CHAPTER 2

Youth Suicidal Behavior and the Schools

> Because the school is the community institution that has the primary responsibility for the education and socialization of youth, the school context has the potential to moderate the occurrence of risk behaviors and to identify and secure help for at-risk individuals.
>
> —John Kalafat

> A very real and practical question that school personnel need to ask concerns the responsibility and liability of the school system with regard to suicide.
>
> —Scott Poland

> The job of school personnel is broader than education alone. It is to alter the trajectory of our students' lives.
>
> —Robert Horner

Because the problem of youth suicidal behavior is so serious, and because children and adolescents spend much of their time in school, it has frequently been suggested that schools take on a more prominent role in youth suicide prevention efforts. For example, in their excellent text *Adolescent Suicide: Assessment and Intervention* (2006), Alan Berman and colleagues ask the reader to do the following:

> Imagine yourself sitting at a symposium on adolescent suicide called in response to media reports of an alarming increase in the incidence of youth suicide. An interdisciplinary panel of distinguished speakers has gathered to present views and explanations for the problem and suggestions for its resolution. The panel focuses on the schools and the intensely competitive pressures of the times as sources of stress. Youth suicide is noted by some panelists to be an international problem. Others question the validity and adequacy of official statistics; still others comment on the problem of journalistic sensationalism. Concerns are raised about suicide clusters, the role of suggestibility and imitation, as well as the availability of guns. Various preventive and intervention strategies are proposed, and the educational system is singled out as uniquely positioned to play a key role in prevention. (p. 21)

Any contemporary school-based mental health professional, including school psychologists, school counselors, and school social workers, could imagine attending such a symposium at any

number of conferences. What is perhaps most interesting about this example, however, is that the symposium it describes occurred over 100 years ago, in 1910. The chair of the symposium was Sigmund Freud, and it was one of the last meetings of the Vienna Psychoanalytic Society (whose members included Carl Jung and Alfred Adler), which was presided over by Freud and held on Wednesday evenings in his living room (Berman et al., 2006). The fact that issues confronting us today were being discussed over a century ago is a useful reminder that the problem of youth suicide is not new, and that this topic has been a vexing and perplexing one for a very long time (Berman, 2009).

SUICIDE PREVENTION IN SCHOOLS: A BRIEF HISTORY

The ominous and troubling increases in youth suicide that occurred during the second half of the 20th century in the United States and other countries spawned the development and growth of suicide prevention programs in schools. The first U.S. studies and subsequent literature reviews that attempted to examine and evaluate these programs began appearing in the 1980s (e.g., Ashworth, Spirito, Colella, & Benedict-Drew, 1986; Nelson, 1987; Overholser, Hemstreet, Spirito, & Vyse, 1989; Ross, 1980; Spirito, Overholser, Ashworth, Morgan, & Benedict-Drew, 1988); grew more prevalent during the 1990s (e.g., Ciffone, 1993; Eggert, Thompson, Herting, & Nicholas, 1995; Garland & Zigler, 1993; Kalafat & Elias, 1994; Klingman & Hochdorf, 1993; LaFromboise & Howard-Pitney, 1995; Mazza, 1997; D. N. Miller & DuPaul, 1996; Orbach & Bar-Joseph, 1993; Reynolds & Mazza, 1994; Shaffer, Garland, Vieland, Underwood, & Busner, 1991; Shaffer et al., 1990; Zenere & Lazarus, 1997); and has continued into the 21st century (e.g., Aseltine & DeMartino, 2004; Ciffone, 2007; Kalafat, 2003; Mazza, 2006; Mazza & Reynolds, 2008; D. N. Miller et al., 2009; Randall, Eggert, & Pike, 2001; Robinson et al., 2013; Schilling, Aseltine, & James, 2016; Singer, Erbacher, & Rosen, 2019; Wasserman et al., 2015; York et al., 2013).

Developed initially in the 1970s, school-based suicide prevention programs grew rapidly during the 1980s. For example, Garland, Shaffer, and Whittle (1989) conducted a national survey of these programs and reported that the number of schools using them increased from 789 in 1984 to 1,709 in 1986. After a period of declining interest in these programs during the 1990s, a renewed interest in them was generated by several factors, including actions by the federal government, such as the *Surgeon General's Call to Action to Prevent Suicide* (U.S. Department of Health and Human Services, 1999) and grants provided through the Garrett Lee Smith Memorial Act (Goldston et al., 2010).

Earlier "first-generation" school-based suicide prevention programs (the subject of studies published in the 1980s) were criticized for their lack of focus regarding their target audience and objectives (Kalafat, 2003). An additional criticism of these programs, and one that may have undermined their effectiveness, was the finding that a large majority of student informational programs appeared to subscribe to a "stress model" of suicidal behavior (Garland et al., 1989). Although well-intended, this model presents a distorted and inaccurate view of suicidal behavior in youth. Specifically, it represents suicide as "a response to a significant or extreme amount of stress, ignoring the substantial amount of research that has shown that adolescent suicide and suicidal behavior are strongly associated with mental illness or psychopathology" (Mazza, 1997, p. 390). Research from clinical settings, for example, has demonstrated that a vast majority of youth who attempted suicide and were seen in a clinical setting had one or more diagnosable mental disorders (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999).

The "stress model" of suicide also has been criticized because it essentially normalizes suicide and suicidal behavior by suggesting that, given enough stress, anyone would be vulnerable to suicide, a position that is not supported by research (Mazza, 1997; D. N. Miller & DuPaul, 1996; D. N. Miller & Mazza, 2018). Program directors who used a stress model in their suicide prevention programs indicated that they avoided using a mental illness model because they feared that linking suicide to mental health problems would discourage youth from disclosing their own suicidal behavior or that of their peers (Garland et al., 1989).

Shaffer, Garland, Gould, Fisher, and Trautman (1988), however, noted that by "normalizing" suicide a stress model could make it a more acceptable behavior among students. They also argued that emphasizing the relationship between suicide and mental illness would make suicide a less appealing method for dealing with problems among potentially suicidal youth. Perhaps most significantly, their review of the literature suggested that informational programs appeared to be least beneficial to those students most likely to be suicidal. The recommendations made by Shaffer and his colleagues, which included essentially putting a "moratorium" on certain prevention programs, aroused significant controversy and discussion about the possible unintended side effects of such programs.

More recent "second-generation" school-based suicide prevention programs generally provided students with the more accurate information that suicide is not the result of stress but rather a possible by-product of serious mental health problems, most typically (but not always) depression. They also focused more on preparing students to respond effectively to their at-risk peers and demonstrated positive effects on student knowledge and intentions to seek help on behalf of their troubled peers (Kalafat, 2003; Mazza, 1997). However, like most other programs evaluated both before and since, they often did not specifically examine the effects of prevention programming on the *behavior* of students considered at risk for suicide.

