STRATEGIES TO IMPROVE YOUTH SUICIDE PREVENTION IN SCHOOLS & COMMUNITIES

The Final Report of the Social Worlds & Youth Well-Being Study Front Range, Colorado

October 2021

Anna S. Mueller,* PhD, Indiana University Bloomington

Sarah Diefendorf, PhD, Indiana University Bloomington

Seth Abrutyn, PhD, University of British Columbia

Katie A. Beardall, Indiana University Bloomington

Robert Gallagher, Indiana University Bloomington

J'Mauri Jackson, Indiana University Bloomington

Yingjian Liang, Indiana University Bloomington

Hillary Steinberg, PhD, Drexel University

James Watkins, Indiana University Bloomington

Hannah Worton, Indiana University Bloomington

*Address correspondence to Dr. Anna S. Mueller, the Luther Dana Waterman Associate Professor of Sociology at Indiana University: Mueller1@iu.edu or SWStudy@iu.edu

Note: All authors made substantial contributions to data collection, analysis, and the writing of this report.

Version 1.0

© 2021 Anna S. Mueller, Sarah Diefendorf, Seth Abrutyn and the Social Worlds & Youth Well-being Research Team. This report is made available under the CC-BY Attribution 4.0 International license <https://creativecommons.org/licenses/by/4.0/>

Table of Contents

<i>Acknowledgments</i>	4
<i>Funding</i>	5
<i>Executive Summary</i>	6
Methodology	6
School Strategies to Support Youth Well-Being	6
Supporting Youth Well-Being Beyond the School	8
Advice from Youth	11
Conclusion	11
<i>Policy Recommendations</i>	12
I. Recommendations for the Schools & the District	12
II. Recommendations for Families	13
III. Recommendations for the Community	14
<i>Introduction</i>	16
Why Schools Matter	16
Communities Matter, Too	16
The Social Worlds & Youth Well-being Study	17
Why the Front Range	17
Expressing Our Gratitude	17
On Blame, Change, & Suicide	18
Methodology in Brief	18
Overview of the Report	19
<i>School Strategies to Support Youth Well-Being</i>	19
I. Including the Whole Child in the Core Aims of Education	19
Demonstrating a Whole Child Philosophy.	19
Why a Whole Child Approach Matters to Suicide Prevention – Encouraging Disclosure.	20
Why a Whole Child Approach Matters – Pursuing the Whole Picture.....	21
When the Focus is on Academics.....	21
When the Focus is on Outside Mental Health Supports.....	22
It’s Not that Staff Don’t Care.....	22
But Not all Staff are On Board.	23
Why Staff Struggle.....	23
The Aims of Education and Strengthening Suicide Prevention.....	24
II. A Culture of Belonging	25
Cultivating a Culture of Belonging.....	25
Everyone, not Just the Ideal-Typical Students.	26
Why this Matters to Suicide Prevention – Not Fitting in Hurts.	27
Why this Matters to Suicide Prevention – Students Speak Up.....	28
Why this Matters – Students’ Voices are Centered.	28

Why this Matters – It Helps Counteract a Culture of Bullying or Exclusion.....	29
Cultures of Belonging & Strengthening Suicide Prevention.....	29
III. Including Mental Health in Multi-Tiered System of Supports.....	30
Identifying the Student Outcomes that Matter.	31
The Structure of the MTSS System.....	32
Consequences for Suicide Prevention.....	34
Are Clinicians Present?.....	35
Referral Strategies & Visibility.....	36
Parents Need to Understand What Schools Can Do.....	36
Clear Websites are Important.	37
The MTSS & Strengthening Suicide Prevention.....	38
<i>Supporting Youth Well-Being Beyond the School.....</i>	<i>39</i>
I. The Role of the District.....	40
II. The Role of Safe2Tell.....	41
Safe2Tell Saves Lives.	41
The Involvement of Police.	42
Misuse of Safe2Tell.	44
III. The Role of Families	45
...In the Production of School Cultures.....	45
...In Connecting Youth to Help.	47
...Generating Pressure.	48
IV. The Role of Mental Healthcare.....	49
V. The Role of Pediatricians & Primary Care Providers	51
VI. The Role of Faith Communities.....	55
<i>Advice for Adults from Youth.....</i>	<i>56</i>
<i>Limitations.....</i>	<i>58</i>
<i>Conclusions</i>	<i>59</i>
<i>References</i>	<i>59</i>
<i>Appendix A: Methodology</i>	<i>61</i>
Data	62
Analytic Approach	64
<i>Author Bios</i>	<i>65</i>

Acknowledgments

Many people and organizations played critical roles in bringing this project to fruition. We are deeply grateful to the school district at the heart of this study for being willing to collaborate with the research team on this project so that we can accomplish our shared goal of making youth's lives happier and healthier. We also appreciate the support, guidance, and opportunity to learn from school leaders. They shared their schools with us, as well as the daily joys and struggles of educating youth in the 21st century. They made us feel welcome, and they shared their insights, concerns, struggles, and strategies to support the students in their building. This study benefitted from their collective wisdom. In addition to the leadership teams, we would like to acknowledge the school and district-based mental health teams and the teachers, librarians, security, and other school staff, who spent substantial time helping us understand the world of students and schools from their perspective. It was an absolute honor to spend time in schools with such dedicated and passionate staff.

We also deeply appreciate the families and students who took the time to share their experiences with us, so that we could learn from their perspectives and give voice to their concerns. Thank you to all the folks who welcomed us into their living rooms, who met researchers for coffee, who organized focus groups of their friends or family for us, or who helped us network within the community. This support was crucial to the success of this project and was deeply appreciated. We also understand, particularly for people who are currently supporting youth who are struggling with mental health challenges or for people who have lost loved ones to suicide, how hard it can be to discuss mental health or suicide with anyone, let alone researchers. We recognize how precious the gift of your insights are and thank you for it. While this report represents only the first step in how we will be translating what was shared into knowledge that can be used for change, we hope that this first step is meaningful and that the information that was collectively shared will enable positive change.

We would also like to thank community members, including professionals in the local mental health community, police departments, and faith communities who spoke with researchers about their diverse roles, concerns, and strategies to support youth well-being. The broad support for this project is further evidence of how much this community, writ large, cares about youth.

Beyond the local community, we would also like to express our eternal gratitude to Christine Harms and Emily Fine, who originally brought Dr. Anna Mueller to Colorado, to share her past research on suicide. Those early presentations led to conversations with specific school districts which in turn led to the collaborative development of the Social Worlds & Youth Well-Being Study. In addition, we would like to thank Dr. Jill Harkavy-Friedman and the reviewers at the American Foundation for Suicide Prevention for providing the first external funding for this project. They recognized the importance of this

work, despite its fairly radical departure from more traditional research projects on youth suicide.

Bodhi, Leesa, Lena, Emily, Cat, Chris, and David – and others who must remain unnamed – thank you for taking the time to make Colorado feel more like a second home. The hikes, the lunch dates, and the smiles help make research away from home tremendously easier.

Finally, the principal investigator and the co-investigators, Drs. Mueller, Diefendorf, and Abrutyn, would like to acknowledge the amazing research assistance of the Social Worlds & Youth Well-Being research team. While these fantastic graduate and undergraduate students are all listed as co-authors on this report, we wish to further recognize how profound their contribution was. Their energy, organization, brilliant insights, and passion for public sociology and improving youth's lives made this project possible. It is a privilege to be able to collaborate with this group to produce science for a better world.

Funding

This project is supported by Grant SRG-1-090-18 awarded to Anna S. Mueller from the American Foundation for Suicide Prevention. The broader project is also supported by a grant from the Western Colorado Community Foundation awarded to Anna S. Mueller and Sarah Diefendorf. Findings from our work in Western Colorado at times helped contextualize our findings from the Front Range. This project is also supported by funds from the Luther Dana Waterman Associate Professorship from Indiana University awarded to Anna S. Mueller in 2020 and funds from the Social Science Research Center Faculty Seed Grant from the University of Chicago awarded to Anna S. Mueller in 2018. Additionally, in 2021, this project received funding from the National Institutes of Mental Health under grant R01-MH127170 (PI: Anna S. Mueller, Co-I: Seth Abrutyn). This NIMH funding will allow us to continue this collaboration with the District in the coming years. The content of this report is solely the responsibility of the authors and does not necessarily represent the official views of the American Foundation for Suicide Prevention, the National Institute of Mental Health, or our other funders.

Executive Summary

The *Social Worlds and Youth Wellbeing Study* examines the impact of social environments on youth's welfare and resilience to identify strategies for improving youth mental health and suicide prevention in schools and 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 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 Front Range School District (FRSD) 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. The full report begins on page 16.

Methodology

This report presents results from interview, fieldwork, and survey data collected between October 2018-June 2021. Combined, this data represent 192 interviews with youth, school staff, parents, and community mental health providers, 22 months of fieldwork in schools and at school and community events, and two different surveys, one with FRSD families (with 1,230 family respondents) and one with FRSD school staff (with 1,004 staff respondents).

First and foremost, the data collected for this research make clear that each school in the District provides excellent academic opportunities to its students. In addition, each school is staffed by a lot of caring adults who genuinely want to help youth in a variety of ways, including with their mental health. Additionally, our data show that suicide prevention is deeply important to the District, schools, and local families.

School Strategies to Support Youth Well-Being

In this report, we identify three strategies that schools use to promote youth well-being and prevent suicide: (1) Including the Whole Child in the Core Aims of Education; then developing a (2) Culture of Belonging, and finally (3) Including Mental Health in Multi-Tiered Safety Systems.

1. Include the Whole Child's Development in the Core Aims of Education

Whole child educational philosophies are powerful for suicide prevention, as they encourage school staff to take on the work of mental health promotion and suicide prevention, and to build systems of support within the school building that can function to accomplish these aims. A whole child educational philosophy is one that prioritizes the mental health, social emotional needs, and the general wellbeing of youth alongside academic goals. In our data from our staff survey, high schools with stronger whole child educational philosophies are also significantly more likely to strongly endorse that they value being a trusted adult for students; that the District places appropriate emphasis on mental health; that mental health should not be left solely to parents; that they feel comfortable with the amount of mental health work they must do as part of their job; and that school-based support systems (often known as multi-tiered system of support teams

or student intervention teams) help students get the social-emotional support they need. The priorities of a school matter. We find that students are more willing to disclose mental health struggles to staff in schools that are guided by whole child educational philosophies. The task of prioritizing whole child educational philosophies in a school is not a simple or easy one; schools require resources, support from their communities, and especially support from parents..

2. Develop a Culture of Belonging

The second major strategy to prevent suicide and promote well-being is for schools to create a strong culture of belonging. While a whole child educational philosophy in a school building can provide a space in which educational aims are understood alongside other aspects of well-being, a culture of belonging within a school fosters the celebration and support of the diversity of interests, expressions, and identities *among the student population*. A culture of belonging helps make students feel that they are a valued member of their school community and that their voice and experiences matter. It also fosters trust between students and school staff and creates a space where students feel safe in speaking up about their needs, including their mental health struggles. A culture of belonging does not have a narrow set of expectations for what defines student success and what is worthy of celebration. Like past research has shown (Mueller and Abrutyn 2016), cultures with narrow expectations for “good” youth or ideal students can harm mental health by making it harder for all students to feel they belong. Making sure that schools and families alike celebrate diverse forms of success – and not success that is simply based on academic or athletic excellence – can send powerful messages to students about who matters. To help foster a culture of belonging in which diverse forms of success are celebrated, schools should also review who receives visible, public attention – whether through pep rallies, celebrations, newsletters, or simple daily acts of attention – as past research along with our study suggest that this shapes who students perceive as mattering to the school (whether it is true or not) (e.g., Eder et al. 1995). Additionally, addressing bullying, teasing, and other ways that peers ostracize each other for not fitting in is also critical to fostering a culture of belonging. A culture of belonging can be a powerful antidote to the more exclusionary culture youth often experience through social media.

