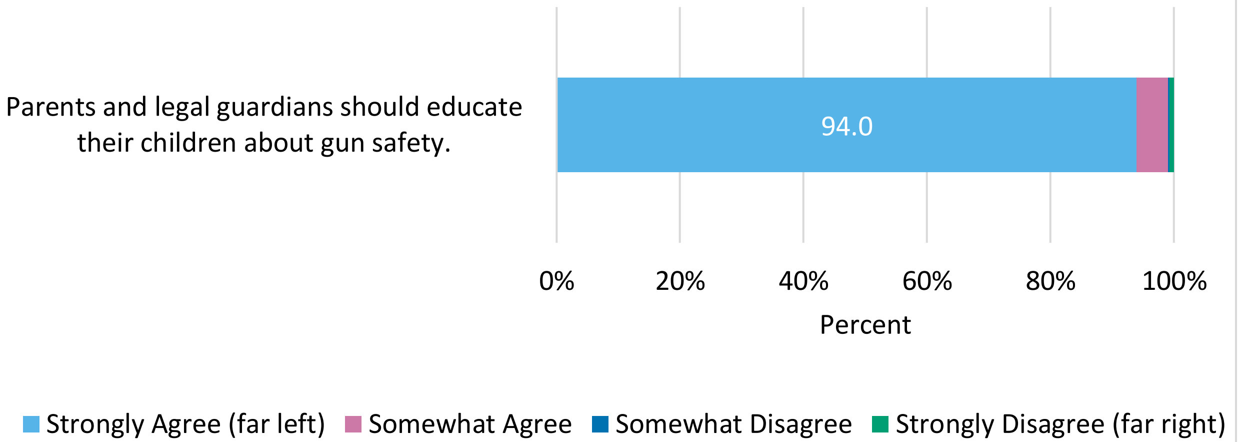


Figure 17: About 99 percent of school staff AGREE that parents and legal guardians should educate their children about gun safety
Parents and legal guardians should educate their children about gun safety.
94.0
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

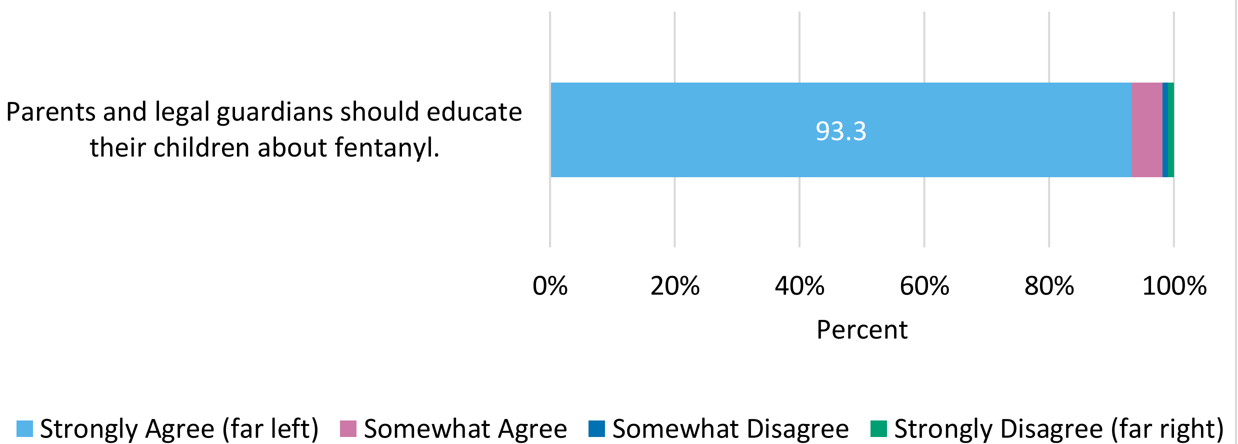


Figure 18: About 98 percent of school staff AGREE that parents and legal guardians should educate their children about fentanyl
Parents and legal guardians should educate their children about fentanyl.
93.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

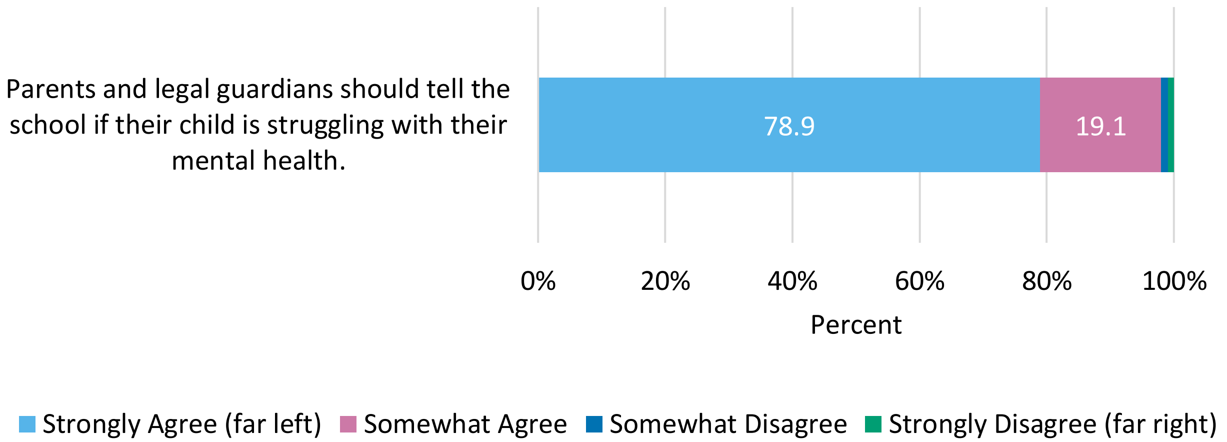


Figure 19: Ninety-eight percent of school staff AGREE that parents and legal guardians should tell the school if their child is struggling with their mental health
Parents and legal guardians should tell the school if their child is struggling with their mental health.
78.9
19.1
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

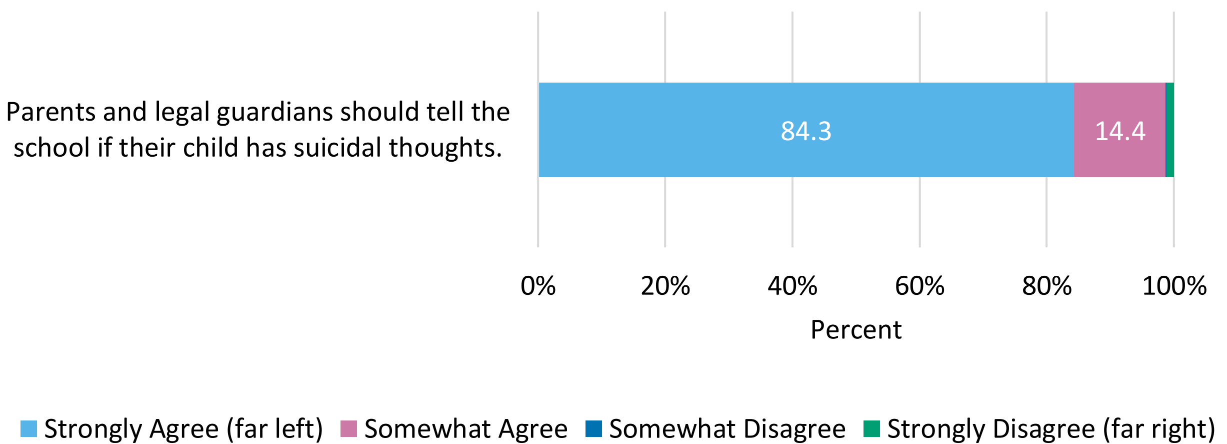


Figure 20: About 99 percent of school staff AGREE that parents and legal guardians should tell the school if their child has suicidal thoughts
Parents and legal guardians should tell the school if their child has suicidal thoughts.
84.3
14.4
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

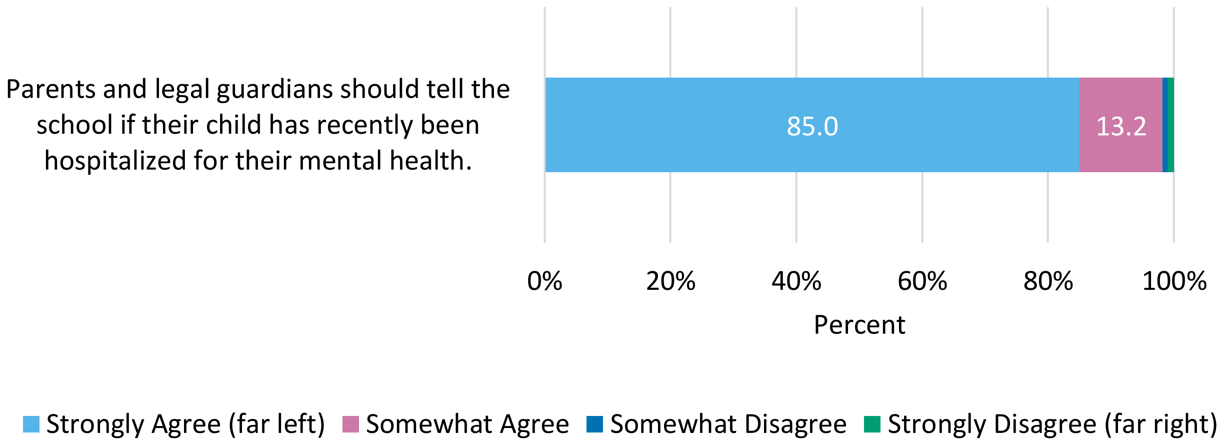


Figure 21: About 98 percent of school staff AGREE that parents and legal guardians should tell the school if their child has recently been hospitalized for their mental health
Parents and legal guardians should tell the school if their child has recently been hospitalized for their mental health.
85.0
13.2
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

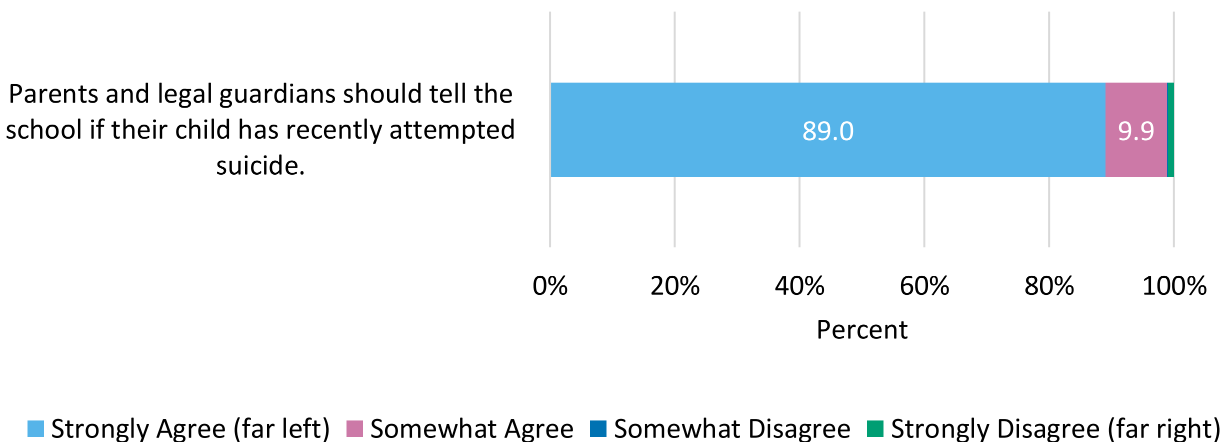
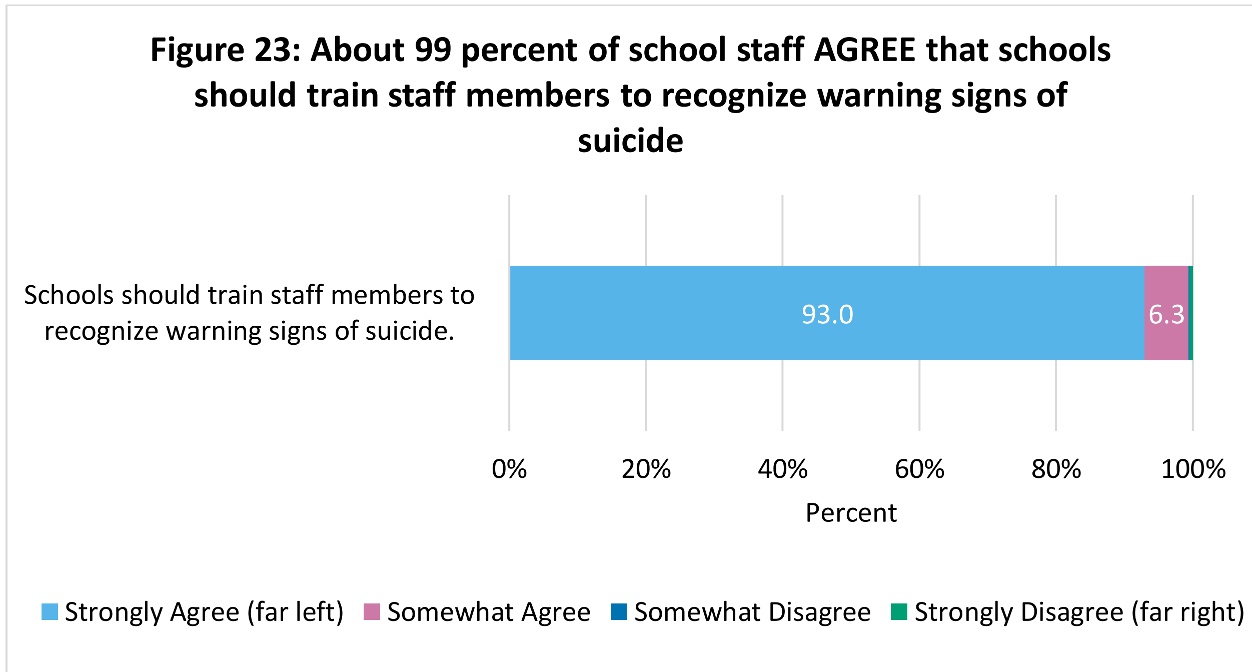
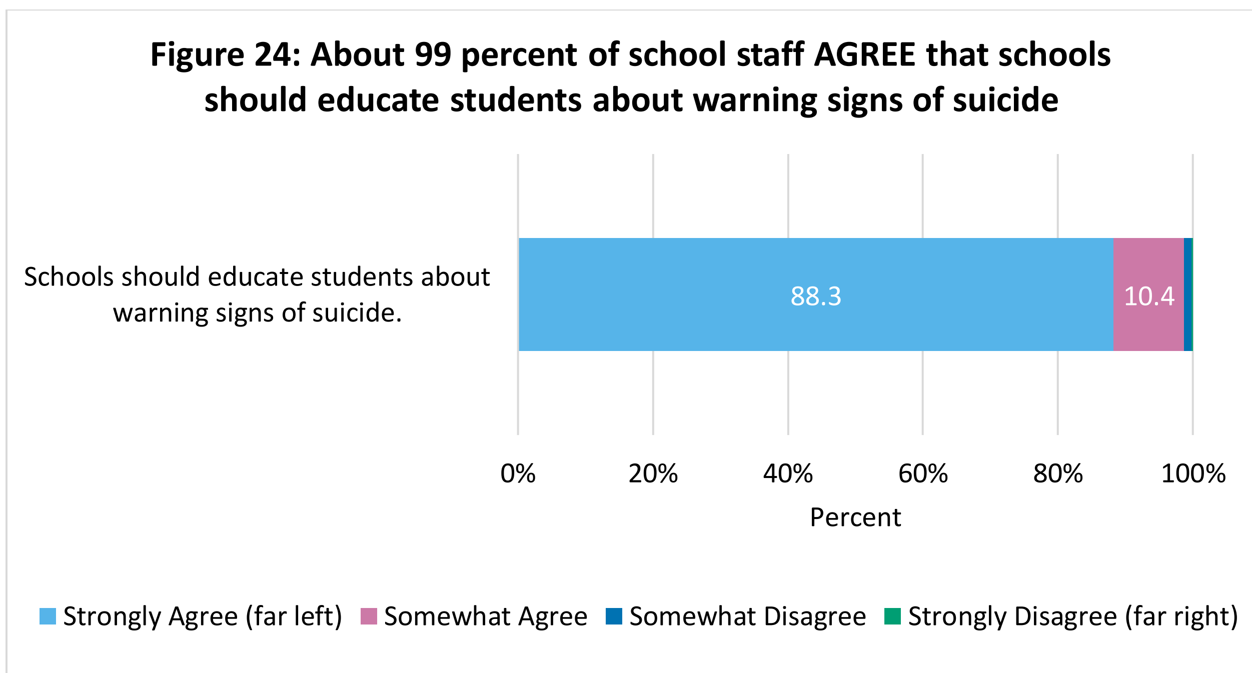


Figure 22: About 99 percent of school staff AGREE that parents and legal guardians should tell the school if their child has recently attempted suicide
Parents and legal guardians should tell the school if their child has recently attempted suicide.
89.0
9.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Staff's Beliefs about Schools' Roles in Mental Health





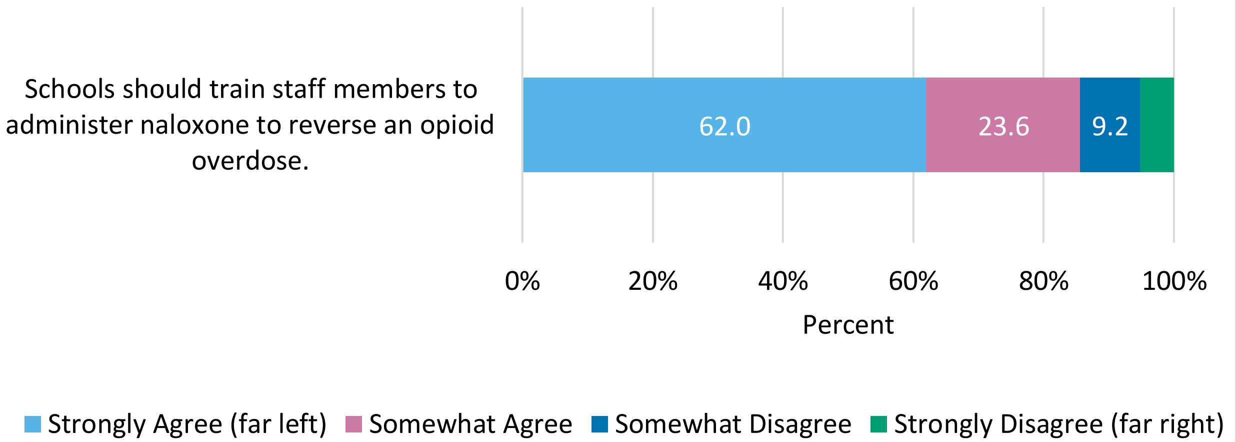


Figure 25: About 86 percent of school staff AGREE that schools should train staff members to administer naloxone to reverse an opioid overdose
Schools should train staff members to administer naloxone to reverse an opioid overdose.
62.0
23.6
9.2
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

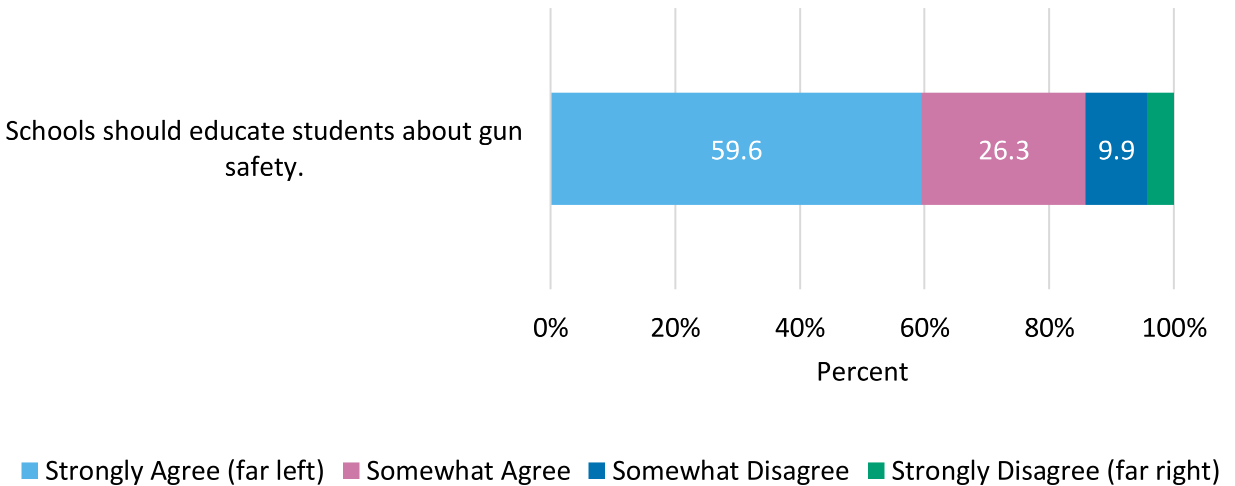


Figure 26: About 86 percent of school staff AGREE that schools should educate students about gun safety
Schools should educate students about gun safety.
59.6
26.3
9.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

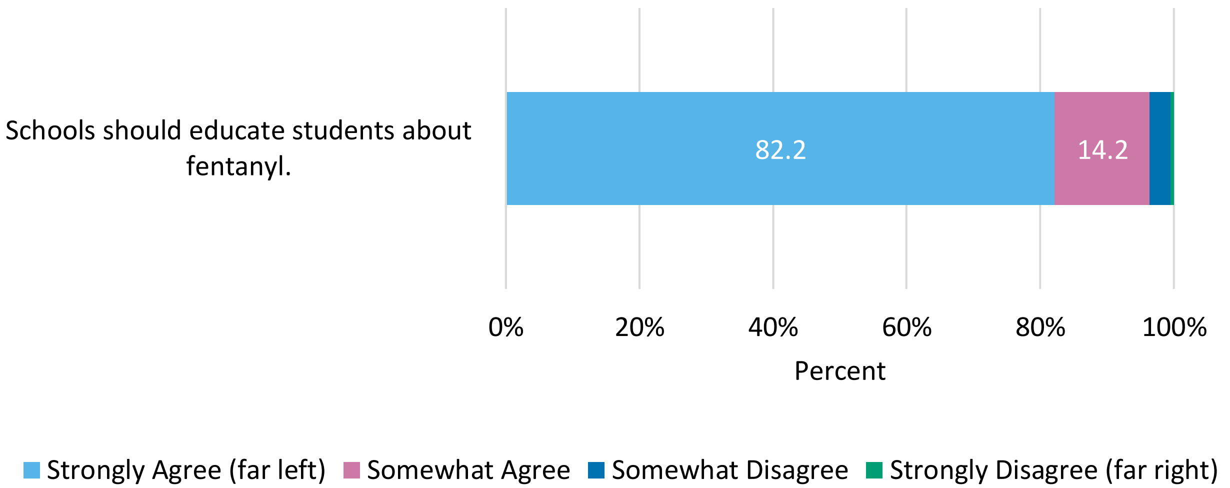


Figure 27: About 96 percent of school staff AGREE that schools should educate students about fentanyl
Schools should educate students about fentanyl.
82.2
14.2
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

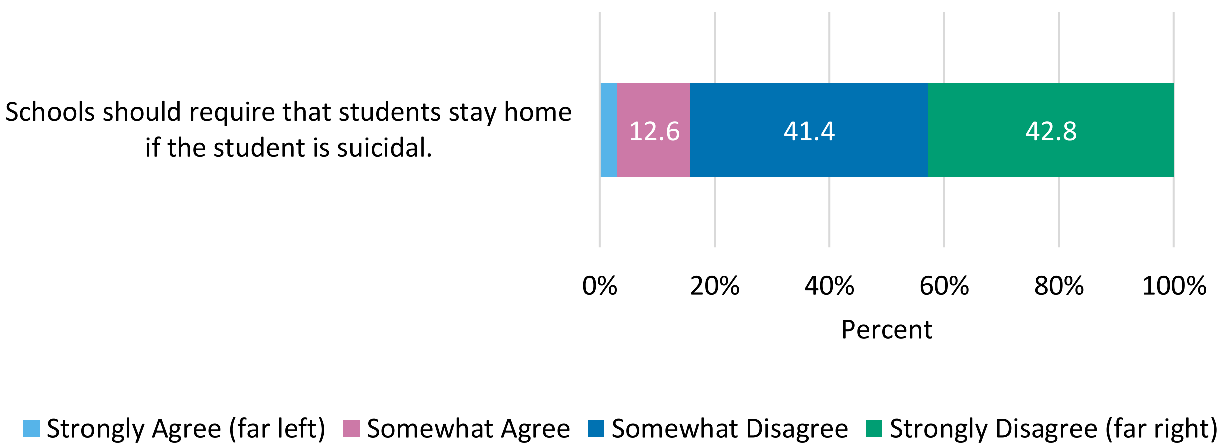


Figure 28: About 16 percent of school staff AGREE that schools should require that students stay home if the student is suicidal.
Schools should require that students stay home if the student is suicidal.
12.6
41.4
42.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

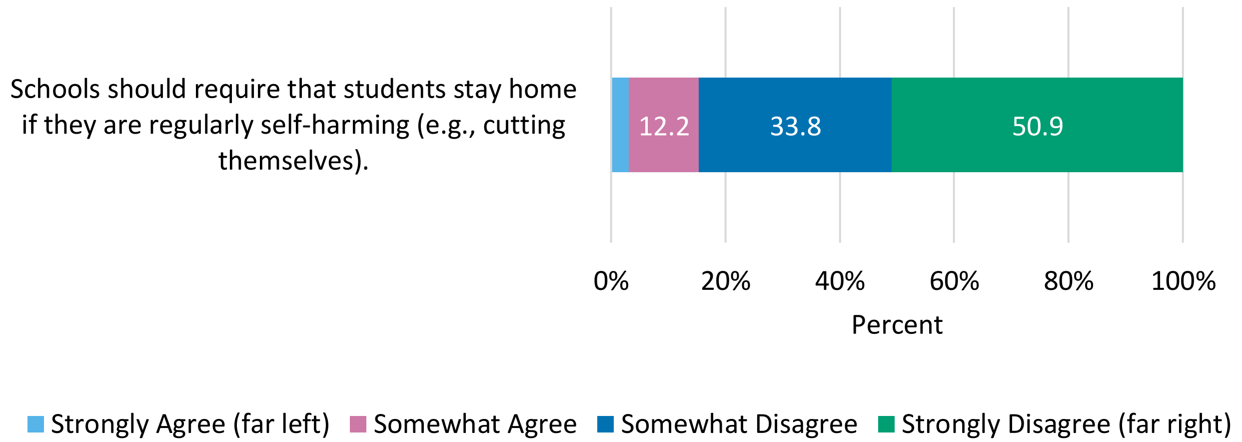


Figure 29: About 15 percent of school staff AGREE that schools should require that students stay home if they are regularly self-harming (e.g., cutting themselves)
Schools should require that students stay home if they are regularly self-harming (e.g., cutting themselves).
12.2
33.8
50.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

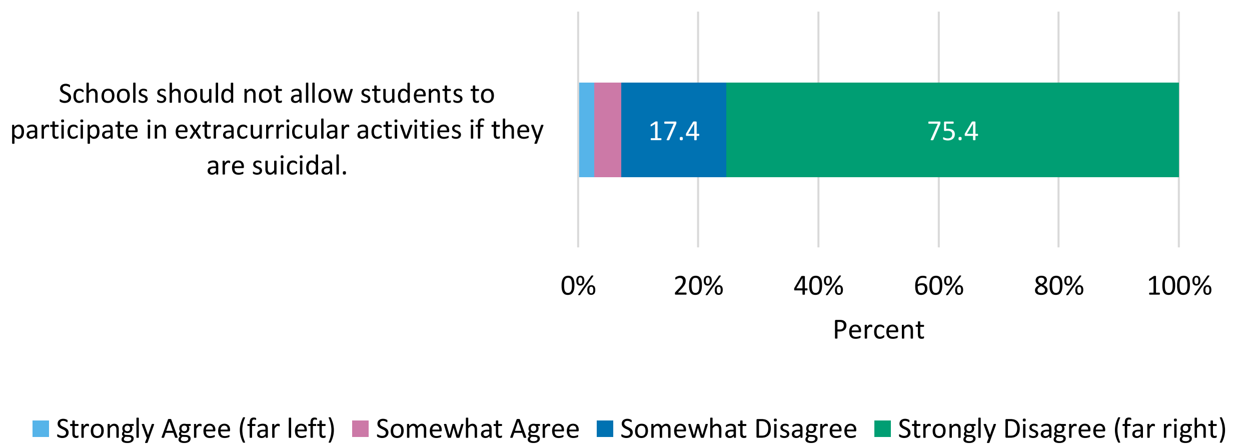


Figure 30: About 7 percent of school staff AGREE that schools should not allow students to participate in extracurricular activities if they are suicidal
Schools should not allow students to participate in extracurricular activities if they are suicidal.
17.4
75.4
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Figure 31: About 93 percent of school staff AGREE that schools should provide access to mental health therapy in the school building

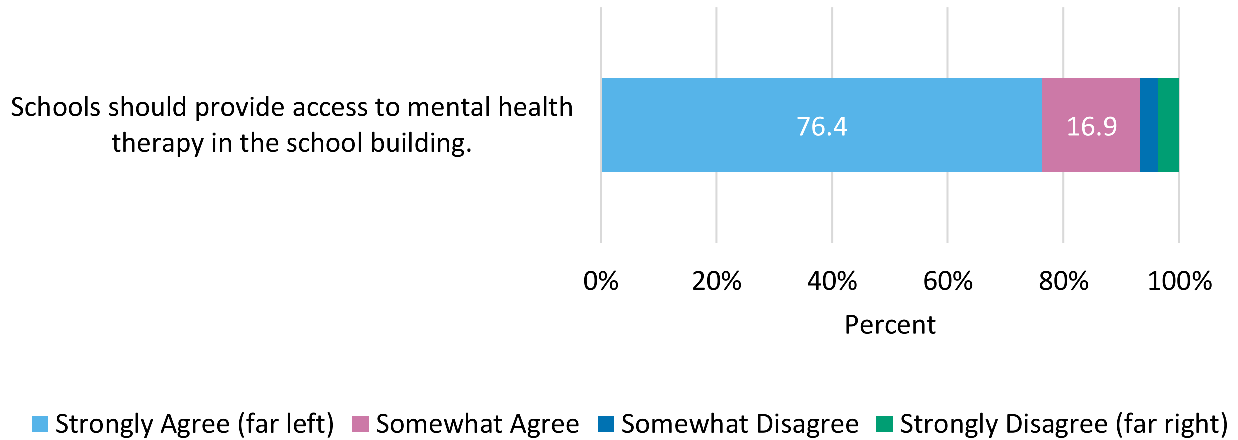
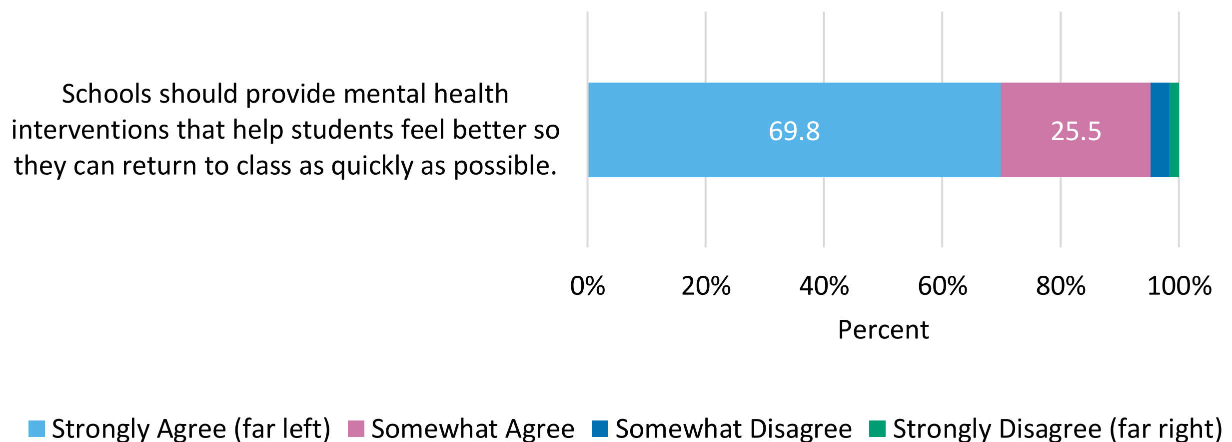


Figure 32: About 95 percent of school staff AGREE that schools should provide mental health interventions that help students feel better so they can return to class as quickly as possible



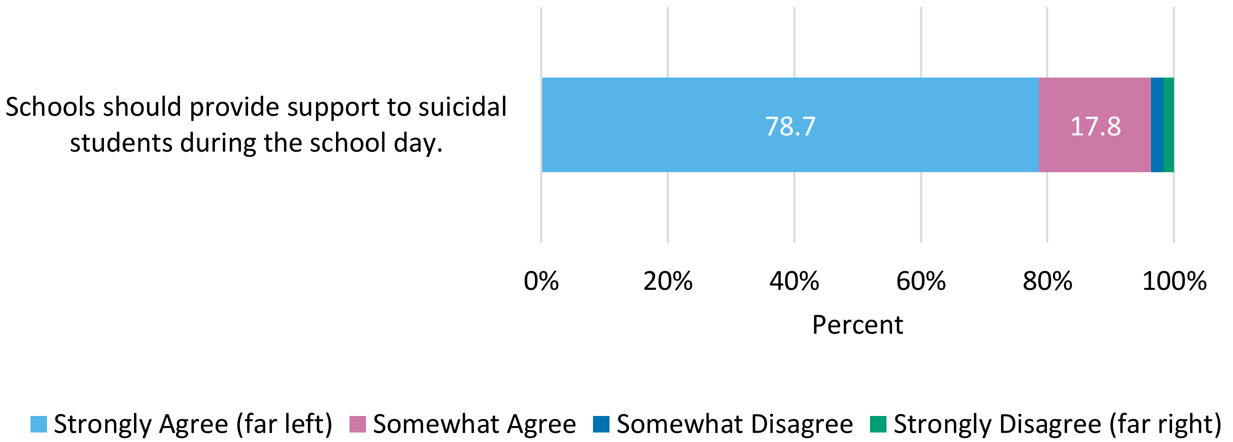


Figure 33: About 97 percent of school staff AGREE that schools should provide support to suicidal students during the school day
Schools should provide support to suicidal students during the school day.
78.7
17.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

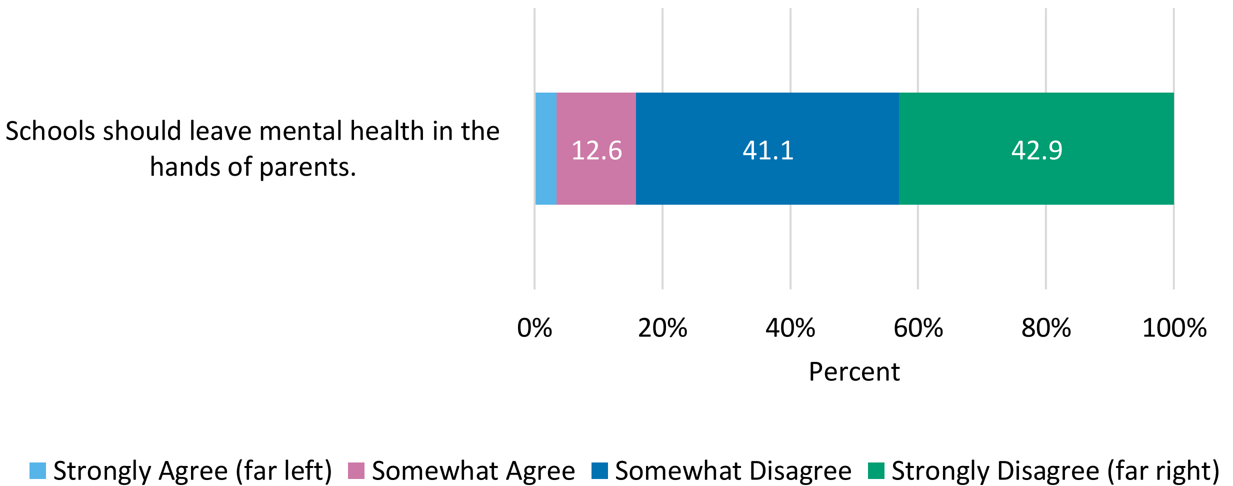
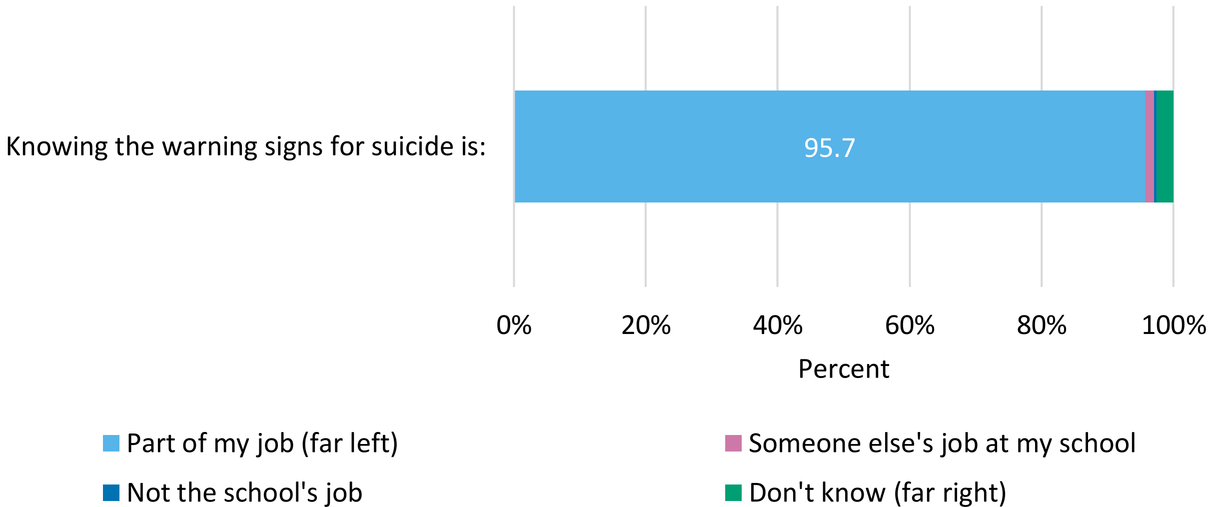