More recent school-based suicide prevention programs provide students with the accurate information that suicide is not the result of stress, but rather a possible by-product of serious mental health problems, most typically depression.

These programs have also been criticized for assuming that changes in knowledge and attitudes will lead to behavioral change, which has not been empirically demonstrated (Berman et al., 2006; D. N. Miller & DuPaul, 1996; York et al., 2013). Although gains in student knowledge about youth suicide and changes in student perceptions about seeking help for problems through suicide prevention programs are important, they may not result in a reduction of actual suicidal behavior (Kalafat, 2003; Mazza, 1997; Mazza & Reynolds, 2008; D. N. Miller & Mazza, 2013, 2017, 2018).

Although it is difficult to identify a "typical" school-based suicide prevention program, a common one appears to be a curriculum-based, classroom-centered, lecture-discussion program, usually consisting of three to six classes at the high school level (Goldsmith et al., 2002). The goals of these programs have typically included (1) increasing awareness about youth suicide, (2) discussing and dispelling various myths and misinformation about suicide, (3) increasing student recognition of risk factors and possible warning signs, (4) changing attitudes about accessing help, and (5) providing information about resources in the school and community. Many programs also provide similar information and gatekeeper education sessions for school staff members. Some programs also use additional components, such as emphasizing peer support networks and teaching students problem-solving and crisis-management skills (D. N. Miller & Mazza, 2018).

The typical school-based suicide prevention program appears to be a curriculum-based, classroom-centered, lecture-discussion program, usually consisting of three to six classes at the high school level.

The proliferation of suicide prevention programs in the schools during the last several decades does not necessarily imply, however, that all school personnel approve of or support this development. In fact, school personnel may have several legitimate and reasonable questions and concerns about this issue. For example, how effective are school-based prevention programs? Why should schools be involved in youth suicide prevention? Is this problem really the responsibility of the schools?

EVALUATING SCHOOL-BASED SUICIDE PREVENTION PROGRAMS

The evaluation of school-based suicide prevention programs is a relatively recent development. A review of the global status of school-based suicide prevention programs in the early part of this century indicated that the United States and Canada were "in the forefront" (Leenaars et al., 2001, p. 381) of these efforts. An increasing number of countries are adopting some form of suicide prevention programming in their schools, including Japan, where suicide has been a taboo subject for centuries. Nevertheless, many underdeveloped countries have no school-based suicide prevention programs to speak of (or, for that matter, suicide prevention programs of any kind). Even among developed countries, school-based suicide prevention efforts were described as only being in the beginning stages of development and "lagging some 20 years behind" the United States and Canada (Leenaars et al., 2001, p. 381). Since that time, there has been an increase in published studies examining school-based suicide prevention programs in other countries, although they remain limited and many experience significant challenges in their development and maintenance (e.g., Wolf, Bantjes, & Kagee, 2015).

Given the relatively recent development of suicide prevention programs in schools, it is not surprising that research evaluating them is still in its infancy and that much more research is needed to evaluate their effectiveness. Of course, before evaluating something, we first need to define what it is we want to measure, and that can be more difficult than it may initially appear. For example, Chapter 1 described the importance of conceptualizing suicide as only one component of the broader construct of suicidal behavior. Viewed this way, the concept of "suicide prevention" becomes more expansive and can be understood as interventions to reduce *any* form of suicidal behavior, including suicidal ideation, suicide-related communication, suicide attempts, and suicide.

Additionally, evaluating the effectiveness of school-based suicide prevention programs is challenging for several reasons. First, although the most obvious way to determine program effectiveness would be to evaluate the degree to which it prevented suicides from occurring, it is almost impossible to measure in schools (Erbacher et al., 2015). Because a child's or adolescent's death by suicide is (thankfully) a rare event, as a low base-rate behavior it is inherently difficult to establish a direct causal connection between the implementation of school-based suicide prevention programs and a reduction in student suicides. Erbacher and her colleagues (2015) provide a useful hypothetical example of why this is the case:

> Let's imagine your school district implements a comprehensive suicide prevention program that provides universal and selective interventions services for all 100,000 students. In the year before the suicide prevention effort was implemented, 11 students died by suicide. If 9 students died by suicide the year following implementation, would your prevention program be considered effective? What if 13 students died by suicide? Statistically, it is impossible to demonstrate

> that your suicide prevention program was the cause of the +2/–2 variation in suicide deaths. Politically, it is impossible to celebrate 9 student deaths instead of 11. Further, you will never know how many lives were saved because of the program. Perhaps there would have been 23 suicides that year had no programming been implemented. There is no way to measure what could have happened. (p. 77)

Consequently, most school-based suicide prevention programs have not evaluated effectiveness in terms of reductions in death by suicide. Instead, most evaluation studies to date have focused on variables such as student reports of increased knowledge regarding suicide warning signs or school personnel reports of increased knowledge regarding how to identify and refer potentially suicidal youth (Erbacher et al., 2015). Other possible variables that can be measured and examined include the number of student referrals, the number of students seeking help, the number of reports of student suicidal ideation, and the number of reported suicide attempts before and after the implementation of a suicide prevention program. For example, some studies have demonstrated efficacy in reducing suicidal ideation and suicide attempts (Calear et al., 2016; Katz et al., 2013; Wasserman et al., 2015).

Although an increasing number of studies examining the effectiveness of school-based suicide prevention programs have been published in recent years, they remain relatively small. Many also exhibit serious methodological limitations, including establishing suicide-related outcomes, identifying mechanisms of change, and meeting the challenges associated with establishing control conditions, particularly a lack of randomized control trials (D. N. Miller et al., 2009; Robinson et al., 2013; York et al., 2013).

Randomized controlled trials (RCTs) are considered the "gold standard" when evaluating treatment outcomes. An RCT was used to examine the effectiveness of school-based suicide prevention programs conducted by Wasserman and her colleagues (2015), who randomly assigned 11,110 high school students from 168 schools in the European Union to one of three interventions or a control group. The primary outcome measure was the number of suicide attempts made at a 3-month and 12-month follow-up after intervention implementation. One of the interventions—the Youth Aware of Mental Health Programme (YAM)—was found to be effective at reducing both suicide attempts and suicidal ideation in comparison to the other treatment groups and the control group. More information about the YAM, a universal (Tier 1) suicide prevention program, is provided in Chapter 5.