3. Include Mental Health in Multi-Tiered System of Supports

Schools can better prevent suicide and promote student well-being effectively through a highly structured, multi-tiered support systems. All schools have some form of a multi-tiered system of supports (MTSS) though they sometimes go by different names. These MTSS systems are how schools work to meet external requirements and standards (set often by state and federal Departments of Education) and to accomplish their internal goals. Sometimes these goals are more strictly focused on academics, and sometimes they are more broadly focused on the whole child’s needs. The purpose of these safety systems is to catch student struggles before they develop into larger, harder-to-support problems. To most effectively support the mental health and well-being of students, schools should explicitly include mental health promotion as a goal of the MTSS and include mental health outcomes as measurable outcomes used to evaluate how well the MTSS is serving the school community. This way, suicide prevention is truly embedded within the systems in a school building, and this approach can leverage existing strategies and resources that

schools already have and are familiar with. A well-developed, institutionalized, and multi-layered MTSS will ensure that the MTSS can effectively help support vulnerable students and their families and teachers. Indeed, one way to help mitigate issues of staff mental health concerns and burnout is through effective MTSS systems. As our data suggest, staff feel MTSS systems make their jobs easier, especially in buildings with well-developed MTSS systems. MTSS leaders also report that the MTSS system helps staff develop empathy and a willingness to engage in supporting the mental health of students. But teachers especially must buy into the MTSS framework as well as a focus on mental health and upstream suicide prevention. Teachers and staff generally support schools placing importance on student mental health, but they sometimes struggle to find the time and energy to support suicide prevention on top of all other their other tasks and obligations. Thus, making sure that the MTSS is designed with the labor of teachers and other school staff in mind is crucial. The MTSS must reduce the burden on individual staff members and increase staff confidence that students identified as needing mental health support will be effectively supported by the system (and not by the staff member alone). A strong consideration of these issues will ensure system effectiveness.

Supporting Youth Well-Being Beyond the School

While schools play an outsized role in suicide prevention, schools cannot do this labor alone. Suicide prevention is very much everyone's business, and it will take us all to change the world for youth. In this report, we also identify strategies to support youth well-being and prevent suicide that are “Beyond the School.” In particular, we also found that the promotion of mental health and suicide prevention is supplemented several additional layers in the mental health safety system that include (1) the District, (2) Parents, (3) the Mental Healthcare System, (4) Pediatricians, and (5) Faith Communities.

1. The Role of the District

The first layer is intimately tied to the school's safety system by way of the leadership and support of the District. District mental health staff were trained in suicide prevention, crisis response, and danger assessment, to name a few. In addition, the District actively worked with schools at every education level to maintain communication about school needs and challenges and District initiatives and resources. The District also provided an added its own safety system that reviewed all reports of mental health, behavioral and social-emotional problems. A critical issue facing the District revolves around building and maintaining trust between parents and staff communities. While some of these issues were unique to COVID-19, many were observed prior to the pandemic. Ultimately, we suggest that using this report to strengthen the mental health safety nets will contribute to this challenge.

2. The Role of Safe2Tell

It is important to note one further tool we found schools and the District using to keep kids safe: Safe2Tell. Safe2Tell is an anonymous tip line designed, initially, to prevent violence like rampage shootings, but which has evolved in the District to also prevent suicide. In our observations, 8-10 youth who were at high risk of suicide or suffering severe mental health problems, were identified and triaged through Safe2Tell. Our data suggest Safe2Tell is really an effective tool for strengthening the safety net. However, there were

two issues that we observed and heard about from our respondents. First, many times—usually after school hours—police officers arrived at students homes without warning to perform a wellness check. A quarter of parents were uncomfortable with this practice, feeling that it made for a more intense or stressful experience. Parents and students of color were especially wary of police involvement. One consequence of this wariness was hesitation among some students we spoke with in using Safe2Tell. We suggest critically reviewing procedures to ensure that all families feel comfortable when police are involved and also finding a way to involve school resource officers in wellness checks as youth are more familiar with their own building's officer. The second issue we found was in the misuse of Safe2Tell for the purpose of reporting non-emergencies or bullying and harassing fellow students. While both of these were relatively rare instances and did not outweigh the benefits of the system, raising awareness about its proper use to discourage misuse and bullying is vital to ensuring Safe2Tell remains a trusted tool in the safety net.

3. The Role of Families

Families, as a second layer in the community's system of support, play an important role in producing and maintaining a mental health safety nets. We find that most parents want schools to support student mental health. However, parents often select one school or another based on criteria that may counteract the promotion of mental health. For instance, we found some parents prioritized academic success over principles centered on the whole child. Sometimes these two factors aligned, producing safer schools, while in other cases parents were less enthusiastic about schools prioritizing mental health over other important goals, like academic success, which contributed to staff being less enthusiastic about prioritizing mental health.

Families also play an important role in advocating for help from schools. We saw examples of parents who reached out to schools and created a meaningful partnership with staff to help their child, but we also saw examples of parents who became frustrated when they searched for help and could not find the information they needed as easily as they had hoped.

Perhaps more troubling, our research finds that a significant number of parents are likely to keep information about their child's mental health and suicidality from schools, which constrains the school's ability to contribute to supporting the student. This is problematic since students spend the majority of their waking hours in schools. It also means that student does not have access to the numerous evidence-based strategies that school staff have to support their well-being, such as school-oriented safety plans.

Finally, as our data suggest, parents play an important role in how much academic pressure kids feel. Youth were clear that pressure to meet expectations, particularly academic expectations, was a major source of stress and strain on their mental health. Making sure that families work to balance the expectations that youth excel at school, sports, and in extracurricular activities with their social-emotional well-being is essential to helping them manage their stress and mental health.

In addition to this suggestion, there are several strategies families can employ to further promote mental health and aid suicide prevention. First, they should learn to talk competently about suicide with their children. Second, they should be helped in learning to

familiarize and use all of the resources at their disposal such their pediatricians with whom they should talk to about their child's mental health or crisis response resources before a crisis occurs. Finally, we see it is as imperative that parents build stronger partnerships with schools by communicating frequently about their child's mental health challenges and issues before they become crises.

4. The Role of Mental Healthcare

Mental healthcare is critical to supporting families, schools, and communities in suicide prevention. In general, like most areas in the U.S., we find that the Front Range community needs greater resources devoted to treating mental health and supporting suicide prevention. Our data from families and mental health professionals highlight the difficulty in finding a therapist and, in times of crisis, pediatric psychiatric hospital beds. In addition, many parents find the mental healthcare system difficult to navigate, which means they often then turn to the school for help. While working with the schools and facilitating communication about a crisis is preferred, schools would be better able to do this work if external mental health resources were more available. Finally, while mental health stigma is not a major issue in this community, there is some discomfort in asking others for recommendations of therapists and talking frankly about the need for mental health supports. These gaps in mental healthcare are problematic; particularly because youth who have access to a supportive therapist shared that it was an incredibly positive and important form of support for them.

5. The Role of Pediatricians & Primary Care Providers

Pediatricians, primary care providers, and family medicine are fourth layer of the mental health safety system outside of schools. In our data, medical doctors have a lot of power to help parents amidst a crisis or to be absent partners who may not even come to mind. While our data reveal that most families in Front Range would seek their doctor's help if they were concerned about their child's mental health, a substantial minority report that their doctors do not discuss mental healthcare with them. Moreover, we find that in practice, families are more likely to seek help from schools or mental healthcare professionals, which not only places excess burdens on these resources, but also creates an unnecessary gap in the safety system. Some of this hesitance to use family medicine for mental healthcare stems from parents not being confident that pediatricians are qualified to advise them on mental health. This confidence hinges not only on questions about their expertise, but also fears that doctors might not want to help for fear of legal liability. A second reason for not pursuing help is more direct: parents report that previous efforts to ask doctors for advice were unhelpful. We also heard about instances where primary care providers did not use best practices (and even used harmful practices) when discussing suicide with youth in crisis. We recommend that doctors are trained during medical education in mental health and suicide prevention, that they maintain this training just as they would keep up with advances in medicine. Additionally, every pediatric or PCP office must put into place protocols designed to support youth mental health and that are consistent with best medical practices.

6. The Role of Faith Communities

Faith communities can play an important role in suicide prevention efforts and mental health awareness. Students and adults that participate in faith communities report

finding a powerful source of support from them. Consistent with other sources of support, however, we find that families are hesitant to use faith communities to their fullest potential. Only a small proportion of religious families, for instance, report that they would be very likely to seek support if they were concerned about their child's mental health, and some report that they would be very *unlikely* to turn to their faith community for mental health supports. Our data suggest that some of this reticence is due to firsthand or secondhand experiences with religious leaders who provide little support when a parent or student does reach out.

A second barrier stems from some faith communities that hold strict cultural norms around what a good person of faith looks like. Sometimes youth report encountering negative messages or responses from their faith community about who they are, including regarding having a mental illness. These experiences, youth feel, stigmatize mental illness and reduce their willingness to see their faith community as a source of support.

We recommend that faith communities include suicide prevention in their mission, both in terms of faith leaders being trained in suicide prevention but also in shaping a message that emphasizes unconditional support, inclusion, and openness.

Advice from Youth

Youth have a variety of suggestions for how suicide prevention can be improved. Youth made clear is that it is critical adults listen to them and take their concerns seriously. Adults, according to youth, grew up in a different time, and therefore, we do not always understand the intricacies of what it is like to grow up today. Youth admonish that these differences require adults to “just listen” to youth. Youth also want to play a role in evaluating and creating support systems for youth mental health, and they want mental health to be a year-round focus in their schools. Youth also want their schools to teach them the warning signs for suicide, to work to address mental health stigma and increase belongingness for all, and for their families, schools and communities to pay greater attention to drug and alcohol use and abuse. Many youth felt that drug and alcohol use and abuse were significant problems and tied substance use to their understandings of suicide in the community.

Conclusion

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, further illustrating 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.

Policy Recommendations

Improving suicide prevention and decreasing youth suicide rates are extremely important but incredibly challenging public health goals. As we have discussed in this report, there is rarely one cause or reason as to why someone dies by suicide. The complexity of suicide also makes it challenging to prevent. And while blame is common in the aftermath of suicide, it is counterproductive. Instead, we argue that we should focus on the tangible changes that school districts, schools, families, health professionals, and community members can enact for more robust mental health safety nets and effective suicide prevention efforts.

Our goal is to offer policy recommendations 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 Front Range Community. We can all make a difference in the lives of youth; again, ‘suicide is everyone’s business.’

I. Recommendations for the Schools & the District

1. Schools and the District should adopt a Whole Child philosophy that values mental health wellbeing alongside strictly academic and occupational goals;
2. Schools and the District should increase the number of mental health staff in school buildings to ensure schools have the capacity to support the whole child without burning out or overwhelming staff;
3. Schools should cultivate a culture of belonging that celebrates a diverse array of successes among students; schools should review who among the student body receives public and visible attention and who does not, taking care to distribute visibility equitably;
4. Schools and the District should provide additional mental health and suicide prevention training for staff to ensure that staff, who care deeply about students, feel equipped to be full active participants in mental health safety nets within schools;
5. Multi-tiered systems of support within schools should be tuned to suicide prevention; specifically,
 - a. Having a mental health problem should warrant additional support from the MTSS;
 - b. Root causes of youth’s challenges – including possible mental health struggles – should be considered by MTSS teams when problem-solving;
 - c. Schools should have in-house strategies to support common mental health challenges, possibly even including therapists on campus
 - d. the MTSS must be designed with the labor of teachers and counselors and other school staff in mind will ensure it is more effective, and ensure that it is a system that can help teachers and staff do their job and support student mental health and not be an additional burden;
6. Schools and the District should create an information campaign about what schools can do to build trust, awareness, and communication with families in the District.