Figure 34: Sixteen percent of school staff AGREE that schools should leave mental health in the hands of parents
Schools should leave mental health in the hands of parents.
12.6
41.1
42.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Staff's Beliefs about Their Role in Student Mental Health



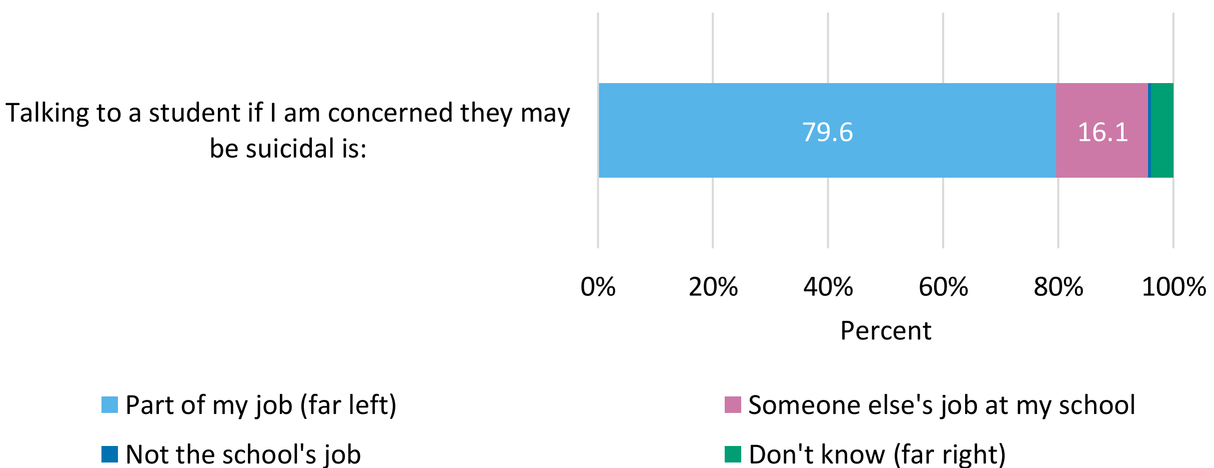


Figure 37: All but one staff member reported that it is part of their job to tell a school counselor, school psychologist, or school administrator that they are concerned a student may be suicidal

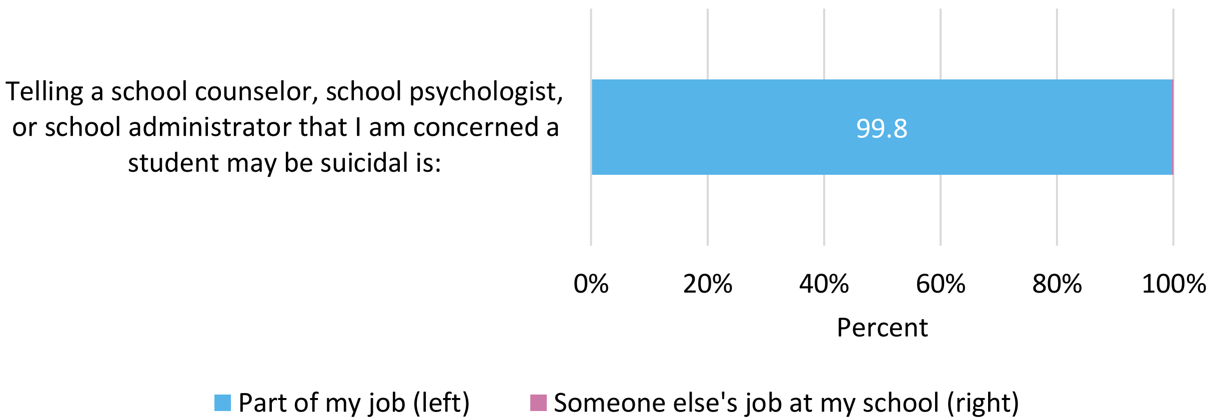
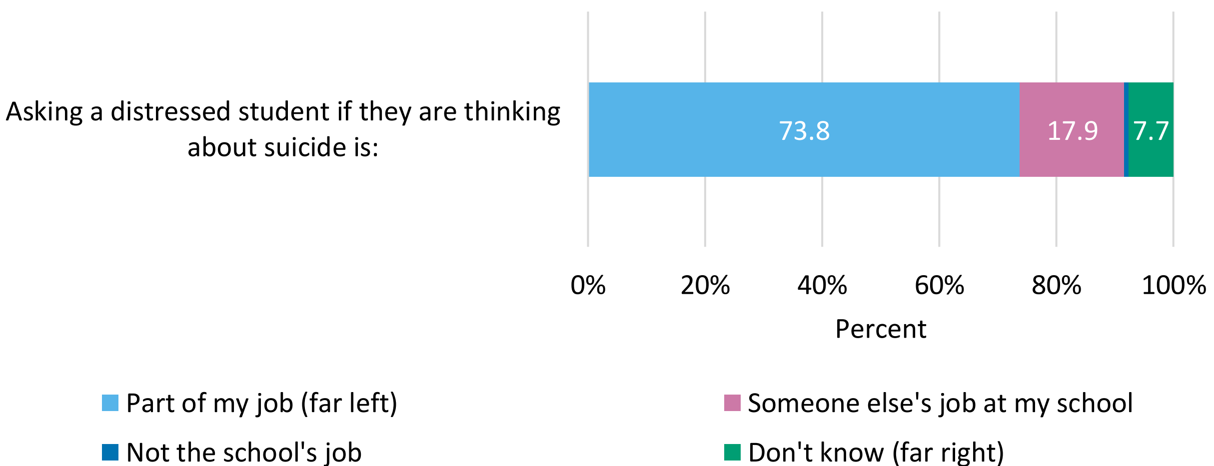


Figure 38: Less than one percent of school staff report that asking a distressed student if they are thinking about suicide is NOT the school's job



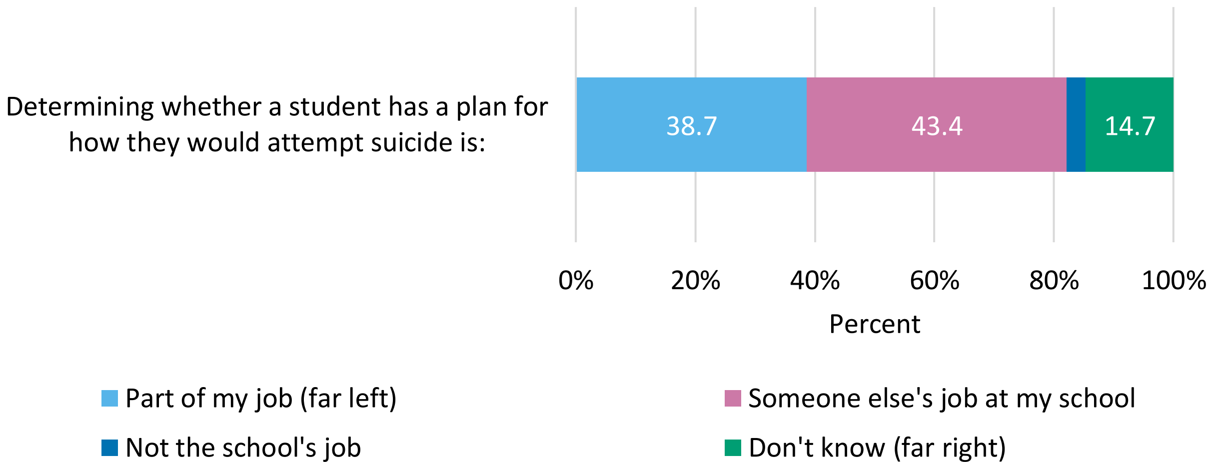


Figure 39: Only 3.2 percent of school staff report that it is NOT the school's job to determine whether a student has a plan for how they would attempt suicide
Determining whether a student has a plan for how they would attempt suicide is:
38.7
43.4
14.7
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

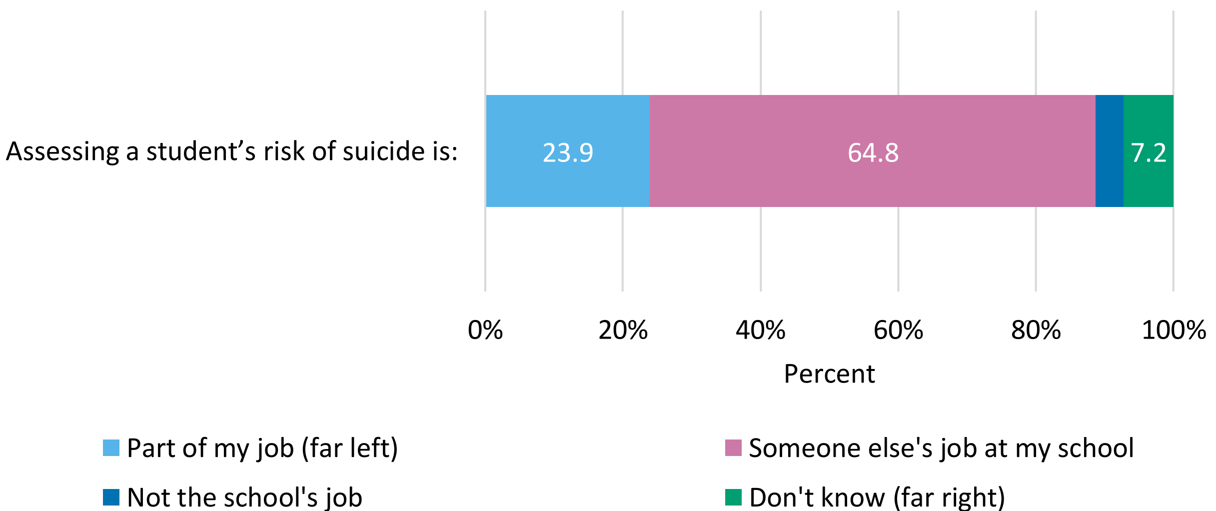


Figure 40: Only 4.1 percent of school staff report that it is NOT the school's job to assess a student's risk of suicide
Assessing a student's risk of suicide is:
23.9
64.8
7.2
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

Figure 41: About 75 percent of school staff report that making sure a student's safety plan is followed during school is part of their job

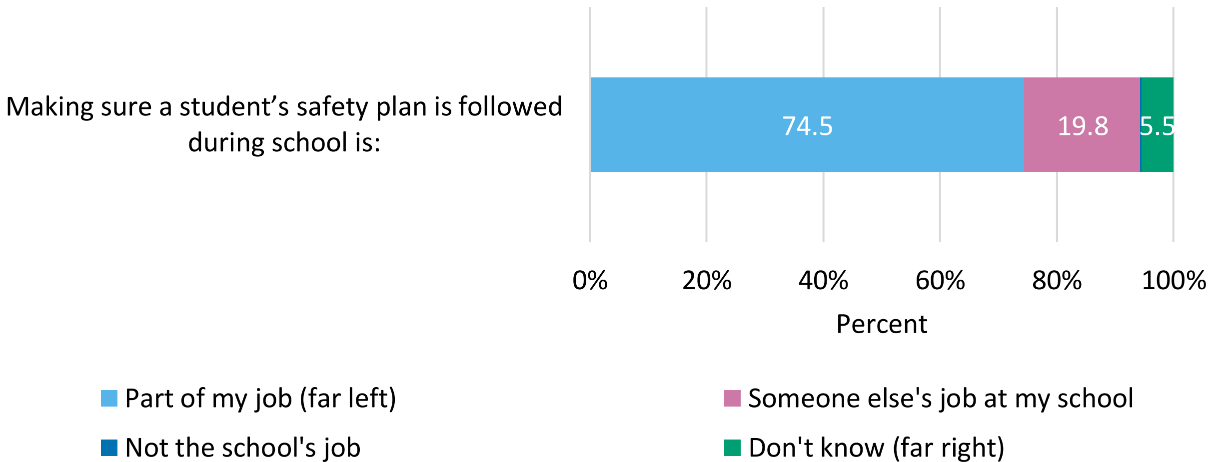
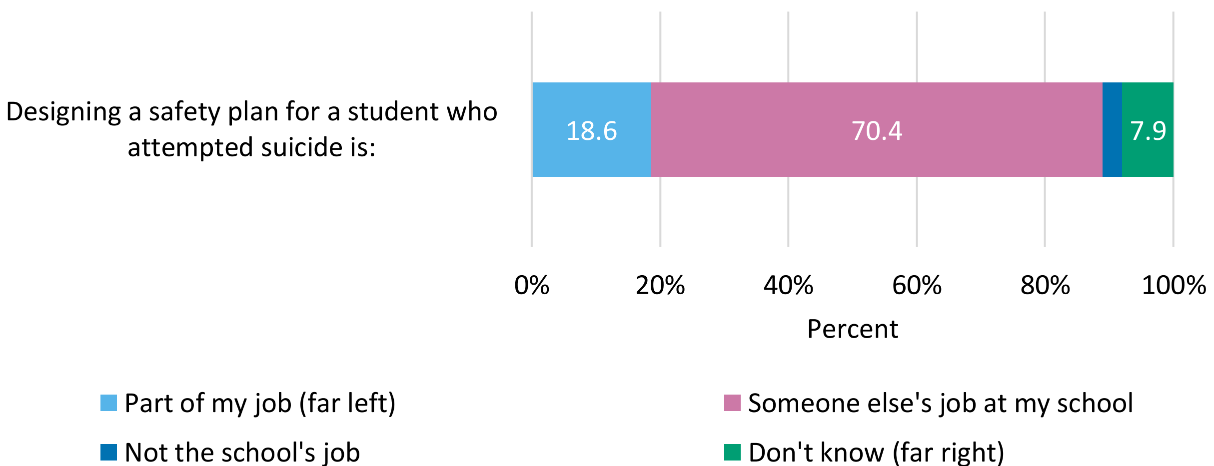
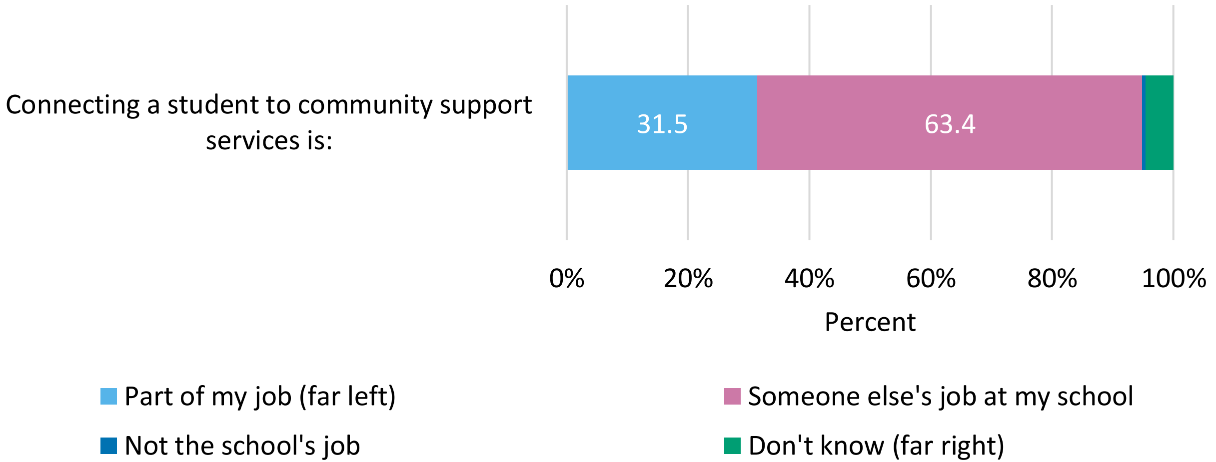
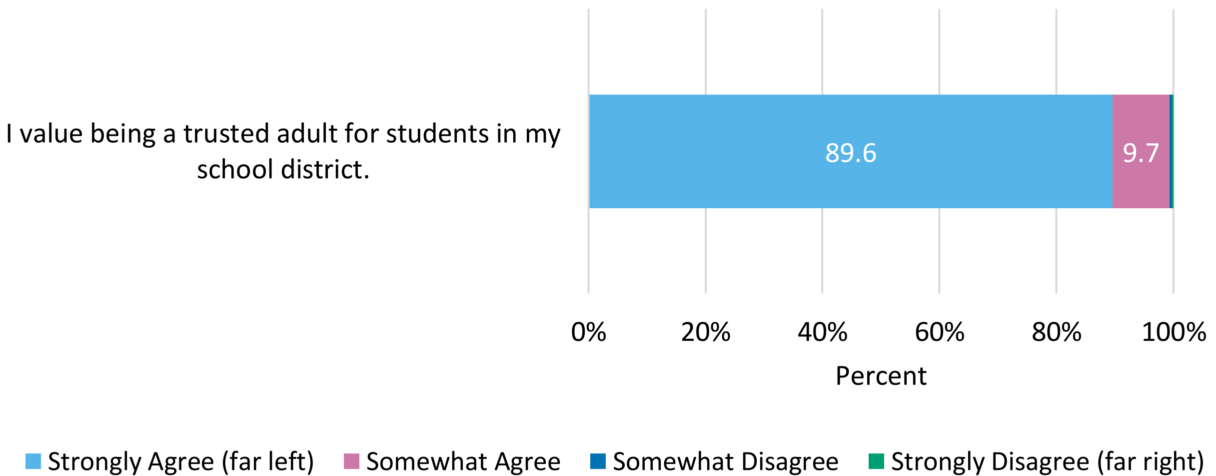


Figure 42: About 3 percent of school staff report that designing a safety plan for a student who attempted suicide is NOT the school's job

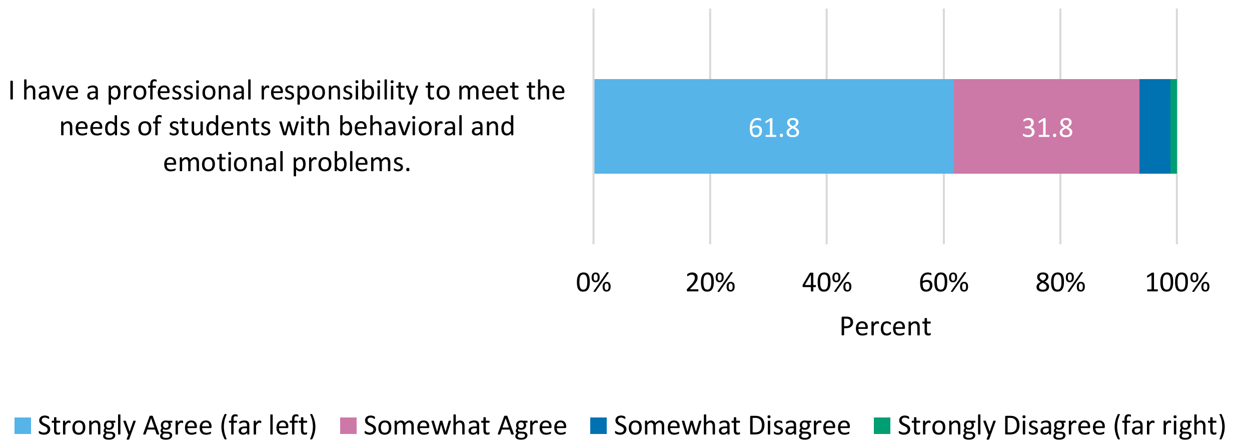


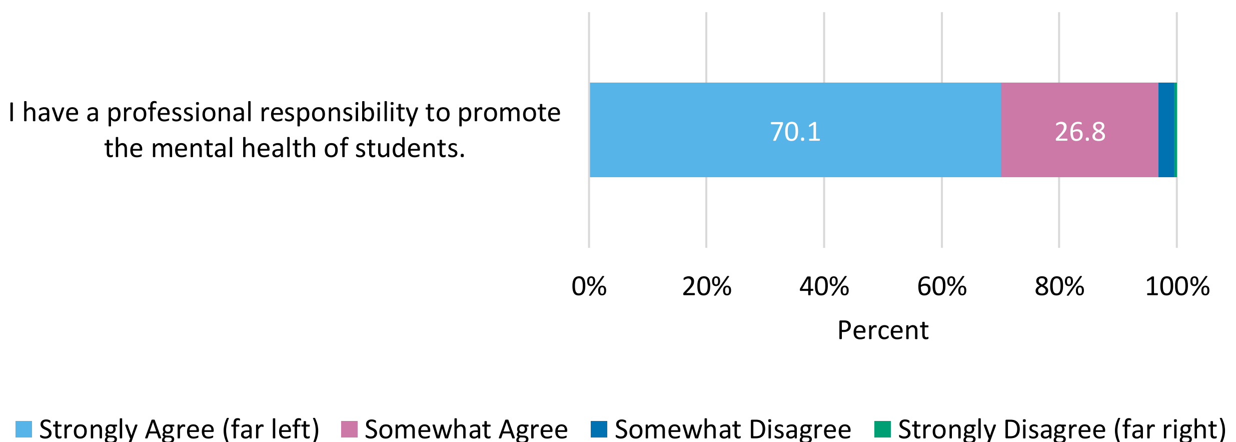


Staff Feelings about Being a Trusted Adult for Students



Staff's Understanding of their Professional Responsibilities





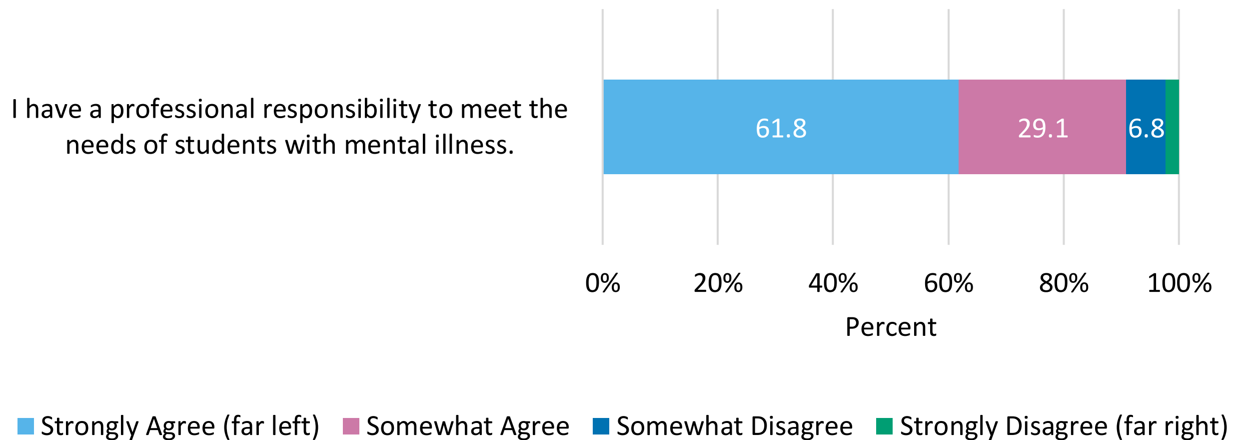


Figure 47: About 91 percent of school staff AGREE that they have a professional responsibility to meet the needs of students with mental illness
I have a professional responsibility to meet the needs of students with mental illness.
61.8
29.1
6.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

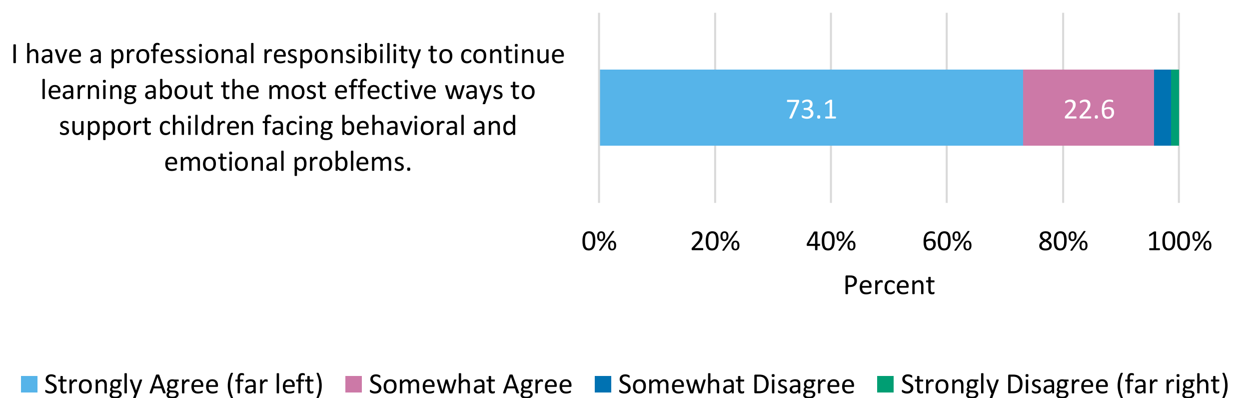


Figure 48: About 96 percent of school staff AGREE that they have a professional responsibility to continue learning about the most effective ways to support children facing behavioral and emotional problems
I have a professional responsibility to continue learning about the most effective ways to support children facing behavioral and emotional problems.
73.1
22.6
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

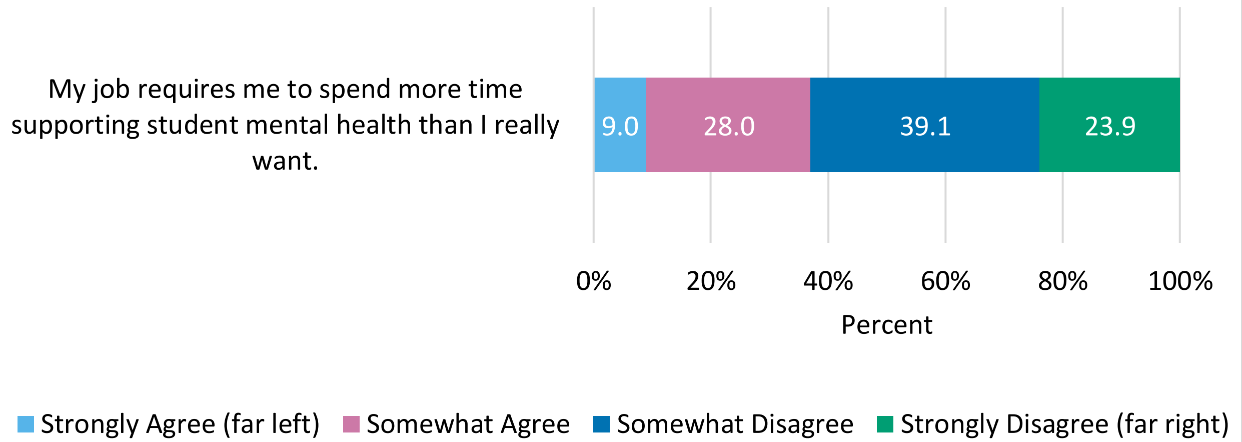


Figure 49: About 37 percent of school staff AGREE that their job requires them to spend more time supporting student mental health than they really want
My job requires me to spend more time supporting student mental health than I really want.
9.0
28.0
39.1
23.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

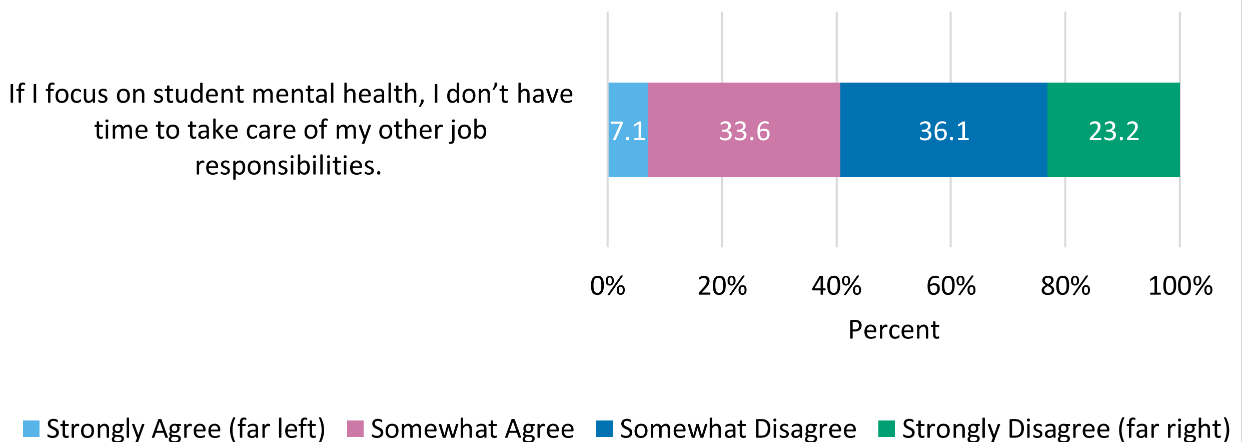


Figure 50: About 41 percent of school staff AGREE that if they focus on student mental health, they don't have time to take care of their other job responsibilities
If I focus on student mental health, I don't have time to take care of my other job responsibilities.
7.1
33.6
36.1
23.2
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

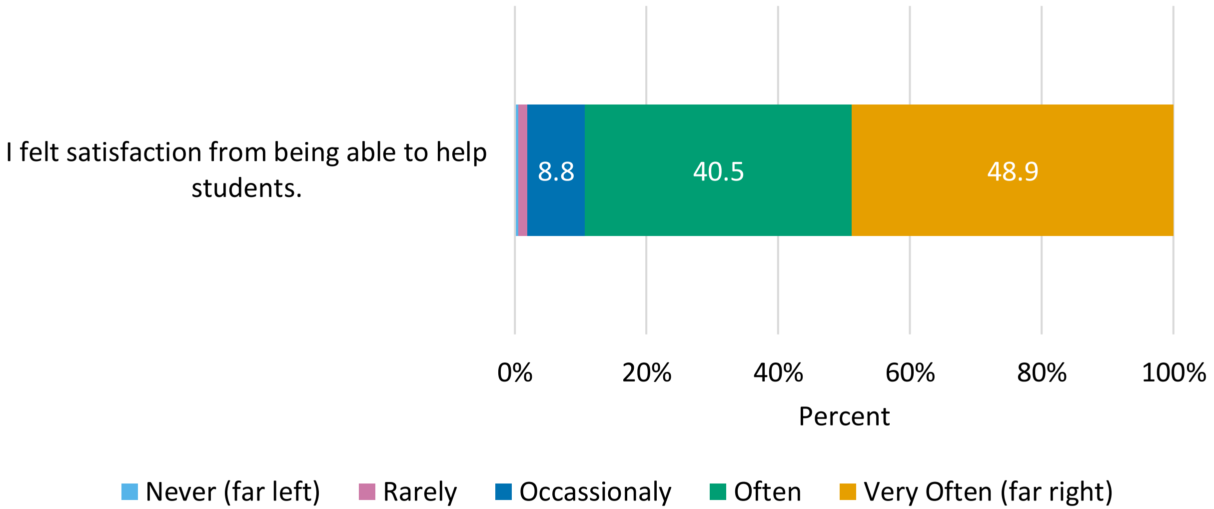


Figure 51: Nearly 90 percent of staff report feeling satisfaction from helping students often or very often
I felt satisfaction from being able to help students.
8.8
40.5
48.9
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

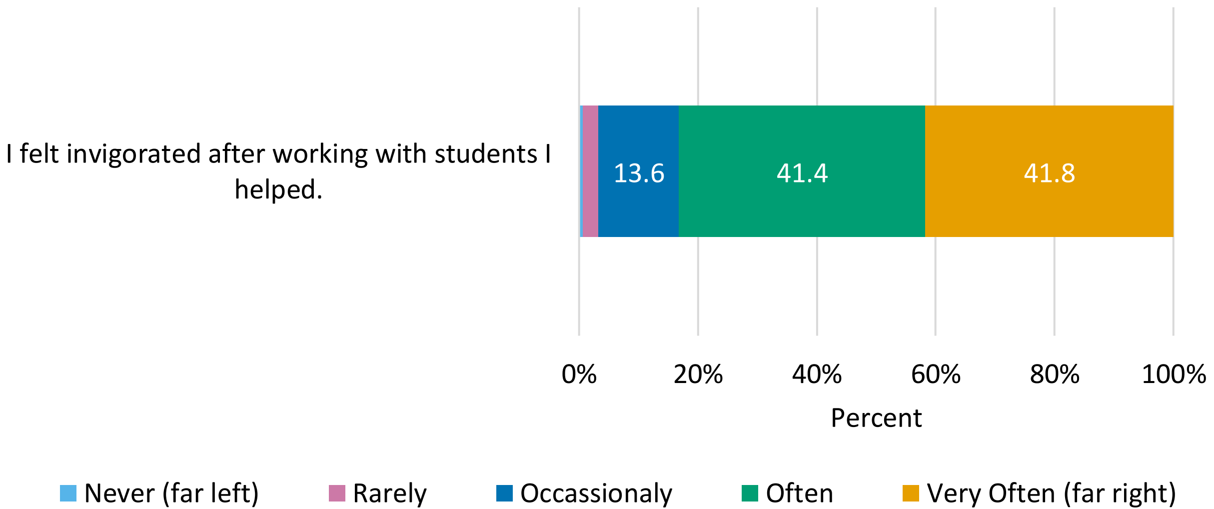


Figure 52: Over 80 percent of staff report feeling invigorated after working with students they helped often or very often
I felt invigorated after working with students I helped.
13.6
41.4
41.8
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

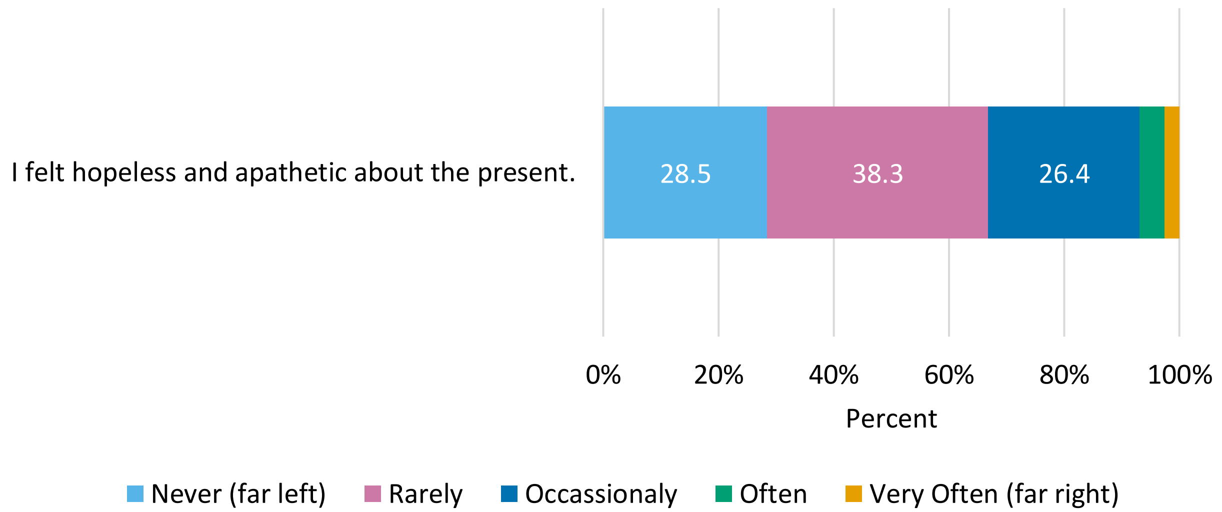


Figure 53: Sixty-six percent of staff report report feeling hopeless about the present never or rarely
I felt hopeless and apathetic about the present.
28.5
38.3
26.4
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