Program evaluation is an essential but often overlooked aspect of suicide prevention in schools. Although it does not specifically address suicide prevention in schools, an excellent guide to program evaluation in schools within a multi-tiered systems of support (MTSS) framework is provided by Morrison and Harms (2018). Wandersman and Florin (2003) pose 10 questions about program evaluation that are useful to consider in evaluating school-based suicide prevention programs:

- What are the needs and resources in your schools?
- What are the goals, target population, and desired outcomes?
- How does the prevention or intervention program incorporate knowledge of science and best practices in this area?
- How does the prevention or intervention program fit with preexisting programs?
- What capacities do you need to put this prevention or intervention program into place with quality?

- How will this prevention or intervention program be carried out?
- How will the quality of implementation be assessed?
- How well did the prevention or intervention program work?
- How will continuous quality improvement strategies be incorporated?
- If the intervention is successful, how will the intervention be sustained?

EFFECTIVE ELEMENTS OF SCHOOL-BASED SUICIDE PREVENTION

Despite the limited number of studies currently available, our knowledge regarding the effective elements of school-based suicide prevention continues to accumulate. For example, providing school-based services that are comprehensive, in the sense that they address multiple components including suicide prevention, intervention, and postvention, is critically important (D. N. Miller & Mazza, 2018; Singer et al., 2019). In addition, effective programs identify at-risk and high-risk students, deliver services to them, and actively promote and support students seeking help for themselves and/or their peers who might be experiencing and exhibiting suicidal behavior. Given that youth will often disclose their suicidal thoughts and/or behaviors to peers rather than to adults, it is important that peers know who to turn to in their schools for help, as well as the resources available in the school and in their local community (D. N. Miller & Mazza, 2018; Singer et al., 2019).

Effective school-based suicide prevention programs should also be integrated into the school and be considered part of the general education curriculum (Mazza & Reynolds, 2008; D. N. Miller & Mazza, 2018). When these programs are provided, all students within a grade level or school are assured of receiving a universal set of interventions, while a subset of these students will receive additional services to meet their individual needs. This model is consistent with other population-based, public health models designed to provide academic, social, emotional, and behavioral supports in schools (Doll & Cummings, 2008a; McIntosh & Goodman, 2016). For example, the Collaborative for Academic, Social, and Emotional Learning (CASEL) recommends the implementation of social and emotional learning (SEL) programs in schools and advocates that they be an integral part of the academic curriculum rather than merely a supplement to it (CASEL, 2015).

A third aspect of effective programs is that the issue of youth suicidal behavior should be grounded in the field of mental health, with the understanding that mental health problems typically underlie and contribute to the development of suicidal behavior in children and adolescents. A lack of mental health problems, however, should not be viewed as synonymous with a high degree of mental health. Rather, mental health should be viewed on a continuum and from the perspective of a dual factor model (Suldo, 2016), which includes both mental health problems (i.e., psychopathology) as well as optimal mental health (i.e., few or no symptoms of psychopathology and a high level of subjective well-being). Providing this structure communicates to students that an absence of mental health problems should not necessarily be equated with optimal mental health. For example, Greenspoon and Saklofske (2001) and Suldo and Shaffer (2008) identified a subgroup of children who reported low psychological distress but also low levels of subjective well-being.

In addition to general programmatic aspects of school-based suicide prevention, we also know a great deal about what "works" in effective school-based suicide prevention. For example, we know that presenting information to students and school personnel can increase the knowl-

edge those groups have about youth suicidal behavior and can lead to an increased number of referrals to school mental health professionals (Kalafat, 2003; Mazza, 1997; D. N. Miller & DuPaul, 1996). We know that presenting information to students about youth suicide can help change their attitudes about it (Kalafat, 2003), and that discussing possible warning signs of suicide does not result in negative and unintended side effects, such as increasing negative mood or having the counterintentional effect of increasing suicidal behavior (Robinson, Calear, & Bailey, 2018; Rudd et al., 2006; Van Orden et al., 2006).

We know that providing information to students regarding suicide awareness and intervention, teaching them problem-solving and coping skills, and reinforcing protective factors while addressing risk factors may lead to improvements in students' problem-solving skills as well as reductions in self-reported suicide vulnerability (D. N. Miller et al., 2009; Singer et al., 2019). We know that there are reliable and valid screening and assessment measures and methods (Goldston, 2003; Gutierrez & Osman, 2009); that they can be used at schoolwide, classwide, and/or individual levels (Gutierrez & Osman, 2008; Reynolds, 1991); that they can effectively identify students who are at risk for suicide (Gutierrez & Osman, 2008, 2009); and that the use of these screening devices does not lead to an increased level of self-reported distress or suicidal behavior among students (Gould et al., 2005), as some had feared.

We know that schools can create and promote environments that actively support protective factors among students, resulting in a decreased likelihood of suicidal behavior. For example, students reporting a high degree of connectedness to their school were found to be less likely to report having suicidal thoughts or making suicide attempts (Marraccini & Brier, 2017). And perhaps most significantly, we know that some school-based prevention programs have demonstrated efficacy in reducing student suicidal ideation and attempts (Calear et al., 2016; Katz et al., 2013; Wasserman et al., 2015; Zenere & Lazarus, 2009).

INEFFECTIVE ELEMENTS TO AVOID

We also know that some approaches to school-based suicide prevention will likely *not* be effective, such as brief, one-time-only inservice programs (Kalafat, 2003). Students frequently do not retain the information that was taught, and there is rarely any follow-up to determine if students are using or benefiting from the content. They do not allow for adequate time and resources to be effective, nor do they allow the opportunity to monitor all students' reactions to the material presented. Like other mental health programs of short duration, any knowledge gains do not necessarily equate with behavioral change, and behavioral change is the most important variable to consider in suicide prevention (D. N. Miller & Mazza, 2018).

Suicide prevention programs should not include media depictions of suicidal behavior or presentations by youth who have made previous suicide attempts, because research suggests that they may be counterproductive for vulnerable youth, including possibly increasing the possibility of contagion effects (an issue that will be discussed extensively in Chapter 8). Although the use of outside consultants for developing or evaluating prevention programs can be beneficial, completely outsourcing prevention programs rather than developing local expertise among existing school personnel fails to enhance available local resources and therefore is not recommended. Poorly implemented programs that lack treatment integrity, regardless of their quality or the frequency of their use, will likely not have positive effects on student behavior.

Finally, suicide prevention programs may be ineffective when they fail to teach students explicit skills for helping them reduce any suicidal behavior they may be experiencing as well as the mental health problems that typically underlie suicidal behavior (D. N. Miller & Mazza, 2018; Singer et al., 2019). Given that psychotherapeutic interventions such as DBT (Linehan, 1993) have demonstrated empirical effectiveness in reducing suicidal behavior in adolescents (McCauley et al., 2018; A. L. Miller et al., 2007), integrating the core components of this therapeutic approach would appear to be beneficial (D. N. Miller & Mazza, 2018). Mazza and his colleagues (2016) developed a curriculum program that involves teaching DBT skills to adolescents to assist in emotion regulation problems, including (but not limited to) suicidal behavior. This program (discussed in Chapter 5) provides one model of what schools can do to address students' SEL, which can both promote mental health and potentially decrease the likelihood of suicidal behavior.