7. Suicide prevention and mental health awareness should be year-round and not relegated to the Autumn months;
8. Schools should offer regular training for students in warning signs for suicide;
9. Schools should offer regular trainings for non-mental health staff in warning signs for suicide;
10. Schools and the District should increase resources and awareness around substance use;

II. Recommendations for Families

11. Academic pressure is one of the most painful experiences that youth reported, across schools, in this District. This pressure, youth reported, comes in part from their parents. As a result, we suggest that families work to help their children balance pressure to meet expectations (be they academic, extracurricular, or athletic) and their child's social-emotional well-being;
 - a. We recommend that families review the resources offered by the program Challenge Success, <https://challengesuccess.org/resources/>
 - b. We also recommend the book *The Gift of Failure: How to Step Back and Let Your Child Succeed* by Jessica Lahey and the book *How to Raise an Adult: Break Free of the Overparenting Trap and Prepare Your Kid for Success* by Julie Lythcott-Haims
12. Families need to be competent in talking to youth about suicide;
 - a. We recommend families (and school staff) listen to this 14 minute podcast that covers the major issues in how to get help for someone you love who is at risk of suicide. The information is correct and is similar to what Dr. Mueller recommends: <https://www.npr.org/2021/04/02/983823424/how-to-reach-out-when-someone-you-know-may-be-at-risk-of-suicide>
 - b. We recommend families review the "What Not to Say" and "10 Things to Say" overviews provided on the website www.speakingofsuicide.com, and refresh their knowledge as needed.
 - c. The book *After a Suicide: A Toolkit For Schools* (2nd Edition), a joint publication between the Suicide Prevention Resource Center, the Education Development Center, and the American Foundation for Suicide Prevention, also has information and tips for how to talk to youth about suicide. This publication is free as a PDF online here: <https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf>.
 - d. Finally, we recommend that families do a suicide gatekeeper training which will help parents become comfortable discussing suicide effectively, such as LivingWorks SafeTalk, LivingWorks Start, or QPR training. These trainings can be purchased online, though trainings are also often offered through the District.

- e. Remember talking about suicide directly and clearly saves lives, but we often need help learning how to talk about such a difficult topic; these resources will help;
- 13. Families should discuss mental health with their pediatricians at every doctors visit; this will help normalize talking about mental health and seeking help for mental health struggles for their child and will build this kind of relationship with their primary care physician outside the context of a crisis (which will help if a crisis ever happens);
- 14. Families should familiarize themselves with crisis resources before a crisis happens if at all possible; having an action plan for how to seek help for suicidality would be ideal;
- 15. Families should inform the school of their child's mental health challenges and experiences so that the school can be a partner in supporting their child's well-being; concerns about a school's ability to fulfill their role should be discussed with the school;
- 16. If a child experiences a hospitalization for a mental health issue, families should inform the school (just as they would for a physical health issue) to ensure that the school can help support the child, including planning for the child's return to the school and safety at school;

III. Recommendations for the Community

- 17. Schools need more funding to accomplish these goals; It is clear in our data that schools are leaned on heavily to provide mental health support for youth; they are the lynchpin of youth support, but we need to better fund schools to provide this crucial work we are asking them, and relying on them, to do;
- 18. Faith communities need to better support suicide prevention efforts and mental health awareness;
 - f. Faith communities should include suicide prevention in their missions, and hone their message to be one of inclusion, openness, and unconditional support.
 - g. We recommend that organizations with expertise in suicide prevention and mental health promotion reach out to faith communities and provide them with the knowledge, training, and resources they may need to grow into this extremely needed aspect of community care. There are trainings developed specifically for faith communities, such as Colorado-based LivingWorks Faith;
- 19. Pediatricians and Primary Care Physicians need to train themselves in mental health and suicide prevention; they also need to ensure that their offices have protocols to support youth mental health that are consistent with best medical practices;
- 20. All doctors during medical school and residency training should receive training in mental health and suicide prevention, but this is especially important for

pediatricians, family medicine doctors, primary care providers, and emergency medicine;

21. School counselors, school psychologists, school social workers, and other school-based mental health professionals should receive training in suicide prevention in schools during their graduate training. It is no longer acceptable to claim that suicide prevention and even suicide risk assessments are not the job of these groups of individuals (something we did sometimes hear, in and out of this community);
22. There is a severe need for more therapists, psychologists, and pediatric hospital beds in the community. Schools, families, faith communities, and even pediatricians can only do so much – some youth will need more specialized care, possible only from mental health professionals;
23. Suicide researchers should be attentive to how schools works, what schools need, and the resource scarcity that often characterizes schools and design suicide interventions that help youth but are also effective, equitable, and sustainable in schools;
24. While Safe2Tell should continue, Safe2Tell should clarify language about what an “unhealthy behavior” is and isn’t; additionally, creating a mechanism for anonymously reporting non-crisis level mental health concerns to school staff may be useful as youth felt uncomfortable with the potential for an “over” response if they used Safe2Tell;
25. Mobile mental health crisis teams that are staffed by mental health professionals who can respond to serious Safe2Tell tips rather than police may improve Safe2Tell.

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 (e.g., Rosin 2015). A major barrier to reversing trends in youth suicide is that suicide's complexity makes it nearly impossible to 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.

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, 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 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 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 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 community's wrap-around resources and complementary strategies, 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 the School District 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 better mental health safety systems in schools and communities to better help youth who are struggling and to improve suicide prevention?

Why the Front Range

While two school districts are participating in the Social Worlds & Youth Well-being Study, this report focuses on our findings from our collaboration with our front range school district. For the purposes of this report, we will call this district "Front Range School District" [FRSD], a pseudonym. FRSD was the first district to volunteer to collaborate with researchers as part of this study after hearing the principal investigator, Dr. Anna S. Mueller of Indiana University Bloomington, give a keynote address featuring her research on youth suicide and suicide clusters at the annual Colorado Safe Schools Summit hosted by the Colorado School Safety Resource Center in 2018.

While school districts around the U.S. are struggling with the rising rates of youth suicide, FRSD recognized suicide to be a problem relevant to the District. Additionally, the problem has not resolved, despite the implementation of many existing evidence-based suicide prevention interventions, including Sources of Strength and Safe2Tell, and using many best practices for suicide prevention in schools, including protocols for suicide risk assessments and regular training to help staff identify signs of suicide in students and appropriately triage students to supports.

Expressing Our Gratitude

One barrier to improving our strategies to prevent suicide in schools is that schools and districts are rarely eager to allow researchers to examine their procedures and protocols for their limitations or gaps. For that alone, we are deeply grateful to the District, the School Board, 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 FRSD, school districts around the U.S., and for the scientific understanding of suicide and suicide prevention 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, & Suicide

During our time in Front Range, we witnessed media coverage and community discussions that ultimately can be characterized as discussions about who was at fault – be it schools, families, etc. – for youth suicides. Following a collective trauma like a suicide loss, it is very human to search for who is at fault 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 us all to move the dial on youth suicide. Indeed, this report will show this to be true. For this reason, we have made the choice to focus on what does and does not work without naming particular schools or people. Every school we studied had strengths and weaknesses; strategies we could learn from, and strategies that could be shifted to close 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 school and District'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 change that diminishes 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) fieldwork, and 3) surveys. The data in this report were collected between October 2018-June 2021, and combined, represent 192 interviews with youth, school staff, parents, and community mental health providers, 22 months of fieldwork in schools and at school and community events, and two different surveys, one with FRSD families (with 1,230 family respondents) and one with FRSD school staff (with 1,004 staff respondents).

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

We begin this report by discussing the strategies that schools use to support youth well-being and prevent suicide, beginning with (1) Including the Whole Child in the Core Aims of Education; then developing a (2) Culture of Belonging, and finally (3) Including Mental Health in Multi-Tiered Safety Systems. We then shift to discussing strategies to support youth well-being that are “Beyond the School.” In this section, we begin with the role of the District in supporting youth and the work of schools. We then proceed to discuss the role of families, mental healthcare, pediatricians, and faith communities. We conclude the presentation of our findings with Advice from Youth (though insights from youth are also included throughout). We then conclude the report with a brief discussion of our limitations and policy implications.

School Strategies to Support Youth Well-Being

Schools use a variety of strategies to cultivate safety and well-being for their students and to shore up mental health safety nets. Not all schools use the same strategies, and we learned different things from each school. While implementing all of the strategies we discuss in the following sections may not always be necessary, each strategy we identify contributes to mental health safety nets and positive mental health cultures in schools.

I. Including the Whole Child in the Core Aims of Education

“Every flourishing society has debated the aims of education,” writes professor and education researcher Nel Noddings in 2005 in the journal *Educational Leadership*. “Some people argue,” she continued, “that schools are best organized to accomplish academic goals and that we should charge other institutions with the task of pursuing the physical, moral, social, emotional, spiritual, and aesthetic aims that we associate with the whole child. The schools would do a better job, these people maintain, if they were freed to focus on the job for which they were established” (Noddings 2005: 4). In this brief quote, written before youth suicide rates began to climb in the U.S., Noddings captures one of the central tensions in education that we found matters profoundly to how schools go about the daily business of suicide prevention.

In short, schools vary in how committed they are to whole child educational philosophies, and specifically, in how willing they are to consider mental health promotion and suicide prevention as a core aim of education. This variation in turn changes how willing students and parents are to disclose mental health struggles to school personnel and consider schools as a place where support can be accessed. It also shapes the systems schools have in place to promote well-being and prevent suicide as well as how willing school staff are to do the daily work of suicide prevention and mental health promotion. Ultimately, as we will show, these consequences weaken mental health safety nets in schools with less of a whole child educational philosophy.

Demonstrating a Whole Child Philosophy. Schools demonstrate their commitment to a whole child educational philosophy through a variety of mechanisms. The first is through slogans and mottos that are clearly communicated to other staff. “We say...all the time in this building: [we must know] students by name and need, by name and

need,” shared a school staff member from one of Front Range School District’s four high schools. Indeed, this was a refrain that we heard from multiple staff members in the building and a norm that we saw implemented in counseling and other administrative team meetings designed to support students where they were. For example, walking into this building every day, students are greeted by a smiling counselor holding up a poster board with a joke. When we asked the counselor why she does this daily, she shared that it actually allows her to check student well-being as they file past – are they smiling? Are they tired? Do they look stressed? Scanning student faces for signs of distress as they trudged through hallways is a practice we observed by many staff in this building. Moreover, when students just did not look right, a staff member tracks them down to check-in.

In our data from our staff survey, high schools with stronger whole child educational philosophies are also significantly more likely to strongly endorse that they value being a trusted adult for students; that the District places appropriate emphasis on mental health; that mental health should not be left solely to parents; that they feel comfortable with the amount of mental health work they must do as part of their job; and that school-based support teams (multi-tiered system of support teams or student intervention teams) help students get the social-emotional support they need.

Why a Whole Child Approach Matters to Suicide Prevention – Encouraging Disclosure. A whole child educational philosophy has powerful implications for suicide prevention. In schools that explicitly emphasize whole child educational philosophies, we observed multiple instances of students self-disclosing their serious suicidal thoughts to school staff and asking for – and receiving – meaningful help. One typical example from a school with a strong whole child educational philosophy comes from this exchange:

Staff Member A: [A young man] reached out and he’s feeling really suicidal. He told me he’s having suicidal thoughts daily. He is seeing his therapist and there is also a social worker that was assigned to them...

Staff Member B: well [what’s] notable is that he reached out to you [Staff Member A]...[saying to the group] [She] and I are working with [him].

Staff Member C: His friend also talked to me about the struggles in his home and that he was suicidal...then I reached out to (Staff Member B) and [she] kindly told me that you all were [already] on it.

Staff Member B: ...He’s really struggling so we need to be circling the wagons, making sure he feels the support.