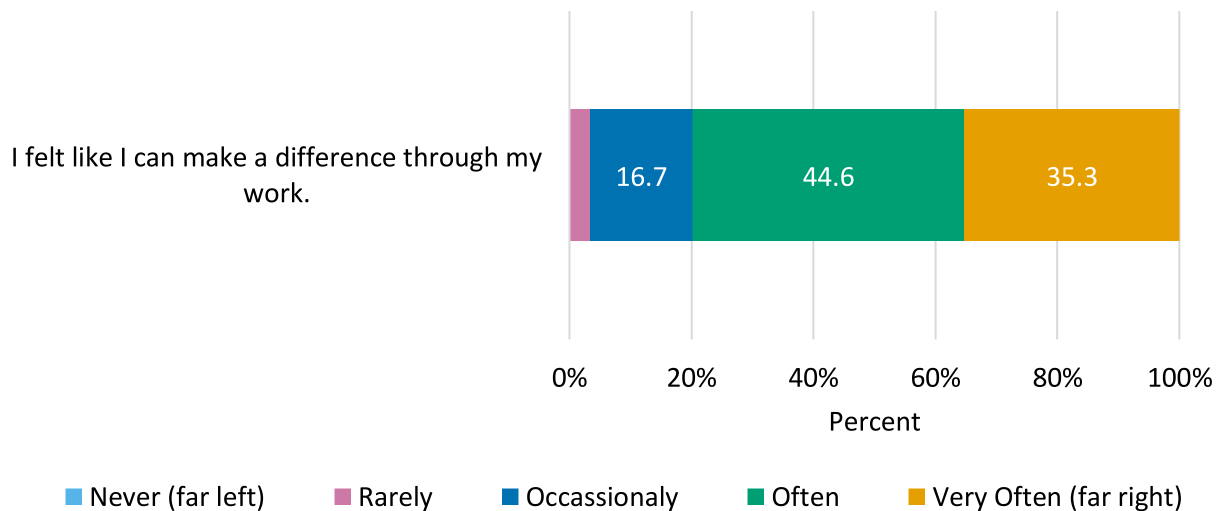


Figure 54: Nearly 80 percent of staff believe they can make a difference often or very often
I felt like I can make a difference through my work.
16.7
44.6
35.3
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

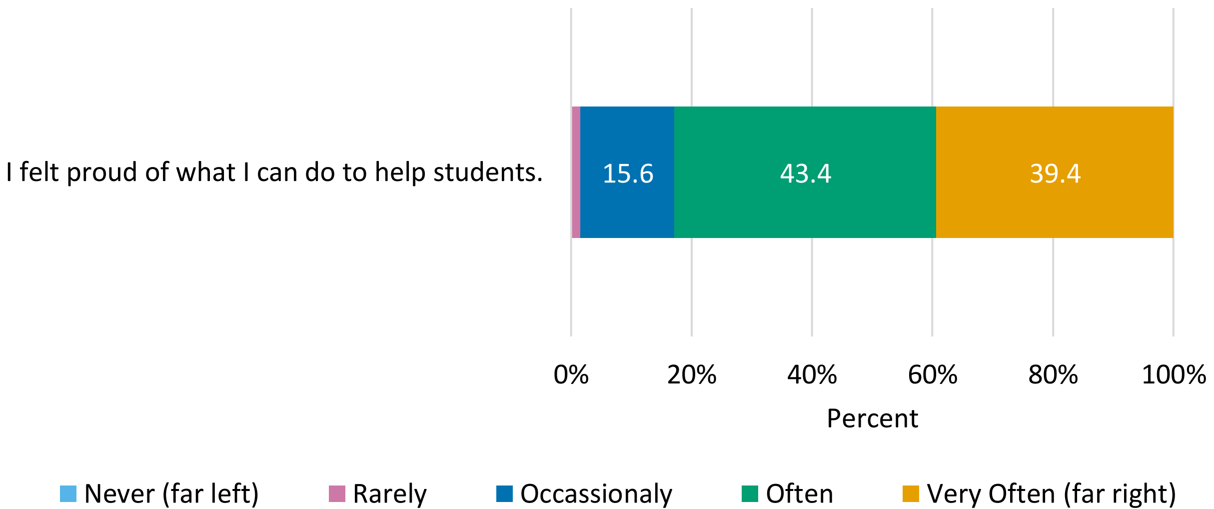


Figure 55: Over 80 percent of staff report feeling proud of helping students often or very often
I felt proud of what I can do to help students.
15.6
43.4
39.4
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

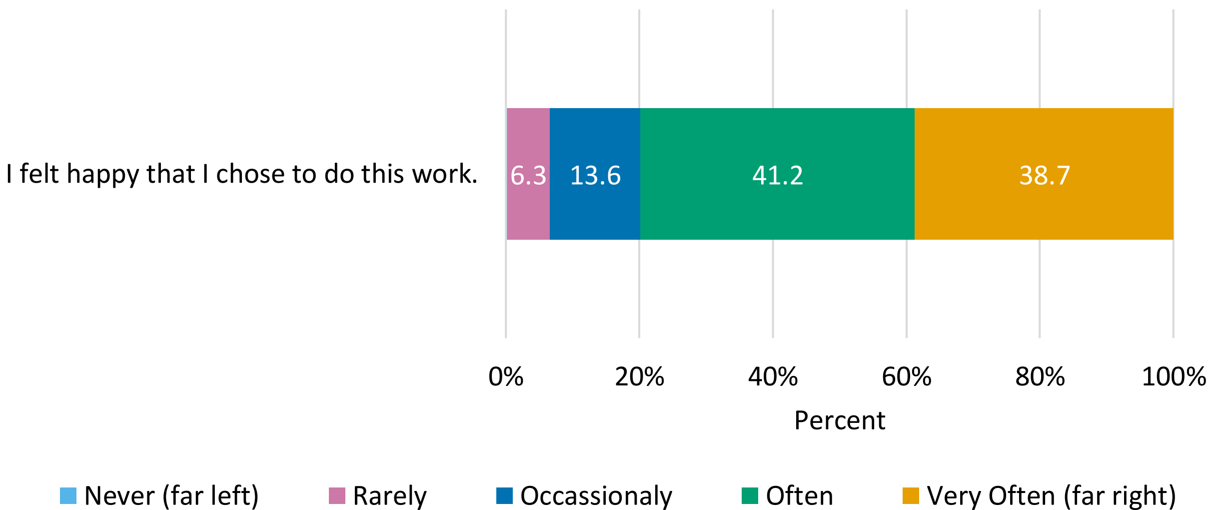


Figure 56: About 80 percent of staff report feeling happy about choosing this work often or very often
I felt happy that I chose to do this work.
6.3
13.6
41.2
38.7
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

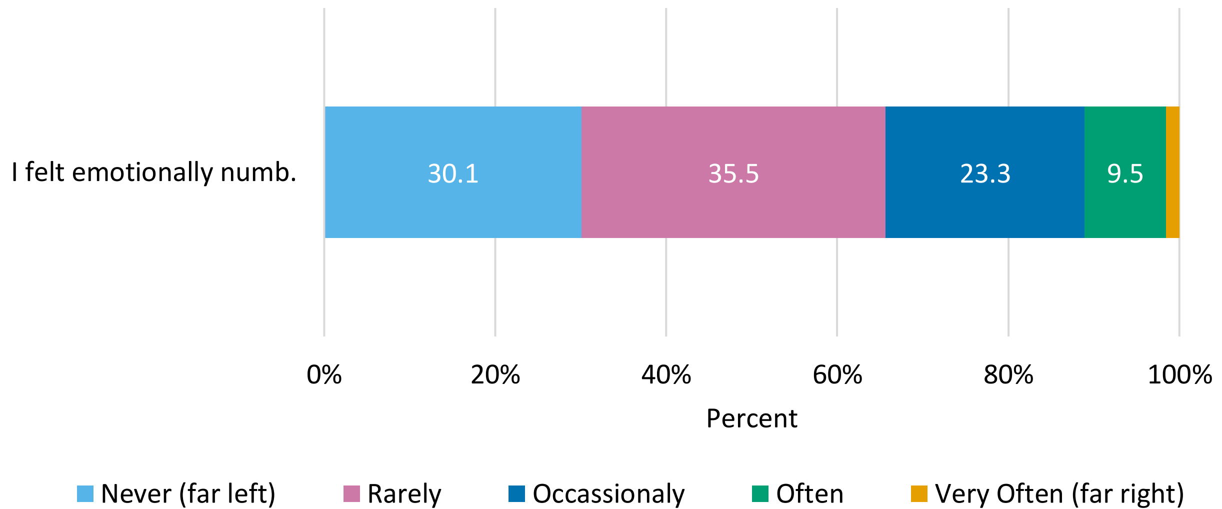


Figure 57: About 10 percent of staff report feeling emotionally numb often or very often
I felt emotionally numb.
30.1
35.5
23.3
9.5
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

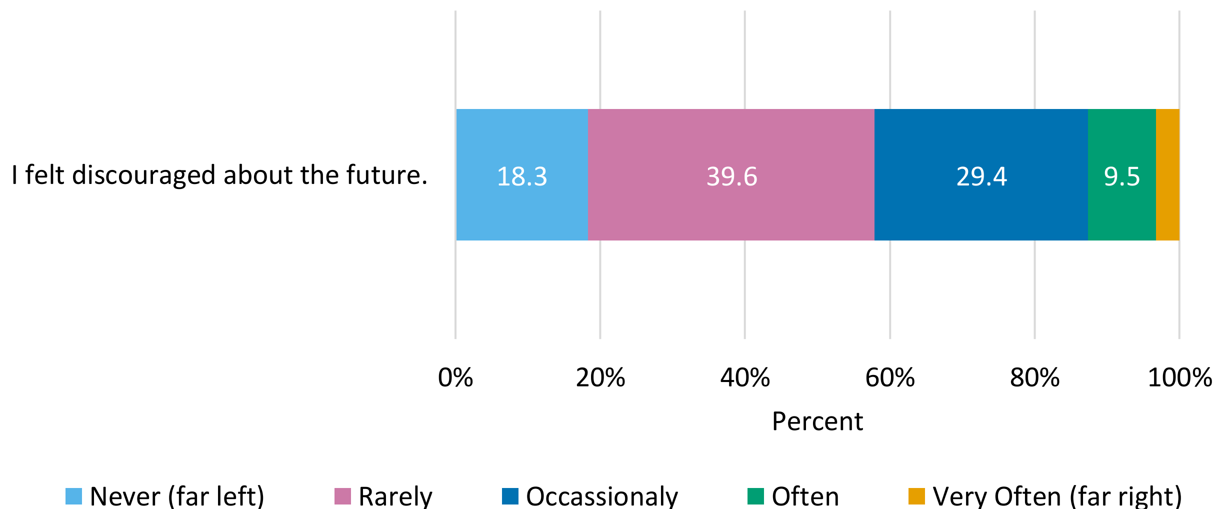


Figure 58: About 60 percent of staff report they are never or rarely discouraged about the future
I felt discouraged about the future.
18.3
39.6
29.4
9.5
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

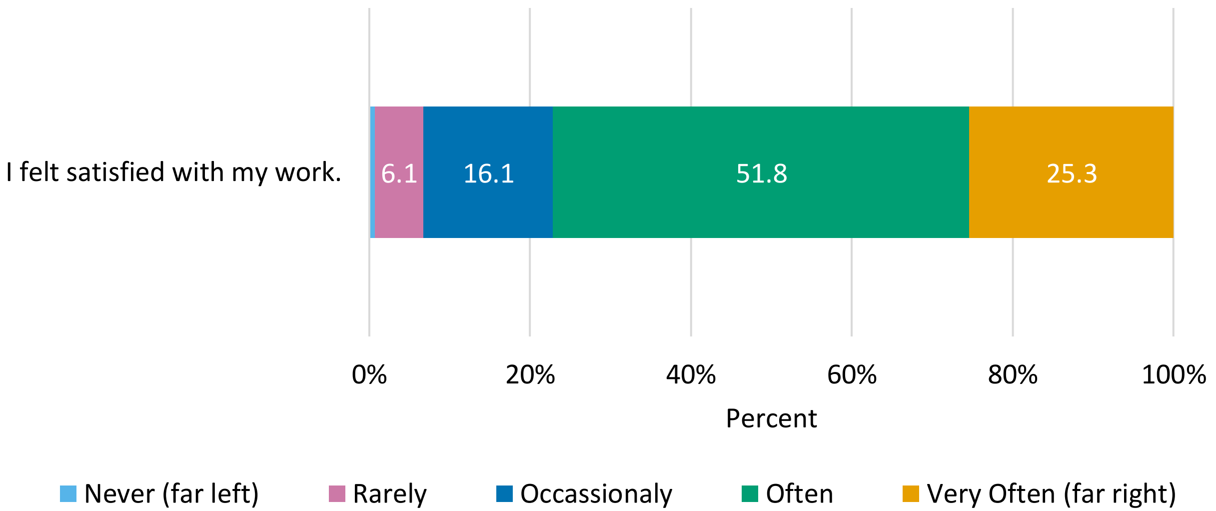


Figure 59: Over 75 percent of staff report they feel satisfied with their work often or very often
I felt satisfied with my work.
6.1
16.1
51.8
25.3
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

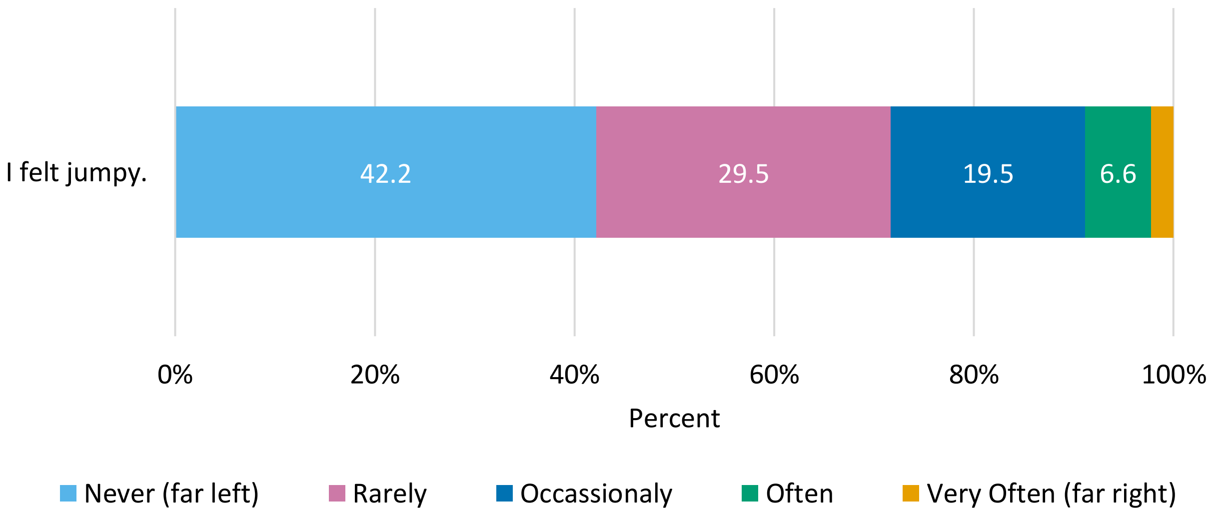


Figure 60: Over 70 percent of staff report never or rarely feeling jumpy
I felt jumpy.
42.2
29.5
19.5
6.6
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

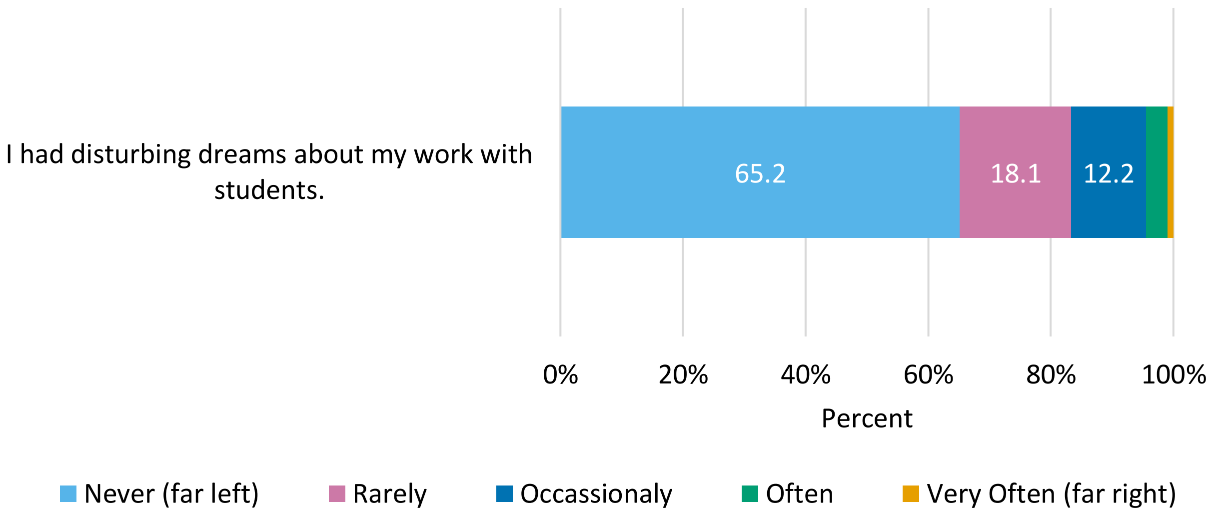


Figure 61: Over 80 percet of staff report never or rarely having disturbing dreams about their work with students
I had disturbing dreams about my work with students.
65.2
18.1
12.2
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

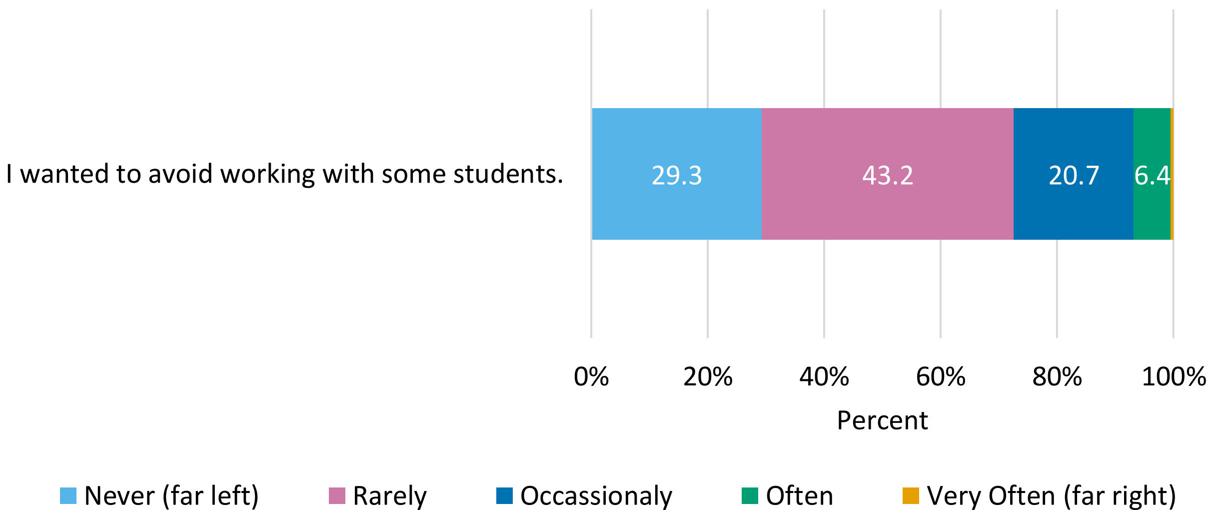


Figure 62: About 70 percent of staff report never or rarely wanting to avoid working with some students
I wanted to avoid working with some students.
29.3
43.2
20.7
6.4
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

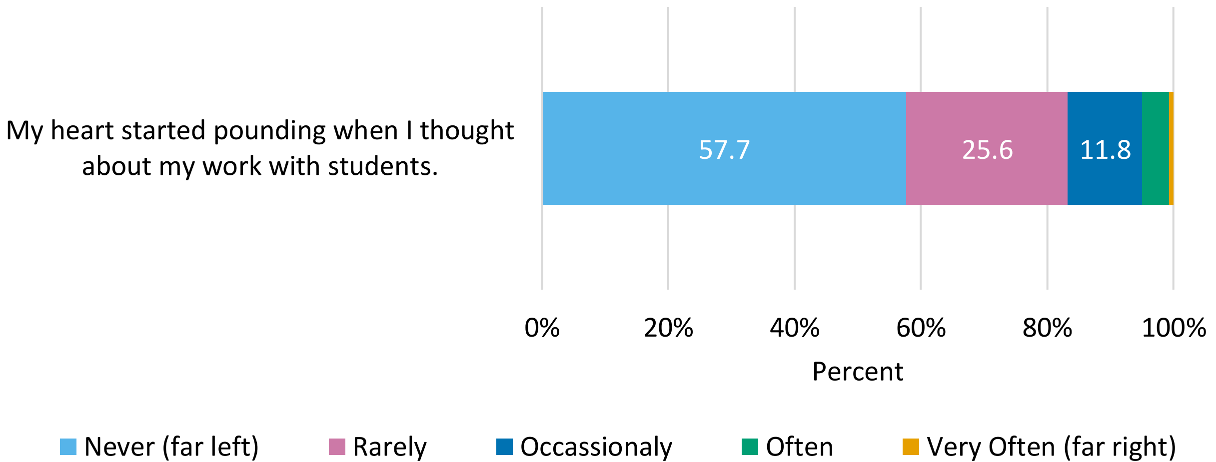


Figure 63: About 83 percent of staff report having never or rarely having a pounding heart when thinking about working with students
My heart started pounding when I thought about my work with students.
57.7
25.6
11.8
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

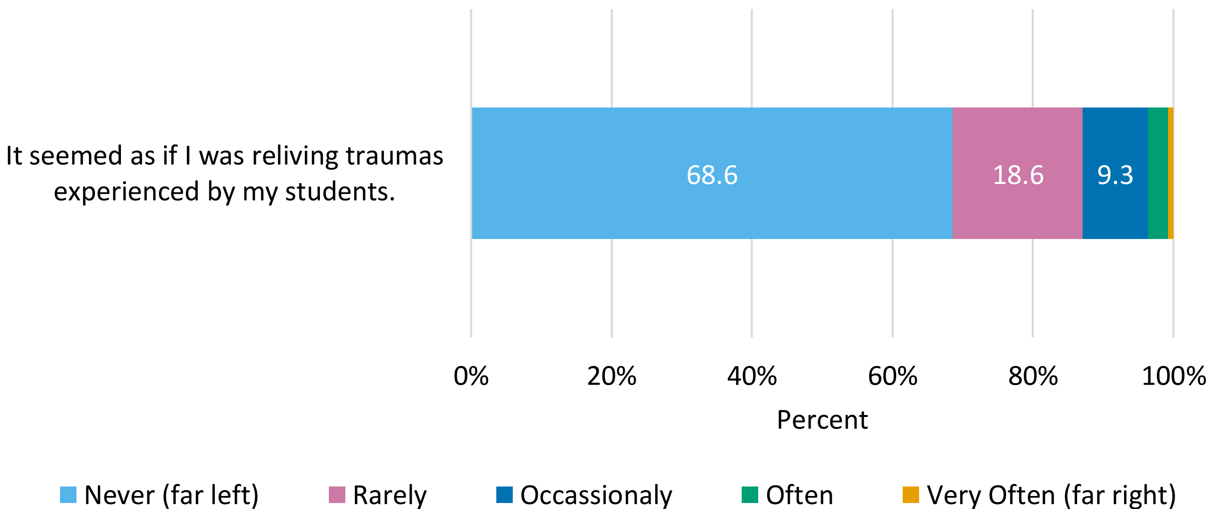


Figure 64: Almost 90 percent of staff report never or rarely reliving student traumas
It seemed as if I was reliving traumas experienced by my students.
68.6
18.6
9.3
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

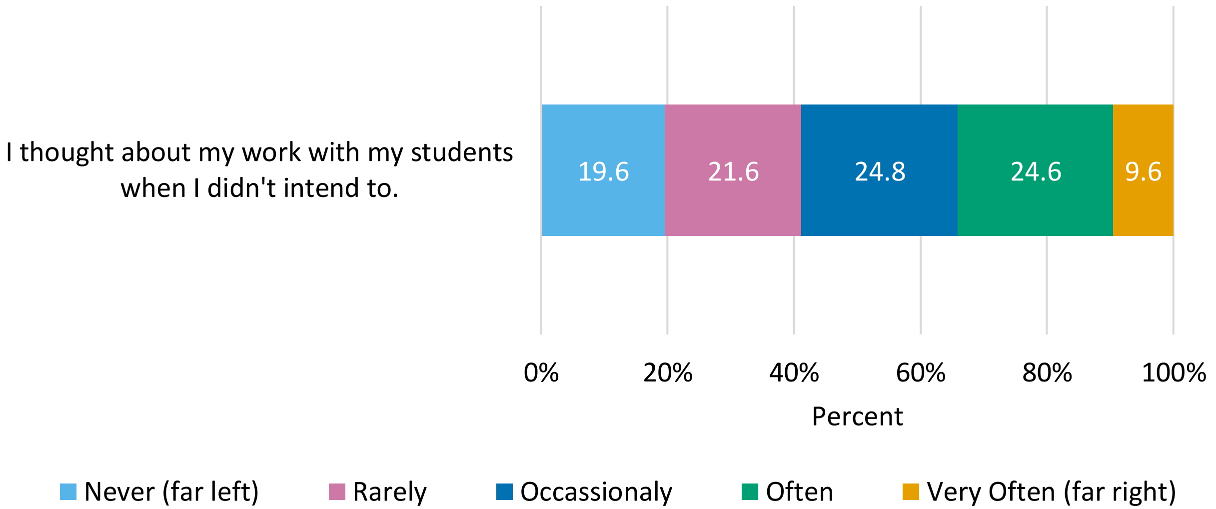


Figure 65: About 40 percent of staff report never or rarely thinking about work when they do not intend to
I thought about my work with my students when I didn't intend to.
19.6
21.6
24.8
24.6
9.6
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

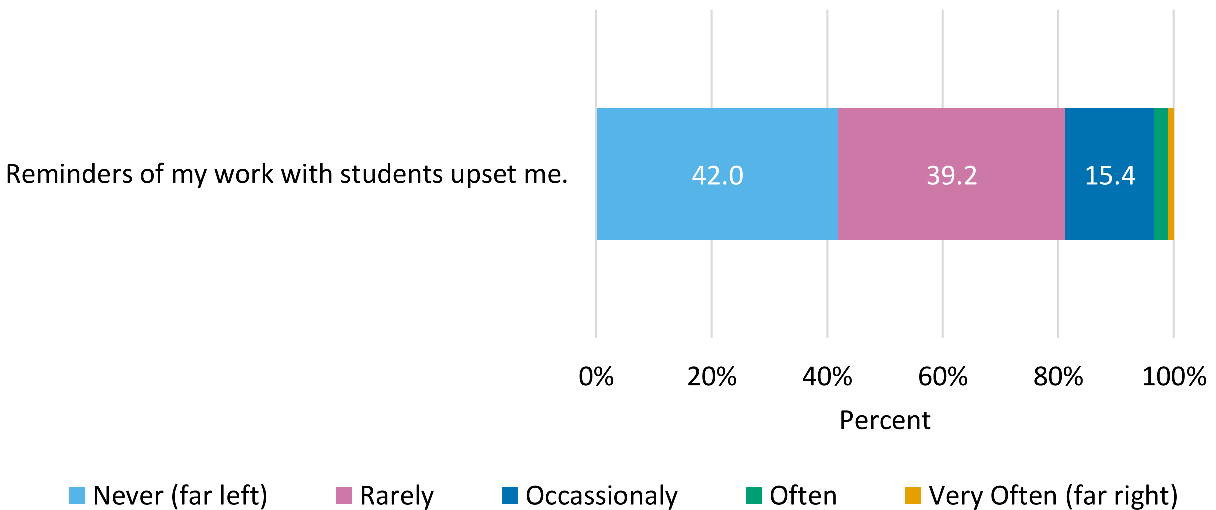


Figure 66: About 80 percent of staff report never or rarely being upset by reminders of working with students
Reminders of my work with students upset me.
42.0
39.2
15.4
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

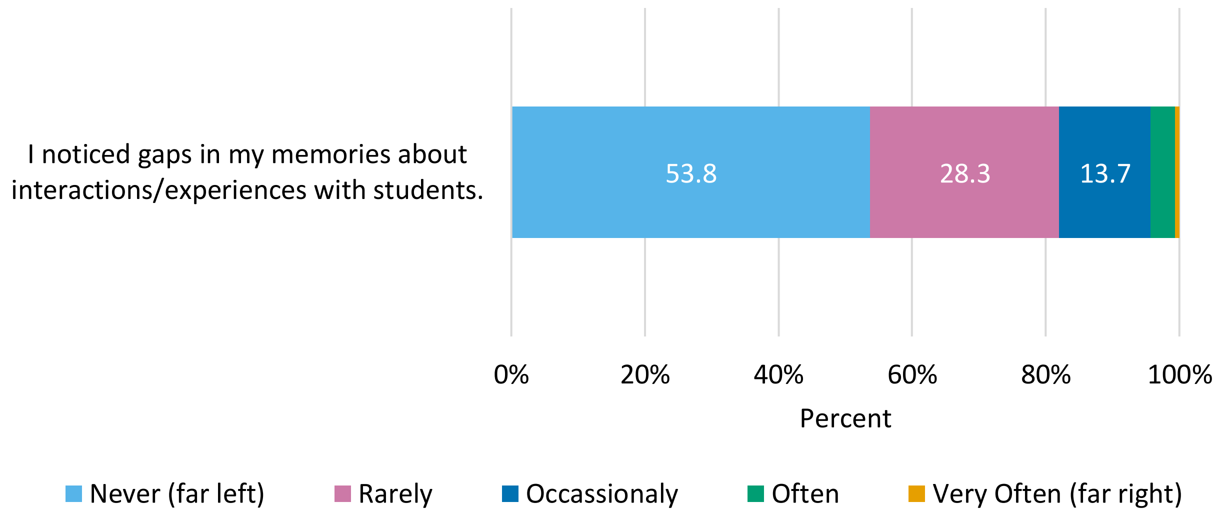


Figure 67: Eighty-two percent of staff report never or rarely noticing gaps in their memories about student interactions
I noticed gaps in my memories about interactions/experiences with students.
53.8
28.3
13.7
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

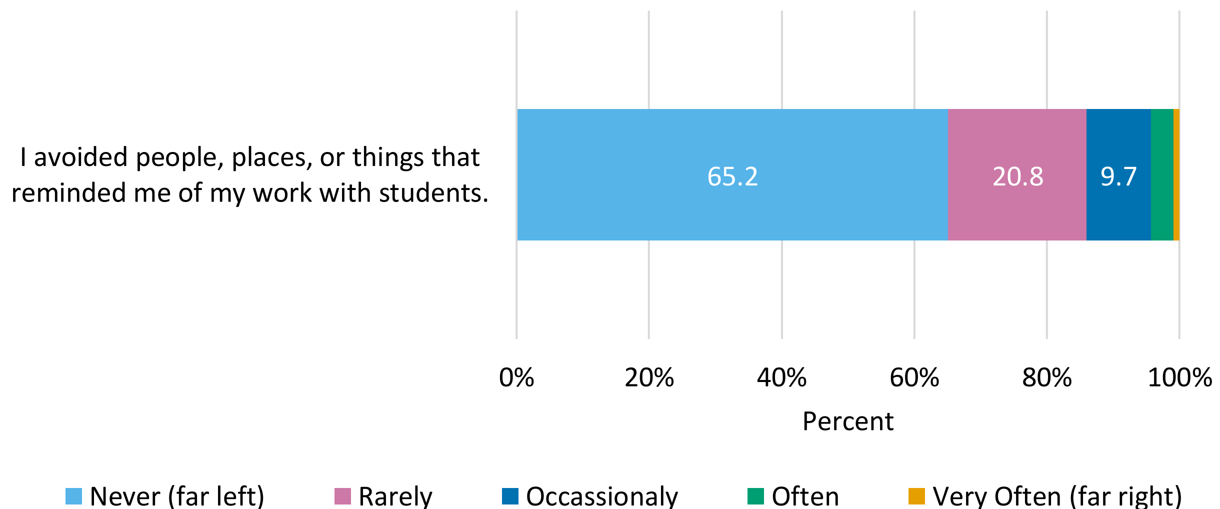


Figure 68: About 85 percent of staff report never or rarely avoiding work reminders
I avoided people, places, or things that reminded me of my work with students.
65.2
20.8
9.7
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

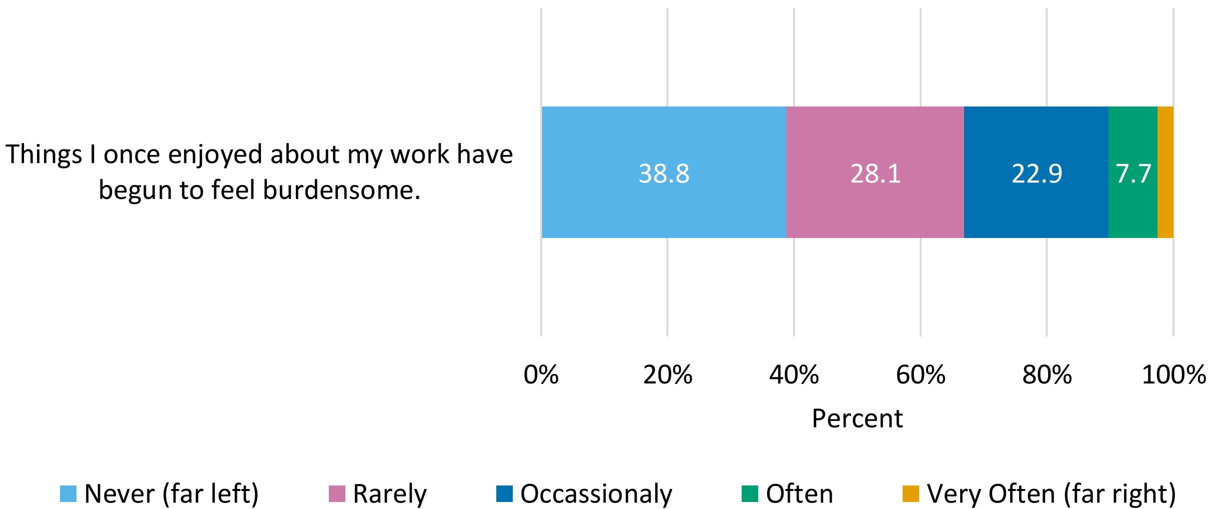


Figure 69: About 2/3 of staff report never or rarely feeling burdened by things at work they once enjoyed
Things I once enjoyed about my work have begun to feel burdensome.
38.8
28.1
22.9
7.7
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

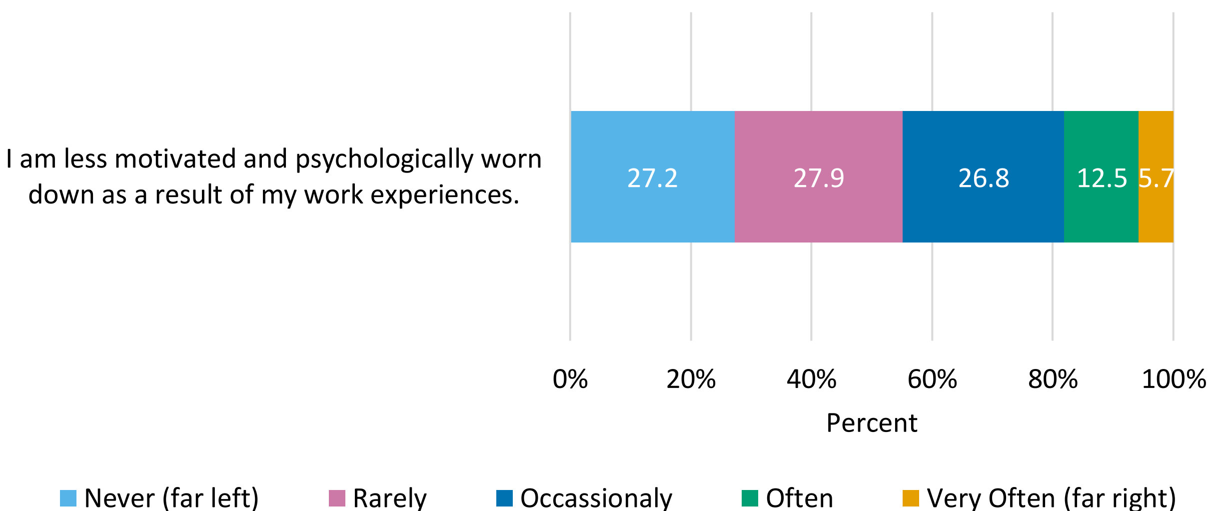


Figure 70: About 55 percent of staff report feeling never or rarely psychologically worn down
I am less motivated and psychologically worn down as a result of my work experiences.
27.2
27.9
26.8
12.5
5.7
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