Although much remains to be learned about school-based suicide prevention, what we already do know is substantial, and this knowledge can and should be used in schools to reduce youth suicidal behavior. One example of how prevention efforts can lead to meaningful change involves a large district in southern Florida. Data collected over three decades in the Miami–Dade Public School District provide compelling anecdotal evidence that school-based suicide prevention can indeed reduce the incidence of youth suicide. The suicide prevention programs implemented in the Miami–Dade public schools are particularly interesting because they remain one of the few examples of a school-based suicide prevention program demonstrating long-term reductions in actual suicidal behavior rather than simply changes in students' knowledge and attitudes about suicide. In addition, the programs implemented in the Miami–Dade school district are noteworthy for their universal, districtwide focus.

SUICIDE PREVENTION IN THE MIAMI–DADE COUNTY PUBLIC SCHOOL DISTRICT

Located in Miami, Florida, the Miami–Dade County Public School District is the nation's fourth largest, serving 345,000 students in 392 school sites. The district is urban and highly diverse, with students speaking 56 different languages and representing 160 different countries of origin.

In 1988, 18 students died by suicide in the Miami–Dade district. The level of alarm and concern generated by these suicides provided the impetus for developing a districtwide suicide prevention program, which formally began the following year. The prevention program included multiple components at multiple levels, which have been modified as needed in the intervening years since the program began.

The effects of the prevention program on various aspects of suicidal behavior, including suicidal ideation, suicide attempts, and suicide, was conducted over a 5-year period. Both the number of student suicide attempts and the number of student suicides decreased substantially following program implementation (Zenere & Lazarus, 1997). Despite its methodological limitations, this case study provided initial evidence that school-based suicide prevention programs can potentially reduce youth suicidal behavior, including its most serious forms (i.e., suicide attempts and suicide). It was also the only study found in a literature review to demonstrate promising evidence for educational/clinical (as opposed to merely statistical) significance (D. N. Miller et al., 2009). A follow-up longitudinal study over an 18-year period indicated that the

reduction in the number of both student suicide attempts and student suicides has been sustained over time (Zenere & Lazarus, 2009), including through the 2017–2018 school year (F. J. Zenere, personal communication, July 30, 2018).

Although Miami–Dade is the only school district I am aware of that has collected and published data on the effects of its suicide prevention programs over an extensive period, it is not the only major metropolitan school district implementing suicide prevention programs on a massive districtwide level. For example, the Los Angeles Unified School District (LAUSD), which includes 1,147 schools, serves approximately 734,000 students, and is second in size only to the New York City Public Schools, began implementing a youth suicide prevention program in 1986. The LAUSD provides a variety of suicide prevention, intervention, and postvention services, including training school personnel about the risk factors and warning signs of suicide, providing consultative support services, training crisis teams, and implementing postvention support in the aftermath of a student, staff, or parent death by suicide (Lieberman et al., 2008).

COMPONENTS OF COMPREHENSIVE SCHOOL-BASED SUICIDE PREVENTION PROGRAMS

Berman and colleagues (2006) identified seven components that from their perspective characterized comprehensive school-based suicide prevention programs: (1) early detection and referral-making skills, (2) resource identification, (3) help-seeking behavior, (4) professional education, (5) parent education, (6) primary prevention, and (7) postvention. Each of these components is now briefly described.

Early detection and referral-making skills refers to the need to teach students and school personnel the risk factors and possible warning signs of suicide, as well as what they should do and what procedures they should follow in making a referral if they suspect a student might be suicidal. *Resource identification* is necessary because an effective referral requires having competent professionals in the school to conduct suicide risk assessments and competent professionals in the community to whom referrals can be made if necessary. Community resources, mental health agencies, psychiatric hospitals, and private practitioners can be evaluated to ensure the competencies of those professionals to whom at-risk or high-risk students may be referred. Resources in the school designed to help students should also be clearly communicated to them (Berman et al., 2006). Further information on these topics is presented in Chapters 5 and 6.

One of the collateral benefits of resource identification for students is that it makes the idea of *help-seeking behavior* more normative (Berman et al., 2006). When schools and communities demonstrate concern about the need to provide services to suicidal youth as well as the quality of those services, awareness increases as well as the potential for greater destigmatization of suicidal people. As a result, a greater acceptance of resource utilization may be created. It is even possible that student compliance with treatments might increase. Related to resource identification is *professional education*, in the sense that an improvement in school personnel's education regarding youth suicide increases the schools' identified resources (Berman et al., 2006). Further information on these topics is provided in Chapters 1 and 5.

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If the broad view of the school's role includes educating all segments of the community, then *parent education* regarding youth suicide is an important component of school-based suicide prevention efforts as well. Parents or caregivers should be provided with information regarding the risk factors and warning signs for suicide in much the same way that this information is provided to students and school personnel. In addition, given that most youth suicides occur by use of a handgun and take place in the home, outreach programs on gun management and safety can be conducted for parents (Simon, 2007), particularly those with sons or daughters considered at risk or at high risk for suicidal behavior (Berman et al., 2006). The issue of guns and youth suicide is discussed extensively in Chapter 4.

Parents/caregivers should be provided with information regarding risk factors and warning signs for suicide in much the same way that this information is provided to students and school personnel.

Primary prevention strategies (what are described as *universal* or Tier 1 strategies in this book) are likely "the most effective and probably the most cost-effective" (Berman et al., 2006, p. 320) procedures available for school personnel in suicide prevention efforts. Berman and his colleagues (2006) recommend that these programs teach health-enhancing behaviors through teaching behavioral skills. They recommend that these programs begin in elementary school, that they be reinforced through follow-up training, and that they focus on building students' adaptive skills and competencies. Universal (Tier 1) strategies are discussed in Chapter 5.

Finally, these authors suggest that comprehensive, school-based suicide prevention programs should contain *postvention* procedures. As defined by Berman and colleagues (2006), these procedures should be followed not only if or when a student dies by suicide, but also in those situations in which a serious but nonfatal suicide attempt occurs. For example, postvention procedures would be used in situations in which a student made a damaging suicide attempt, was then hospitalized for several days as a result, and is now returning to school. These issues are discussed briefly in Chapter 7 and more prominently in Chapter 8.