There are several important things to note from this exchange. First, the young man reached out to school staff when he felt suicidal. This is an ideal scenario from a suicide prevention standpoint. Second, multiple school staff were aware of this young man’s suicidality because multiple students reported it. Redundancies in knowledge and reporting further ensure that someone will get this student the help they need, thereby helping to prevent suicide effectively. Third, the staff response is to ensure the student feels supported *in the school building* while also ensuring that outside mental health resources are in place (the therapist, the social worker). In this way, schools become a part of this student’s mental health safety net, rather than simply relegating the student’s mental health support needs to outside experts or their family. Fourth, staff members have

substantial knowledge about this student's broader life – some of which came up outside of this exchange. Staff use that knowledge to support him through this time of psychological crisis. This implies this student has an enduring, multifaceted relationship with school staff. Finally, as we noted above, this is a typical exchange for this school. Students often self-disclose their or their friends' struggles to school staff because school staff members are seen as adults who care about all aspects of students' lives. As a result, staff often know a lot about students' lives, and students generally feel extremely well supported by staff in this building. While a whole child educational philosophy may not solve all problems with youth seeking help from adults, overall our results suggest it does make a difference.

Why a Whole Child Approach Matters – Pursuing the Whole Picture. Whole child educational philosophies also encourage school staff to pursue the full picture of why a student was struggling in school and to find solutions to problems, regardless of their nature, in the school building. This is important because mental health problems in students are not always obvious. Sometimes the only signs of mental health problems are poor attendance or bad grades. Schools with a whole child educational philosophy also have more strategies – from meeting with students to having students fill out surveys about how they learned best and what they liked most at schools and beyond – to ensure they fully understood how to support students best in the building. These schools also often have layers of staff or intervention teams who can support students, ensuring that support work did not just fall on the school counselors (something we discuss more in the third section of this report). This is important because school counselors often have very heavy caseloads.

When the Focus is on Academics. Not all schools have a strong commitment to whole child educational philosophies. Instead, in some schools, the emphasis is primarily on academics and the development of skills and responsibility. In turn, this more strictly academic approach is associated with a more narrow view of possible causes of behavioral or academic problems in schools. For example, instead of framing student issues in terms of students' "name and need," these schools frequently discuss student issues regarding a "skill or will" problem. This is salient because framing the problem as a "skill" or a "will" problem situates the deficit within the student; either the student lacks the will to work hard or the skill to learn. There is less room to recognize mental health solutions as potentially important to addressing students' needs in this framing.

A typical example occurred at a staff meeting to discuss how to help struggling students. The conversation about a student with poor grades focused on his quiet personality and how his "motivation" was "lacking," even though staff acknowledged that the student's mother had shared that the family had had a really hard year. As the team struggles to get to the bottom of the student's challenges, the staff member who interacted with the child's mother began by mentioning that the family had had a tough year, but then quickly shifted to her own assessment: "I'm just guessing it seems like he has the skills and the tenacity in class but he doesn't do things out of class." As she continued to describe him, she moved the conversation further away from challenges he and his family may have faced to questions of "will": "My first question," she say, "would be 'how do you organize yourself outside of school to stay on top of your work?' there may be some executive functioning issues."

There are two things worth noting in this exchange. First, though the student may be experiencing challenges associated with the hard time his family is having, no one picks

up that thread or pursues whether the student is okay on a social-emotional level. Instead, the team focuses on whether the student is motivated to learn or has executive functioning strategies. While addressing executive functioning issues could be helpful to the student's academics, it is also possible that social-emotional or mental health issues may play a role in *why* the student's executive functioning may be less than optimal. However, again, that possibility is not discussed, so we do not know. There is also no discussion of how to make sure the student feels supported at school. Second, unlike the example in a school where a whole child philosophy prevails, this team moves on without identifying any solutions to support the student. Finally, this is a typical exchange for this school.

When the Focus is on Outside Mental Health Supports. Another major difference between schools with a whole child educational philosophy compared to a more strictly-academic educational philosophy is that school staff in more strictly-academic schools disproportionately pursue supports that are *outside* of the school building. In more strictly-academic schools, staff members see their role as connecting students to out-of-school resources (e.g., therapists), often through the help of District staff who specialize in this service. This pattern is clear in the following typical exchange about a student who was failing her math class. "Her grades in math are missing missing missing late missing missing missing late. So it's hard to know how she'd do. She's missing a lot of class," a staff member explained. One of the school mental health workers immediately asked, "does she present as struggling with depression?" The student's school counselor said emphatically, "Yes," while other staff members noted details about family struggles in the student's home. As the group begins to discuss how they can support this student, the team stresses: "the biggest thing is get her counseling support. Her basic needs need to be addressed. School is secondary, and we can support her with math. We can put her into study hall to help her get through the missing work..."

There are two things to note about this example. First, the team immediately recognizes how important it is to address this student's mental health problems. Second, the changes the team suggests to support the student within the school building are largely academic. The mental health work is actually done by connecting the student to District-level supports and is focused on getting the student out-of-school support. This suggests that the team sees addressing mental health needs as largely beyond their role and instead the job of outside experts.

Our staff survey data support this trend. Schools with more strictly-academic educational philosophies place a significantly higher emphasis on the importance of the District-level Social and Behavioral Services staff to suicide prevention than schools that we characterize as being guided by a whole child educational philosophy. Having the support of District-level mental health teams that can connect students and families to outside clinicians is an exceptional service this District provides. But it is still important to have within-school mental health supports to avoid having gaps in mental health safety nets. These gaps in a school building can be especially difficult if students struggle to sustain therapy appointments or other external mental health supports for a variety of access issues that are common (e.g., transportation, finances, etc.).

It's Not that Staff Don't Care. While schools with more strictly-academic educational philosophies disproportionately miss opportunities to address the mental health or social-emotional side of student problems, this is not to say that these schools do not care about the well-being of their students. There are no significant differences in staff

beliefs about how important teachers, school counselors, school psychologists, nurses, and other school staff members were to suicide prevention, in *every* building. Additionally, over 90 percent of staff report that knowing the warning signs for suicide was a part of their job in every school. Over 70 percent recognize that talking to a student if they were concerned the student was suicidal was a part of their job (with nearly everyone else endorsing that it was someone else's job within the school building [24 percent]). Most people that we interviewed, observed, or surveyed felt that schools play an important role in suicide prevention. Additionally, there were no statistically significant differences across school buildings in staff comfort discussing suicide, mental health, or building resilience with students.

But Not all Staff are On Board. While most staff that we spoke with or who took our surveys embraced their responsibility to help youth mental health and engage in suicide prevention, a small but vocal minority expressed reservations. We provided an open-ended question at the end of the survey asking staff to tell us anything else they felt was important for us to understand their experiences with mental health in schools. In response, one staff member told us that even having worked in a school with significant number of crises, “[schools] are still an educational institution, and not a mental health provider.” Another asserted: “I believe there is a fine line between us being caring, trusted adults and RESPONSIBLE parties for nurturing kids' mental health. I am not, and do not want to be, qualified in mental health nuances.” These comments allude to more strictly-academic educational philosophies, where teachers focus on teaching and counselors focus on getting students through graduation or into college, rather than focusing on supporting the well-being of students more generally.

This view is not completely uncommon. Overall, in our staff survey, 7.4 percent of all high school staff felt that mental health should be left in the hands of parents, and 27.5 percent of all high school staff feel they devote more time to supporting student mental health than they want. However, there is statistically significant variation between schools in both of these measures; variation that coincides with whether schools house a whole-child educational philosophy or not. Schools that were more oriented towards the whole child had significantly fewer staff feel they devoted more time to student mental health. Additionally, 20 percent of staff in a school with a more strictly-academic educational philosophy agreed that mental health should be left in the hands of parents, compared to approximately 4 percent in schools with a whole child educational philosophy. We will discuss this later, but it is worth briefly mentioning that staff beliefs in these schools match parent beliefs (see “The Role of Families,” pg 45, for more details).

Why Staff Struggle. Part of school staff's frustration is that they are being pulled in too many directions and that students' needs are perceived to be getting harder to handle. “Students needs are increasing dramatically,” one staff member shared, “and schools are ill equipped to handle it. Especially when it is so difficult to navigate available appointments and insurance with outside providers.” Another staff member concurred: “It is increasingly difficult to meet everyone's needs. Everyone needs a life vest and they all fit differently.” Bottom line, according to another staff member, is that there are “not enough resources or people having time to deal with it.” Staff also felt uncomfortable supporting student mental health; they worried they might not know what to say. These staff recognized the importance their school and District placed on mental health, but as one staff member (who was not a mental health worker) put it, “I feel grossly unprepared.”

Staff also stressed that sometimes their reluctance was related to their own struggles with mental health, stress, and exhaustion. As one staff member implored, “Please, help the faculty, staff, and community too. We have all struggled at some point. We have been through a shooting, multiple student suicides, teacher sex scandals, and now a pandemic with a zillion different schedules and expectations. We are totally exhausted and in survival mode.”

Some respondents even explicitly called for more resources devoted to maintaining staff mental health within their building. One respondent said: “We need more access to mental health not just for the students, but also for adults. It is expensive, not covered by our insurance, and the provided ‘three sessions’ are difficult to access/not with people we want to stick with. Everyone needs more access, not only our kiddos.”

The bottom line is summarized quite well by a quote from a staff member:

I think most teachers do their utmost to support students in any and every way we can. It takes a lot out of us, but it is important that each student knows there is at least one adult that they can turn to. And I believe most of them do. I do worry about the toll on the teachers--there are some teachers who, because of their relationships with students—bare [sic] this burden more than others. It is important that they have someone to talk to, too. For free, consistently.

If we want schools and the staff within them to take on this emotionally taxing but incredibly important work, they need support and training.

The Aims of Education and Strengthening Suicide Prevention. Several implications for suicide prevention emerge from our discussion of the aims of education. First, whole child educational philosophies are powerful for suicide prevention because they encourage school staff to take on the work of mental health promotion and suicide prevention in the school building and build systems of support that function to accomplish these aims. Second, school staff must consider the role of mental health and social-emotional needs when addressing student challenges, even if the challenges appear academic. Frames for understanding students – like “skill” vs. “will” or “name and need” – should encourage the consideration of mental health and other challenging life experiences (e.g., bereavement, economic insecurity), alongside student issues like motivation, executive functioning, and skills. These frames meaningfully shape conversations about how to help students. They set the tone for how staff approach student challenges and are a meaningful way leaders convey their educational philosophies. Third, since youth spend most of their waking hours in schools and because schools are the primary extrafamilial social context of youth’s lives, schools must have robust strategies to support students’ mental health that are available *in the school building*. They cannot just handle these concerns by referring students to the District, outside professionals, or relying on families to do this work, though those supports matter too. Finally, all of this matters because students pick up on the priorities of schools. We find that students are more willing to disclose mental health struggles to staff, including serious suicidal crises, in schools guided by whole child educational philosophies.

There are reasons that schools shy away from whole child educational philosophies. For one, it is not always easy to practice a whole child educational philosophy. “When we start digging into students by name and by need,” explained a school leader from a school with a strong whole child educational philosophy, “we are taking on so many more

responsibilities by finding out what's really going on with every single one of our students.” As staff alluded to, understanding the full needs of students can be emotionally taxing. This is especially true when many students who are struggling with mental health challenges are experiencing real traumas, such as homelessness or bereavement; solutions to which are, of course, beyond the capacities of schools alone. School staff also experience their own mental health struggles or stress at work. When staff are overburdened, it is simply harder to do an excellent job at the many tasks that lay before them. Thus, for schools to embrace whole child educational philosophies, they require resources, the support of their communities, and especially the support of parents. We will return later to the roles of resources, communities, and parents. But first, we review other strategies that schools use to make schools safer for youth and enable more effective suicide prevention.