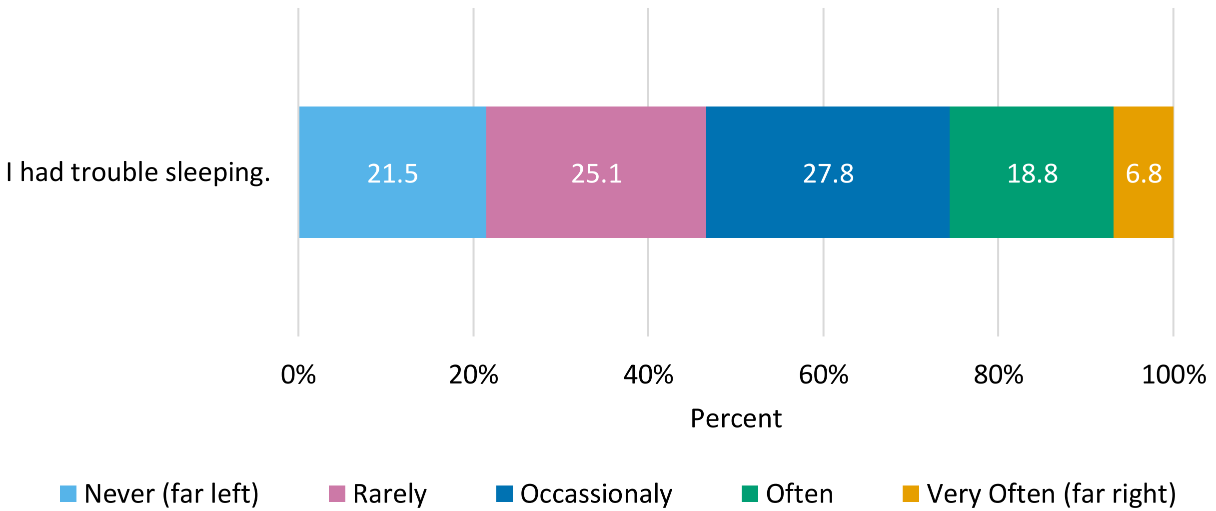


Figure 71: Over half of staff report having at least occassional trouble sleeping
I had trouble sleeping.
21.5
25.1
27.8
18.8
6.8
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

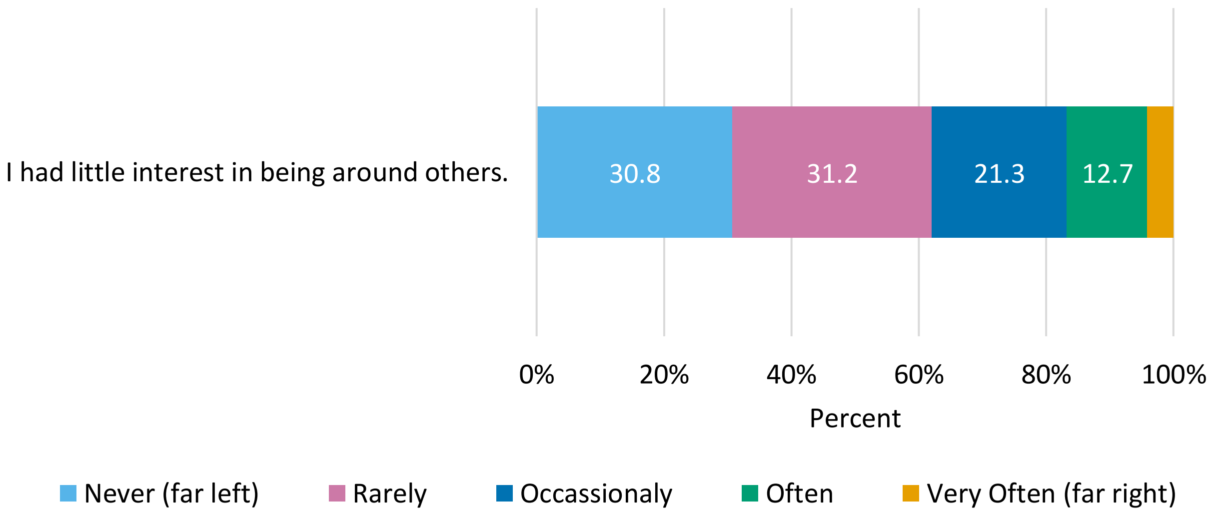


Figure 72: About 2/3 of staff report never or rarely having little interest in being around others
I had little interest in being around others.
30.8
31.2
21.3
12.7
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

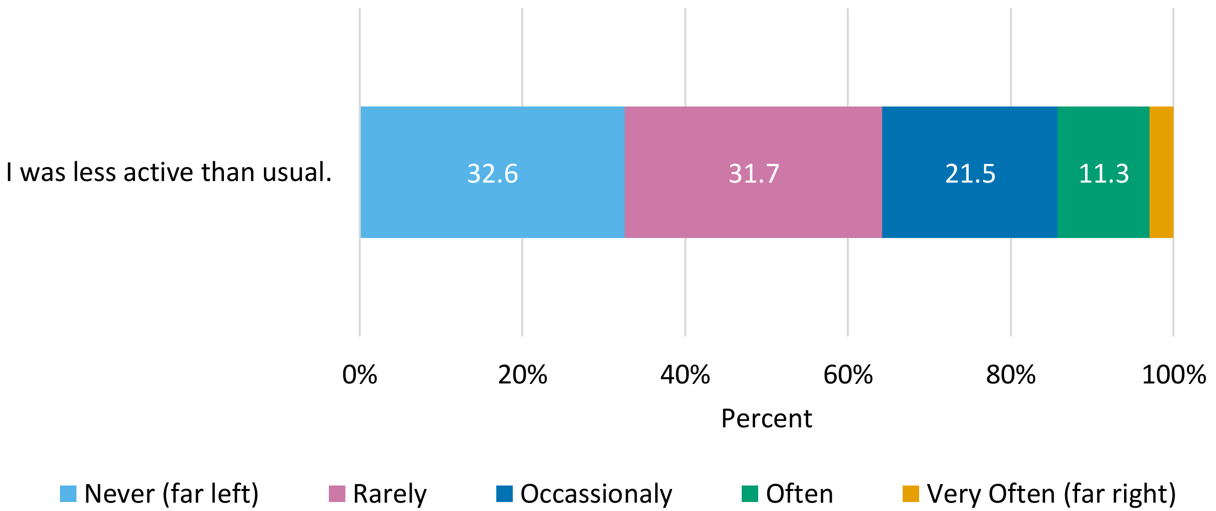


Figure 73: About 2/3 of staff report never or rarely having less activity than usual
I was less active than usual.
32.6
31.7
21.5
11.3
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)

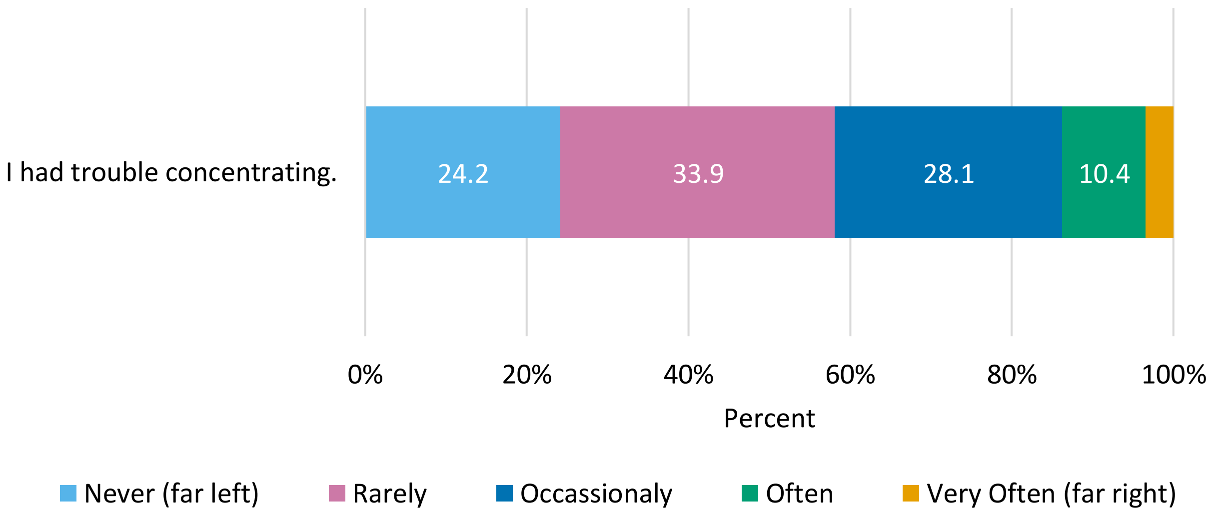
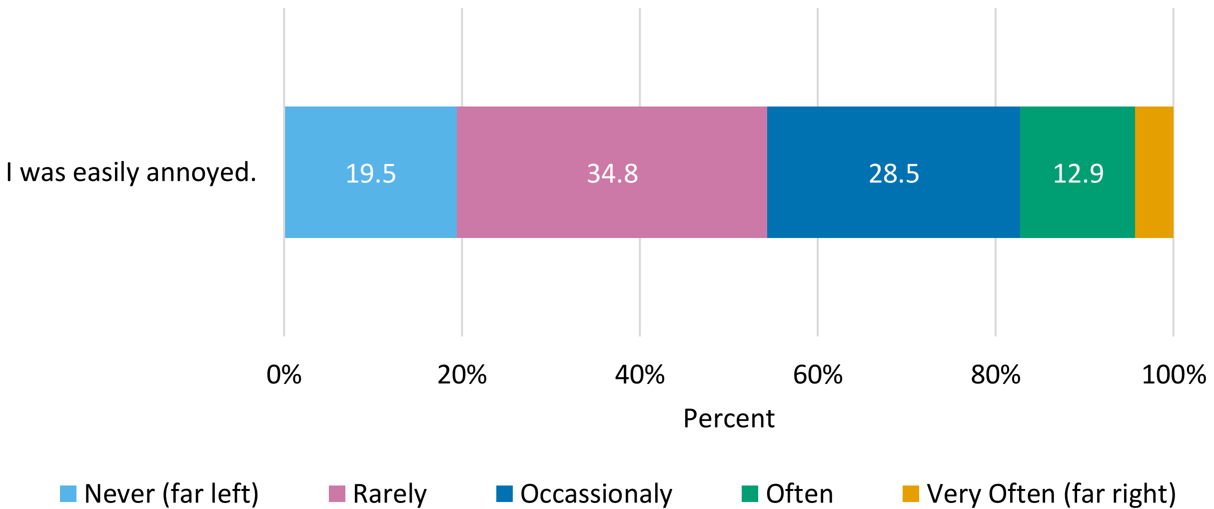


Figure 74: About 58 percent of staff report never or rarely having trouble concentrating
I had trouble concentrating.
24.2
33.9
28.1
10.4
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Rarely
Occassionaly
Often
Very Often (far right)



Frequency Supporting Student's Needs – Teachers, Administrators, and other Non-Mental Health Staff

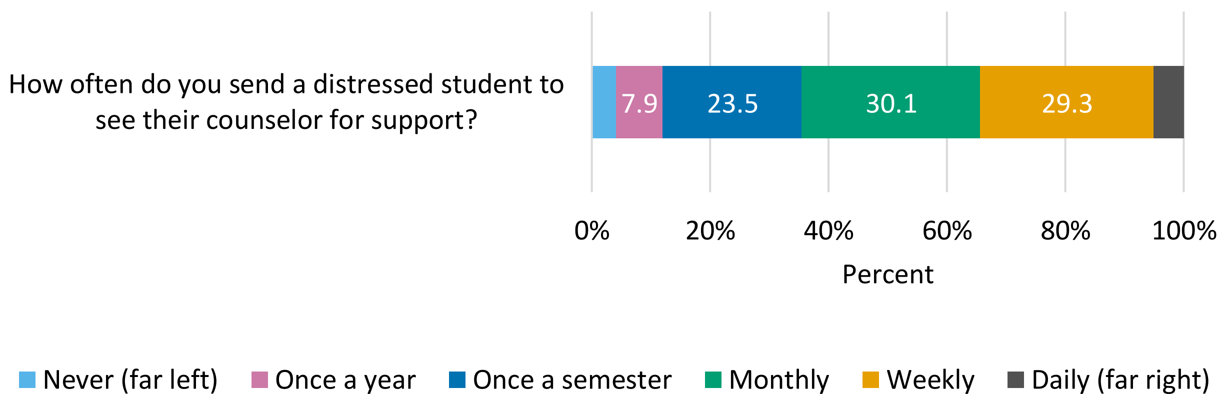


Figure 77: About 50 percent of staff report telling the counselor they are concerned about a student at least once a month or more

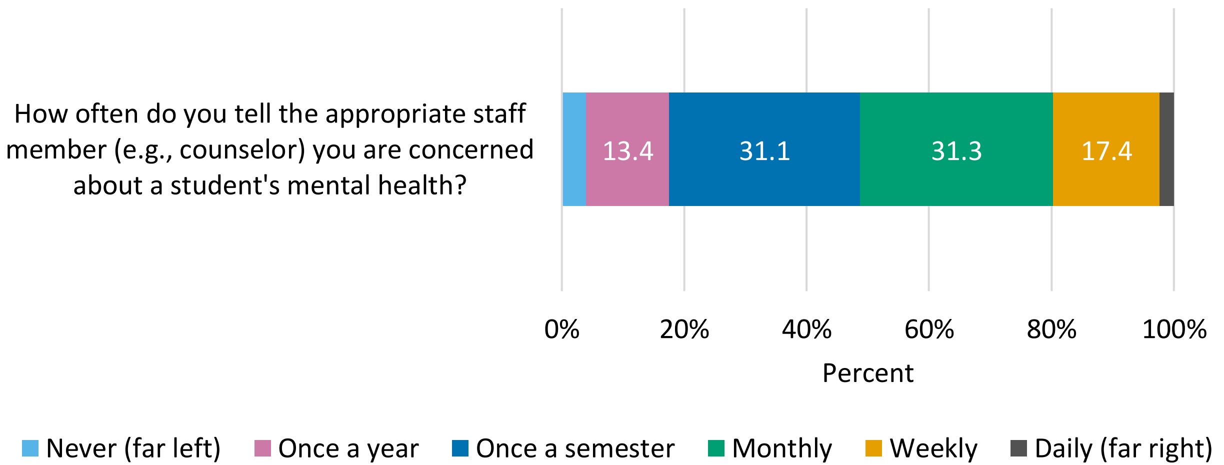
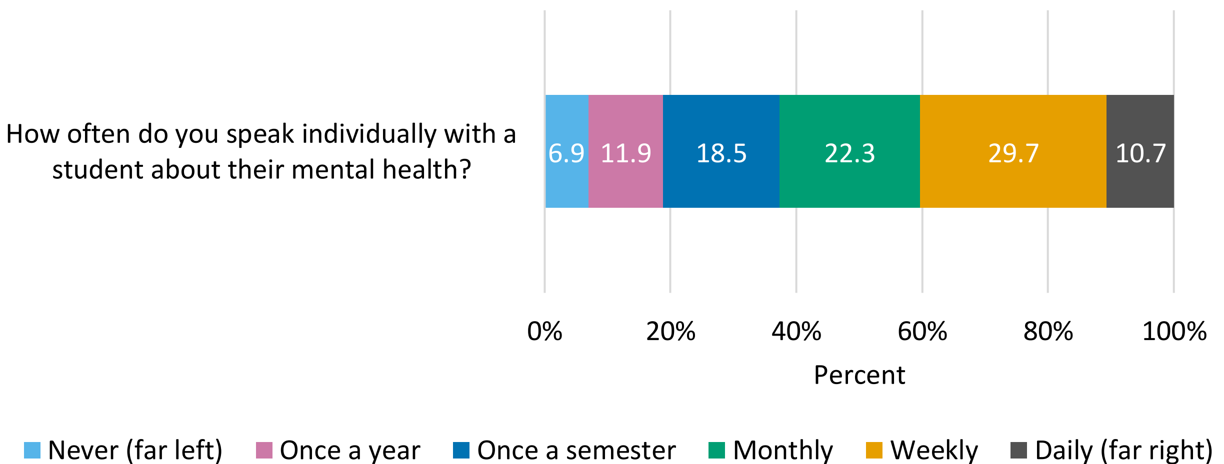


Figure 78: Over 60 percent of staff report speaking individually with students about their mental health at least once a month or more



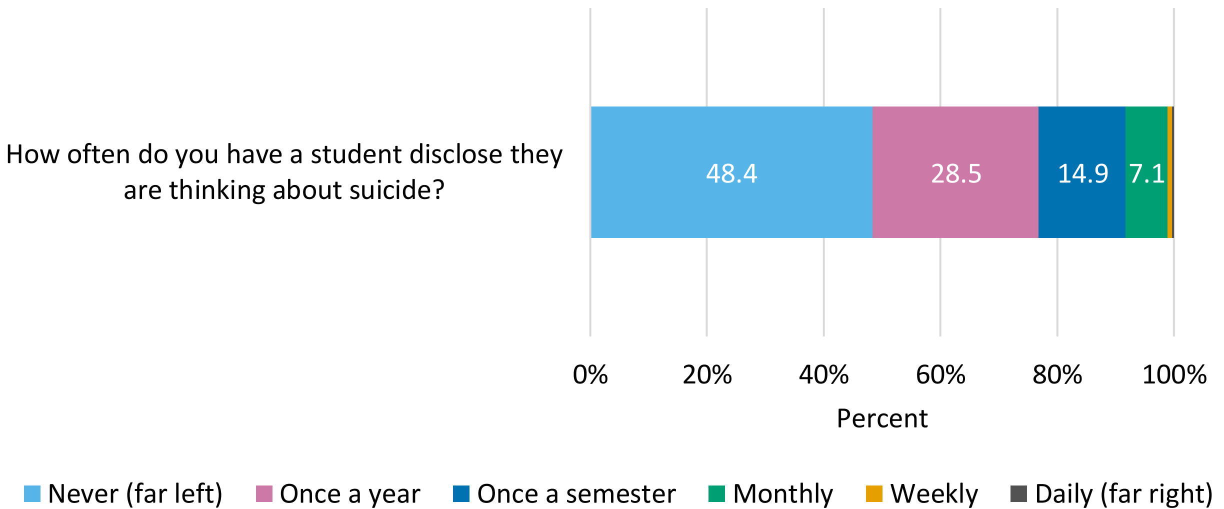


Figure 79: Over 50 percent of non-mental health staff have a student disclose suicidal thoughts at least once a year.
How often do you have a student disclose they are thinking about suicide?
48.4
28.5
14.9
7.1
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Once a year
Once a semester
Monthly
Weekly
Daily (far right)

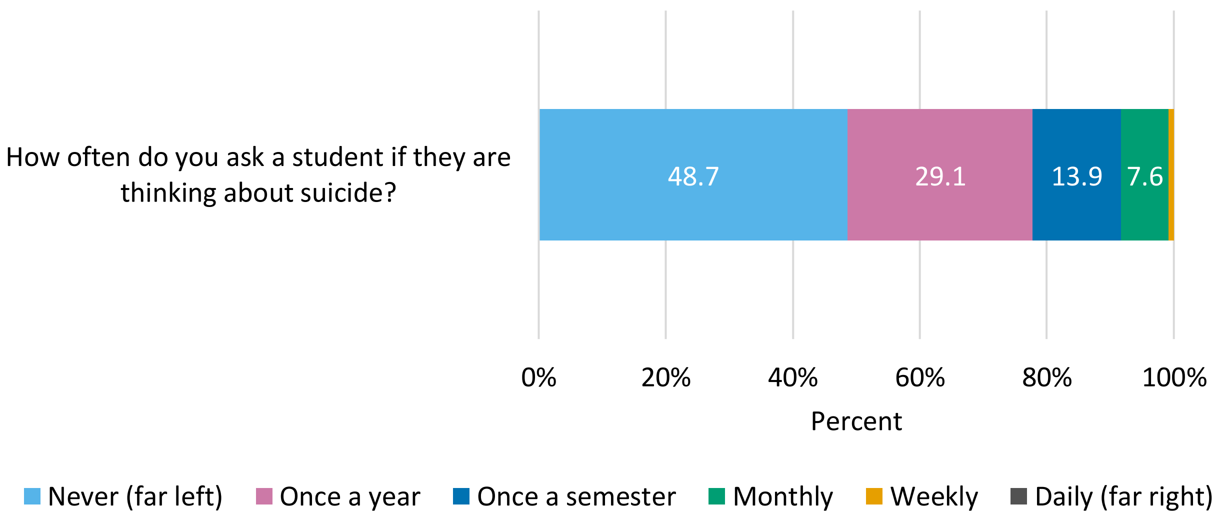
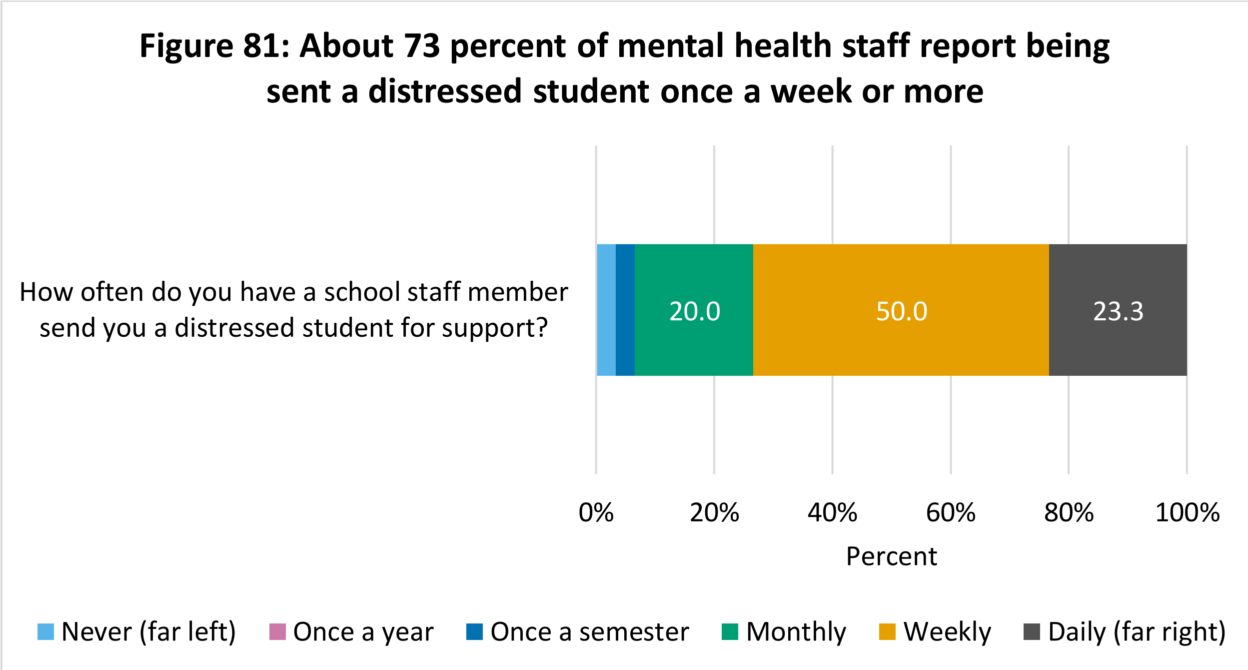
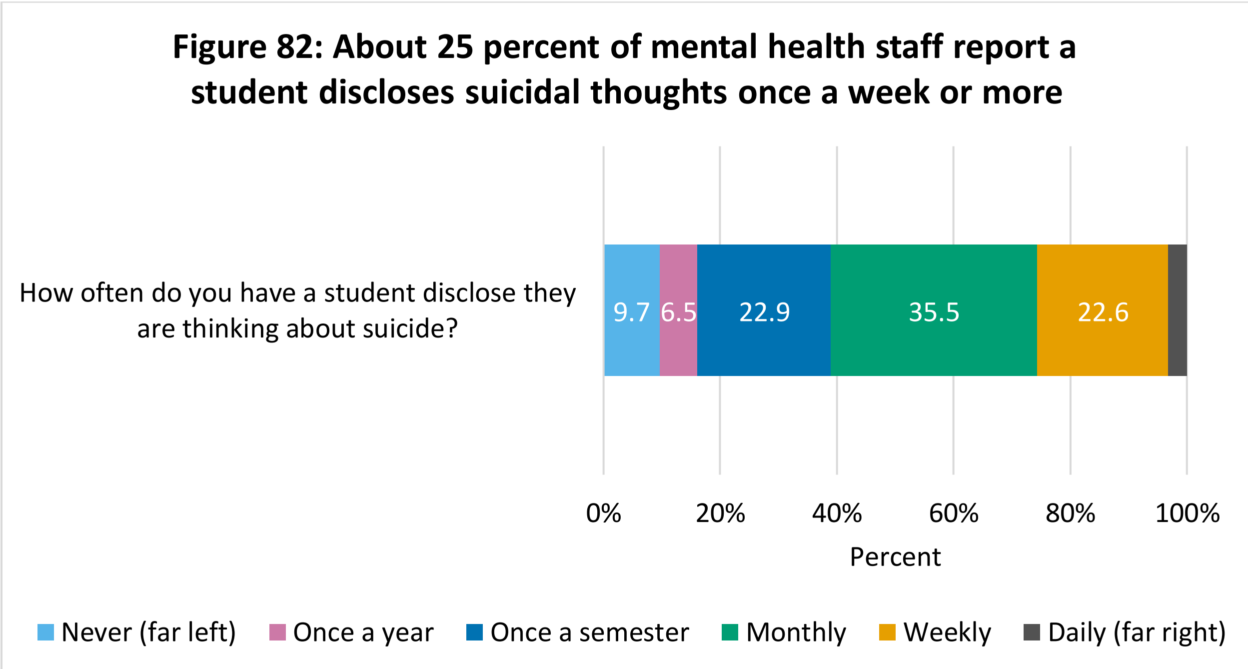


Figure 80: Over 50 percent of non-mental health staff ask a student if they are thinking about suicide at least once a year.
How often do you ask a student if they are thinking about suicide?
48.7
29.1
13.9
7.6
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Once a year
Once a semester
Monthly
Weekly
Daily (far right)

Frequency Supporting Student's Needs Among Mental Health Staff





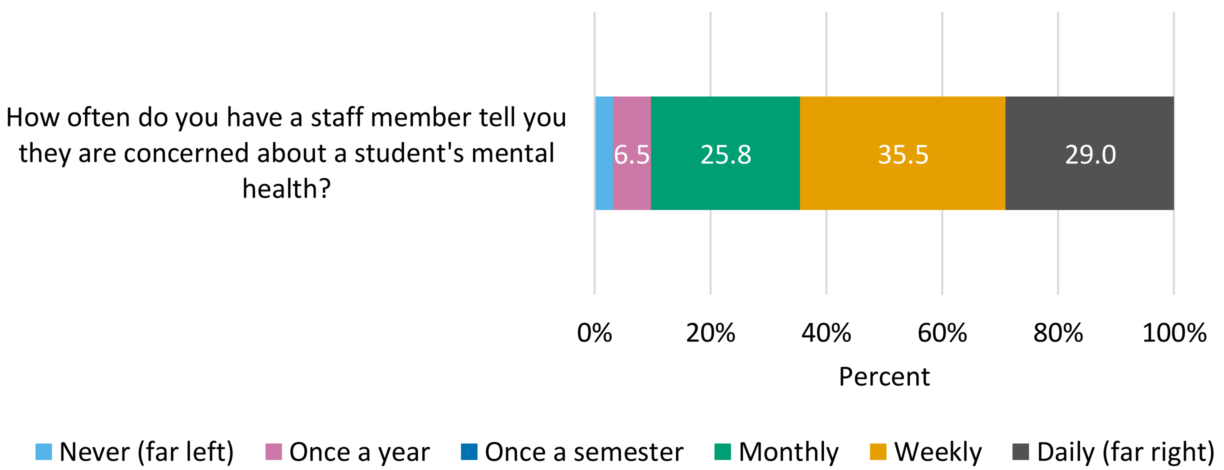


Figure 83: About 2/3 of mental health staff had a staff member share concerns about a student's mental health once a week or more
How often do you have a staff member tell you they are concerned about a student's mental health?
6.5
25.8
35.5
29.0
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Once a year
Once a semester
Monthly
Weekly
Daily (far right)

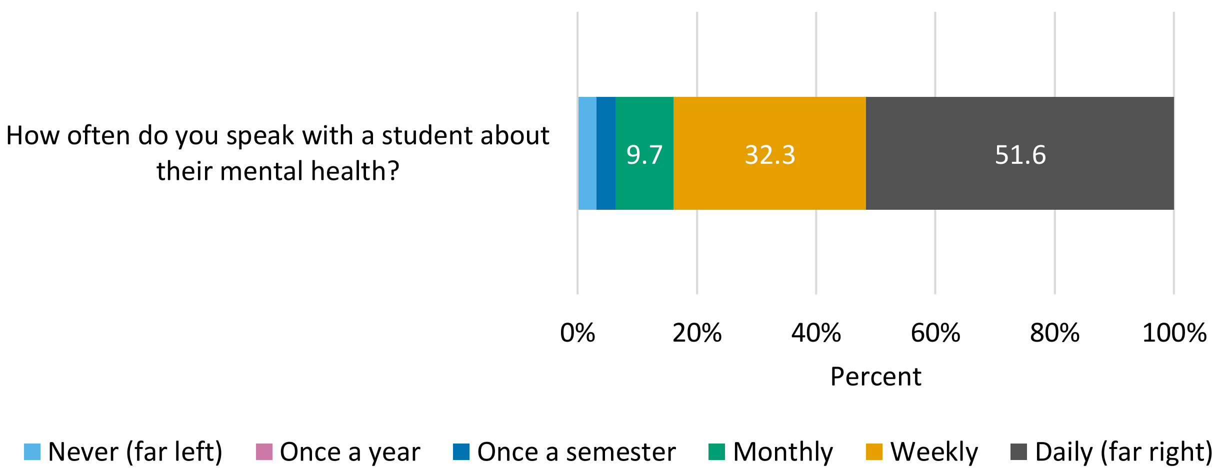


Figure 84: About 82 percent of mental health staff report speaking with a student about their mental health once a week or more
How often do you speak with a student about their mental health?
9.7
32.3
51.6
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Once a year
Once a semester
Monthly
Weekly
Daily (far right)

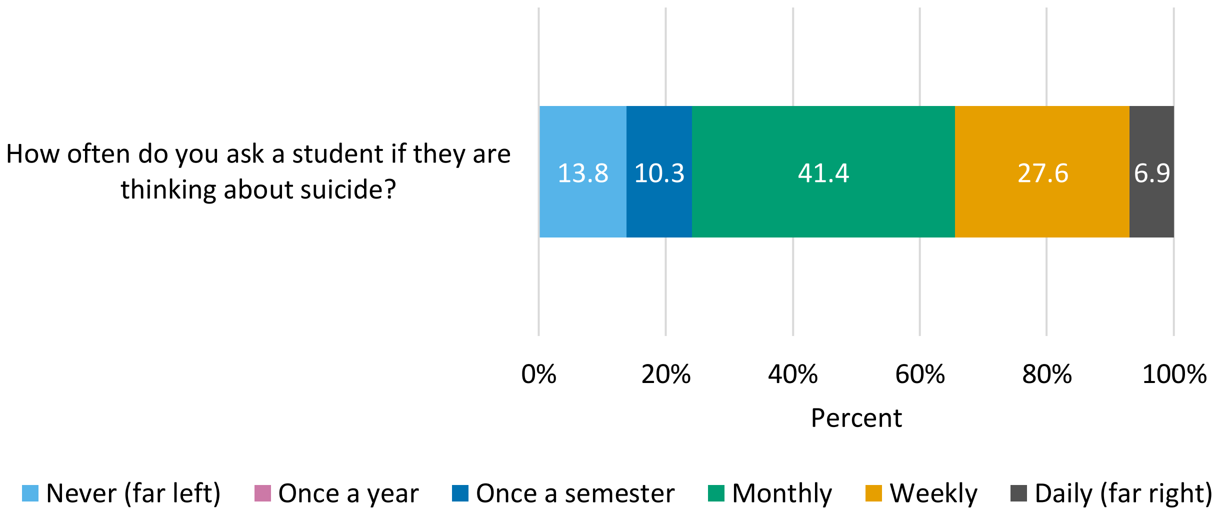


Figure 85: About 1/3 of mental health staff report asking a student if they are thinking about suicide once a week or more
How often do you ask a student if they are thinking about suicide?
13.8
10.3
41.4
27.6
6.9
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Once a year
Once a semester
Monthly
Weekly
Daily (far right)

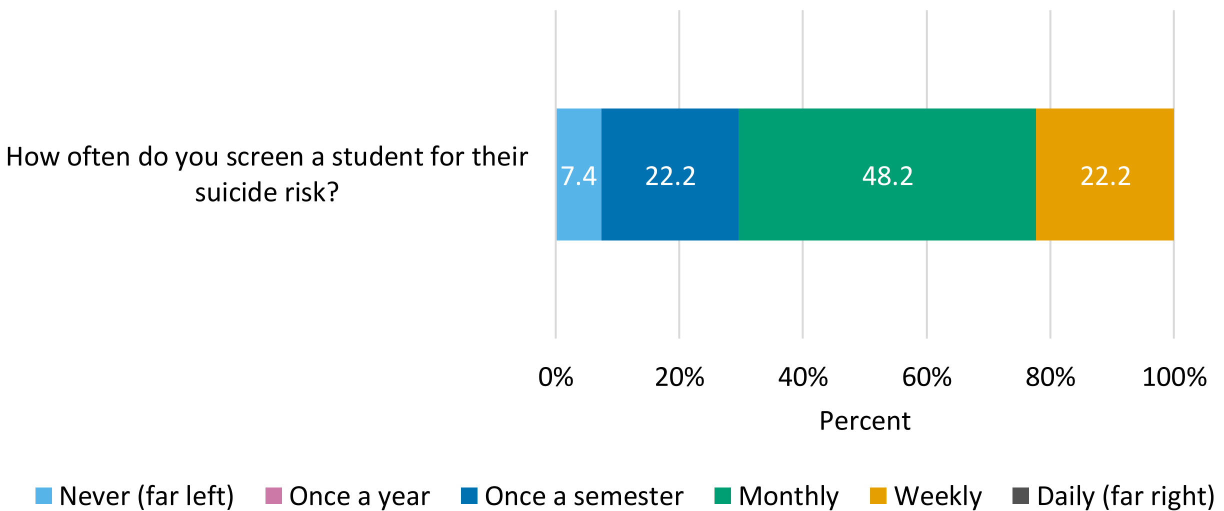


Figure 86: Twenty-two percent of mental health staff members report screening a student for suicide once a week or more
How often do you screen a student for their suicide risk?
7.4
22.2
48.2
22.2
0%
20%
40%
60%
80%
100%
Percent
Never (far left)
Once a year
Once a semester
Monthly
Weekly
Daily (far right)

Figure 87: About 18 percent of mental health staff respondents reported creating a safety plan for students once a week or more