In addition to their comprehensive approach to school-based suicide prevention, one of the clear advantages of these components is the relative ease with which they can be implemented in comparison to other schoolwide initiatives. Unlike some other schoolwide programs (e.g., schoolwide positive behavior intervention and support), implementing the recommendations listed above need not be as costly either financially or in terms of the time and effort of the school staff, and would likely be easier to develop and maintain. Their relative ease of implementation, however, is only one advantage of school-based suicide prevention programs. There are many more important reasons why schools should be involved in suicide prevention, as now described.

WHY SHOULD SCHOOLS BE INVOLVED IN SUICIDE PREVENTION?

In addition to emerging evidence that school-based suicide prevention programs can be effective (e.g., Kalafat, 2003; D. N. Miller et al., 2009; Robinson et al., 2013; Singer et al., 2019; Wasserman et al., 2015; York et al., 2013; Zenere & Lazarus, 1997, 2009), schools should be involved in youth suicide prevention efforts for many other reasons. First, given the substantial amount of time that children and adolescents spend in school, educational facilities provide an ideal

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place for focused, suicide prevention efforts. Schools are places where "student attention is held relatively captive, where teaching and learning are normative tasks, and where peer interactions can be mobilized around a common theme" (Berman et al., 2006, p. 313). Second, as is discussed in greater detail later in this chapter, school personnel have an ethical responsibility to make reasonable and appropriate efforts to prevent youth suicide whenever possible, including creating clear policies and procedures regarding this topic (Jacob, 2009).

School personnel have an ethical responsibility to make reasonable and appropriate efforts to prevent youth suicide whenever possible, including creating clear school policies and procedures regarding this topic.

Third, a strong relationship exists between youth suicide and mental health problems, and school personnel are being increasingly asked to take on a greater role in addressing these issues, particularly in the areas of prevention and mental health promotion (Mazza et al., 2016; D. N. Miller, Gilman, & Martens, 2008; Power, DuPaul, Shapiro, & Kazak, 2003). Although some school personnel may question the appropriateness of this responsibility, they ultimately have little choice in the matter, given that no institution other than the school system oversees the mental health needs of children and adolescents (Mazza & Reynolds, 2008). The presence of mental health problems is a primary risk factor for the development of suicidal behavior, and both preventing and providing treatment for mental health problems is a major characteristic of effective suicide prevention programs.

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A fourth reason that schools should be involved in suicide prevention is the shortage of mental health professionals trained to respond to youth suicidal behavior. In general, adequate training among mental health professionals in the assessment and management of suicidal individuals is surprisingly limited (Schmitz et al., 2012), and this extends to school-based mental health professionals. For example, several national surveys indicate that school psychologists perceive themselves as requiring additional training in suicide risk assessment (D. N. Miller & Jome, 2008), prevention and intervention (Debski et al., 2007; D. N. Miller & Jome, 2010), and postvention (O'Neill et al., 2020). Given this situation, a variety of school practitioners would clearly benefit from additional information and training on these topics.

Another important reason for school personnel to be more actively involved in suicide prevention is its relationship to the school's primary function—education. For example, low academic achievement has been found to be associated with both depression and suicidal behavior (Thompson, Connelly, Thomas-Jones, & Eggert, 2013). One study found that adolescents with poor reading ability are more likely to experience suicidal ideation or attempts and to drop out of school than youth with typical reading ability, even when controlling for psychiatric and demographic variables (Daniel et al., 2006).

Similarly, there may also be a relationship between *perceived* academic performance and youth suicidal behavior. For example, one study found that perceptions of failing academic performance were associated with an increased probability of a suicide attempt among a group of adolescents, even when controlling for self-esteem, locus of control, and depressive symptoms (Richardson, Bergen, Martin, Roeger, & Allison, 2005). A longitudinal follow-up study found that perceived academic performance, along with self-esteem and locus of control, were significantly associated with suicidal behavior, with perceived academic performance found to be a particularly good long-term predictor (Martin, Richardson, Bergen, Roeger, & Allison, 2005).

To avoid any possible confusion, these findings should *not* be interpreted as suggesting that child or adolescent academic problems, or even perceived academic problems, will generally or inevitably result in increased student suicidal behavior. Based on what we know about possible causal variables associated with suicide, academic problems would not, by themselves and in isolation, lead to the development of suicidal behavior. Nevertheless, these and other studies illustrate the significant relationship between students' mental health and their academic achievement (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Taylor, Oberle, Durlak, & Weissberg, 2017) and provide the useful reminder that improvement in one of these areas can have positive effects in the other (D. N. Miller, George, & Fogt, 2005). For example, improving students' academic success often has the collateral effect of enhancing students' behavior and mental health (Berninger, 2006). Consequently, effective mental health interventions and effective academic interventions should be viewed as complementary and integrally related.

LIABILITY ISSUES, LEGISLATIVE OUTCOMES, ETHICAL RESPONSIBILITIES, AND BEST PRACTICES

If these reasons are not persuasive enough, there are also legal, legislative, and ethical reasons that school personnel should adopt school-based suicide prevention programs. Liability issues involving schools and youth suicide, legislation requiring school-based suicide prevention programs, and the ethical responsibilities that school personnel have in preventing youth suicide and responding to youth suicidal behavior are each discussed in the next sections, along with the importance of best practices when implementing school-based prevention programs.

Liability Issues

School districts, as well as school employees, can and have been sued by parents or caregivers under conditions in which a student has died by suicide. Some school personnel may understandably fear being held liable for a student's suicide if they fail to adequately inform others—especially parents and caregivers—about a student's potentially suicidal behavior. This concern is likely the result of the well-known case of *Tarasoff v. Regents of the University of California* (1976), which established that a psychotherapist has a duty-to-warn if the therapist's client poses a serious threat to others. What does *not* appear to be widely known, however, is that the *Tarasoff* decision has not been universally adopted by other courts, and even California's highest court refused to extend the *Tarasoff* duty-to-warn requirement to cases involving suicide (Fossey & Zirkel, 2011).

A review of published court decisions in which families have sought to hold school officials liable for students' suicides reveals that a vast majority of these decisions were found in favor of school officials (Fossey & Zirkel, 2004, 2011; Jacob, Decker, & Timmerman Lugg, 2016; Zirkel, 2019; Zirkel & Fossey, 2005). In addition, *none* of these decisions at the time of this writing have resulted in a school-based mental health professional or other school employee being held liable for a damages award. As summarized by Zirkel (2019) in his comprehensive review of the published case law in this area through early 2019, "the outcome odds for plaintiffs (i.e., parents) are low against school districts and—based on the deeper pockets of the district and the lesser legal bases applicable

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to individual defendants—negligible for school psychologists or other district employees" (p. 30). Although this is of course subject to change in future judiciary decisions, courts have clearly been reluctant to hold school personnel liable for youth suicides under a variety of circumstances (Fossey & Zirkel, 2011; Jacob et al., 2016; Zirkel, 2019).