II. A Culture of Belonging

Feeling like you belong is a powerful protection against suicidal thoughts and attempts (Joiner 2005). And indeed we found that the second major strategy to prevent suicide and promote well-being is for schools to create a strong culture of belonging. A culture of belonging is one in which it is easier for all students to feel as though they belong to the school community. To do this, school staff often go to great lengths to communicate that *all* students are welcomed, valued, and important to the school, regardless of their social identities, personal challenges, skills, talents, or sociodemographic background. A culture of belonging also values student voices and concerns and, importantly, fosters spaces for students to address their needs, experiences, and challenges. In this sense, a culture of belonging stands in contrast to a school culture that tries to fit students and their needs into existing molds, ideals, or structures. A culture of belonging often also goes hand in hand with a school culture that emphasizes the mental health and wellbeing of students alongside their academic successes. Importantly, we find that students respond to a culture of belonging. It particularly encourages trust between students, school staff, and parents, which in turn facilitates disclosures of mental health struggles. Thus, a culture of belonging cultivated within a school environment, can facilitate suicide prevention.

Cultivating a Culture of Belonging. A culture of belonging can be fostered through messages put forth by school leadership. These messages set a powerful standard for school norms and expectations staff and students; for example, by making it clear that both educational success and mental health and emotional wellbeing are equally important. As one parent shared:

Our [school administrator] got up on the stage [at a freshman back to school night] and said: ‘so we’re going to do things different this year. In years past, and maybe you’ve seen me do this...before, we put up on the screen of all our stats, all of our achievements, and we have a lot. We have really smart kids.’ [The administrator said] like, ‘I’m not doing that ever again. I will literally never do that again, because we are moving away from that culture, and we’re focusing on are our kids, okay? We’re focusing on our community, okay? Because that’s what matters to us. Our kids are going to achieve no matter what, but if our students are not mentally and emotionally okay, we’ve achieved nothing.’ And I literally just. I’m sitting in an auditorium full of parents, some that I know, some that I don’t, most that I don’t, and I’m just

bawling my eyes out because, yeah. That is exactly how every single school should be operating.

School administrators also communicate the importance of a culture of belonging by making it clear to parents, students, and staff that their high school will be a place of inclusion. For example, one school administrator stated, "If you were to come to [this high school] for a tour, one of the things I would want you to do, I'd want you to look at who our students really are. Pink hair, blue hair, green hair, piercings...tattoos...if it makes you uncomfortable to see two girls holding hands walking down the hallway, this place may not be a great fit." By repeatedly sharing a message of inclusion, administrators can generate a culture of belonging that has substantial repercussions for how students and parents experience support in the buildings.

Belonging can be fostered through less formal mechanisms as well. For example, at one school, a mental health team comprised of various school staff had a brief conversation about a pregnant student. One staff member suggested that they all send the student a maternity shirt that the staff member had seen online, which read "You are loved" along with a note from the school that would read, "Love, [school name]." The purpose is to go above and beyond to make sure every student knows they matter to the school and that they were welcome.

Everyone, not just the Ideal-Typical Students. All of the schools we observed cultivated a sense of pride and meaning surrounding being a student at their school. For some students, especially those who fit the mold of an ideal student at their school, this process also generates a sense of belonging. However, this is distinct from a culture of belonging that produces mental health benefits for the majority. In schools where belonging is achieved by fitting into narrow and clearly communicated ideals, students who do not fit the mold often feel left out. They also understand their status as lesser than other students in the building – less deserving of attention from adults in the building. They perceive adults to be more focused on supporting and celebrating the ideal-typical students. The typical ideal students are generally the high achievers, the athletes, etc. - students who help the schools maintain their reputation for academic and athletic excellence. As one student summarized:

If you're not an athlete,...then [the administration] makes it pretty clear that [it] does not care as much about you. I guess [it's] very biased towards sports teams... Administrators spend most of their time with the sports kids and kind of ignores people who aren't. And I feel like that would really hurt. I mean I don't really care that much because I don't really care about [their] approval of me. But if you do, then that sucks.

A recent graduate of the same school shared that:

[My school] kind of [had] this mentality of, we would all have this off campus lunch thing and we would all leave to go to lunch. And when we'd come back there would be one of the administrators standing up in front of the door and they would not say hi to everyone, they would say hi to the football players and the cheerleaders and that is fine by me. I don't need the administrators to say hello to me. But for a lot of people who already were feeling the social class

stereotypes of my high school and then felt like also not represented by our school leaders...I think that set a terrible example right from the bat.

Why this Matters to Suicide Prevention – Not Fitting in Hurts. Schools with narrower beliefs about ideal students generate an environment where students who do not fit within these celebrated statuses struggled, in part because their peers let them know they do not belong through teasing and bullying. “High school has been really hard,” Timothy, a sophomore, shared, “[I don’t fit in] and I don’t have like the coolest stuff...in order to be accepted here, you...got to be a certain person and not somebody that you really are...Everybody has to act the same, then you’ll be accepted. But if you don’t act the same as everybody, you’re not accepted here.” For Timothy, school was not a place where he could just be himself. It was instead a place where he expected harassment in the hallways. Eventually, his treatment at school had impacted him so negatively that he told his parents, who in turn talked to the school’s administration. “At first, I was really mad [at] my parents [for telling the school, and taking that choice away from me],” Timothy explained. He continued:

I was like pretending to handle it fine. But I wasn’t handling it fine, I didn’t know what to do anymore...I wasn’t suicidal, but I was very depressed and upset about myself thinking like where did I go wrong with myself? Just because well these kids are bullying me, like there’s obviously something wrong with me. But I mean after turning to administration, I really felt more accepted. I feel like I have people to talk to. Whenever I need anything, I’d go talk to my administrator or whoever. And that’s very comfortable for me to go talk to them.

Several things are worth noting about Timothy’s experience. First, despite experiencing significant emotional distress related to how he was treated at school, he did not feel comfortable speaking to anyone at school about his struggles. He did not expect to be supported at school. Second, after his parents forced him to disclose what was happening, he formed an important and supportive relationship with several school administrators that he now trusts enough to talk to anytime he is struggling. This matches our broader observations at this school that staff really care about student well-being, though they do not always have sufficient tools to provide support. Despite this positive, however, Timothy’s struggle with the exclusive culture at this school continued. The administrators could never fully turn things around for him, though their efforts and support made a huge difference to Timothy, as he notes above. But Timothy still wants his school to do better. “Somebody has to stand up to the school,” Timothy shared, “Why can kids come into the school and be so hateful toward others and get away with it? Why is that acceptable at our school?” Timothy’s optimistic. He believes change is possible. “I wanted [my efforts to speak to school staff about how I have been treated] to be inspirational [for the school].” Finally, Timothy’s experiences are typical at this school, where many students experienced downsides to the exclusive culture. Cultures can be tricky to produce and change. Thus, it is not surprising that the administrators’ best efforts to support Timothy didn’t change how he was treated. However, one way that research shows schools reinforce cultures is how they make choices about which students they celebrate, pay attention to, or grant visibility

to (Eder et al. 1995). This is why something as small as who gets a “hello!” as they walk in the school can ultimately matter to students.

Why this Matters to Suicide Prevention – Students Speak Up. Students in schools with what we call a culture of belonging often have radically different experiences than Timothy’s. When students enter a school, and feel as though their voices matter, regardless of how smart, talented, or popular they are, and that their mental health and emotional wellbeing matter, we find they are more willing to reach out for help from school staff. Alex, a sophomore at a school with a strong culture of belonging, was drawn to the school because he felt he would be welcomed and supported by school staff:

The [staff I spoke with during 8th grade recruitment] basically said ‘inside these walls is a representation of what society is and who is in it...you’ll see...two girls holding hands, two boys holding hands. And if you don’t like any of that go away.’ And I was like, ‘Okay cool. This is great. This is where I need to be.’

When Alex eventually had a problem with a teacher (he felt the teacher’s policies were deeply unfair), he went straight to a school administrator. He asked for help advocating for his and his fellow students’ well-being. “And she talked to him!” Alex shared, delighted by his impact.

Alex did the same thing when he was concerned about a student having (what he described as) a mental health breakdown in a bathroom at school. Alex went directly to the main office and disclosed his concern, immediately linking the distressed student to help from various adults in the building. The next day, Alex went to the school’s counseling office to get support for himself since he felt concerned about his experience with the distressed student from the day before. For Alex, the messages that all were welcome, followed by school staff taking a minor complaint seriously, made him feel supported and like his voice and experiences mattered. It made him trust the adults in his building. Like a strong whole child educational philosophy, being in a building with a culture of belonging fosters trust, shaping how students seek help. Alex’s disclosures of his own mental health challenges as well as those of his peers are typical in this building. Students feel safe bringing forward their own struggles. While no school can make every child or parent happy, in nearly every case in this school, the student is supported and provided appropriate help in and out of the building.

Why this Matters – Students’ Voices are Centered. A culture of belonging also fosters mental health and well-being by centering the needs of their students and valuing students’ voices. We saw several different ways this was achieved. One administrator had instituted recurring advisory meetings that encouraged all students to come and ask “tough” questions and be heard. “We listen to kids,” one administrator shared:

I have kids, from all walks of life and we have about 30 of them [each month]. And they will literally tell us the good, bad and ugly of what's going on. And they will...They're hard hitting questions. We're very honest with them. We never pull punches with them. We never not answer their questions. And I think that's important, just to listen to kids and they come, they're athletes and they're in the band, and they're transgender and they're [so on]... And we just put them all in a room and say, tell us what's going on, and they will speak their

mind. And it's... I think it's a really important thing for them too to feel that and so it helps us stay connected.

But, we also observed less formal means of centering students' voices, particularly when there is a concern about their well-being. For example, a mental health support team member in a school with a strong culture of belonging brought up a student they were concerned about due to an unstable family situation. The team discussed recent conversations with the student, which revealed uncertainty in their understanding of what the student was going through. One team member immediately said, "[Student] is in the building today so we can connect up with her today and find out the best way to approach this. I don't want to jam her up anymore than she feels but obviously we need to make sure that she's safe." In this example and myriad others, the first step for the team is almost always to check in with the student to hear their perspective. While these mental health support teams, teachers, and administration alike all communicate with parents about concerns, this approach allows students to feel prioritized, safe, and taken seriously when they are struggling. They can feel like they still belong and are cared for in a space that centers a student's mental health needs alongside their educational outcomes.

Why this Matters – It Helps Counteract a Culture of Bullying or Exclusion. A culture of belonging is also important because it is at odds with the adolescent culture that many youth describe, particularly in the age of social media. While social media use can be a source of positivity and entertainment for students and can provide a sense of belonging and a way to connect with friends, concerns about cyberbullying were prevalent among the Front Range high schoolers we spoke with. Youth explained to us that people post harsh messages on their Instagram feeds or sometimes even create fake Instagram accounts so that they can troll students anonymously. While these accounts often get taken down, the hurt is real.

Additionally, social media facilitates youth's already heightened tendencies toward social comparison and feelings of social exclusion. As Amber, a teen, points out, "if I have friends, who I'll spend a whole weekend with, and then they'll say something else about all the other friends they spent time with that weekend or whatever, that hurts." Indeed, it is really hard for teens to see photographic evidence of what their friends do without them; even if rationally, they can admit that it is not reasonable for their friends to include them 100% of the time (or for them to include all of their friends in every activity). Things that used to be invisible for teenagers in the '90s and 2000s are often completely visible today. This scenario atrophies youth's relationship with adults; many of us adults just did not grow up under similar circumstances, and thus it is hard for us to get it. Michael, a sophomore we interviewed, explains that the prevalence of cyberbullying via social media in recent years has made it even more difficult for adults to understand youth's experiences: "a lot of the people that we talk to grew up with...things [being] different back then. There weren't all the social media, a lot more platforms for bullying." This scenario also heightens the importance of school life and school cultures. Youth are constantly plugged into their classmates' and friends' lives through social media. Ensuring that schools house a positive youth culture of belonging can help counteract exclusionary cultures and bullying that youth experience all too frequently online.