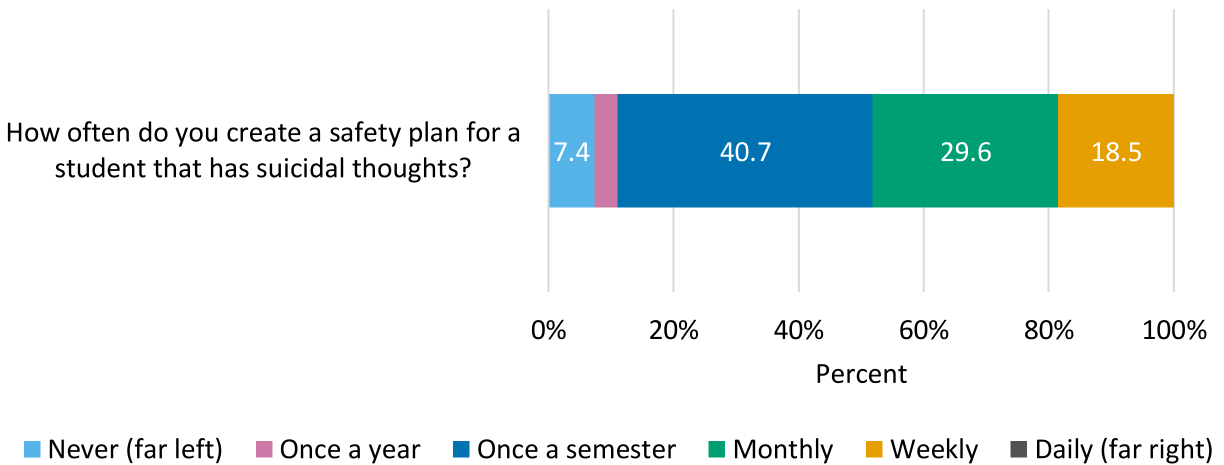
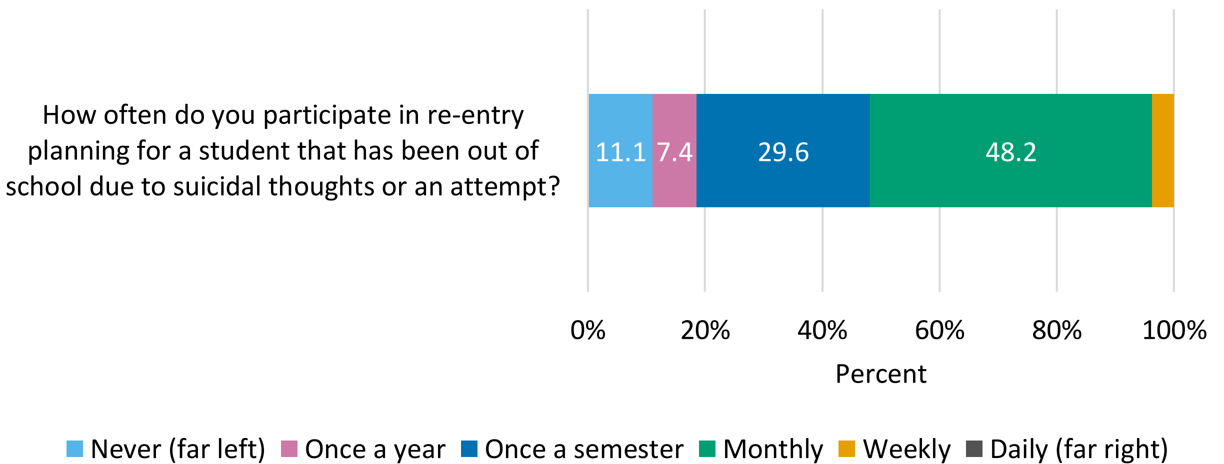


Figure 88: About 50 percent of mental health staff report participating in a re-entry meeting for a suicidal student once a month or more



Attitudes Towards Support Protocols for Administrators & School Mental Health Staff

Figure 89: About 72 percent of administration and school mental health staff AGREE that they have been trained to create safety plans for students at risk of suicide

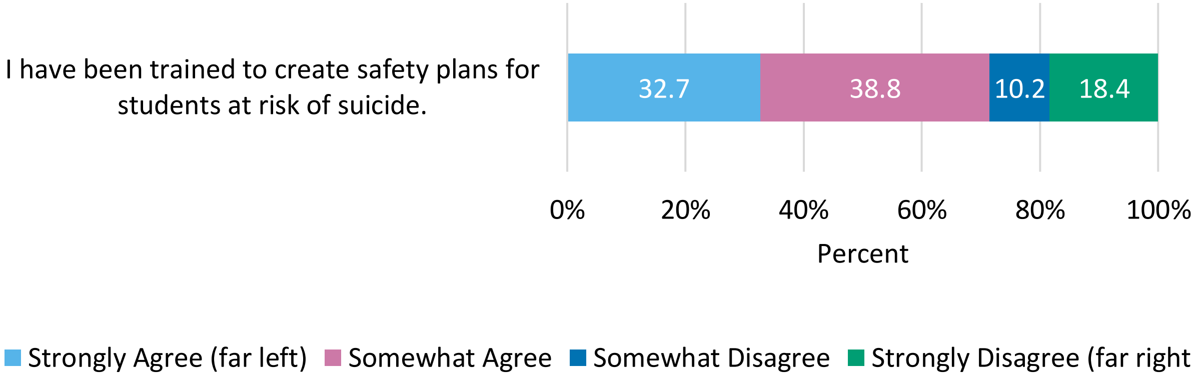
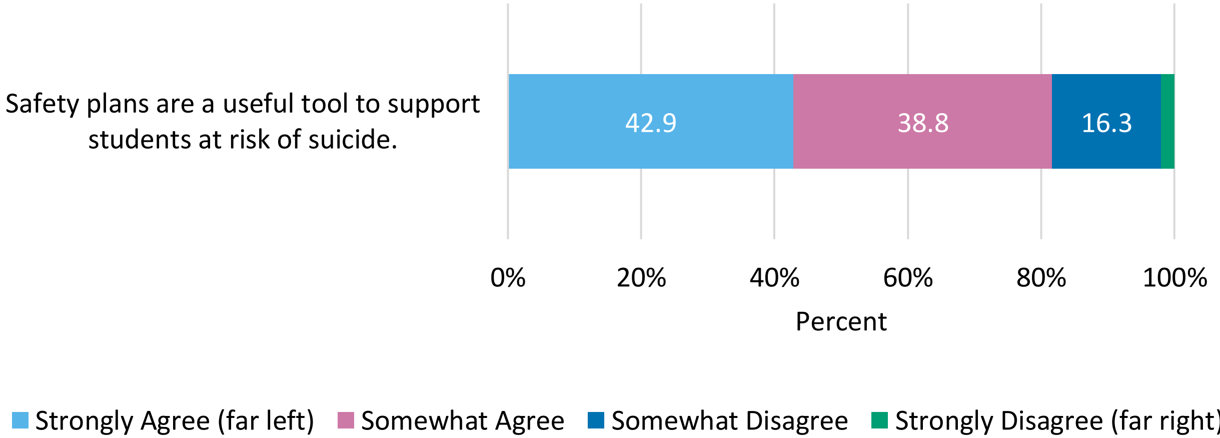


Figure 90: About 82 percent of administration and school mental health staff AGREE that safety plans are a useful tool to support students at risk of suicide



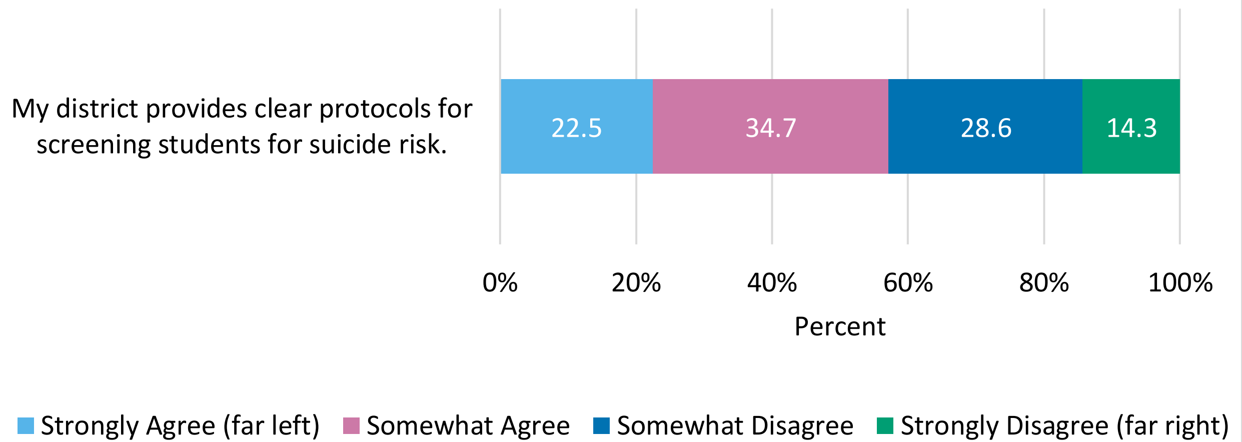


Figure 91: About 57 percent of administration and school mental health staff AGREE that the district provides clear protocols for screening students for suicide risk
My district provides clear protocols for screening students for suicide risk.
22.5
34.7
28.6
14.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

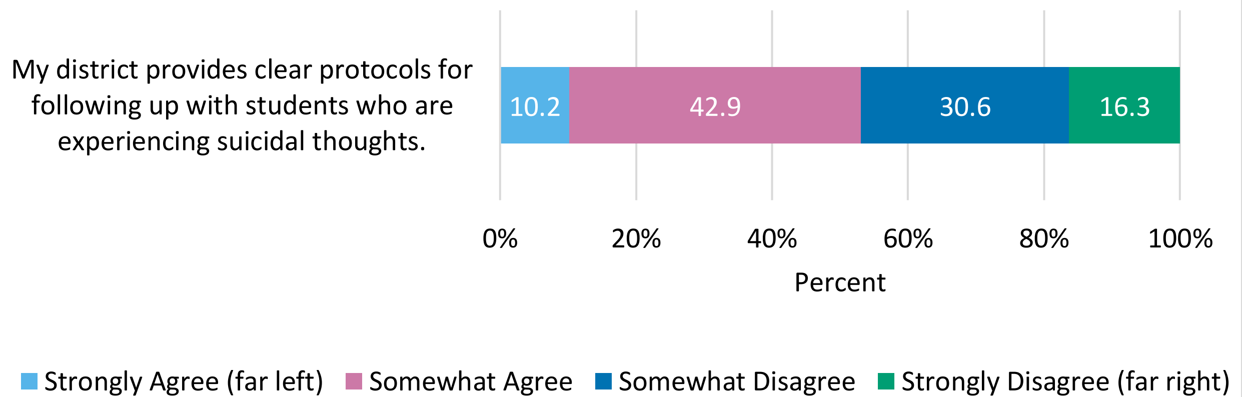


Figure 92: About 53 percent of administration and school mental health staff AGREE that the the district provides clear protocols for following up with students who are experiencing suicidal thoughts
My district provides clear protocols for following up with students who are experiencing suicidal thoughts.
10.2
42.9
30.6
16.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

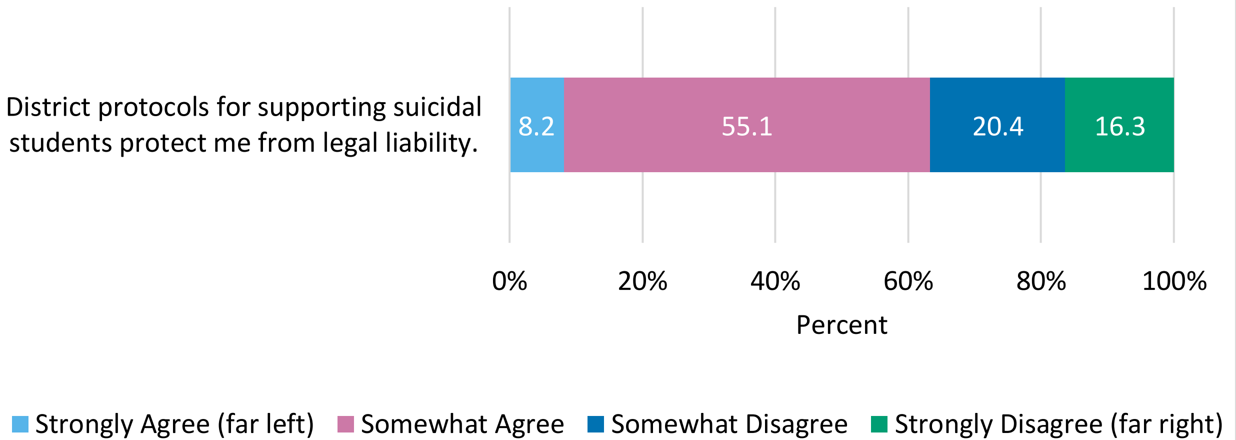


Figure 93: About 63 percent of administration and school mental health staff AGREE that the district protocols for supporting suicidal students protects them from legal liability
District protocols for supporting suicidal students protect me from legal liability.
8.2
55.1
20.4
16.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

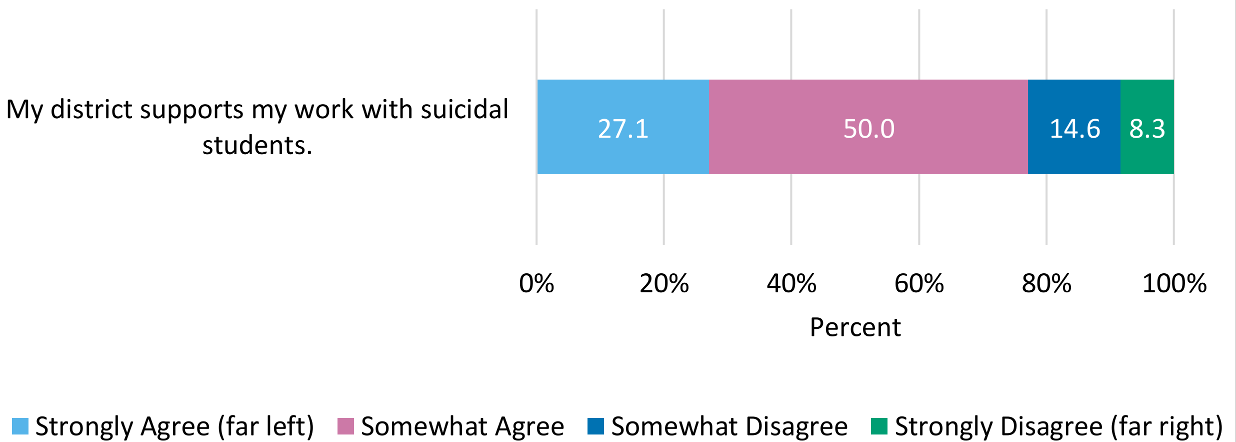


Figure 94: About 77 percent of administration and school mental health staff AGREE that the district supports their work with suicidal students
My district supports my work with suicidal students.
27.1
50.0
14.6
8.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

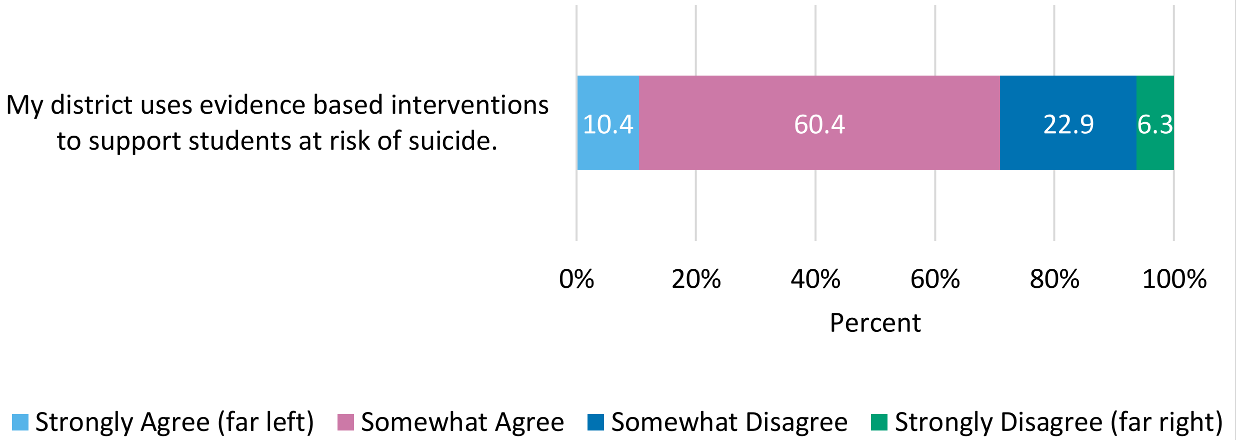


Figure 95: About 71 percent of administration and school mental health staff AGREE that the district uses evidence based interventions to support students at risk of suicide
My district uses evidence based interventions to support students at risk of suicide.
10.4
60.4
22.9
6.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

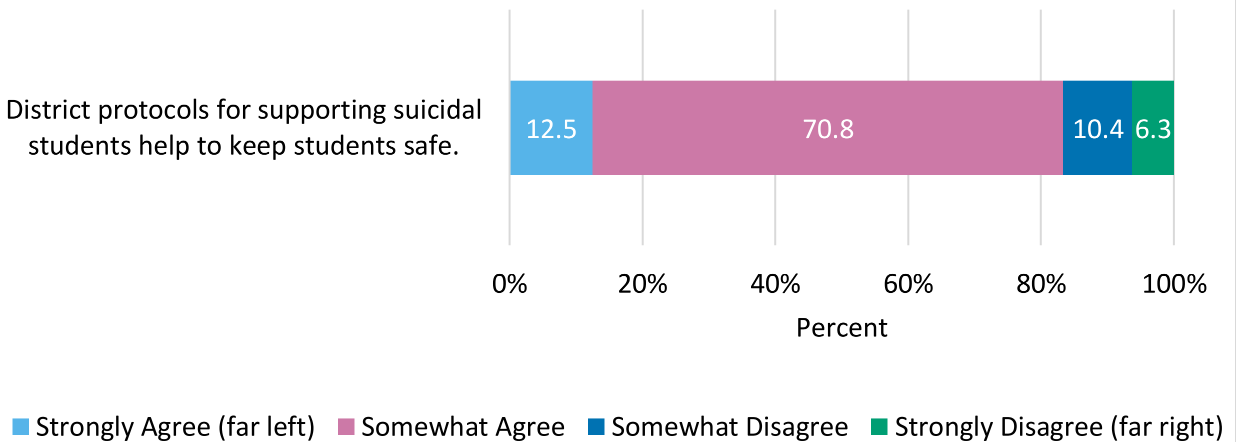
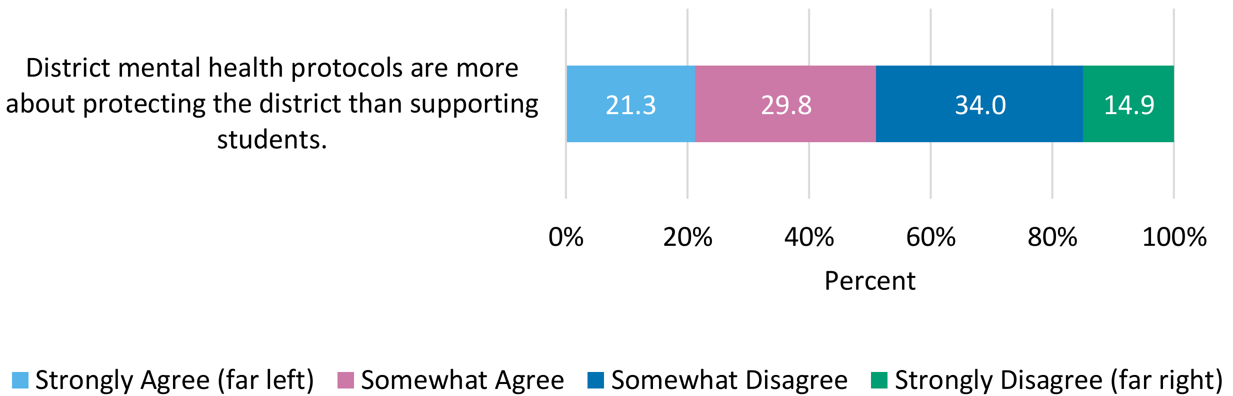
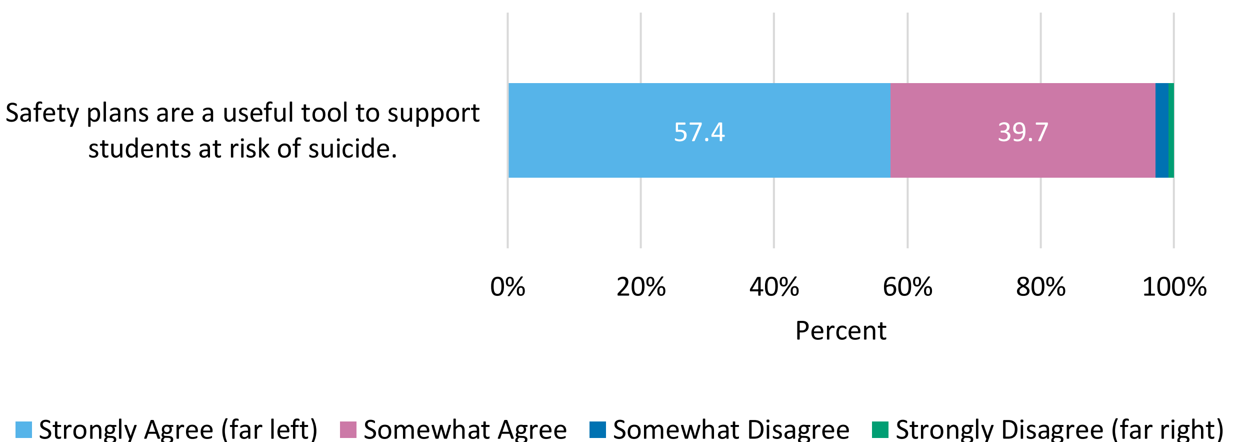


Figure 96: About 83 percent of administration and school mental health staff AGREE that district protocols for supporting suicidal students help to keep students safe
District protocols for supporting suicidal students help to keep students safe.
12.5
70.8
10.4
6.3
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)



Attitudes Towards Support Protocols among Teachers, Special Ed Staff, etc.



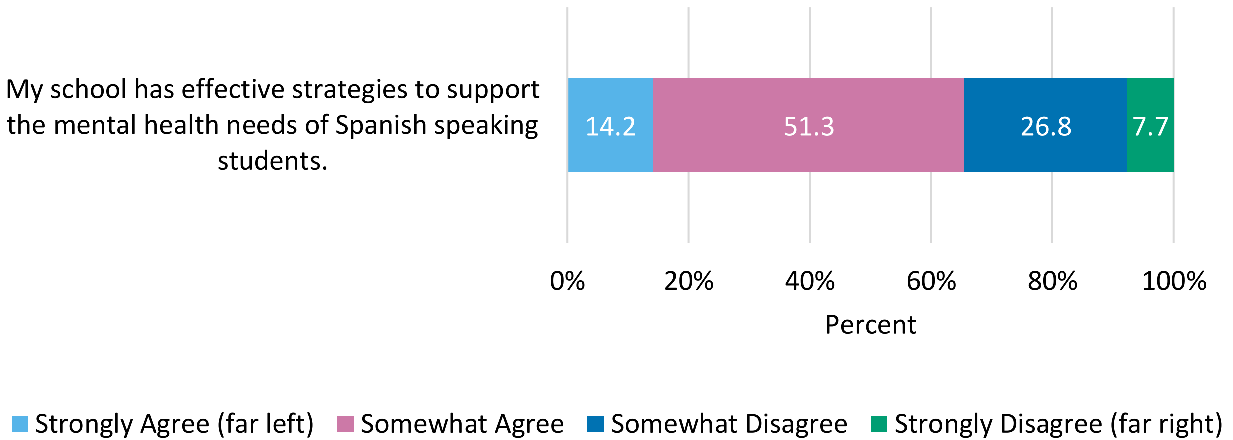


Figure 99: About 66 percent of classroom staff AGREE that their school has effective strategies to support the mental health needs of Spanish speaking students
My school has effective strategies to support the mental health needs of Spanish speaking students.
14.2
51.3
26.8
7.7
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

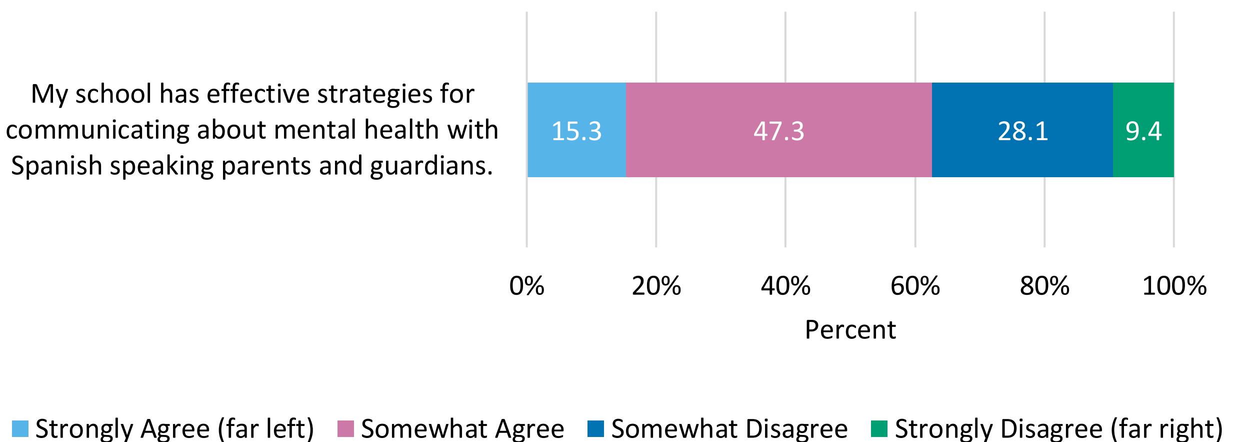


Figure 100: About 63 percent of classroom staff AGREE that their school has effective strategies for communicating about mental health with Spanish speaking parents and guardians
My school has effective strategies for communicating about mental health with Spanish speaking parents and guardians.
15.3
47.3
28.1
9.4
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

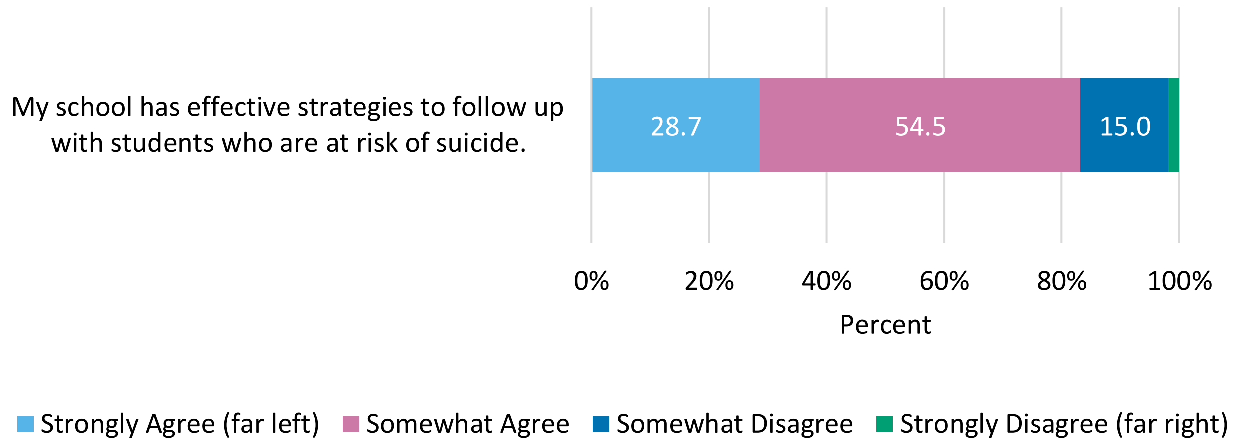


Figure 101: About 83 percent of classroom staff AGREE that their school has effective strategies to follow up with students who are at risk of suicide
My school has effective strategies to follow up with students who are at risk of suicide.
28.7
54.5
15.0
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

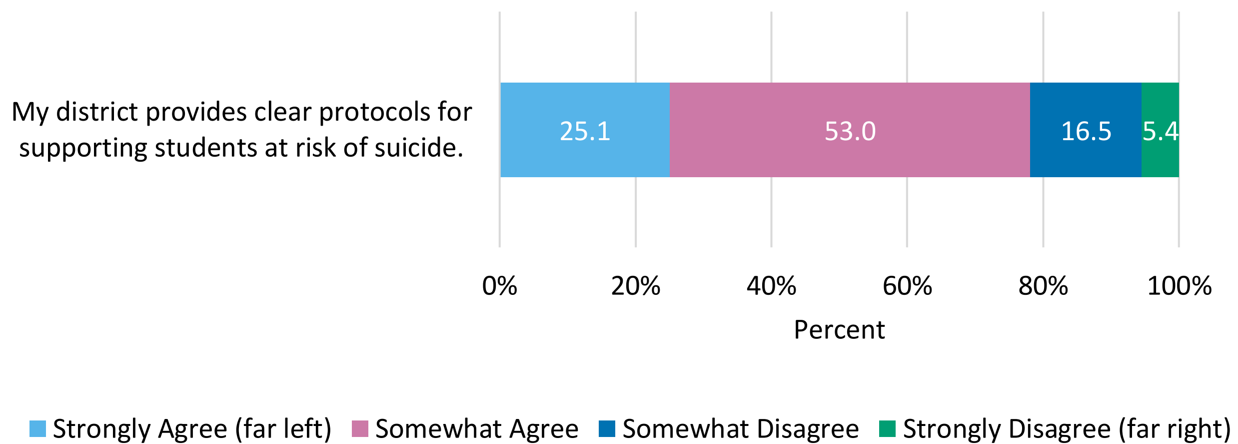


Figure 102: About 78 percent of classroom staff AGREE that the district provides clear protocols for supporting students at risk of suicide
My district provides clear protocols for supporting students at risk of suicide.
25.1
53.0
16.5
5.4
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

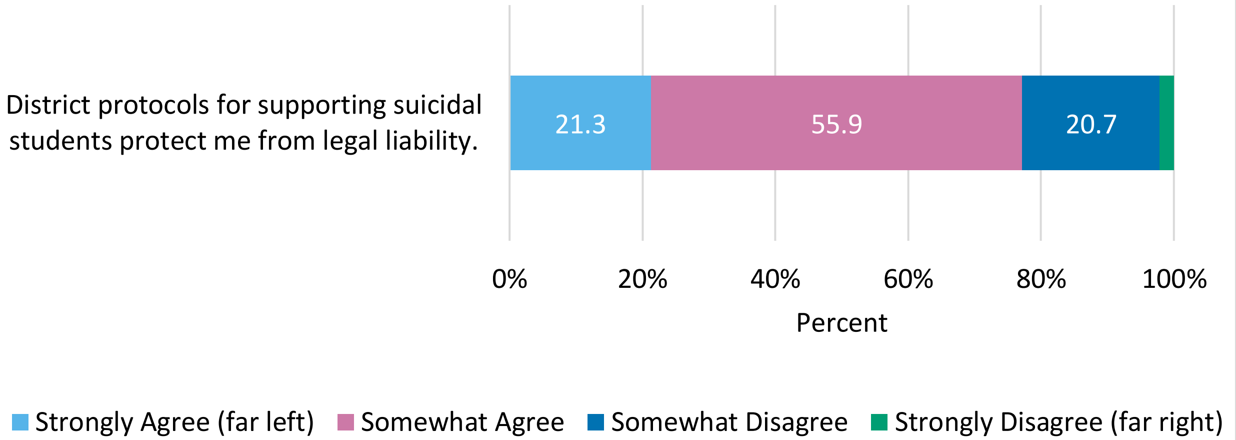


Figure 103: About 77 percent of classroom staff AGREE that district protocols for supporting suicidal students protect them from legal liability
District protocols for supporting suicidal students protect me from legal liability.
21.3
55.9
20.7
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

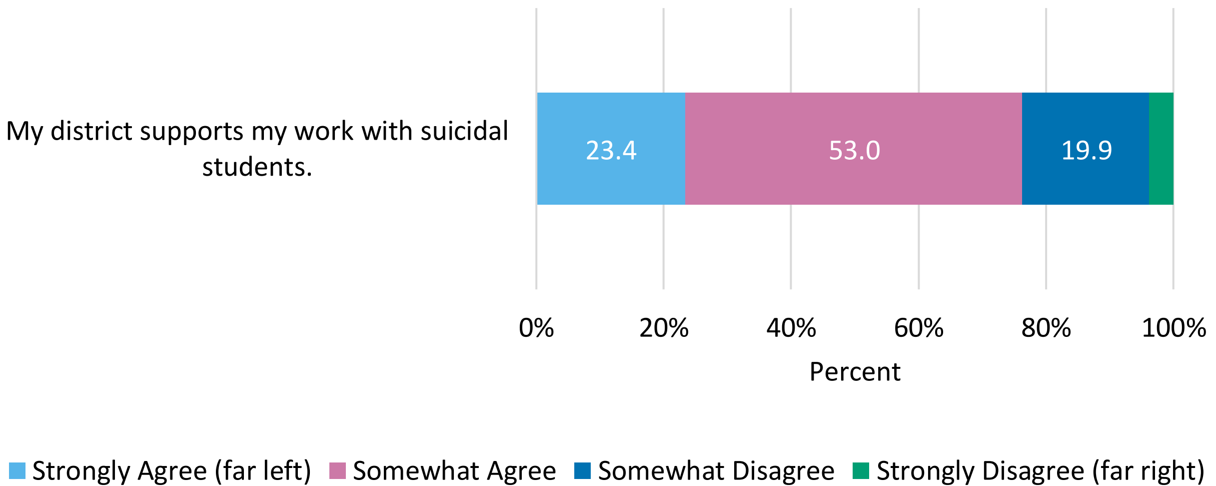


Figure 104: About 76 percent of classroom staff AGREE that the district supports their work with suicidal students
My district supports my work with suicidal students.
23.4
53.0
19.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

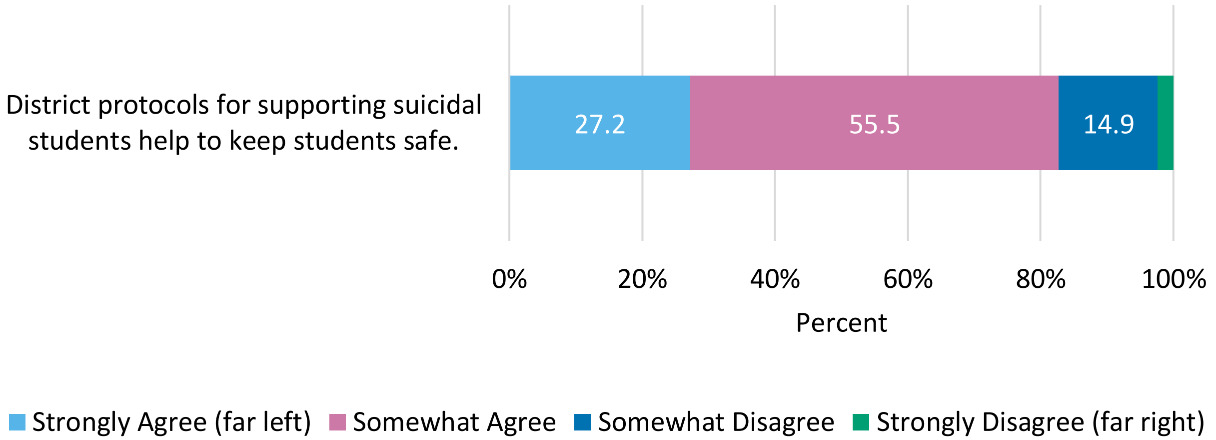


Figure 105: About 83 percent of classroom staff AGREE that district protocols for supporting suicidal students help to keep students safe
District protocols for supporting suicidal students help to keep students safe.
27.2
55.5
14.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