School personnel should understand that the liability issues involving schools and suicide typically involve the related issues of *negligence* and *foreseeability*. In the context of suicide, negligence may be defined as "a breach of duty owed to an individual involving injury or damage (suicide) that finds a causal connection between a lack of or absence of duty to care for the student and his or her subsequent suicide" (Erbacher et al., 2015, p. 52). For example, if a student dies by suicide and the student's parents or caregivers believe that school personnel were negligent in not preventing their child's death when they could have reasonably done so (e.g., school personnel failed to monitor a student in school when it was known the student was imminently suicidal), school personnel may be held liable by the courts.

School personnel should understand that the liability issues involving schools and suicide typically involve issues of *negligence* and *foreseeability*.

Additionally, school personnel put themselves at risk for potential lawsuits if they do not act appropriately to prevent a *foreseeable* suicide. All school personnel have a duty to protect students "from reasonably foreseeable risk of harm" (Jacob, 2009, p. 243). Schools can be held liable "if it is found that a reasonable person would have been able to recognize that a student was in an acute emotional state of distress and that self-harm or danger, in some way, could and should have been anticipated" (Erbacher et al., 2015, p. 52). That said, "foreseeability is not synonymous with predictability" (Berman, 2009, p. 234). Rather, foreseeability refers to a "reasonable assessment of a student's risk for potential harm" (Berman, 2009, p. 234). Of course, what is considered "reasonable" is open to interpretation, but in general the courts have given schools wide latitude in this regard (Fossey & Zirkel, 2011; Zirkel, 2019).

An example of a school district that was held liable in the wake of a student's suicide is *Wyke v. Polk County School Board* (1997). In this case, a 13-year-old student named Shawn Wyke died by suicide in his home in 1989 after two prior suicide attempts (both by hanging) at his school. Shawn's mother, Carol Wyke, sued the Polk County School Board, claiming that her son's death by suicide had been foreseeable and that the school district was negligent in not preventing it. At the time of his death, Shawn was living with Helen Schmidt, the mother of Carol Wyke's ex-boyfriend. The trial revealed clear evidence that the school failed to notify either Carol Wyke or Helen Schmidt about either of Shawn's suicide attempts at the school. The jury ruled against the school district, holding it liable for not offering suicide prevention programs, for not providing adequate supervision of Shawn, and for failing to notify either Carol Wyke or Helen Schmidt that Shawn was suicidal. As noted by Erbacher and colleagues (2015) "This case should have resulted in all schools increasing and documenting suicide prevention training for staff and developing guidelines to ensure that parents are promptly notified of the suicidal behavior of their child, but unfortunately few school administrators are aware of the important lessons from this case" (p. 57).

Another example of a school district being found liable for a student's suicide is *Armijo v. Wagon Mound Public Schools* (1998). In this case, a 16-year-old student named Philadelphio Armijo died by suicide from a self-inflicted gunshot wound after he was suspended for allegedly threatening violence toward a teacher who had reported him for harassing an elementary school student. The school principal directed a school counselor to drive Armijo to his home but did not attempt to contact his parents. Evidence presented during the case indicated that Armijo had engaged in suicidal behavior and that the school knew about it. For example, on the day of his suicide, Armijo reportedly told a school aide that he might be "better off dead." In the view of

the Tenth Circuit Court of Appeals, there was evidence demonstrating that the principal and the counselor left Armijo alone at home, with access to a firearm, when they knew he was suicidal.

School personnel can and have been sued for actions such as failing to notify parents regarding their child's suicidal communications, failing to intervene in situations in which a student communicated a suicide plan, and failing to follow established school policies and procedures related to youth suicidal behavior (Berman, 2009). Although schools and school employees who have been sued under these conditions have typically not been found liable by the courts, any school board member, school administrator, or school staff member can attest that lawsuits directed against one's own school district—or to a school district employee—should be avoided whenever possible. The cost of such lawsuits, not only in monetary terms but also in time, labor, and the bad publicity such lawsuits generate, is extensive, regardless of the outcome.

School personnel can and have been sued for actions such as failing to notify parents regarding their child's suicidal communications, failing to intervene in situations in which a student communicated a suicide plan, and failing to follow established school policies and procedures related to youth suicidal behavior.

What should school personnel do to decrease the probability of becoming targets of a lawsuit related to youth suicidal behavior? First, they should be aware that lawsuits have seldom, if ever, occurred except under the conditions that (1) a student dies by suicide and (2) the parents or caregivers of the deceased youth believed that school personnel could have prevented it but failed to do so. Many school administrators and other school practitioners, in dealing with the numerous daily challenges confronting our nation's schools, may understandably react to the previous statement with relief. For example, some school personnel may have experienced a student's suicide rarely if at all, depending on their years of experience and other factors.

Although even one child or adolescent suicide is one too many, the relative infrequency of youth suicide (although *not* suicidal behavior, as we saw in Chapter 1), at least compared to other problems faced by students and schools, may give school personnel a false sense of security. Youth suicide does occur, frequently when it is least expected, and school personnel are often left confused, scared, and floundering about what to do when it does. This lack of planning and foresight also creates the heightened probability that mistakes will be made in response to a student's death by suicide, resulting in the increased possibility of litigation. Indeed, the results of several court cases, such as *Kelson v. The City of Springfield* (1985), *Eisel v. Board of Education of Montgomery County* (1991), and the aforementioned *Wyke v. Polk County School Board* (1997), have been interpreted to suggest that schools should develop clear suicide prevention policies and procedures, including notifying parents or caregivers of any suspected or possible suicidal behavior exhibited by their child and ensuring that school personnel be adequately oriented to the school's policies and procedures regarding youth suicidal behavior (Jacob et al., 2016).

School personnel would also be well advised to be less concerned about avoiding lawsuits related to suicide and more concerned about taking proactive steps to better prevent suicide in their schools (Erbacher et al., 2015). As noted by Erbacher and colleagues (2015), "rather than risking the time, money, stress, and stigma of being involved in a lawsuit, schools should do everything in their power to prevent a suicide from occurring" (p. 51). Zirkel (2019), a lawyer and leading expert on the case law involving suicide and the schools, comes to a similar conclusion: "Instead of fear of liability . . . the focus should be on ascertaining and adopting the evidence-based best practices related to student suicide that are the hallmarks of successful schools" (p. 31).