Cultures of Belonging & Strengthening Suicide Prevention. In sum, cultures of belonging can directly improve students' well-being by discouraging feeling rejected for

not fitting into narrow expectations, making students feel like valued members of their school community (regardless of their personal characteristics), and encouraging them to seek help at school. Like past research has shown (Mueller and Abrutyn 2016), cultures with narrow expectations for “good” youth or ideal students can harm mental health by making it harder for all students to feel they belong. Making sure that schools celebrate diverse forms of success – and not success that is simply based on academic or athletic excellence – can send powerful messages to students about who matters. Schools should also review who receives visible, public attention – whether through pep rallies, celebrations, newsletters, or simple daily acts of attention – as past research along with our study suggest that this shapes whom students perceive as mattering to the school (whether it is true or not) (Eder et al. 1995). Additionally, addressing bullying, teasing, and other ways that peers ostracize each other for not fitting in is also critical to fostering a culture of belonging.

Of course, as with philosophies of education, cultures of belonging at school are complex, and multiple people – from school leaders, to staff, parents and students – play a role in their production. This matters for two reasons. First, to encourage any change in school culture, all groups must participate. Second, different people with different priorities are drawn to different school cultures, thus, furthering the reproduction of the school’s culture over time. As Alex shared above, he was drawn to his school because of the culture of belonging – and thus, he was primed the day he walked into the building to contribute to keeping that same culture alive. Many parents that we spoke with identify the school’s reputation more generally and culture of belonging specifically as factors that play a major role in their decision on where to send their children for high school. Even Timothy was drawn to his school, in part because of his older sibling’s success there. Schools can draw people in with their cultures of belonging. However, we also observed many instances of schools facing pressure to maintain their existing cultures of athletic and academic excellence; cultures that can be balanced with a culture of belonging, but the endeavor was trickier. Cultural change is possible though it will take the entire community. This endeavor is, we argue, worth it as it can help make schools a happy, healthy place for youth regardless of their individual experiences, social identities, talents, or challenges.

III. Including Mental Health in Multi-Tiered System of Supports

The third major strategy that we identify that schools use to prevent suicide and promote student well-being effectively is a highly structured, multi-tiered system of supports. All schools have some form of a multi-tiered system of supports (MTSS) though they sometimes go by different names. The Colorado Department of Education defines MTSS as:

a prevention-based framework of team-driven data-based problem solving for improving the outcomes of every student through family, school, and community partnering and a layered continuum of evidence-based practices applied at the classroom, school, district, region, and state level... At the school level, building teams implement their identified priorities and build a tiered system that fits their respective context. School teams identify the fidelity and student outcomes they wish to achieve and then identify the data needed to monitor progress toward those outcomes. They also outline the practices used

at each tier, as well as the systems that enable staff to both implement the identified practices and to gather the required data.¹

These MTSS systems are how schools work to meet external requirements and standards (set often by state and federal Departments of Education) and to accomplish their internal goals. Sometimes these goals are more strictly focused on academics, and sometimes they are more broadly focused on the whole child's needs. The purpose of this system of supports is to catch student struggles before they develop into larger harder-to-support problems.

Although both the individuals involved in the MTSS system and its structure vary from school to school, there are some commonalities even within a district. MTSS systems generally involve multiple types of staff members, from teachers to administrators to counselors, school psychologists, social workers, and other support staff. Their work is often accomplished through regular recurring meetings where staff discuss student challenges and brainstorm solutions to these challenges. Then specific staff, whether interventionists, teachers, or counselors, are tasked with implementing solutions and ensuring students are helped by the suggested solutions. Staff may also communicate with students, parents, or teachers as they work to solve student challenges. To understand the role of the MTSS in suicide prevention, we begin by briefly discussing how the school's educational philosophy shapes the MTSS before discussing how the structure of the MTSS impacted its ability to prevent suicide and promote well-being.

Identifying the Student Outcomes that Matter. Schools and districts can determine how central mental health is to their core aims of education. Schools and districts can also determine whether mental health is one of the student outcomes supported by MTSS systems. We find that the goals and focus of the MTSS within schools vary; some focus more on students' mental health concerns, while others are tuned to address academic or disciplinary issues. The goals of the MTSS are tightly coupled to the educational philosophy guiding the school's work. Schools with more strictly academic educational philosophies identify students for support in their MTSS meetings because of academic or behavioral concerns; poor grades are the most common problem students have, followed by attendance issues. These schools also have their MTSS teams review data closely linked to their identified goals: test scores, grades, and academic histories. The solutions pursued by MTSS teams are also guided by the outcomes the school identify as a priority. For example, if the goal in an MTSS meeting is to support students until they pass state competencies (an important goal), then interventions tend to focus on bringing math and English skills up to state-required levels.

Schools with more whole child educational philosophies generally address a broader array of student concerns through their MTSS system, including suicidal crises, mental health challenges, family struggles, economic insecurity, health issues, and academic concerns. While schools in this district do not have equal rates of students experiencing economic insecurity, all schools have students experiencing diverse challenges (including family, mental health, economic security, and academics). Thus, differences in how MTSS operate are not simply a function of school-specific problems but reflect priorities set by MTSS and school leaders. Subsequently, these priorities encourage

¹ For more on, MTSS in Colorado and this definition visit: <https://www.cde.state.co.us/mtss>

more diverse ways of gathering student data that give voice to the complex “roots of the problem,” as one team member put it. These MTSS teams use more than grades to understand students’ lives, including interviews and surveys with students, teachers, and parents.

A school prioritizing student mental health will use the MTSS as a resource for suicide prevention and to promote mental health. Students rarely talk in terms of the “MTSS” of their school. It is largely a system that runs in the background, away from student perception. However, students we interviewed suggest that schools would do a better job with suicide prevention if that make sure students know that school counselors *are* there to support their mental health. Students also suggested that students should be thoroughly and repeatedly encouraged to seek help from counselors. Essentially, students also wish that schools would make mental health a student outcome that matters, so that this aspect of counselors’ work is recognized as important. As students’ testimonies suggest, counselors are crucial to MTSS systems. They are the heart of every MTSS system we observe. And yet, in some schools, students do not perceive their counselors as ‘available.’ According to Sarah, a teen we spoke with, when she and her peers sought help from counselors, they felt dismissed due to their counselor’s workload: “all my friends who I knew that had [my counselor] as [their] counselor, they were just like, ‘she doesn’t help with anything.’ And then she makes me feel bad for going to ask for help because [my counselor] says how busy [the counseling office is].” Students often noted that their counselors are perceived to be just there for scheduling. As Meredith, a junior, stated:

When I was a freshman and I came into high school, the counselors were only there for scheduling purposes. So when you came to them, they never asked you, “Well how are you doing?” They would only ask, ‘Okay what do you need right now?’ There was always... it had to be something about the schedule.

These examples from youth highlight how critical it is for schools to prioritize mental health as an outcome that matters and for that prioritization to impact the work of counselors especially. Youth make important decisions about when and how to seek help, and whether youth decide to turn to members of the MTSS or not greatly depends on whether they understand those staff members as being there to support their well-being and caring about mental health.

The Structure of the MTSS System. One of the most profound differences in the MTSS systems that we observed in schools concerns their structure. That is, how many staff members are involved, how many times a week the MTSS team meets, and how many strategies the MTSS has (including sub-teams) to accomplish the often-challenging work of supporting the school’s most vulnerable students. For example, in one school, the MTSS is divided into multiple teams that could address multiple concerns. Broad whole-building challenges are assigned to the Prime Team consisting of school administrators, school resource officers, security staff, mental health staff, and interventionists. General student problems are fielded by the five standing Student Intervention Teams [SIT Team], which had approximately five people serving 25 percent of the student body). More intensive student problems are handled by the ad hoc Individual Support Team with a ratio of

approximately five people to one or two students.² The work of the MTSS teams are also discussed frequently at the weekly administrative team meetings, ensuring that all leaders in the school understand current student needs and interventions. The work of the MTSS is even brought into Professional Learning Communities (PLCs),³ which are the primary community for staff in schools. PLCs are a place where teachers and other staff members work together with colleagues to develop new instructional skills, analyze student data, and address professional concerns. In PLCs, the goals of the MTSS are tied to instruction and student learning. In this way, teachers, and not just the school's mental health workers, are clear about the goals, purpose, and strategies used in the MTSS and their role within the MTSS.

In this school, the SIT teams are the heart of the MTSS, and they meet frequently: 4 different teams meet every week for about 40 minutes. Each team focuses on a different part of the alphabet of student last names, with the corresponding counselors and administrators present. All administrators sit on at least one SIT team. The frequent meetings allow the teams to follow students over time while also ensuring that more student needs could be addressed each week. There is also fairly tight communication between the various SIT teams and other MTSS teams, facilitated by their highly structured and regularly recurring meeting times and the one staff member who attended every SIT team meeting. Another school with a similarly intense MTSS structure is also characterized by multiple weekly meetings, tight communication across different group meetings, different types or categories of school staff present in meetings to support students (which allows for different perspectives and insights), and layers of strategies to support students based on their needs.

Not every school has as formal and institutionalized a structure or as many different groups within its MTSS. Indeed, the two examples above are likely on the extreme end given the extent and organization of their MTSS. Other schools in the district have one MTSS team that meets anywhere from once a week to once a month. The frequency varies depending on what else the team members have on their plate (which could be quite substantial since part of our data collection was during the COVID-19 pandemic). Meeting less meant less time for students:

We meet for one hour a week. It's hard to really dive into a kid in less than 20 minutes if you're going to do a good deep dive of test scores, and did something happen in between fifth and seventh grade? That's where we see a dip. They missed four months of school. The reality is they're struggling in math because they have gaps in knowledge, and we never went back to fill in those gaps - an MTSS team member

These teams also do not have the same structures to facilitate communication with other teams in the building (like counseling teams or administration teams), which further undermines their ability to support students. SIT team members in these schools make it clear that they wish they could have more time to help more students. "We [are early] in

² Note, "SIT Teams" is generic language found in many schools, similar to MTSS. However, "Prime Team" and "Individual Support" Team are pseudonyms.

³ For more on Professional Learning Communities, visit the Colorado Department of Education: <https://www.cde.state.co.us/uip/strategyguide-plc>

developing this program... We have a lot of kids who just deserve someone to take a deeper look to say, can we help you and support you better?... Open up our eyes to it being our responsibility as educators to dig a little bit deeper to get to what that story really tells us," one staff member shared.

It does take a lot of time to develop an effective MTSS. One school with an extremely elaborate MTSS is over six years into their MTSS development process – a process leadership admits is sometimes challenging. For one thing, you can't just mandate from the top, as one MTSS leader put it:

I think people miss a huge piece of developing intervention systems when it's mandated from the top...the right people [from within the school] have to be picked [to help lead it] because they have to have the respect [of the building]. Otherwise, teachers will see [the MTSS system] as one more thing on their plate versus this is something that can be taken off your plate...We spent a lot of years really talking to teachers about, [our MTSS process, explaining that] it's not one more thing... We really spent time creating systems that worked for teachers that streamlined, that created efficiencies for teachers. We did work through PLCs to create meaningful work for teachers, that wasn't just, 'we're meeting and we have to do these things, because district says, or admin says.' And I think that was crucial for us, is to have teachers leading teacher buy in.

Consequences for Suicide Prevention. These structural differences in MTSS systems matter substantially to whether the MTSS serves mental health promotion or suicide prevention well. Less time spent in MTSS meetings each week means less time to support students and more missed students. Parents perceived this, particularly when they had a child that was not getting as much support as they needed:

I would say [that at my child's school], unless [your child is] on one end of the spectrum – either very high grades, high involvement or very special needs, very low, troublemaker – unless if you're one of those, [you don't get support]. If you're somewhere in the middle, there's not a whole lot that makes you stand out so you become known to too many people...that's kind of, I think, what I've seen, especially, I think, with my son. He wasn't far enough down on that spectrum that anybody was wanting to help him, and he was just lost in that middle area. And I was like, this kid needs help. And it was just really easy to look over him and think [his struggles weren't] that urgent or that big of a need.