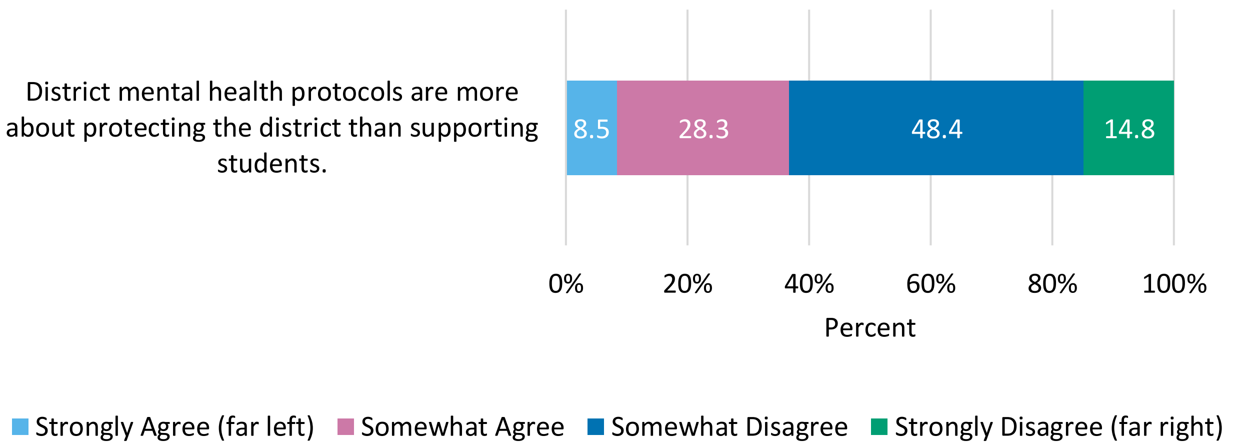
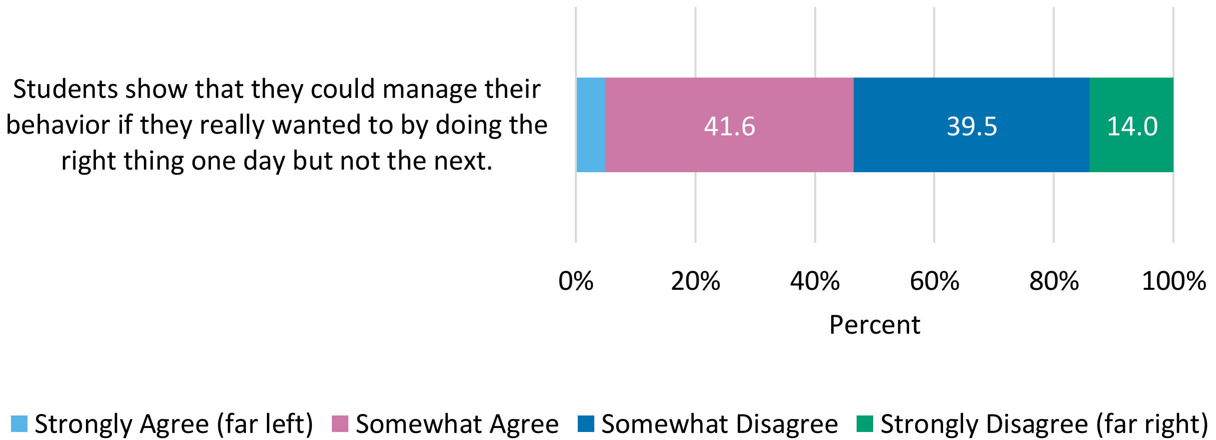
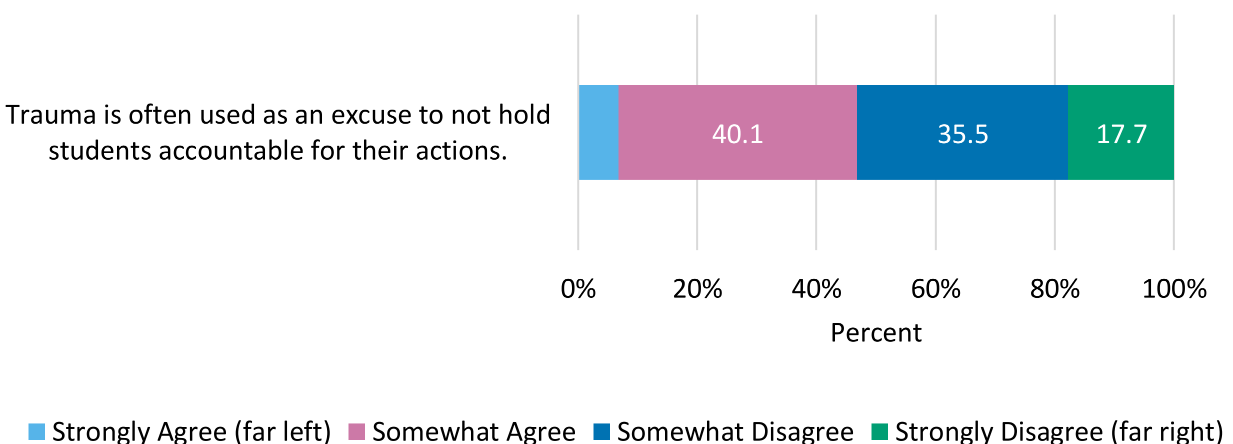


Figure 106: About 37 percent of classroom staff AGREE that district mental health protocols are more about protecting the district than supporting students
District mental health protocols are more about protecting the district than supporting students.
8.5
28.3
48.4
14.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Staff Attitudes towards Students' Experiences of Trauma





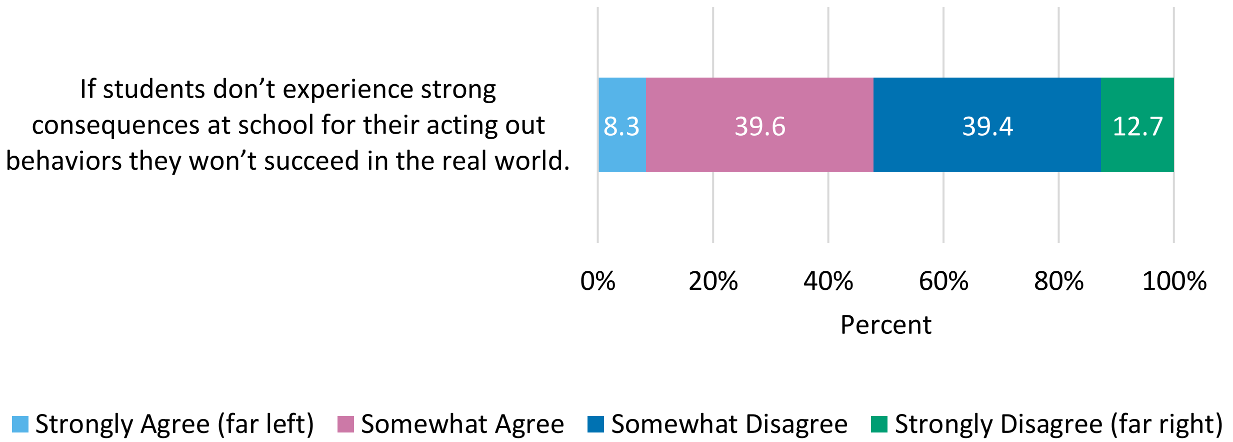


Figure 109: Fourty-seven percent of staff AGREE that if students don't experience strong consequences at school for their acting out behaviors, they won't succeed in the real world
If students don't experience strong consequences at school for their acting out behaviors they won't succeed in the real world.
8.3
39.6
39.4
12.7
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

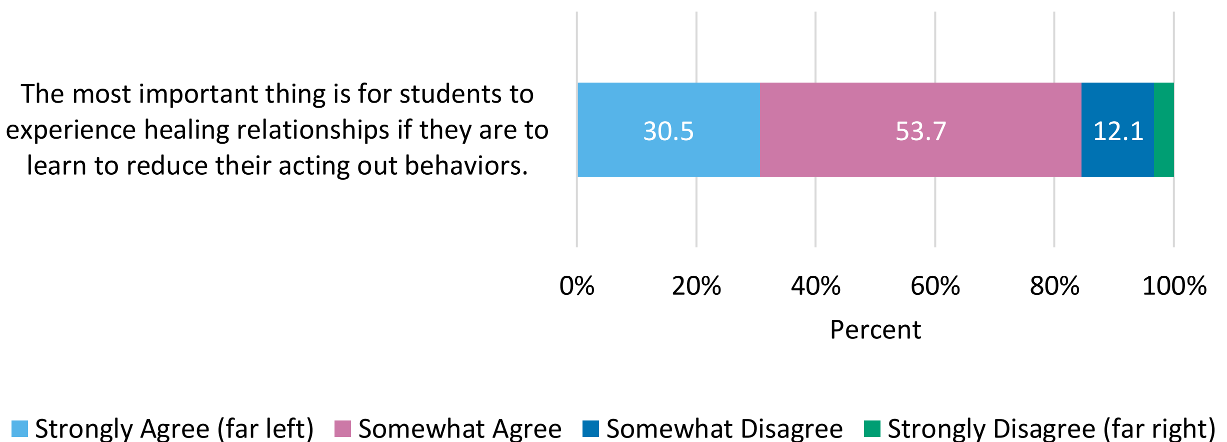


Figure 110: Over 80 percent of staff AGREE that students should experience healing relationships if they are to learn to reduce their acting out behaviors
The most important thing is for students to experience healing relationships if they are to learn to reduce their acting out behaviors.
30.5
53.7
12.1
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

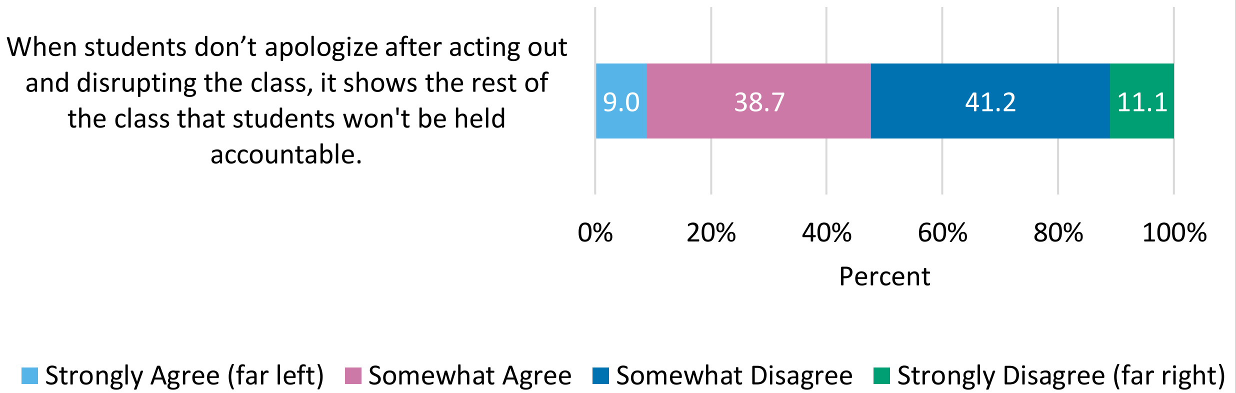


Figure 111: About 48 percent of staff AGREE that when students don’t apologize after acting out, it shows the rest of the class that students won't be held accountable
When students don’t apologize after acting out and disrupting the class, it shows the rest of the class that students won't be held accountable.
9.0
38.7
41.2
11.1
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

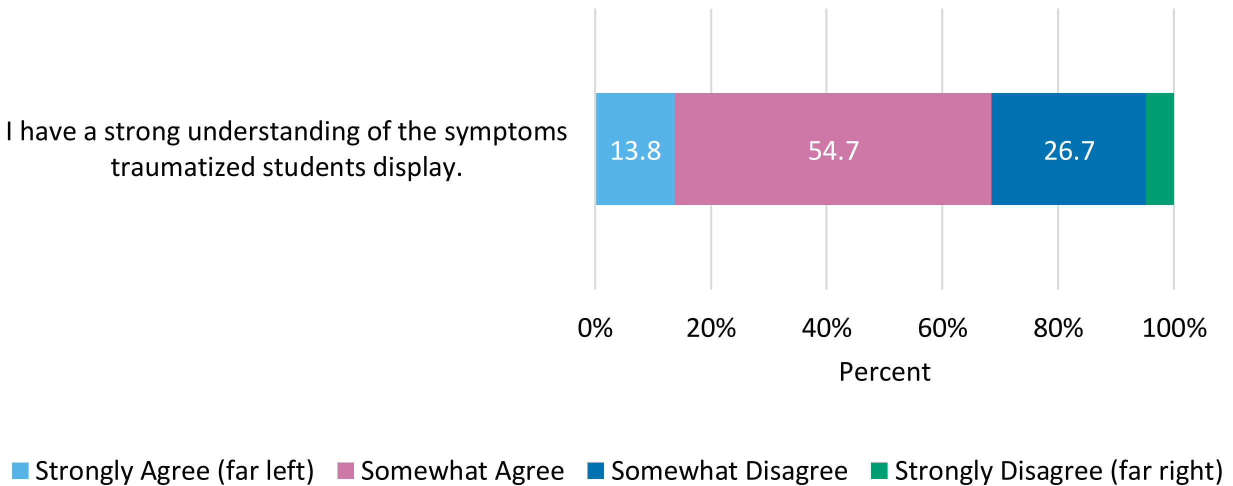


Figure 112: Over 65 percent of staff report a strong understanding of the symptoms traumatized students display
I have a strong understanding of the symptoms traumatized students display.
13.8
54.7
26.7
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

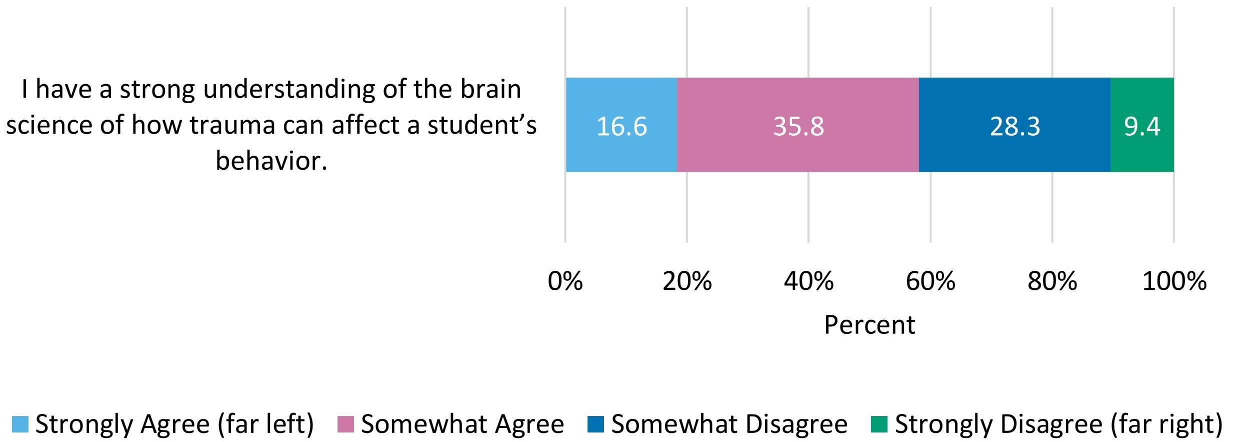


Figure 113: Fifty-two percent of staff report a strong understanding of the brain sceince of how trauma can affect a student's behavior
I have a strong understanding of the brain science of how trauma can affect a student's behavior.
16.6
35.8
28.3
9.4
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

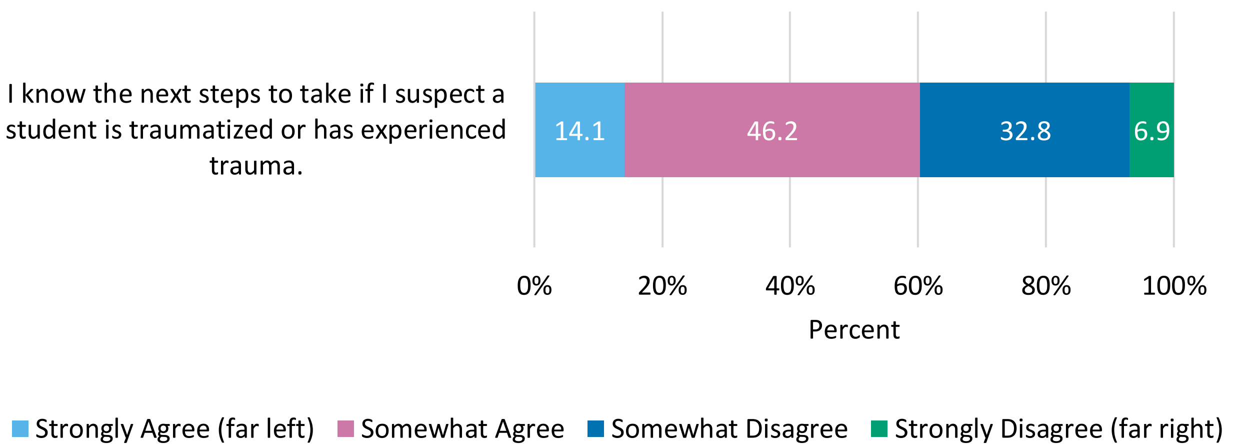


Figure 114: Over 60 percent of staff report knowing the next steps to take if they suspect a student is traumatized or has experienced trauma
I know the next steps to take if I suspect a student is traumatized or has experienced trauma.
14.1
46.2
32.8
6.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

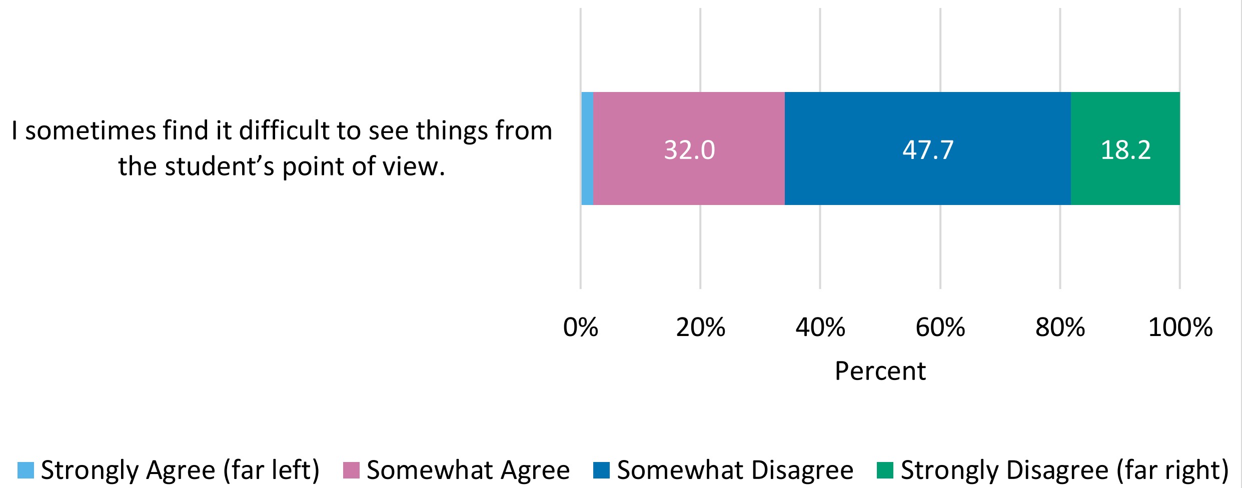


Figure 115: Over 65 percent of staff do not find it difficult to see things from the student's point of view
I sometimes find it difficult to see things from the student's point of view.
32.0
47.7
18.2
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

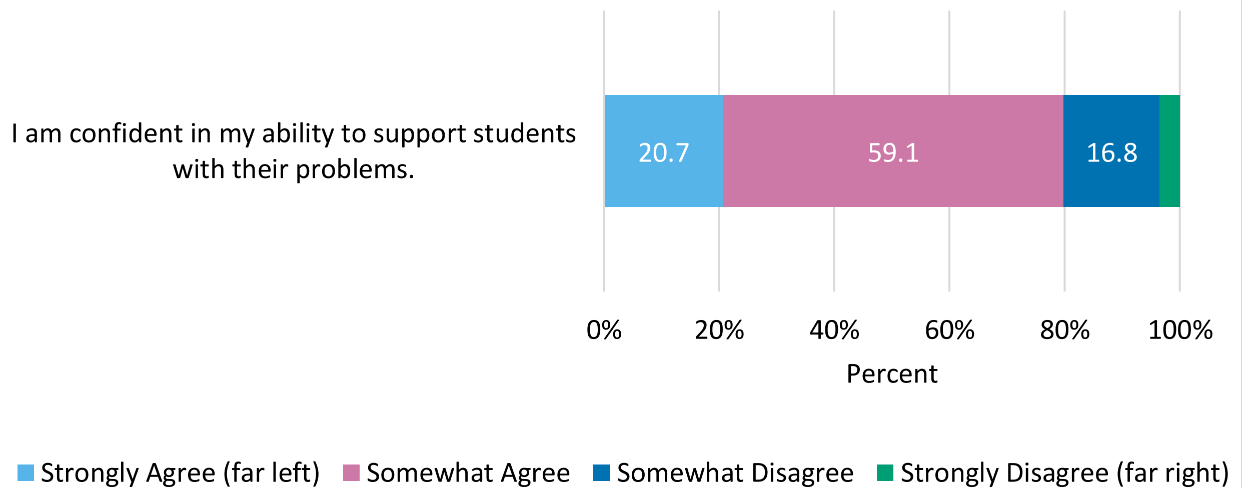
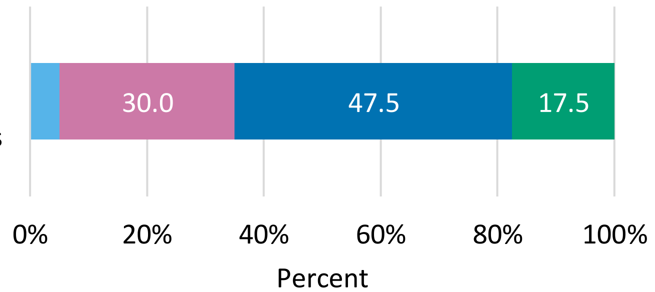


Figure 116: Almost 80 percent of staff are confident in their abilities to support students with their problems
I am confident in my ability to support students with their problems.
20.7
59.1
16.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Staff Attitudes towards Families

Figure 117: Sixty-five percent of staff DISAGREE that their school is more likely to blame families for challenging behavior than collaborating with them to better understand factors contributing to their child's behavior at school

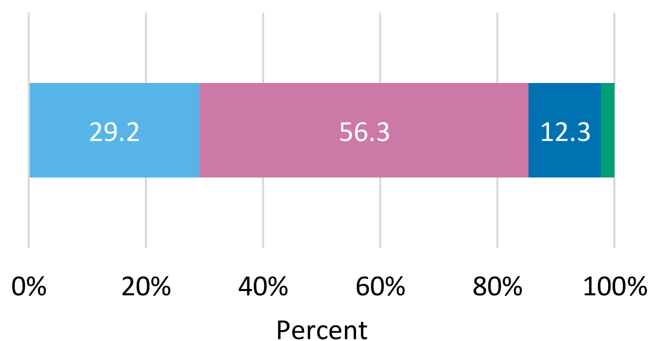
At my school, we are more likely to blame families for challenging behavior than to find ways of collaborating with them to better understand factors contributing to their child's behavior at school.



Strongly Agree (far left) | Somewhat Agree | Somewhat Disagree | Strongly Disagree (far right)

Figure 118: Over 85 percent of teachers report that they can create positive relationships with parents or caregivers of students who may be struggling with behavior or emotions

I can create positive relationships with parents or caregivers of my students who may be struggling with behavior or emotions.



Strongly Agree (far left) | Somewhat Agree | Somewhat Disagree | Strongly Disagree (far right)

Figure 119: Sixty percent of staff report that they can work with families who have done damaging things to their children

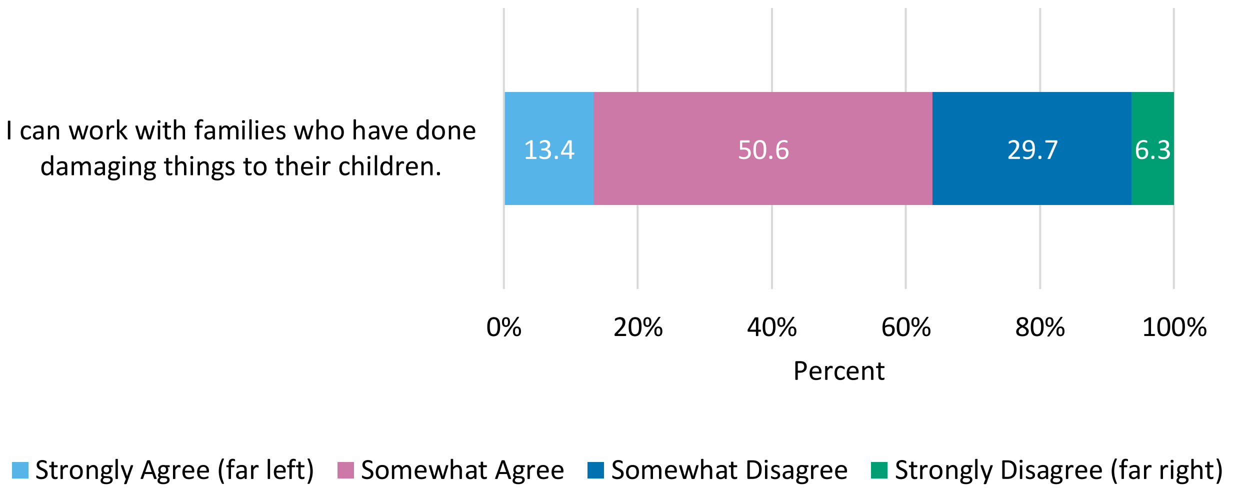
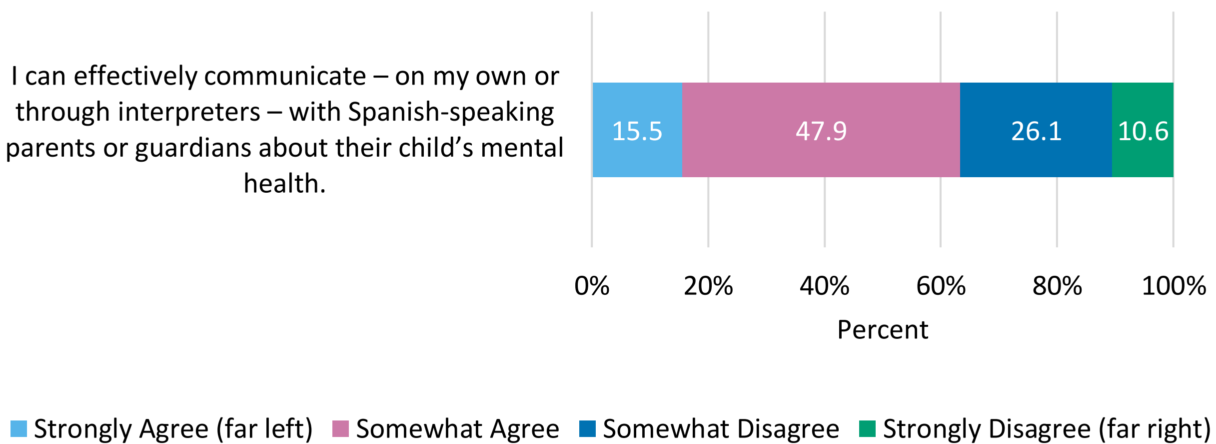
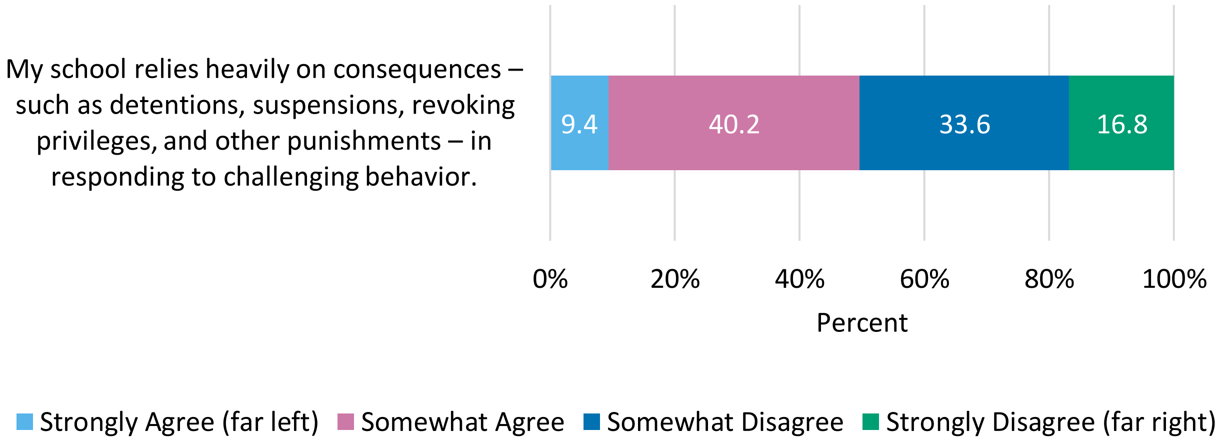


Figure 120: Sixty percent of staff report they can communicate – on their own or through interpreters – with Spanish-speaking parents or guardians about their child's mental health



Staff Attitudes towards Discipline and Punishment



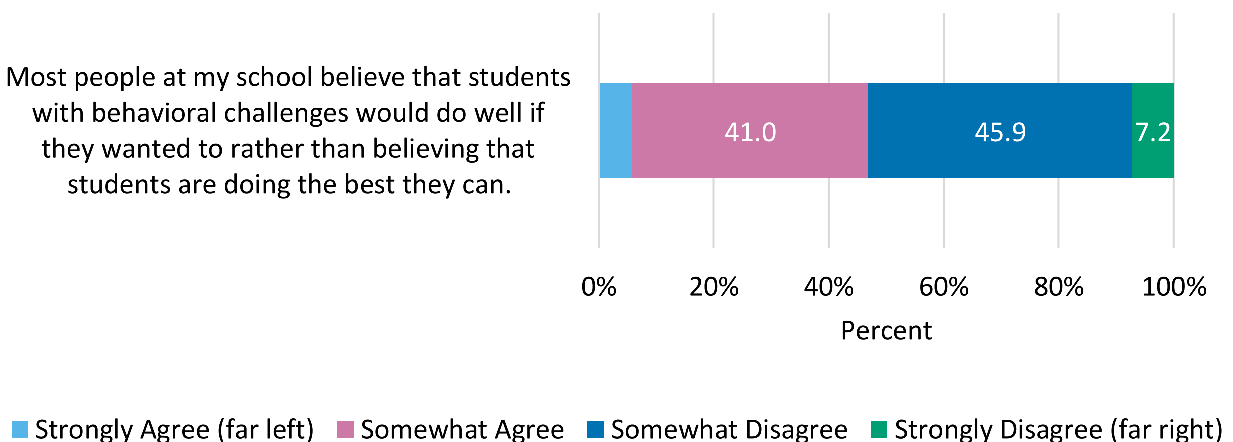
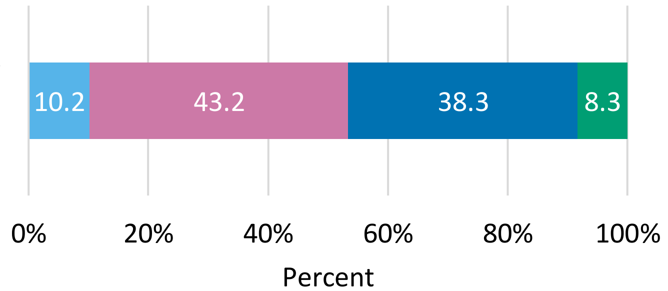


Figure 123: Fifty-three percent of staff AGREE that most classroom teachers frequently send students to someone outside the classroom to deal with behavior problems in their school

In my school, most classroom teachers frequently send students to someone outside the classroom – for example, the principal or assistant principal – to deal with behavior problems.

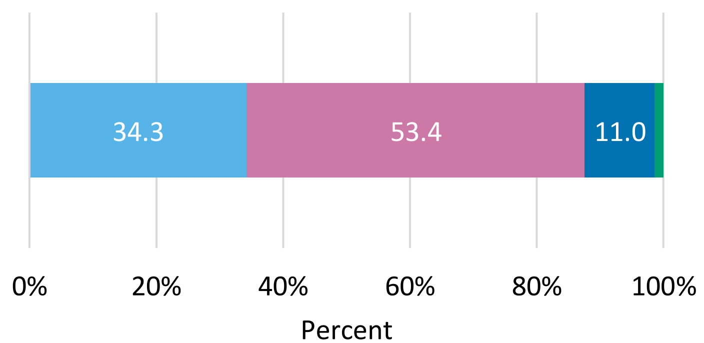


Strongly Agree (far left) Somewhat Agree Somewhat Disagree Strongly Disagree (far right)

Staff's Attitudes Towards Collaboration & Colleagues

Figure 124: Over 85 percent of staff report bring able to contribute to a student support team process when a student has behavioral or emotional problems

I can contribute to a student support team process when the student in question has behavioral or emotional problems.



Strongly Agree (far left) Somewhat Agree Somewhat Disagree Strongly Disagree (far right)

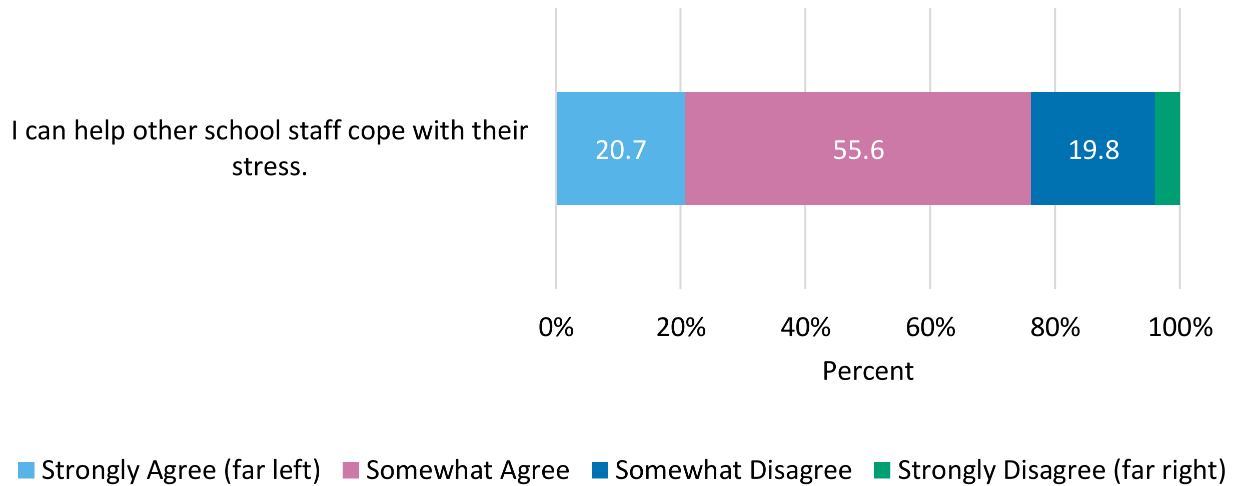


Figure 125: Over 75 percent of staff AGREE that they can help other school staff cope with their stress
I can help other school staff cope with their stress.
20.7
55.6
19.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

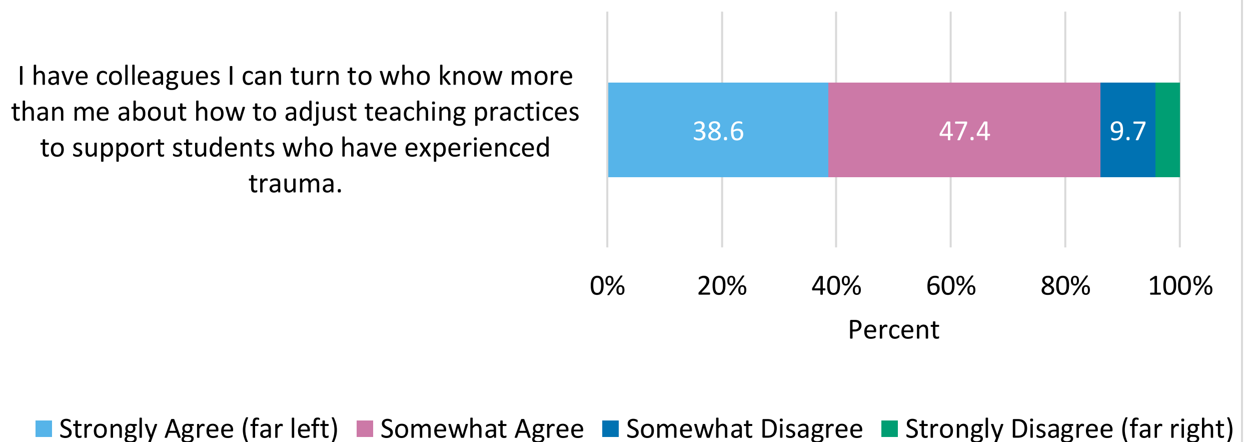


Figure 126: Over 85 percent of staff report having colleagues they can turn to for advice about how to adjust teaching practices to support students who have experienced trauma
I have colleagues I can turn to who know more than me about how to adjust teaching practices to support students who have experienced trauma.
38.6
47.4
9.7
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

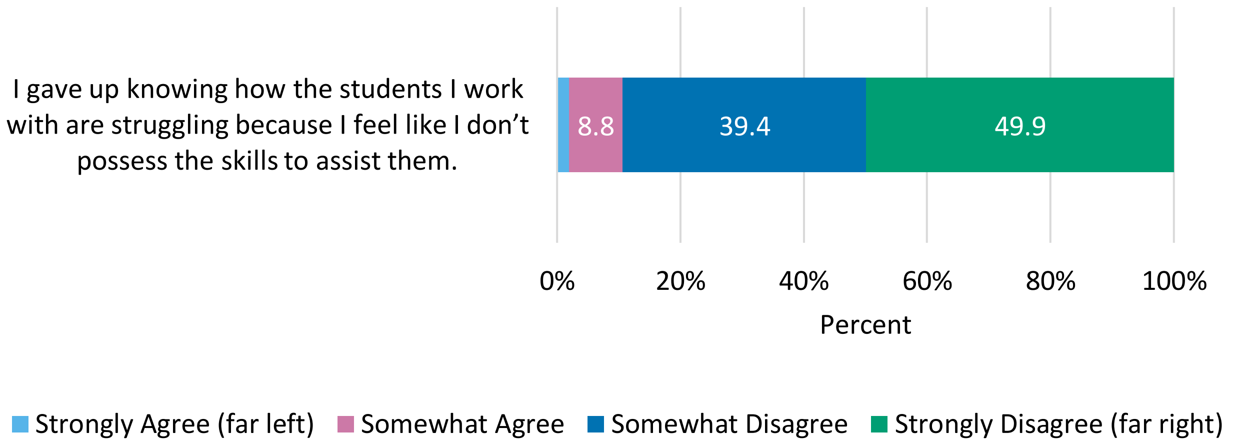


Figure 127: Ten percent of staff gave up knowing how their students are struggling because they felt like they didn't possess the skills to assist them
I gave up knowing how the students I work with are struggling because I feel like I don’t possess the skills to assist them.
8.8
39.4
49.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