That said, school district personnel (particularly school administrators) will understandably want to have a clear understanding of any potential liability issues when implementing school-based suicide prevention programs. To that end, they should be cognizant of the seminal

court cases previously mentioned as well as future court cases as they appear. Erbacher and her colleagues (2015) offer several recommendations for how school personnel can best protect themselves from liability issues related to student suicide:

- *Maintain liability insurance.* Health and mental health professionals in schools, including school psychologists, school counselors, school social workers, and school nurses, should consider acquiring individual malpractice insurance.
- *Seek supervision from colleagues.* Although school-based mental health professionals should be competent in the areas of suicide prevention, risk assessment, intervention, and postvention, consulting with other professionals provides additional perspectives and increases the probability of an effective response.
- *Keep good records.* Documentation is critical, as without records there is no evidence. All actions that were taken regarding a potentially suicidal student, including suicide risk assessments, should be documented. Careful documentation and record keeping can save a school district from an unfavorable ruling in the courtroom.
- *Document crisis training.* Mandatory crisis training in suicide prevention should be provided to all school personnel. Dates of trainings and the names of the individuals attending them should be documented, as should the components of the training.
- *Provide best-practice response.* All schools should be engaging in evidence-based suicide prevention, intervention, and postvention. Doing so greatly limits the potential of being found liable by the courts.

Legislation

In addition to court cases, governmental legislation, particularly at the state level, has resulted in required training for many school-based professionals in youth suicide prevention. For example, the Jason Flatt Act (named after the son of Clark Flatt, who founded the youth suicide prevention organization known as the Jason Foundation after his son died by suicide) requires all educators in a state to complete youth suicide awareness and prevention training to gain and maintain teacher certification. The Jason Foundation provides online resources for training at no cost to school districts. The Jason Flatt Act has been mandated in 20 states as of this writing, including Alabama, Alaska, Arkansas, California, Georgia, Idaho, Illinois, Kansas, Louisiana, Mississippi, Montana, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming.

Eleven states (Alaska, Delaware, Georgia, Idaho, Iowa, Kansas, Louisiana, Maryland, Nebraska, Tennessee, and Texas) at the time of this writing mandate annual suicide prevention training for school personnel. Twenty other states (Arizona, Arkansas, Connecticut, Illinois, Indiana, Kentucky, Maine, Massachusetts, Mississippi, Nevada, New Jersey, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, Washington, West Virginia, and Wyoming), plus the District of Columbia, mandate training in suicide prevention for school personnel but do not require the training to occur annually. The state of California mandates that training in suicide prevention be offered, but it is not an individual teacher requirement. Thirteen states (Alabama, California, Colorado, Florida, Michigan, Minnesota, Missouri, Montana, New York, North Dakota, Oklahoma, Rhode Island, and Wisconsin) at the time of this writing have laws in place that encourage training in suicide prevention for school personnel.

Twenty states (Alabama, California, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Mississippi, Missouri, Montana, Nevada, Oregon, Pennsylvania,

Tennessee, Utah, and Washington) at the time of this writing, plus the District of Columbia, require statewide school suicide prevention, intervention, and postvention policies and/or suicide prevention programming. An additional seven states (Arkansas, Louisiana, Maryland, New Jersey, Oklahoma, Texas, and Virginia) encourage such policies and or programming.

School personnel, especially those involved in suicide prevention, should be aware of the requirements and policies of their state. Unfortunately, there is some evidence that this may not be occurring as much as it should. For example, a national study of high school principals found that only about 25% accurately identified their states' laws regarding school-based suicide prevention, and that only 66.1% reported that their schools' suicide prevention programs were in complete compliance with their states' laws (Smith-Millman & Flaspohler, 2019).

All schools and school districts should also have clear policies and procedures regarding youth suicidal behavior and how to respond to it. Clearly articulated policies and procedures provide schools with a mechanism for responding consistently and proactively to youth suicidal behavior and help to guide and support school personnel in their actions (additional information on this topic is provided in Chapter 3). Developing school-based policies and procedures related to youth suicidal behavior is recommended not only because it is legally required (as it is in many states), but also because it is a prime example of both *ethical responsibilities* and *best practices,* which are discussed next.

Ethical Responsibilities

In contrast to laws, which are "a body of rules of conduct prescribed by the state that has binding legal force," *professional ethics* refers to "a combination of broad ethical principles and rules that guide the conduct of a practitioner in his or her professional interactions with others" (Jacob et al., 2016, p. 22). Individuals working in schools are professionals, regardless of their role and function, and therefore they have ethical responsibilities to the children and adolescents they serve. Engaging in a professionally ethical manner involves the application of ethical principles and specific rules to the problems that inevitably arise in professional practice (Jacob et al., 2016).

Many professionals working in the schools, including school-based mental health professionals, are considered responsible for exhibiting professional behavior typically outlined in what often is referred to as "codes of conduct." A crucial distinction between laws and ethics is that professional codes of ethics are generally viewed as requiring decisions that are "more stringent" (Ballantine, 1979, p. 636) than required by law, and frequently require that professionals alter their behavior accordingly to meet these higher ethical standards (Jacob et al., 2016). For example, the American Psychological Association (2017) makes clear that if its "Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard" (p. 3).

Professional codes of conduct often require that school personnel behave in ways that are more stringent than required by law, and frequently require that professionals alter their behavior accordingly to meet these higher ethical standards.

Consequently, practitioners in the schools should be mindful that although they must meet legal requirements in terms of youth suicide prevention, they also have a duty to behave ethically in doing so, and that conforming to ethical codes often requires a higher level of responsibility than merely following the law (D. N. Miller, 2014). Moreover, there is a distinction between *ethical codes* and *ethical conduct.* Although ethical codes "provide guidance for the professional in his or her decision making," ethical conduct "involves careful choices based on

knowledge of broad ethical principles and code statements, ethical reasoning, and personal values" (Jacob et al., 2016, p. 4).

To illustrate these points, consider this situation: imagine you are by yourself, relaxing by a lake, and reading an enjoyable book on a warm summer day. The sun has recently set and the lifeguard who was on duty has left for the day. Suddenly, you hear someone screaming for help. You look up and see an adolescent boy flailing in the water, his arms waving wildly, a look of panic on his face. All signs indicate that he is not able to swim. You quickly perceive that unless someone immediately helps this boy he may drown. You also realize that the lifeguard previously on duty has left, that no one else is around, and that you are the only one in earshot of the boy able to hear his increasingly urgent pleas for help.

What would you do? In most states, there is no legal duty to help or rescue another person. Consequently, there would typically be no legal obligation requiring you to jump into the water and attempt to rescue the person in distress, and your failure to do so would have no legal ramifications. Would you therefore ignore his plea for help? Of course not. Why? Because although attempting to help the person in this situation is not a legal mandate, most of us would agree that it is the ethically appropriate thing to do. Or, said another way, it is the morally and ethically "right" thing to do, given widely accepted cultural and societal values.