This contrasted sharply with how parents generally experienced involvement with more structured and developed MTSS systems. One family whose son has experienced significant mental health problems that disrupted his schooling found their interactions with a well-developed MTSS system to be very supportive, even surprisingly so. The father shared:

I think they've always been available for him and offered for him to come in any time [to the counseling office]. Everyone that he has to interact with knows him well, and always will say good things about him...I was blown away by the level of flexibility that they have though...we got called into this meeting with

[MTSS team members] and they were like, “oh yeah, we can switch this around...and he can do this [offering options to switch his classes mid-year]...I was amazed by that...They [also] have an open door policy [in the counseling office – he can come in anytime]... I know that they're taking more of an active role because of where he's at in his situation, but some things still fall through the crack. They can't be all things to all kids.

It is indeed true that every school in our study struggles to meet the needs of *every* student. And in every school, we met families whose students had not been well-supported. “They’re spread pretty thin,” the mother of the boy in the previous example shared. “I do feel like they care, but I feel like they’re spread thin.” “They’re exhausting their resources,” the father concurred. Indeed, we heard this concern from families around the District. Since schools often work with limited resources, including staff time and energy, it is important to build systems that help schools efficiently engage in the potentially time-intensive and emotionally laden work of supporting the school’s most vulnerable students.

Staff are also sensitive to this issue. One source of reluctance to focus more heavily on mental health in school is that staff are worried about – in the words of one staff member - “resources being directed away from the classroom for a great many reasons [including mental health] and it is making it more and more difficult for a teacher to attend to a child’s educational needs.”

Staff clearly feel that MTSS systems are one effective way to better address the needs of as many students as possible, while preserving resources. Our staff survey data showed that in buildings with well-developed MTSS systems, particularly systems focused on students’ academic and social-emotional needs, staff feels that their MTSS really helps students, both academically and social-emotionally. Perhaps more importantly, as we consider how to build stronger mental health safety nets, staff generally feel MTSS systems make their jobs easier, again, particularly in buildings with well-developed MTSS systems. MTSS leaders also report that the MTSS system helps staff develop empathy and a willingness to engage in supporting the students’ mental health. At one critical point in the development of their MTSS, an MTSS leader recounted a moment when she saw a teacher embrace caring about the whole student:

I remember one teacher saying, vividly, and it's a quote that will stick in my head forever, which is, ‘I don't know this girl, but she's mine now.’ And I knew in that moment, when you can get people to invest, that we had a real shot of [building] really special systems.

Are Clinicians Present? One additional structural difference that is worth noting is that participants in the MTSS had clinical training in some schools. While school counselors, school psychologists, and school social workers are all trained in advising and supporting students’ academics and well-being (and in the District trained to assess students for suicide risk), not all have additional clinical training. Clinical training brings additional expertise in mental health, though it does not mean that these individuals then provide therapy in school (though in some unique programs, it does). Rather it means that they bring these additional skills and knowledge into their interactions with students. This was clearly powerful when students were in crisis, as these staff members were particularly skilled at helping students navigate and regulate their emotions. There were

not many of these individuals in the District, but they were beloved and trusted by students. This may be their own unique brand of magic, or it may suggest that having some staff with clinical degrees (often clinical social workers) is an additional way to strengthen MTSS systems. We do not have the data to distinguish between these two, but the effect was powerful enough to be worth noting. Our professional judgment is that it is both.

Referral Strategies & Visibility. The final feature of MTSS systems that makes a given support system effective is how well-known and visible it is for all members of the school community. A well-known support system is key to creating trust and confidence between parents and students and the school and District, as well as between various individuals and departments throughout the support system. In turn, buy-in across the school community—or the motivation to access and use the support system—is achieved through parents, students, and school staff knowing the support system exists, works, and is a collective effort.

We find variation in both how aware of the MTSS system staff are and how youth are referred to the system. The ideal is that anyone in a school building can refer a student to the MTSS. But that is not always the reality. Some MTSS staff felt that “the onus [was] on the student.” “We have a variable schedule [so students have free periods],” the MTSS staff member explained, “You’ve got time in your schedule, why aren’t you coming to see me? Figure it out. You’ve got all the tools.” As a result, the staff member felt the team, and thus the school, was failing to build a system to support all students. “It’s our responsibility as leaders,” they explained, “to develop systems to say every student is known, loved, cared for and has a path for that.” Indeed, only one school – a school with a strong culture of belonging – experienced a significant number of student self- or peer-referrals.

Instead, staff is the most common source of referrals to the MTSS in all buildings, based on our observations. However, there were significant and substantial differences across schools in how frequently staff referred students to the MTSS system. For example, 37 percent of staff in one school had never referred a student to the MTSS (the maximum across schools), compared to 11 percent of staff in another school (the minimum). On the other end of the spectrum, a high of 84 percent of staff in one building had referred three or more students to the MTSS compared to a low of 23 percent in another building. These differences are substantial and statistically significant. Time and experience should partially help address these gaps between. Schools with more established MTSS systems generally had more staff participation. However, ensuring that all staff in the building understand how to use the MTSS and that the MTSS functions to support the work of staff effectively (making this a valued system for them to invest time and effort in) is also crucial.

Parents Need to Understand What Schools Can Do. An ideal MTSS will also facilitate parents reporting their children’s needs to the school and ensuring that those needs are communicated to MTSS teams. One critical way to ensure parents understand the full range of services schools can offer to support student well-being and needs is to make resources easy to find on school websites.

Parents are not always sure what kind of help they might need or what kinds of supports schools provide. Across all high schools, approximately 30 percent of parents report not knowing whether their school has staff trained in conducting suicide risk assessments (SRAs), and an additional 15 percent of parents disagree that their school had staff trained in SRAs. This is unfortunate because, in fact, all school counselors, school

psychologists, school social workers, and other school-based mental health workers, are regularly and thoroughly trained in how to do evidence-based suicide risk assessments for the students in their buildings. These staff also can help design school-oriented safety plans for when students are at school (for example, to help keep youth safe after they have been hospitalized for suicidality or other mental health challenges.) Similar percentages of parents and guardians reported not knowing whether schools could provide accommodations for mental health struggles (26%) or disagreed that schools would do this (13%), even though all schools that we observed had clear strategies and policies in place to provide accommodations for mental health struggles. These gaps in parents' understanding collectively highlight the need to make sure that information about how to access supports at schools and how schools can help is needed.

Clear Websites are Important. An additional concern parents raised is that information is needed on school websites about accessing mental health resources. Several parents shared with us that they struggled to figure out whom they needed to connect with at a school to obtain the help they needed to support their child through a mental health crisis. For instance, one parent shared:

I know that there is the mental health page on the website, but the link didn't work. There was just a number of things, and I know in that time of the crisis while I was trying to get ahold of the counselors, it was kind of after-hours, but not [that late] and couldn't get through to anybody. In that moment of crisis, it's already scary and if you don't know what to do or you don't know the steps, could there be a process of, "If your kid's going through this, here's what to do? If it's at this time of the day, do this."

This quote reveals several things worth noting. First, the school is an absolutely critical resource that parents turn to, whether they expected to or not, when a psychological crisis happens. Second, websites are crucial places for accessing information. Third, while this district does have after-hours support, it is largely through the District Security team, who is not necessarily whom parents think to turn to in a moment of crisis (though based on our observations, this team would actually likely be able to guide parents effectively). This is not to say that schools must be available 24/7 – that is not possible or reasonable. But making information accessible, organized, and clear can make a tremendous difference to families in crisis.

We reviewed many school mental health websites as part of our research, and while some are clear, creative, and excellent (also personable and kind), not all websites are easy to navigate or even to find. Some also de-emphasize mental health or only bring up mental health by linking to the District's mental health webpages (potentially signaling to parents that mental health is more the realm of the District than the school). Additionally, many webpages did not make clear the skills and training that mental health staff have. For example, school counselors are not always noted as trained in suicide risk assessments. In one school, only a school psychologist is labeled on the website as capable of conducting suicide risk assessments (SRAs) (despite more staff being highly trained in SRAs). Notably, these website problems, and the frustrations they sometimes cause parents, are true in schools with and without highly organized MTSS systems. This highlights the importance of clear channels of communication about resources, and the need for continuous messaging

and advertising of these resources and points-of-contact for accessing one or more support systems.

The MTSS & Strengthening Suicide Prevention. Several implications for strengthening suicide prevention in schools emerge from our discussion of the MTSS systems in schools. The MTSS is an excellent and under-used resource for suicide prevention in schools. MTSS systems are how schools go about the everyday work of supporting vulnerable students. There are established structures and strategies that exist to make MTSSs more effective. However, currently, they are not conceptualized by suicide prevention or education researchers as an ideal location for suicide prevention interventions in schools. Thus, researchers should begin to develop suicide prevention interventions that are compatible with being embedded in MTSS systems. This likely would look like a brief curriculum for PLCs and SIT teams, or even a curriculum on how to tune an MTSS to consider suicide prevention. It also means designing protocols and training to ensure MTSS team members are educated about mental health, suicide prevention, trauma, drug use and abuse, and other common youth struggles that could appear as MTSS teams work to support the needs of youth. Demonstrating how mental health is relevant to accomplishing schools' other goals – like academics and passing state competency exams – is also important to ensuring staff members that hold more strictly academic educational philosophies understand why whole child and trauma-informed approaches are more effective.

While it will require additional research and collaborations between educators, school-based mental health workers, researchers, clinicians, and suicide prevention experts to effectively embed suicide prevention and mental health interventions in MTSS systems, our study offers some initial insights. First, to tune MTSS systems towards suicide prevention, a first step is for schools to explicitly include mental health promotion as a goal of the MTSS and mental health outcomes as a measurable outcome used to evaluate how well the MTSS is serving the school community. In this way, we are truly embedding suicide prevention in schools and leveraging existing strategies and resources that schools have in service to this newer responsibility that schools are facing as youth suicide rates rise.

Second, having a well-developed, institutionalized, and multi-layered MTSS will ensure that the MTSS can effectively help support vulnerable students and their families and teachers. Four meetings a week is better than one; more students can receive attention. Of course, this takes staff dedicating their time to the MTSS, which may leave less time for other obligations unless the MTSS works well to serve both staff and student needs. Thus, third, teachers especially must buy into the MTSS framework as well as the focus on mental health and suicide prevention. Making sure that the MTSS is designed with the labor of teachers in mind will ensure it is more effective. Fourth, we recommend that schools communicate more clearly – and even brag – about the incredible amount of evidence-based trainings, retrainings, and frankly, effort that mental health staff in every building put into mental health and suicide prevention. Mental health staff in this district regularly perform suicide risk assessments on students, followed by triaging students to additional supports. Letting families know how capable staff are could increase parents' and legal guardians' willingness to disclose struggles that they are having at home (an area that needs work, and that we will discuss in a following section). Fifth, schools can strengthen suicide prevention by making sure that mental health information is available on their websites, including information about what to do if your child is in crisis. Specifically,

schools (and the District) should provide guidance about what to do if your child is having a mental health crisis, if they are hospitalized for a mental health struggle, or if they require additional mental health supports at school. Every school has protocols for supporting students through all of these scenarios. Educating parents about these protocols would help parents be better participants in communicating with schools about mental health.

Finally, it is worth noting that in all of these schools, mental health and suicide are major preoccupations of staff, students, and parents. Everyone is concerned. This is evident in our surveys, interviews, and observations with staff, students, and parents. Still, schools sometimes hesitate to take mental health on entirely or be public about how involved and prepared they are. In one observation, mental health staff members were concerned that if their website was too focused on suicide prevention that it might reinforce the idea that suicide was a big problem. Our data suggests this concern is unwarranted and potentially even harmful. Suicidal thoughts, suicide attempts, hospitalizations for suicidality, bereavement by suicide, as well as for other serious mental health problems (e.g., drug abuse, anxiety) are problems in every school we observed, and perhaps many schools in the U.S. in this historical moment. These challenges are not unique to this District or community. As a result, we recommend embracing suicide prevention and including it wherever possible. Talking about suicide saves lives. Providing information about suicide prevention and where to get support saves lives. It also shows that we care and that we understand what's happening in youth's lives today – namely, tragically high rates of suicide.