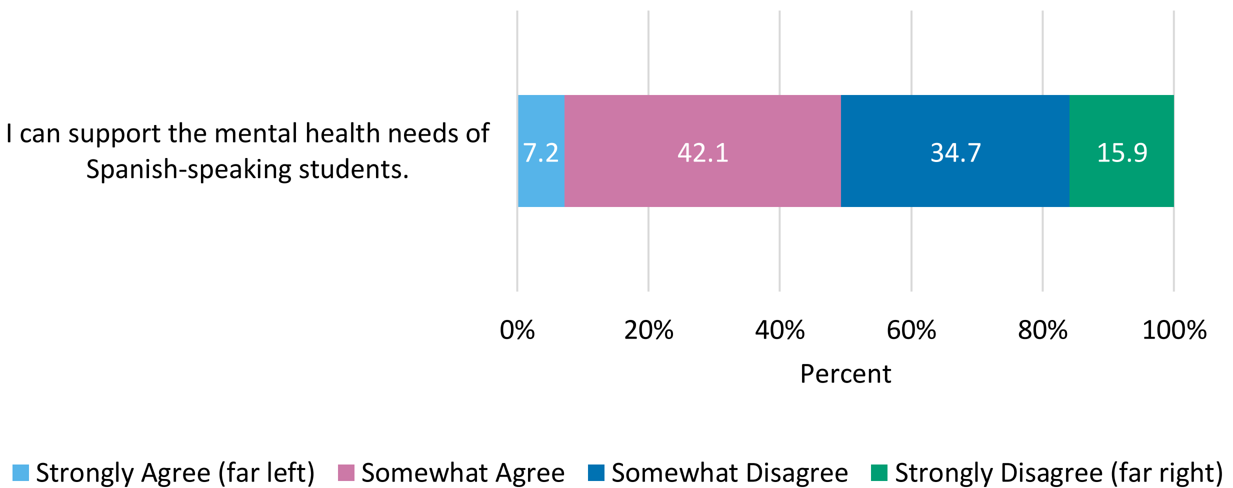
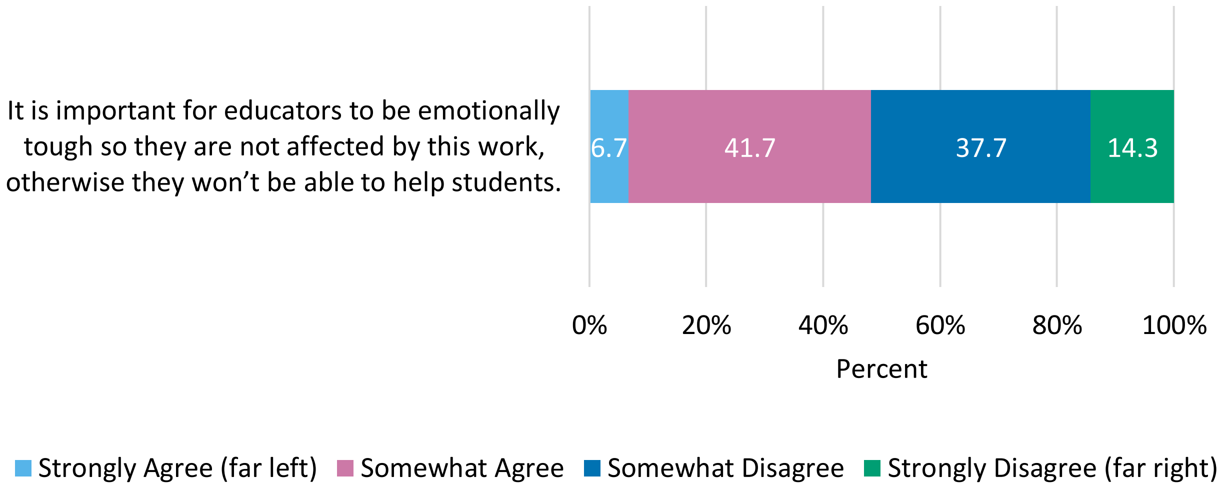
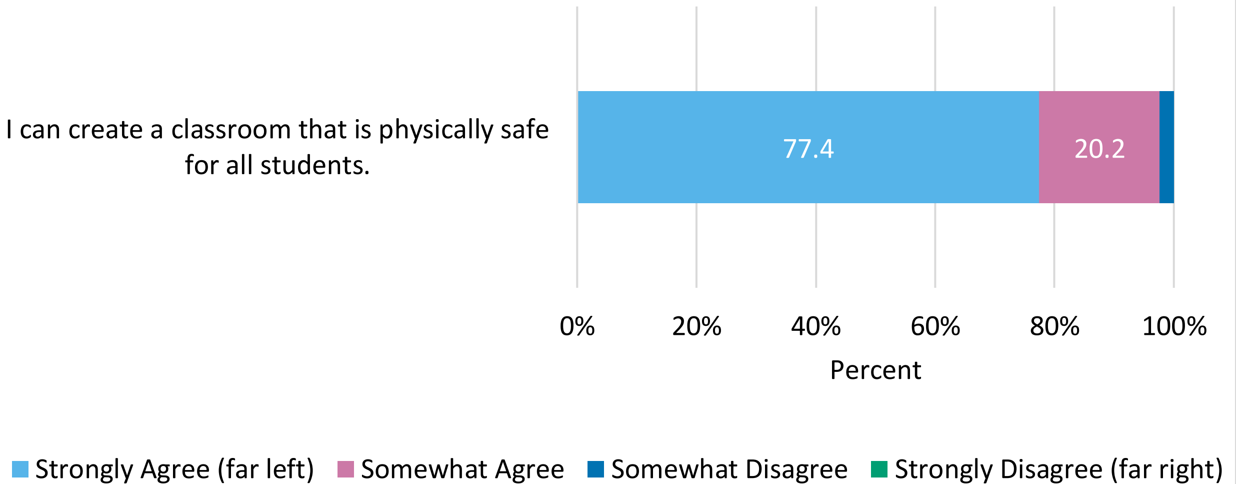


Figure 128: Only 49 percent of staff report being able to support the mental health needs of Spanish-speaking students
I can support the mental health needs of Spanish-speaking students.
7.2
42.1
34.7
15.9
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)



Staff Reports of Classroom Practices



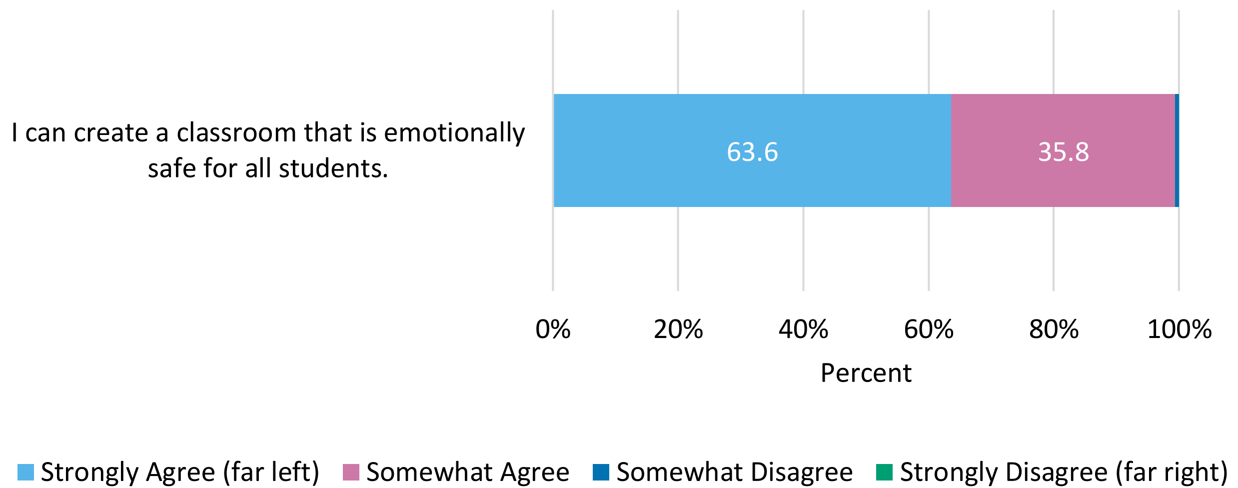


Figure 131: Over 99 percent of staff AGREE that they can create a classroom that is emotionally safe for all students
I can create a classroom that is emotionally safe for all students.
63.6
35.8
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

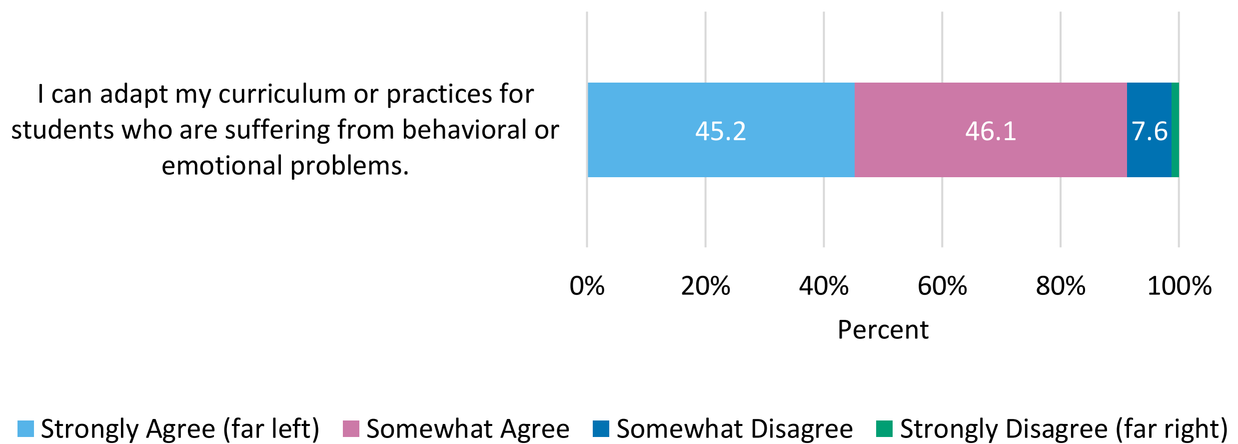


Figure 132: Ninety-one percent of staff report being able to adapt their curriculum or practices for students who are suffering from behavioral or emotional problems
I can adapt my curriculum or practices for students who are suffering from behavioral or emotional problems.
45.2
46.1
7.6
0%
20%
40%
60%
80%
100%
Percent
Strongly Agree (far left)
Somewhat Agree
Somewhat Disagree
Strongly Disagree (far right)

Figure 133: Over 80 percent of staff report knowing how to adjust their teaching practices to support students who have experienced trauma

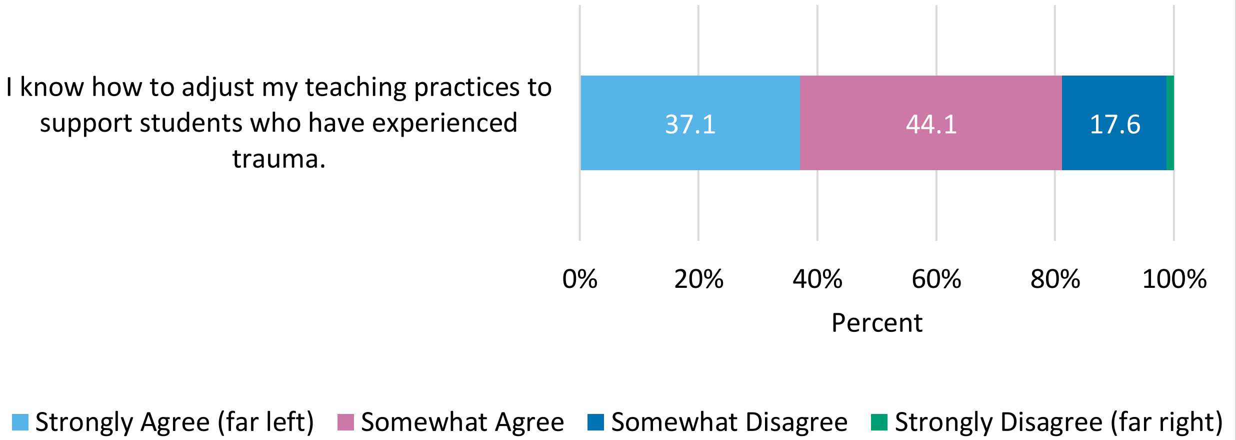
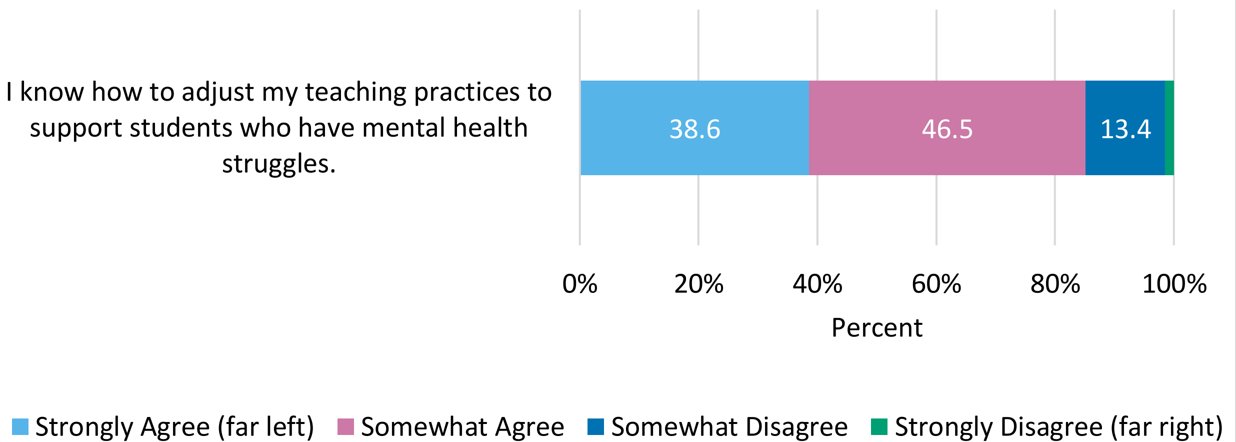
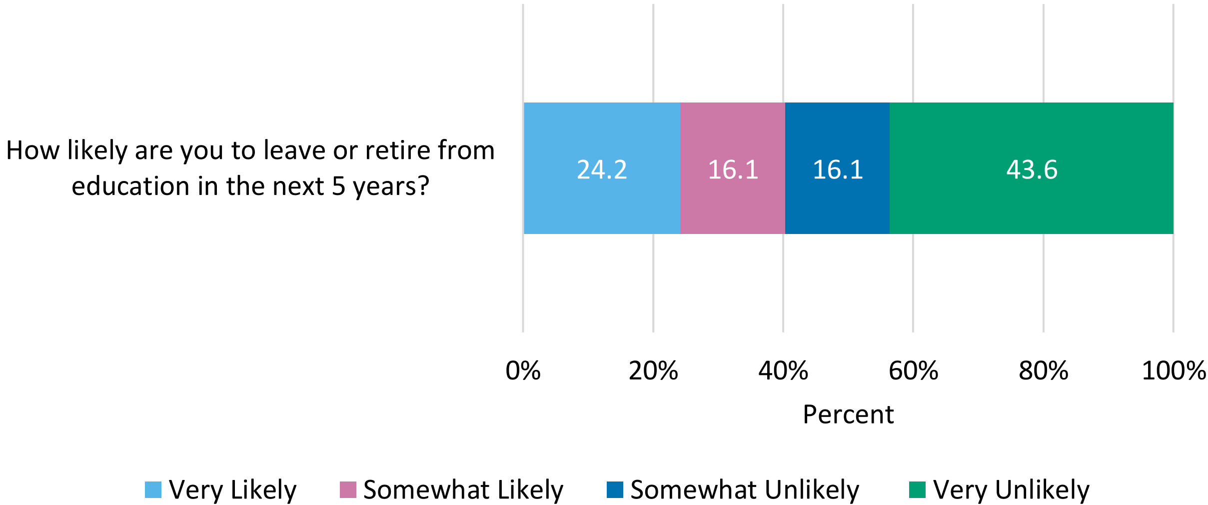


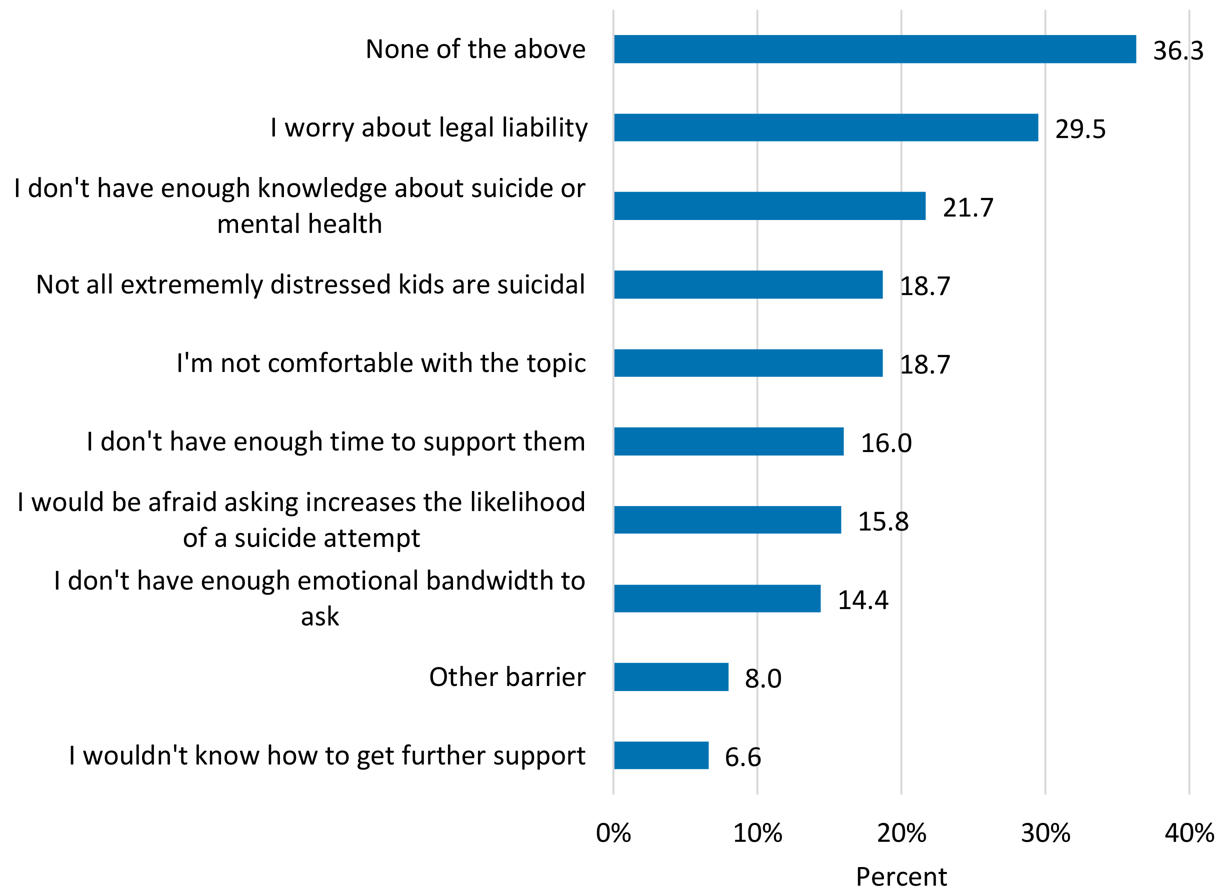
Figure 134: Over 85 percent of staff report knowing how to adjust their teaching practices to support students who have mental health struggles



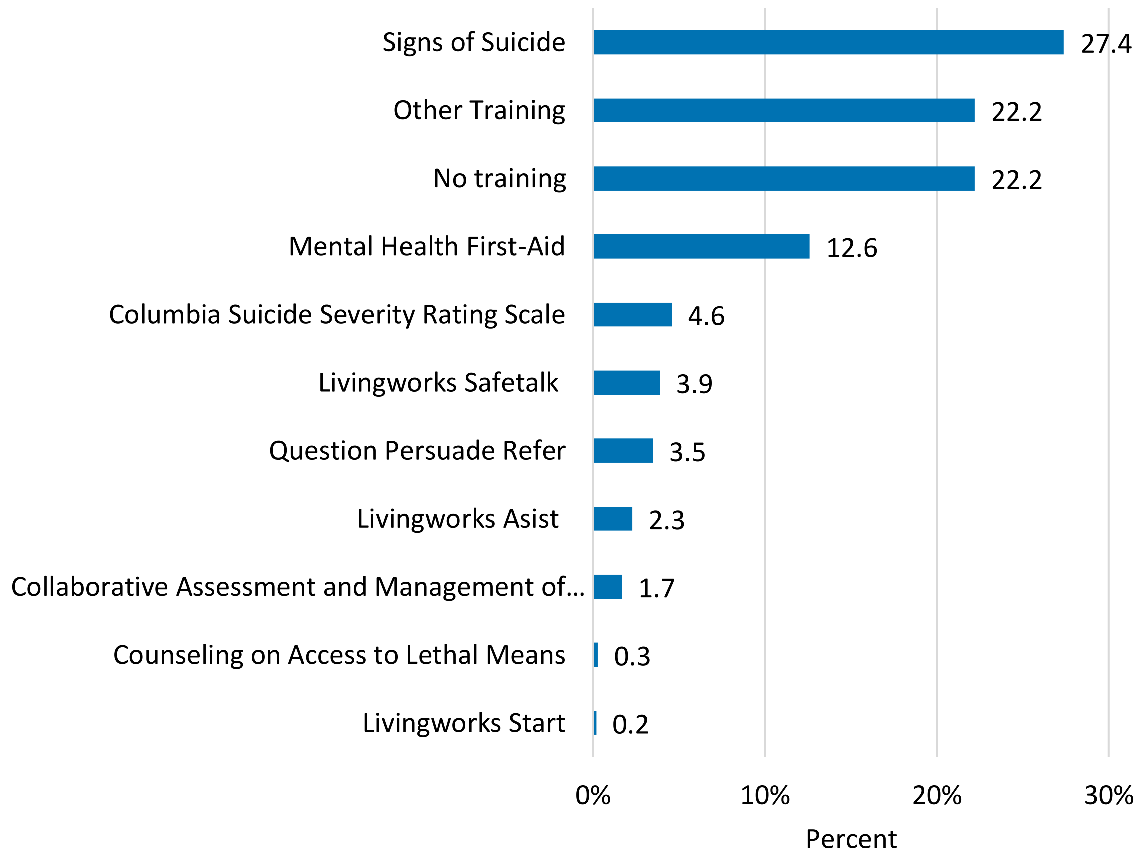
Staff Plans to Leave or Retire from Education in the Next Five Years



Barriers to Asking an Extremely Distressed Student about Suicide



Percent of Staff Who Have Completed Various Suicide Prevention Trainings



A Frequency Distribution Summarizing the Percent of Students that School Staff Have a Strong Relationship With

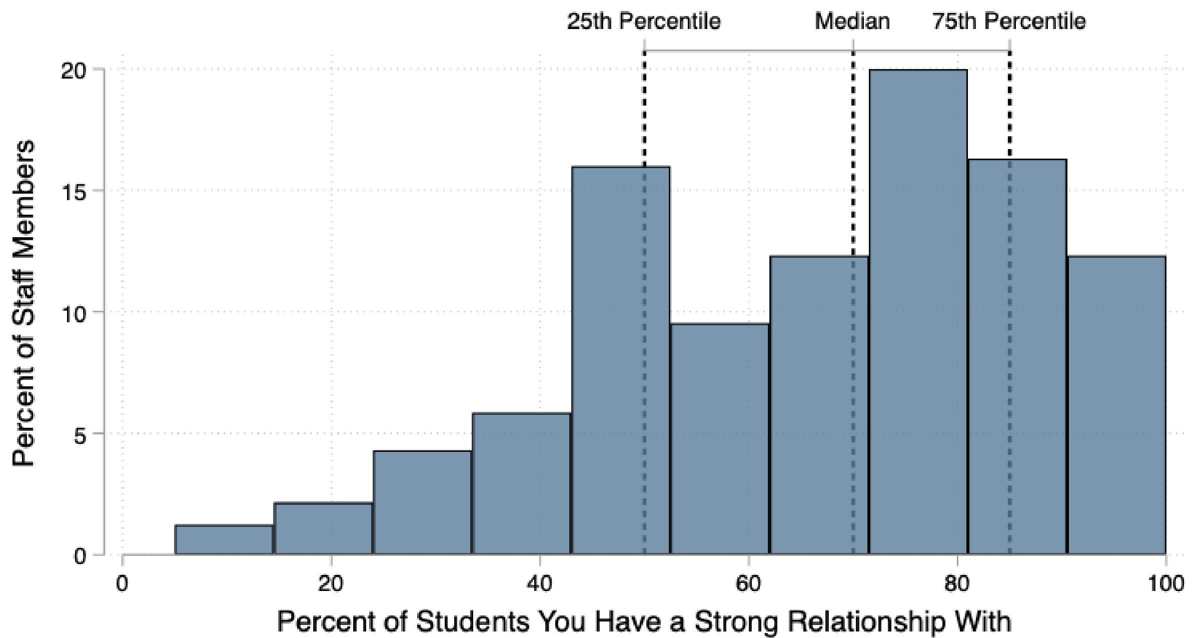


Figure 138: What percent of the students that you teach would you say that you have developed a strong relationship with?				
Minimum	25th Percentile	Median	75th Percentile	Maximum
5.0%	50.0%	70.0%	85.0%	100%

The take home point is that the majority of staff have strong relationships with the majority of students.

The Frequency of Classroom Disruptions due to Student Mental Health or Behavioral Issues

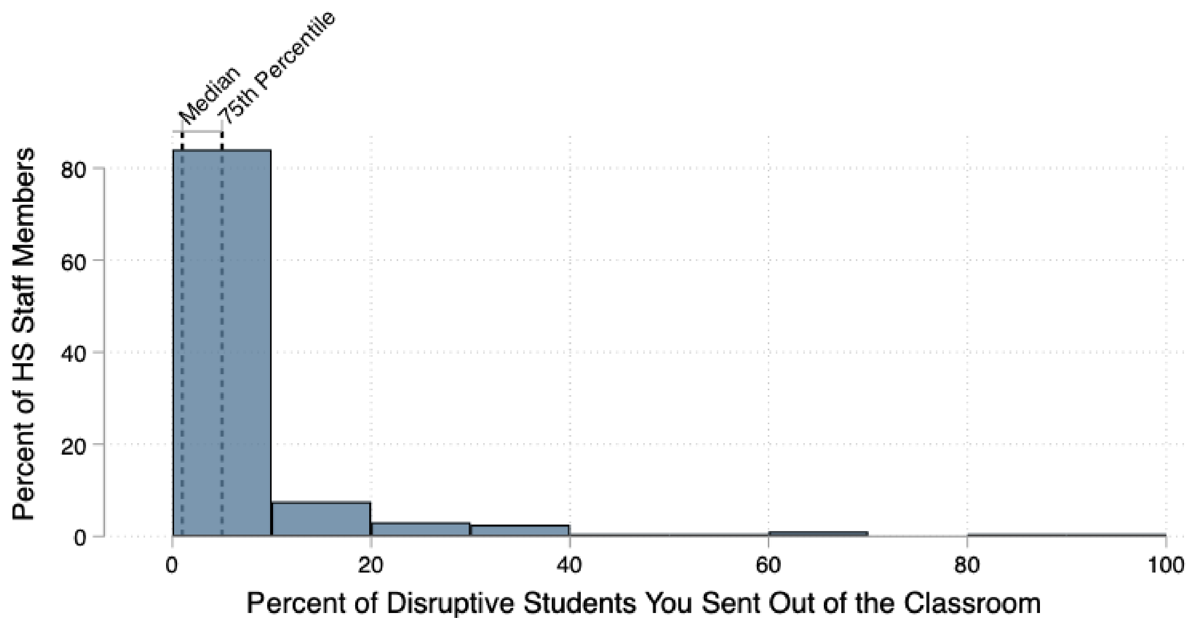


Figure 139: On an average week, what percent of disruptive students did you send out of the classroom?				
Minimum	25th Percentile	Median	75th Percentile	Maximum
0.0%	0.0%	2.0%	8.0%	100%

Take home point: Few students are sent out of classrooms due to mental health or behavioral issues. This rate is lower than what middle schools experience.

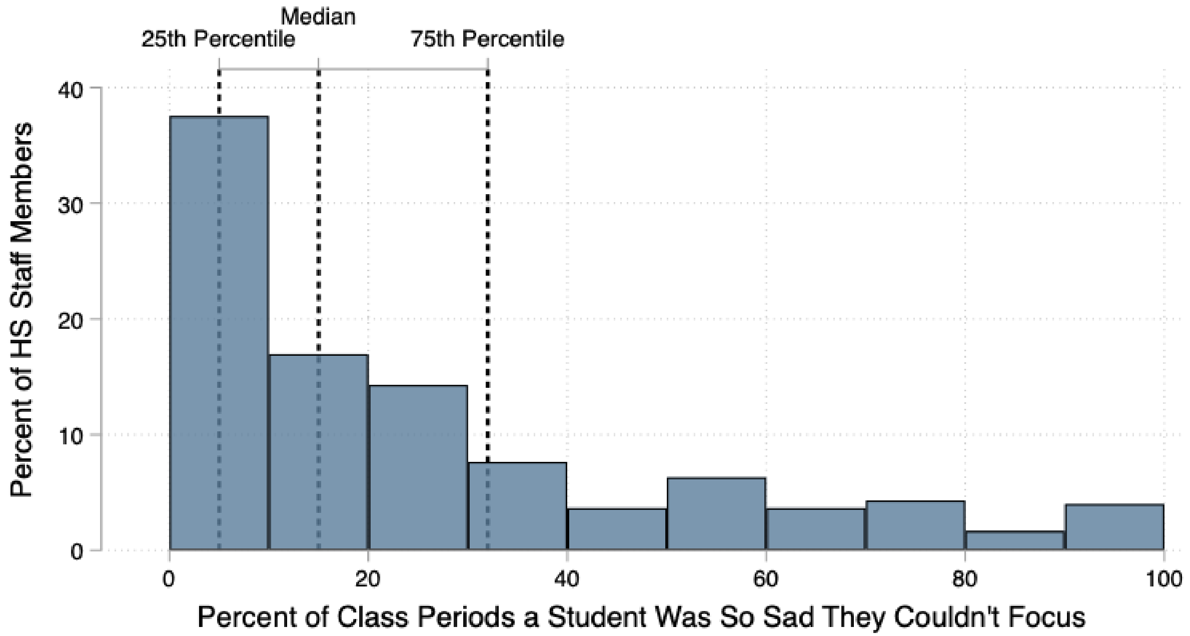


Figure 140: On an average week, what percent of class periods did you have at least one student who seemed so withdrawn or sad or distracted that they could not focus on classroom activities?				
Minimum	25th Percentile	Median	75th Percentile	Maximum
0.0%	5.0%	15.0%	32.0%	100%

Take home point: While students aren't asked to leave classrooms because of mental health issues (the prior figure), teachers are noticing substantial numbers of students in their classes that are having their focus disrupted because of painful feelings like sadness.

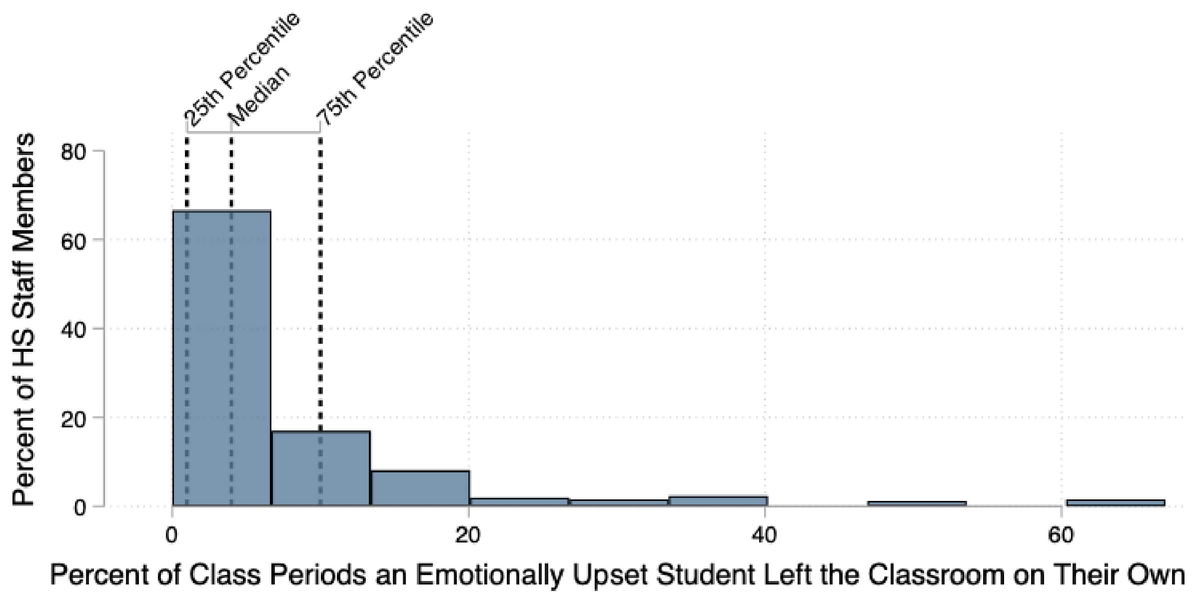


Figure 141: On an average week, what percent of class periods did an emotionally upset student leave the classroom on their own initiative? (with or without your permission)				
Minimum	25th Percentile	Median	75th Percentile	Maximum
0.0%	0.0%	4.0%	10.0%	67.0%

Take home point: Only rarely do teachers have a student who leaves the classroom on their own initiative because they are so emotionally upset; however, for about 25 percent of teachers this happens at least once every 10 class periods.