There are three important ethical issues that should be considered when working with potentially suicidal youth in schools: (1) confidentiality, (2) competence, and (3) advocacy.

Confidentiality

Confidentiality may be defined as "an explicit promise or contract to reveal nothing about an individual except under conditions agreed to by the source or subject" (Siegel, 1979, p. 251). In most cases involving interactions between students and school personnel, the student's concerns would normally be kept confidential. An exception to this requirement, however, is if the student reveals thoughts or behaviors related to possible suicide, in which case the student's parents or caregivers should be notified. Jacob and her colleagues (2016) state that "parents must be contacted in all cases [of possible suicide], whether the risk is determined to be low or high" (p. 215). Some school-based mental health professionals may view parental notification as overly restrictive and potentially damaging to the student–professional relationship but. as bluntly noted by Erbacher and colleagues (2015), "while it may upset the student that you are divulging private information to his or her parents or other necessary school staff, it will be less difficult to repair rapport with a student who is alive than to deal with the potential outcomes if he or she does attempt or die by suicide without parent notification" (p. 62).

The failure to notify parents/guardians in situations where there is reason to suspect that a student may be suicidal is the single most common source for lawsuits (Berman et al., 2009). When there is reasonable evidence that a student may be contemplating suicide, confidentiality must be disregarded, and parents or guardians must be notified. School personnel have a legal and ethical obligation to report any student who is suspected to be potentially at risk for suicide based on the principle of foreseeability discussed earlier. This obligation holds "even if a student denies suicidal ideation or intent" as "it is the duty of the school to notify the parents if information available implies that the student may be suicidal, and it is considered negligence for school personnel to refrain from doing so" (Erbacher et al., 2015, p. 62). Parental notification in cases of suspected suicide should always be documented, ideally with a parental or caregiver signature.

Three issues may arise in situations when it becomes necessary to warn parents that their child might be suicidal. First, in situations where there is suspected child abuse or neglect in the home, school personnel should first contact child protective services. Second, child protective services should be contacted if the parents or guardians refuse to ensure their child's safety, refuse to seek mental health services for their child, and/or do not take their child's suicidal risk seriously. Third, in situations when parents or caregivers may be uncooperative, such as refusing to either personally talk to their child or to pick their child up at school and bring him or her home safely, school personnel should not allow the student to walk or take the bus home without adult supervision (Erbacher et al., 2015).

Competence

School personnel are ethically required to act within their level of competence and not exceed their knowledge and training (Jacob et al., 2016). The term *competent* generally suggests that "the practitioner is able to integrate professional knowledge and skills with an understanding of the client and situation and make appropriate decisions, based on a consideration of both the immediate and long-term effects" (Jacob et al., 2016, p. 16). This indicates that school-based mental health professionals, who most likely possess knowledge, skill, and competence in addressing the mental health problems experienced by youth, should ensure that they are competent in multiple skills related to school-based suicide prevention and take the lead in developing school-based suicide prevention programs. Given their training and experience, school-based mental health professionals would be considered more appropriate for this task than other school employees (e.g., teachers, administrators), who likely lack the necessary knowledge and skills for this role. Because preventing youth suicide is a critical role for school-based mental health professionals, they are ethically obligated to continually evaluate and update their skills in this area.

Advocacy

Advocacy is an important but often underappreciated ethical responsibility of school personnel. As stated in the Professional Standards of the National Association of School Psychologists (NASP; 2020), school psychologists are expected to "act as advocates for all students" (p. 39). In the context of suicide prevention, this suggests that school psychologists (and, by extension, other school-based mental health professionals) should strive to advocate for suicidal youth who, like other vulnerable student populations such as sexual minority youth (e.g., Jacob, 2013), may be stigmatized and/or marginalized by other students (and/or by school personnel) for their suicidal behavior and the mental health problems that typically underlie it.

As just one example, school-based mental health professionals should be aware that many students may not benefit from school-based suicide prevention programs because they are frequently not in school. These include students who are "suspended, housing insecure, in detention, emergency shelters, residential treatment facilities, hospitals, or whose parents have prevented them from participating in suicide prevention programs" (Singer et al., 2019, p. 68). Advocating for these students (who are often marginalized and at a higher risk for suicidal behavior than other students), as well as working collaboratively with others to ensure that they receive adequate supports, is an important role for school-based mental health professionals.

In addition to and in conjunction with expecting professionals to act as advocates, the NASP Principles for Professional Ethics (2010) requires that professionals provide "effective services"

(p. 302) to the youth they serve. Although what is meant by the term "effective services" is not defined, the use of it implies that any services provided demonstrate evidence-based utility. Advocacy requires a proactive (rather than a reactive) approach, and school personnel working with children and adolescents are encouraged to "strive for excellence rather than meeting minimal obligations outlined in codes of ethics and law" (Jacob et al., 2016, p. 315).

Best Practices

Best practices refer to methods, strategies, or techniques that have been demonstrated empirically to lead to more beneficial outcomes for students. Crucially, best practice is *informed* by legal requirements and ethical responsibilities but need not be *limited* by them. That is, although school personnel should behave in ways congruent with legal mandates and their code of professional ethics, meeting these requirements should simply be viewed as the minimum standard expected and does not necessarily reflect or limit what professionals *could or should do*.

Best practice is *informed* by legal requirements and ethical responsibilities but need not be *limited* by them.

For example, providing evidence-based prevention and intervention strategies in schools, whether they are the suicide prevention programs described in this book or one of many other prevention and/or intervention programs (e.g., for substance abuse or bullying), are generally neither legally nor ethically required. However, the use of such programs is not only justified, but also strongly recommended because they serve the broader and best interests of children and adolescents. In other words, such programs exemplify best practices.

CONCLUDING COMMENTS

Many years ago, Robert Horner of the University of Oregon gave a guest lecture at Lehigh University to a group of graduate students who were training to work in schools. "The job of school personnel," he said at one point, "is broader than education alone. It is to alter the trajectory of our students' lives." This memorable statement is a useful reminder of the powerful influence school practitioners have in modifying students' behaviors, improving their outcomes, even changing their lives. Effective school-based suicide prevention programs can potentially do all these things. Indeed, not only can they change lives, they can save them.

School-based suicide prevention programs attempt to accomplish one of the most significant and meaningful goals imaginable—to save young lives from an unnecessary and premature death.

The primary justification for school-based suicide prevention programs is not that their use may better avoid legal entanglements or potential lawsuits, although that outcome is certainly advantageous. Rather, the primary justification for implementing them is that it is the ethically and professionally responsible thing to do. It is ethically and professionally responsible because these programs attempt to accomplish one of the most significant and meaningful goals imaginable—to save young lives from an unnecessary and premature death. What could be more important than that?