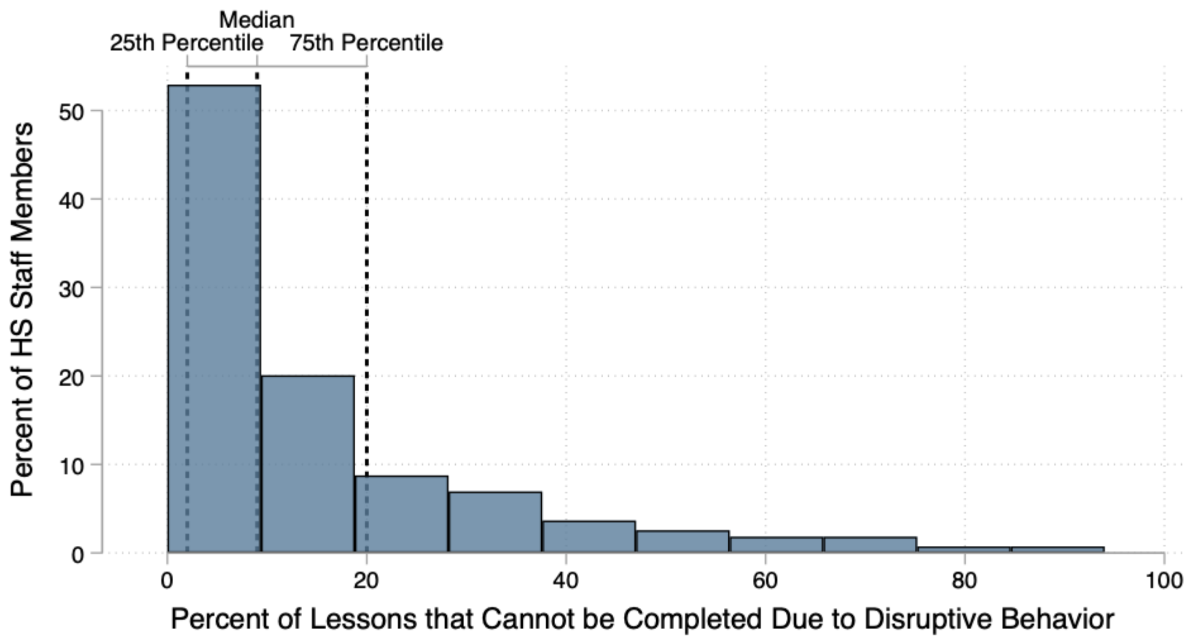
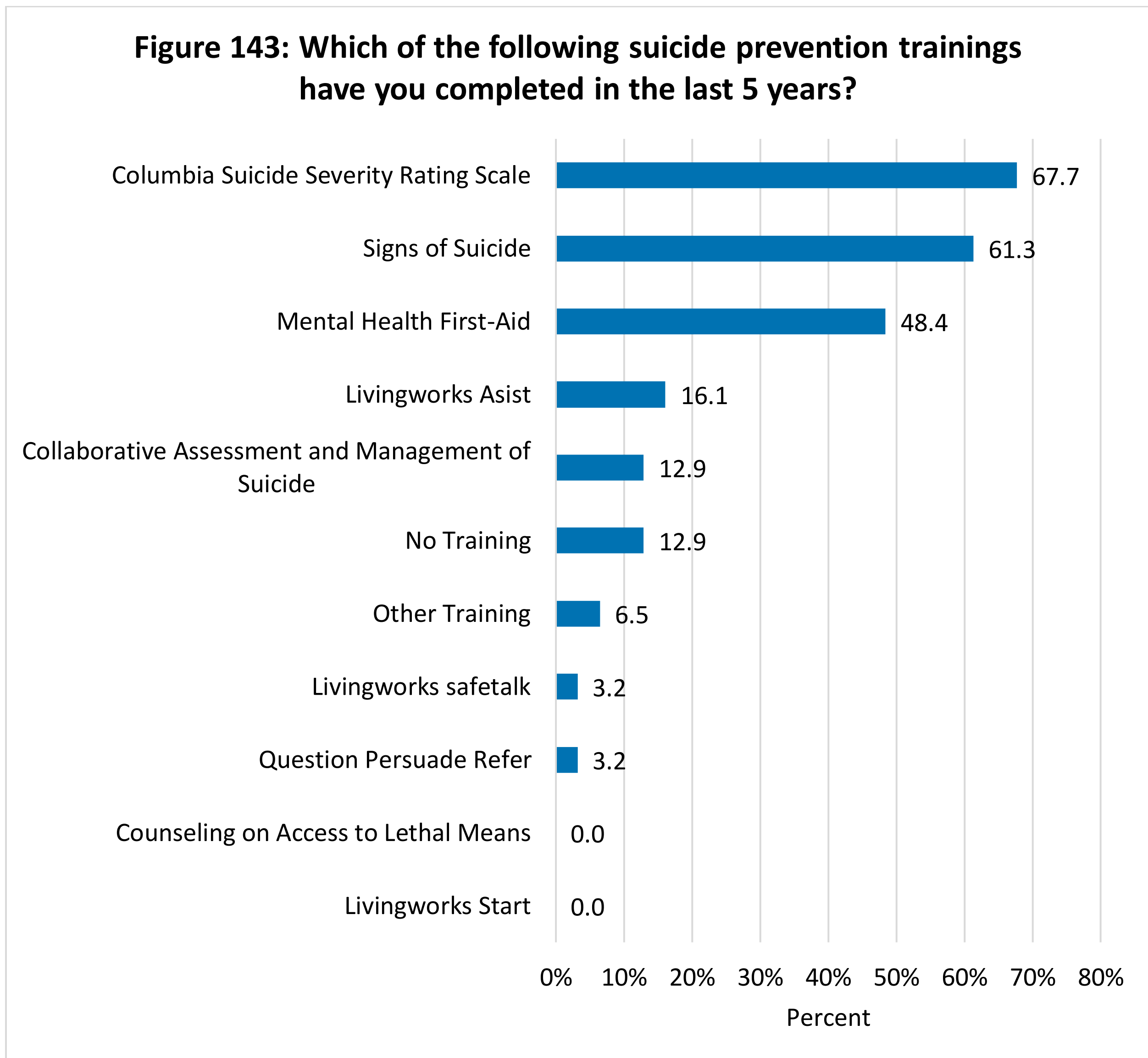


Figure 142: On an average week, what percent of the time were you unable to complete a lesson due to a student acting out/disruptive behavior?				
Minimum	25th Percentile	Median	75th Percentile	Maximum
0.0%	2.0%	9.0%	20.0%	94.0%

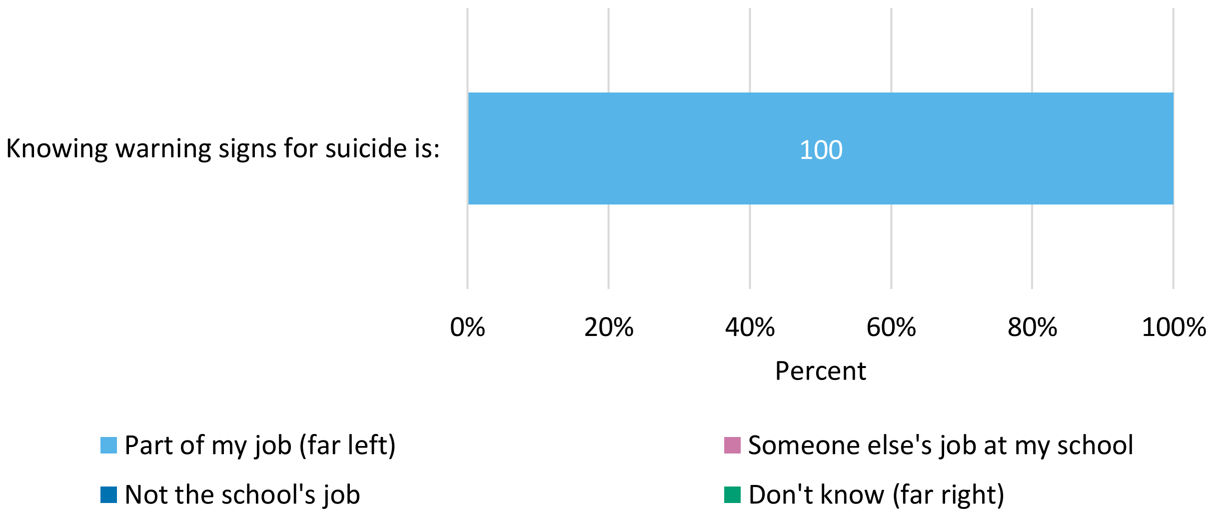
Take home point: Teachers are experiencing fairly regular interruptions of their classroom academic lessons because of students' disruptive behavior. Fifty percent of teachers experience this in 10 percent of their classes.

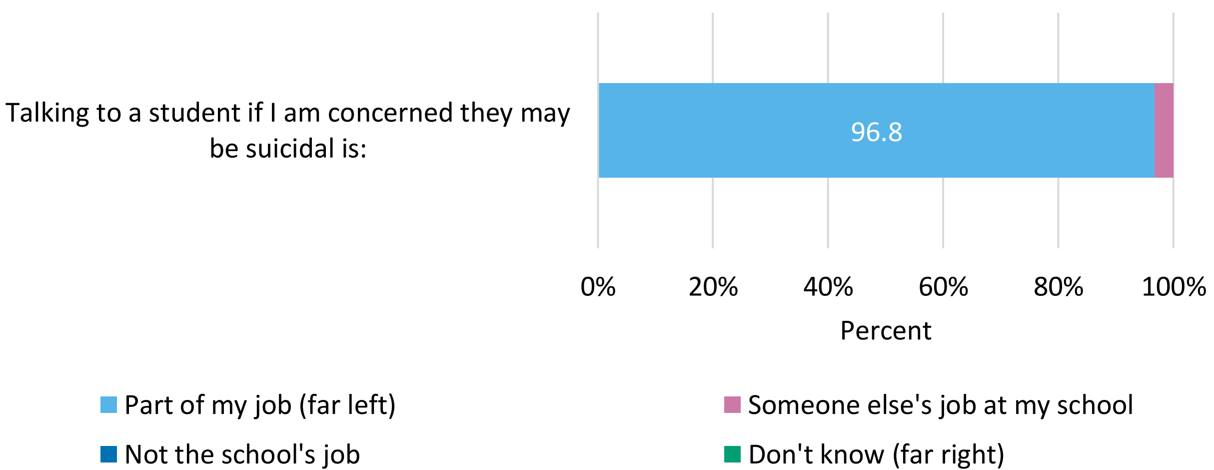
Mental Health Staff's Training in Suicide Prevention



Please note, ideally, 100% would be trained in Living Works ASIST – the highest quality and most comprehensive training on this list.

Mental Health Staff's Attitudes towards Their Role in Student Mental Health





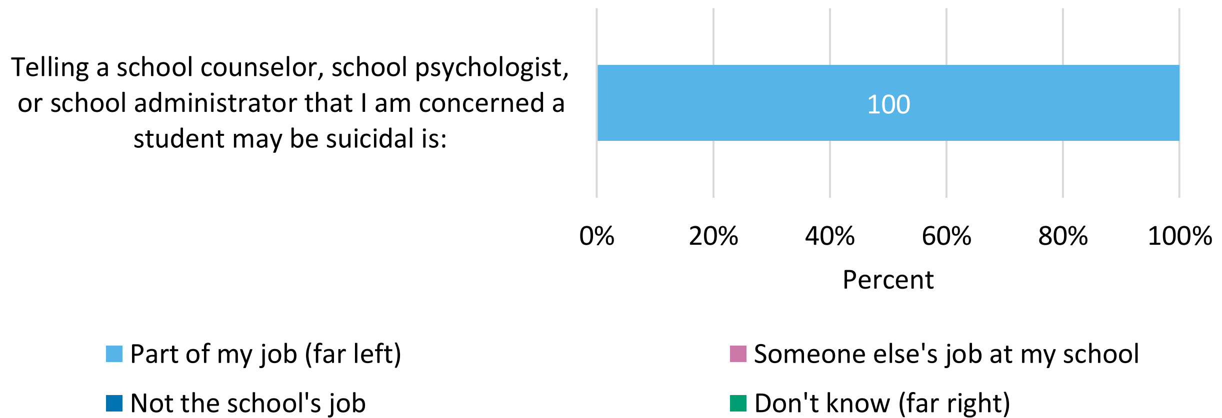


Figure 146: All mental health staff report that telling a school counselor, school psychologist, or school administrator that they are concerned a student may be suicidal is part of their job
Telling a school counselor, school psychologist, or school administrator that I am concerned a student may be suicidal is:
100
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

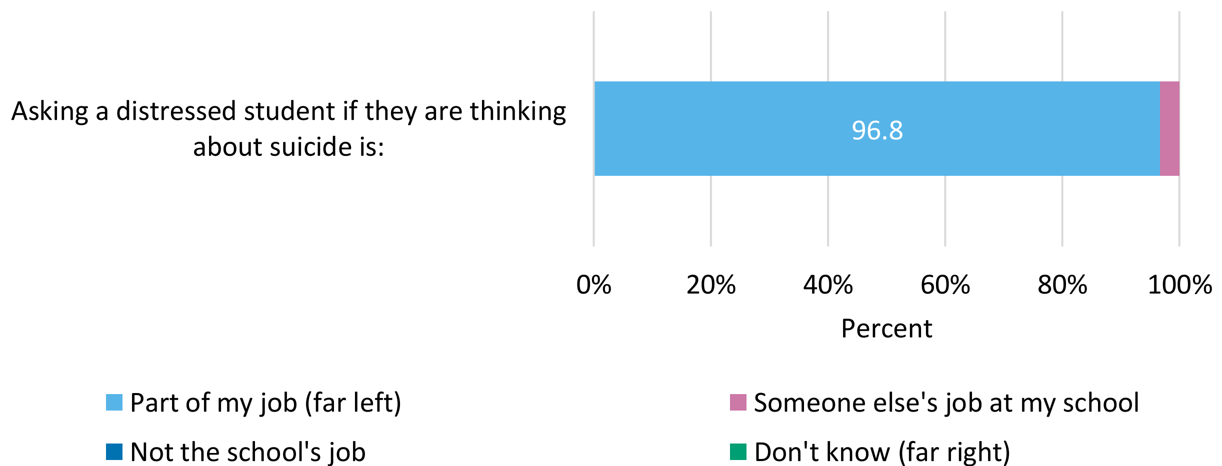


Figure 147: About 97 percent of mental health staff report that asking a distressed student if they are thinking about suicide is part of their job
Asking a distressed student if they are thinking about suicide is:
96.8
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

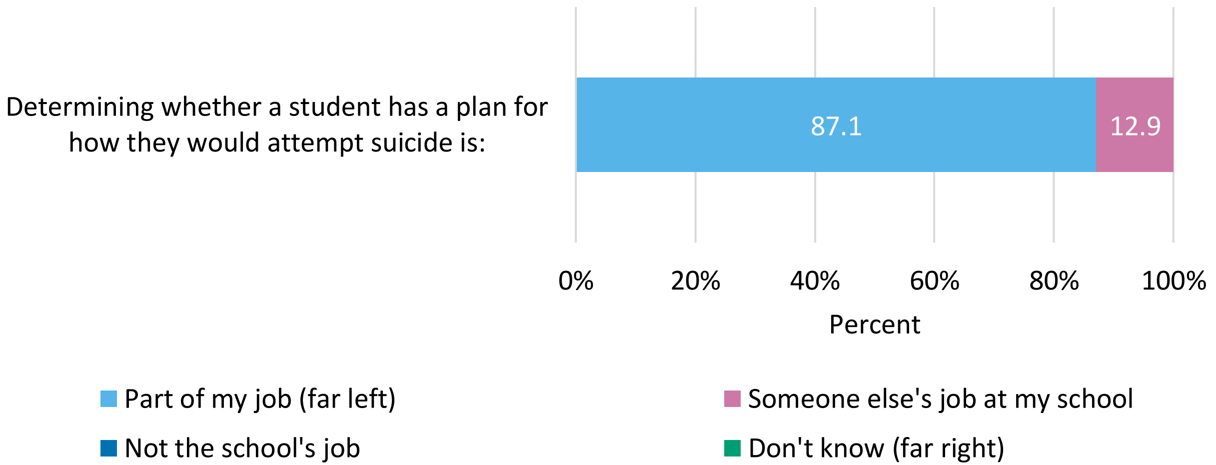


Figure 148: About 87 percent of mental health staff report that determining whether a student has a plan for how they would attempt suicide is part of their job
Determining whether a student has a plan for how they would attempt suicide is:
87.1
12.9
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

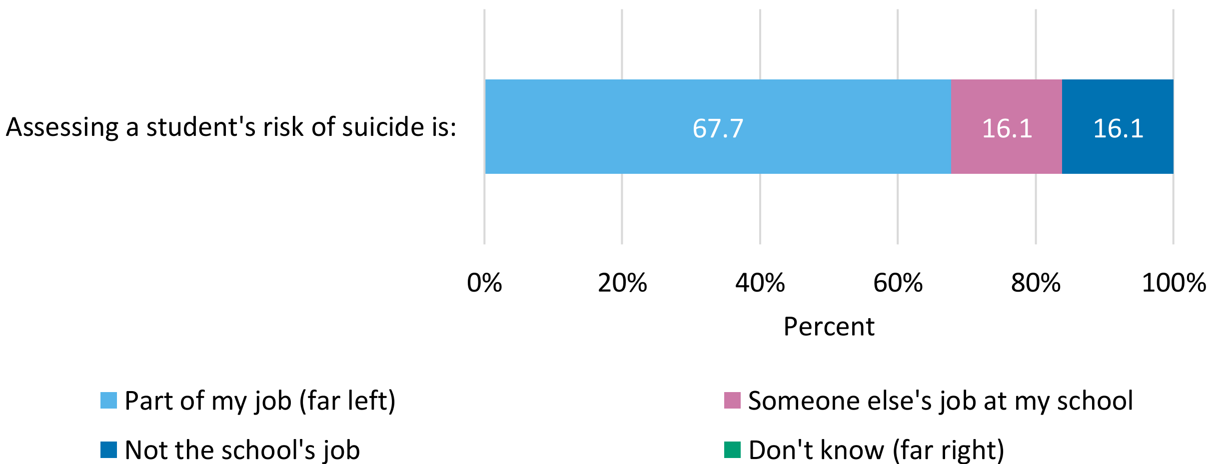


Figure 149: About 16 percent of mental health staff report that it is not their job, or the school's job, to assess a student's risk of suicide
Assessing a student's risk of suicide is:
67.7
16.1
16.1
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

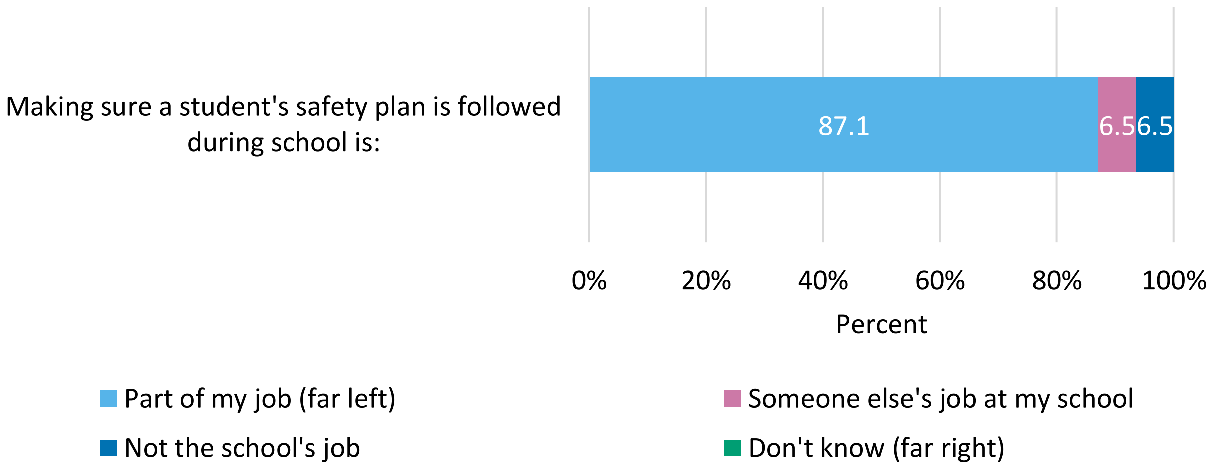


Figure 150: About 87 percent of mental health staff report that making sure a student's safety plan is followed during school is part of their job
Making sure a student's safety plan is followed during school is:
87.1
6.5
6.5
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

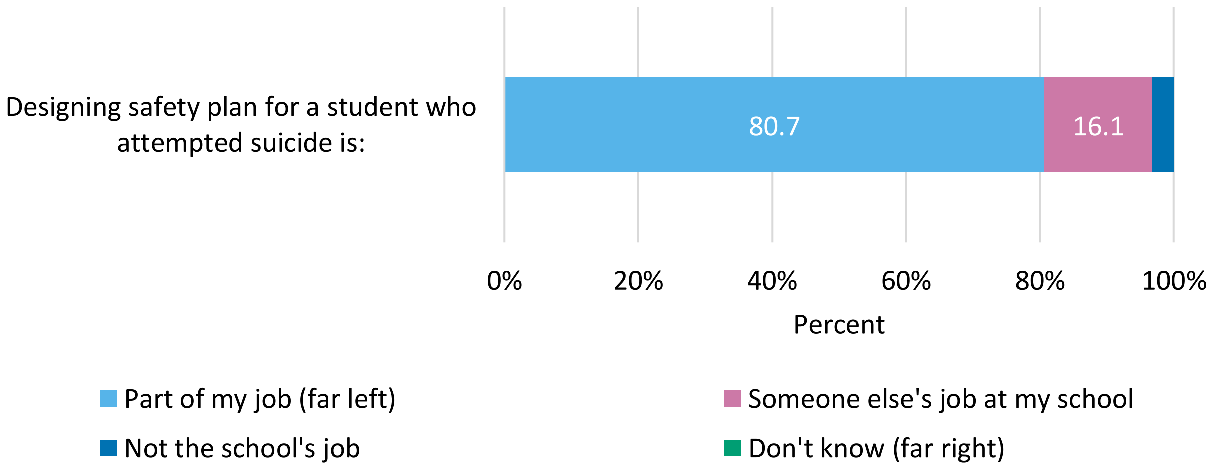


Figure 151: About 81 percent of mental health staff report that designing safety plan for a student who attempted suicide is part of their job
Designing safety plan for a student who attempted suicide is:
80.7
16.1
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

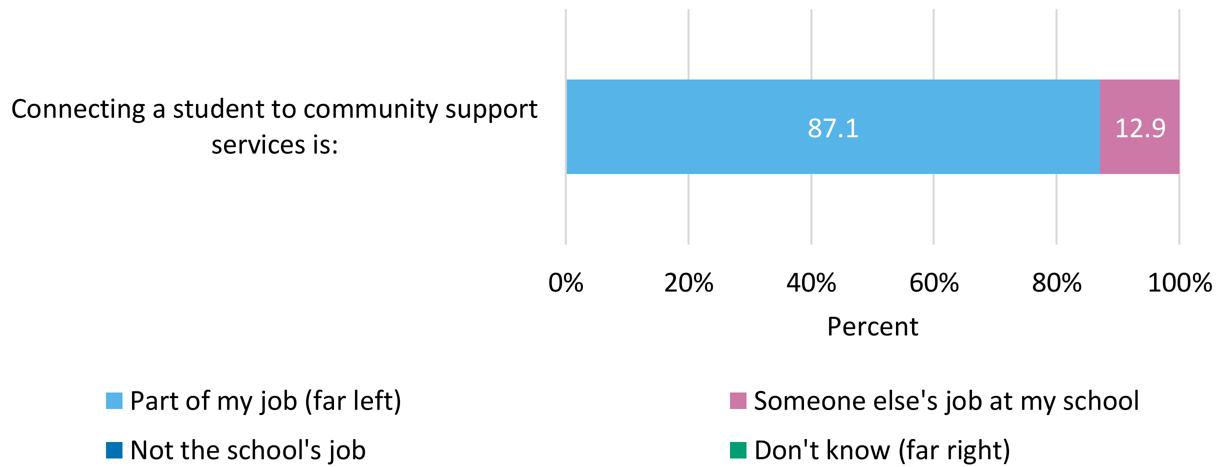


Figure 152: About 87 percent of mental health staff report that connecting a student to community support services is part of their job
Connecting a student to community support services is:
87.1
12.9
0%
20%
40%
60%
80%
100%
Percent
Part of my job (far left)
Someone else's job at my school
Not the school's job
Don't know (far right)

References

Abbott-Chapman, Joan, and Margaret Robertson. 2015. "Youth leisure, places, spaces and identity." In Landscapes of leisure: Space, place and identities, pp. 123-134. London: Palgrave Macmillan UK.

American Foundation for Suicide Prevention. 2020. “American Foundation for Suicide Prevention Annual Report.” https://annual2020.afsp.org/pdfs/AFSP-2020AnnualReport-web.pdf

Bélanger, Mathieu, François Gallant, Isabelle Doré, Jennifer L. O'Loughlin, Marie-Pierre Sylvestre, Patrick Abi Nader, Richard Larouche, Katie Gunnell, and Catherine M. Sabiston. 2019. "Physical activity mediates the relationship between outdoor time and mental health." *Preventive Medicine Reports* 16: 101006.

Berman, Marc G., John Jonides, and Stephen Kaplan. 2008. “The Cognitive Benefits of Interacting with Nature.” *Psychological Science* 19(12) :1207-12. Doi : 10.1111/j.1467 9280.2008.02225.x.

Beyer, Kirsten MM, Aniko Szabo, and Ann B. Nattinger. 2016. "Time spent outdoors, depressive symptoms, and variation by race and ethnicity." *American journal of preventive medicine* 51, no. 3: 281-290.

Binnix, T.M., C. Rambo, S. Abrutyn, and A.S. Mueller. 2018. “The dialectics of stigma, silence, and misunderstanding in suicidality survival narratives.” *Deviant Behavior*, *39*(8), 1095-1106.

Blake Mary Kate. 2020. “Other Duties as Assigned: The Ambiguous Role of the High School Counselor.” *Sociology of Education* 93(4):315–30

Blake, Mary Kate. 2023. “School-Level Bureaucrats: How High School Counselors Inhabit the Conflicting Logics of Their Work.” *Sociology of Education* Online First. https://doi-org.proxyiub.uits.iu.edu/10.1177/00380407231204596

Blosnich, John R., Susan De Luca, Megan C. Lytle, and Chris Brownson. 2020. "Questions of faith: Religious affiliations and suicidal ideation among sexual minority young adults." *Suicide and Life-Threatening Behavior* 50, no. 6 (2020): 1158-1166.

Bratman, Gregory N., Christopher B. Anderson, Marc G. Berman, Bobby Cochran, Sjerp De Vries, Jon Flanders, Carl Folke et al. 2019. "Nature and mental health: An ecosystem service perspective." *Science advances* 5, no. 7: eaax0903.

Bridge, J..A., L.M. Horowitz, C.A. Fontanella, J. Grupp-Phelan and J.V. Campo. 2014. "Prioritizing Research to Reduce Youth Suicide and Suicidal Behavior*." American Journal of Preventive Medicine* 47(3, Supplement 2):S229-S34. doi: https://doi.org/10.1016/j.amepre.2014.06.001.

Bronfenbrenner, Urie. 1979. *The Ecology of Human Development: Experiments by Nature and Design*. Harvard University Press.

Calarco, Jessica M. 2020. *A Field Guide to Grad School: Uncovering the Hidden Curriculum*. Princeton University Press.

Cha, Christine B., Katherine M. Tezanos, Olivia M. Peros, Mei Yi Ng, Jessica D. Ribeiro, Matthew K. Nock, and Joseph C. Franklin. 2018. "Accounting for diversity in suicide research: Sampling and sample reporting practices in the United States." *Suicide and Life-Threatening Behavior*. 48(2):131-139.

Cox, G.R., C. Owens, J. Robinson, A. Nicholas, A. Lockley, M. Williamson, Y.T. Cheung, and J. Pirkis. 2013. Interventions to reduce suicides at suicide hotspots: a systematic review. *BMC public health*, *13*, 214. https://doi.org/10.1186/1471-2458-13-214

Currier, Joseph M., Jesse Fox, Cassandra Vieten, Michelle Pearce and Holly K. Oxhandler. 2023. "Enhancing Competencies for the Ethical Integration of Religion and Spirituality in Psychological Services." *Psychological Services* 20(1):40-50. doi: 10.1037/ser0000678.

Curtin, Sally C., Margaret Warner, and Holly Hedegaard. 2016. "Increase in Suicide in the United States, 1999-2014." NCHS Data Brief 241:1-8

Earnshaw, V.A., D.D. Menino, L.M. Sava, J. Perrotti, T.N. Barnes, D.L. Humphrey, and S.L. Reisner. 2020. "LGBTQ Bullying: A Qualitative Investigation of Student and School Health Professional Perspectives." *Journal of LGBT Youth* 17(3):280–97. doi: 10.1080/19361653.2019.1653808.

Ellis, H.M., J.N. Hook, S. Zuniga, A.S. Hodge, K.M. Ford, D.E. Davis, and D.R. Van Tongeren. 2022. Religious/spiritual abuse and trauma: A systematic review of the empirical literature. *Spirituality in Clinical Practice, 9*(4), 213–231. https://doi.org/10.1037/scp0000301

Erbacher, Terri A., Jonathon B. Singer, and Scott Poland. 2014. *Suicide in schools: A practitioner's guide to multi-level prevention, assessment, intervention, and postvention*. Routledge.

Etzersdorfer, E. and G. Sonneck. 1998. "Preventing suicide by influencing mass-media reporting. The Viennese experience 1980–1996." *Archives of Suicide Research* 4, 67–74 (1998). https://doi.org/10.1023/A:1009691903261

Finkelhor, David, Heather A. Turner, Anne Shattuck, and Sherry L. Hamby. "Prevalence of childhood exposure to violence, crime, and abuse: Results from the national survey of children's exposure to violence." 2015. *JAMA pediatrics* 169, no. 8: 746-754.

Fisher, Lauren B., James C. Overholser, Josephine Ridley, Abby Braden, and Cari Rosoff. 2015. "From the outside looking in: Sense of belonging, depression, and suicide risk." *Psychiatry* 78, no. 1: 29-41.

Fortuna, Lisa R., Debra Joy Perez, Glorisa Canino, William Sribney, and Margarita Alegria. 2007. "Prevalence and correlates of lifetime suicidal ideation and suicide attempts among Latino subgroups in the United States." *The Journal of Clinical Psychiatry* 68(4):572–581.

Fox, Cybelle, & David J. Harding. 2005. “School Shootings as Organizational Deviance.” *Sociology of Education* 78(1): 69-97. https://doi-org.proxyiub.uits.iu.edu/10.1177/003804070507800104

Frank, Kenneth A., Chandra Muller, and Anna S. Mueller. 2013. "The embeddedness of adolescent friendship nominations: The formation of social capital in emergent network structures." *American Journal of Sociology* 119, no. 1: 216-253.

Franklin, Joseph C., Jessic D. Riberio, Kathryn R. Fox, Kate H. Bentley, Evan M. Kleinman, Xieyining Huand, Katherine M. Musacchio, Adam C Jaroszewski, Bernard P. Chang, and Matthew K Nock. 2017. “Risk Factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research.” *Psychological bulletin* 143(2):187.

Gallo, L., and C.A. Wachter Morris. 2022. “Suicide Intervention in Schools: If Not School Counselors, Then Who?” *Teaching and supervision in counseling*, *4*(2), 6.

Giordano, Peggy C. 1995. "The wider circle of friends in adolescence." *American Journal of Sociology* 101, no. 3: 661-697.

Gomez, Judelysse, Regina Miranda, and Lillian Polanco. 2011. “Acculturative stress, perceived discrimination, and vulnerability to suicide attempts among emerging adults.” *Journal of Youth and Adolescence* 40(11): 465–1476. https://doi.org/10.1007/s10964-011-9688-9

Goodrum, Sarah, Jessie Slepicka, William Woodward, and Beverly Kingston. 2022. "Learning from error in violence prevention: a school shooting as an organizational accident." *Sociology of education* 95, no. 4: 257-275.

Haas, Ann P., Mickey Eliason, Vickie M. Mays, Robin M. Mathy, Susan D. Cochran, Anthony R. D'Augelli, Morton M. Silverman, et al. "Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations." *Journal of homosexuality* 58, no. 1: 10-51.

Hallett, Timothy. 2010. “The Myth Incarnate: Recoupling Processes, Turmoil, and Inhabited Institutions in an Urban Elementary School.” *American Sociological Review* 75(1):52–74.

Hamilton, S., C. Metcalfe, and D. Gunnell. 2011. Media reporting and suicide: a time-series study of suicide from Clifton Suspension Bridge, UK, 1974-2007. *Journal of public health (Oxford, England)*, *33*(4), 511–517. https://doi.org/10.1093/pubmed/fdr043

Hawgood, Jacinta, Alan Woodward, Paul Quinnett, and Diego De Leo. 2022. "Gatekeeper training and minimum standards of competency: Essentials for the suicide prevention workforce." *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 43, no. 6: 516.

Joe, Sean and Heather Bryant. 2007. “Evidence-based suicide prevention screening in schools.” *Children and Schools* 29(4):219-227.

Joiner, Thomas. 2005. *Why People Die by Suicide*. Cambridge: Harvard University Press.

King, Cheryl A., and Christopher R. Merchant. 2008. "Social and interpersonal factors relating to adolescent suicidality: A review of the literature." *Archives of suicide research* 12, no. 3: 181-196.

Kondo, Michelle C., Sara F. Jacoby, and Eugenia C. South. 2018. "Does spending time outdoors reduce stress? A review of real-time stress response to outdoor environments." *Health & place* 51: 136-150.

Kosciw, Joseph G., Cailtin M. Clark, Nhan L. Truong, and Adrain D. Zongrone. 2020. The 2019 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools. New York: GLSEN.

Marx, Robert A., and Heather Hensman Kettrey. 2016. "Gay-Straight Alliances Are Associated with Lower Levels of School-Based Victimization of LGBTQ+ Youth: A Systematic Review and Meta-Analysis." *Journal of Youth and Adolescence* 45(7):1269–82. doi: 10.1007/s10964-016-0501-7.

McLemore, Kevin A. 2018. "A Minority Stress Perspective on Transgender Individuals' Experiences with Misgendering." *Stigma and Health* 3(1):53–64. doi: 10.1037/sah0000070.

McLeod, Jane D., Ryotaro Uemura, and Shawna Rohrman. 2012. "Adolescent mental health, behavior problems, and academic achievement." *Journal of health and social behavior* 53, no. 4: 482-497.

Mueller, Anna S. and Seth Abrutyn. 2016. "Adolescents under Pressure: A New Durkheimian Framework for Understanding Adolescent Suicide in a Cohesive Community." *American Sociological Review* 81(5): 877-899.

Mueller, Anna S. and Seth Abrutyn. Forthcoming 2024. *Life under Pressure: The Social Roots of Youth Suicide and What to Do About Them*. Oxford University Press. https://global.oup.com/academic/product/life-under-pressure-9780190847845

Mueller, Anna S., Seth Abrutyn, and Sarah Diefendorf. 2022. Transforming US education to prevent youth suicide. *Contexts*, *21*(4), 14-19.

Needham, Belinda L., Robert Crosnoe, and Chandra Muller. 2004. "Academic failure in secondary school: The inter-related role of health problems and educational context." *Social problems* 51, no. 4: 569-586.

O'Connor, Rory. 2021. *When It Is Darkest: Why People Die by Suicide and What We Can Do to Prevent It*. New York: Random House.

Olcoń, Katarzyna, Yeonwoo Kim, and Lauren E. Gulbas. 2017. "Sense of belonging and youth suicidal behaviors: What do communities and schools have to do with it?." *Social work in public health* 32, no. 7: 432-442.

Pescosolido, Bernice A., and Sharon Georgianna. 1989. "Durkheim, suicide, and religion: Toward a network theory of suicide." *American Sociological Review*: 33-48.

Pirkis, J., L.S. Too, M.J. Spittal, K. Krysinska, J. Robinson, and Y.T. Cheung. 2015. Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis. *The lancet. Psychiatry*, *2*(11), 994–1001. https://doi.org/10.1016/S2215-0366(15)00266-7

Pisani, Anthony R., Peter A. Wyman, Mariya Petrova, Karen Schmeelk-Cone, David B. Goldston, Yinglin Xia, and Madelyn S. Gould. 2013. "Emotion regulation difficulties,

youth–adult relationships, and suicide attempts among high school students in underserved communities." *Journal of youth and adolescence* 42: 807-820.

Redding, Christopher. 2019. “A Teacher Like Me: A Review of the Effect of Student–Teacher Racial/Ethnic Matching on Teacher Perceptions of Students and Student Academic and Behavioral Outcomes.” *Review of Educational Research* 89(4):499-535.

Rosin, Hanna. 2015. "The Silicon Valley Suicides: Why Are So Many Kids with Bright Prospects Killing Themselves in Palo Alto?" The Atlantic.

Schieman, S., A. Bierman, and C.G. Ellison. 2013. Religion and Mental Health. In: Aneshensel, C.S., Phelan, J.C., Bierman, A. (eds) Handbook of the Sociology of Mental Health. Handbooks of Sociology and Social Research. Springer, Dordrecht. https://doi.org/10.1007/978-94-007-4276-5_22

Shankland, Rebecca and Evelyn Rosset. 2017. "Review of Brief School-Based Positive Psychological Interventions: A Taster for Teachers and Educators*." Educational Psychology Review* 29(2):363-92.

Singer, J.B., Terri A. Erbacher, and Perri Rosen. 2019. “School-based suicide prevention: A framework for evidence-based practice.” *School Mental Health* 11:54–71. https://doi.org/10.1007/s12310-018-9245-8

Singer, Jonathon B. 2017. “Identifying and responding to suicide risk in schools.” *Psychiatric Annals* 47: 401-405. https://doi.org/10.3928/00485713-20170703-01

Spencer, Renee. 2007. “It’s not what I expected: A Qualitative Study of Youth Mentoring Relationship Failures.” *Journal of Adolescent Research* 22(4):331-354.

Spillane, James P., Leigh M. Parise, and Jennifer Zolteners Sherer. 2011. “Organizational routines as coupling mechanisms: Policy, school administration, and the techincal core.” *American Educational Research Journal* 48(3):586-619.

The Claire Davis School Safety Act (CRS 24-10-106.3)

The Trevor Project. 2023. 2023 U.S. National Survey on the Mental Health of LGBTQ+ Young People. The Trevor Project.

Trauma Responsive Educational Practices [TREP] Project. https://www.trepeducator.org/

Whitlock, Janis, Peter A. Wyman, and Sarah R. Moore. 2014. "Connectedness and suicide prevention in adolescents: Pathways and implications." *Suicide and Life‐Threatening Behavior* 44, no. 3: 246-272.

Wyman, Peter A. 2014. “Developmental approach to prevent adolescent suicides: research pathways to effective upstream suicide preventive interventions.” *American Journal of Preventive Medicine*. 47(3):251-256. https://doi.org/10.1016/j.amepre.2014.05.039

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