Supporting Youth Well-Being Beyond the School

While schools play an outsized role in suicide prevention, schools cannot do this labor alone. Suicide prevention is very much everyone's business, and it will take us all to change the world for youth. With this next section, we offer insights into how people and organizations beyond the school support youth well-being and support schools in their work. We begin by discussing the role of the District in supporting schools' suicide prevention and mental health promotion efforts. We then discuss the role of families. We see families' role in suicide prevention as two-fold. First, families influence school cultures, and thus, mental health support systems within schools. Second, families impact youth mental health directly by putting often unintended, but none-the-less painful pressure on their children and by facilitating children's mental health help-seeking. We then discuss the role of healthcare – hospitals, therapists, crisis centers, and pediatricians – in suicide prevention. Families' and schools' abilities to intervene are both dependent on access to and the support of healthcare professionals. Some situations are beyond the capacities of families or schools to navigate without clinical guidance and treatment. Finally, we conclude by discussing the role of faith communities. Faith communities can provide wonderful mental health benefits, but they are perhaps not as active in suicide prevention as they could be.

I. The Role of the District

Schools cannot be successful at suicide prevention without the leadership and support of the District. One of the primary ways that the District shapes suicide prevention in the local schools is by setting priorities and developing protocols to translate priorities into reality. The District ensures that all mental health staff is trained in suicide prevention, crisis response, danger assessment. Additionally, all new mental health staff must complete the two-day initial ASIST training (LivingWorks 2021), the gold standard of evidence-based suicide gatekeeper training. Every year, mental health staff go through refresher trainings that reinforce these critical skillsets. Administrators are also offered the opportunity to complete ASIST training; though it is not required, some do.

Aside from the yearly trainings, the District hosts monthly meetings with all mental health staff in schools stratified by education level (elementary, middle, and high schools). The purpose of these meetings is to check in about challenges and needs and to discuss strategies and share resources across schools to support youth well-being. The District also has weekly meetings where they review *all* reports of mental health, behavioral, and other social-emotional problems that students experience each week throughout the District. The District reviews each event to ensure that District policies are followed, that plans for follow-up actions are in place (often follow-up support for the student), and that any needed support or guidance from the District to the school, staff member, family, or student is provided. While this may seem like school business as usual, the District is extremely organized and thorough in its strategies, helping to ensure that youth do not slip through the cracks and that needs are addressed as they arise.

Additionally, the District has staff that connects families to clinicians outside of schools, working with families and youth to match students to clinicians that meet their financial, social, linguistic (etc.) needs. Many in the District commented on how incredible it was to have this kind of support. The District also provides support when schools must respond to crises, such as a suicide loss. In every crisis response we observed, best practices were followed.

Finally, the District supports the implementation of Sources of Strength. This for-profit evidence-based upstream suicide prevention curriculum is highly regarded in the suicide prevention research community for its ability to encourage help-seeking, help youth build resilience, and promote cultures of mental health in schools (Wyman et al. 2010).

One interesting thing worth noting is that despite District emphasis on mental health and extensive protocols and strategies to translate that ideal into action in schools, schools still have much control over what happens in their buildings. They control how they implement mental health promotion and suicide prevention (including who is hired to oversee MTSS systems, and whether counselors' work is supplemented by clinical social workers or other specialists). This means that schools vary in (1) their emphasis on mental health, (2) the human mental health resources available in specific buildings, and (3) how much they rely on the District to support student mental health. Top-down authoritarian strategies to force schools to prioritize suicide prevention may not work efficiently or effectively (as discussed in our section on building MTSS systems). However, it is worth thinking about how the District can encourage a move towards whole-child and trauma-

informed educational practices that will, in turn, our research suggests, improve suicide prevention.

The major issue for the District to work on is building and maintaining trust with the parent and staff communities. When raising this issue, we have to acknowledge the particularly challenging current context, even though it is beyond the scope of this research study. The COVID-19 global pandemic has, across the U.S. and the globe, generated animosity and frustration in communities as school districts, Departments of Public Health, Governors, parents, and school staff struggle to maintain schooling in uncertain times. Still, challenges with trust between the District and some parents were evident from the early days of our fieldwork and in our conversations with some parents. Rebuilding trust is complicated, but one commonality we note across constituents (families, students, schools, and the District) is that all care about mental health, and many want a greater emphasis placed on it. Since every existing evidence-based strategy for suicide prevention (to our knowledge) is already well implemented in this District, our suggestion for accomplishing that shared goal is to focus efforts on some of the strategies to strengthen mental health safety nets identified in this report.

II. The Role of Safe2Tell

Safe2Tell is a program housed at the Colorado Attorney General's Office that allows students, parents, school staff, and community members to report information anonymously to authorities. Those authorities include the local police department, the school district, and school leadership (when the school is identified in the tip). The purpose of Safe2Tell, according to their website, is to "keep yourself or someone you know safe from threats, harmful behaviors, or dangerous situations."⁴ Though "harmful behaviors" could be interpreted more broadly, Safe2Tell cautions that "Safe2Tell is for legitimate safety concerns and focuses on saving lives of Colorado students. Intentionally making false reports is not a good use of school, law enforcement or Safe2Tell time. It also takes valuable resources away from those who are experiencing a genuine crisis and actually need help." Safe2Tell was initially intended to prevent violence, like rampage school shootings, but it has quickly become an important tool for suicide prevention (Harms 2019).

Safe2Tell Saves Lives. Over the course of our field research, we saw Safe2Tell do a lot of good. We observed at least 8-10 youth who were identified by tips through Safe2Tell and who were at high risk of suicide or were experiencing other serious mental health problems that needed immediate intervention. These students were largely off the radar of the school or District, and sometimes off of their parents' radar. Tips come from everyone, including students. Students use Safe2Tell when they aren't sure how to talk to their parents, friends, or school counselors directly. In those instances, they find Safe2Tell easier for seeking help.

Parents also shared examples of how Safe2Tell helped them learn about their child's severe distress. One mom, for instance, told us a story that speaks to Safe2Tell's virtues. After a Safe2Tell tip came in about her daughter, a District mental health team member called her, and told her she needed to return to school to pick up her daughter because

⁴ This language comes from: <https://safe2tell.org/make-report>

there was a serious concern about the daughter's mental health. As the mother drove back to the school, she received a second call from her child's school counselor and the principal letting her know they had eyes on her daughter – to ensure her safety – until the mother arrived at school. The mother was quite surprised to learn that her daughter was experiencing serious suicidal thoughts:

I found out later on the way home [that] she was texting her friend about how she always screws up and how she's going to kill herself and how it's going to be easier on everyone else. Her friend, fortunately, was very sensible and contacted Safe2Tell.

The mother found out it was the friend who reported her daughter to Safe2Tell because the friend's mother called her. In the days that followed this incident, the school maintained their supportive role. "Her counselor was checking on [her] two to three times a day," the mother shared.

There are several things to note about this exchange that help illustrate why Safe2Tell is important and how it helps prevent suicide. First, Safe2Tell facilitated information-sharing between the friend and adults so that this young woman received additional support. Without Safe2Tell it is unclear whether this information would have come to light. Second, Safe2Tell informed the District and the school, who in turn, informed the family, ensuring that a web of supportive relationships could contribute to the safety of this young woman. Third, parents do not always have a clear picture of their child's well-being or emotional state. This mother cared and was involved in her daughter's life, but did not know the extent of her daughter's distress. While not every instance of Safe2Tell plays out as ideally as this one, this example was not outside the norm.

The Involvement of Police. While Safe2Tell tips do not always result in police involvement, one response to Safe2Tell tips includes police officers arriving at a student's home without warning to perform a wellness check. This response is especially likely if the tip is after school hours, if parents or guardians cannot be reached, or if the child is not in a school building (where a school staff member can locate the child). In our survey data, approximately 25 percent of parents were not comfortable with having police show up at their house to perform a wellness check. For parents who had had the police show up at their house, most said it was an "intense" or stressful experience, even if the visit produced important information that helped keep their child safe. One mother shared, "It's super intense [having police show up after a Safe2Tell tip]...It was right after school...So, there's policemen in our house [and while] I think [my son] figured out that this wasn't the type of attention he wanted, I don't think that takes away the pain."

We did find that more parents of color, especially Black parents, felt uncomfortable with having police show up at their house after a Safe2Tell tip. Students of color that we interviewed also noted discomfort around police, though they often made a distinction between police and the School Resource Officer (SRO) assigned to their schools. For example, when asked about his relationship with the SRO assigned to his school, one Black student shared:

I don't feel uncomfortable. [The SRO's] friends with everybody too. He's like the nicest person in the world but...the issue with being black and having the cop in the school is just there's this social bias of cops and so he doesn't bother

me because I don't think about it but I wouldn't feel unsafe without a cop in the school.

A careful read of this student's comments reveals both comfort and hesitation. "I don't feel uncomfortable" is not the same as feeling comfortable. Additionally, while the student recognizes the SRO is friendly and nice, his own black identity shapes his ability to just feel comfortable in the presence of a cop, SRO or not. It requires the student "not think about it too much," which takes psychological effort and could drain psychological resources.

Collectively, our data suggests that SROs who make an effort to be kind, friendly, and supportive to students, particularly students of color and LGBTQ+ students, and who take the time to educate themselves about mental health, disability, and youth, can have that effort pay off in terms of trust. However, school staff of color also recognize that they had the privilege of collaborating with unique SROs. "It's very unique in that [our SROs] have such a good understanding of schools and disability," one staff member (who was also a person of color) shared. She continued:

They're the epitome of what I would love for all SROs to be. In my circle of all my cohort [of school-based mental health workers who graduated from my program together], no one else has this [relationship with their SROs]. All the other SROs I've heard of are young, inexperienced, don't understand disability,⁵ don't want to hear it...it's hard, because we're having all these discussions in the [mental health] world about SROs. And I just have this biased situation...It is unique to our district.

One challenge though is that even when students themselves feel comfortable with the police in their schools, they are also very aware that not all of their friends feel the same. One young Latinx student, who had had nothing but positive experiences with her own SROs, shared with us:

I have friends who do not like the police due to family member situations. Like, let's see. One of my friends is partially Native-American, and their mother when they moved to America was treated very poorly by the police. They really don't trust the police and they get stressed out whenever they seem and tense. I don't get how other people don't know this stuff. I was the only one who noticed, even though he had other friends there. He was really nervous. I know like them, they do not feel that safe. I do.

This sometimes shapes students' willingness to use Safe2Tell for fear that police will be deployed instead of school staff. For example, when asked how they would hypothetically respond to a suicidal friend, Riley, a teenager, shared:

[Whether I used Safe2Tell or not] depends on how urgent I think the situation would be, but I think I feel like at some point it's like, what would [the people at Safe2Tell] do? The police would probably come, but I feel like in some cases that would be more traumatic than just going to their parents.
Anna: Mm-hmm.

⁵ Note, mental illness is a form of disability, so in this example, this staff member is referring to disability as encompassing mental illness.

Riley: Maybe I would offer a helping hand to go to see their parents together first. I feel like I would do a lot of other stuff before I resorted to [to Safe2Tell].

While for many, having police show up at their home unexpectedly is an intense potentially traumatizing (to use Riley's words) experience, it is also worth noting that disproportionate rates of police discrimination, use of force, and violence against black, indigenous, and people of color are well documented (Gilbert & Ray, 2016; LeCount, 2017; Monk, 2019; Rios 2011; Shedd 2015; White, 2015), which may make this relationship between Safe2Tell and the police particularly difficult for families of color. This also highlights the need to be thoughtful about the inclusion of police in mental health safety nets and recognition that Safe2Tell may work to promote safety better for some youth compared to others. Indeed, during our fieldwork, the community (writ large) began critically reviewing these procedures with hopes of identifying other strategies that will feel comfortable for all students and families. This is particularly important because SROs – the police officer that our data suggest more students feel comfortable with, at least in this District – are often not available to respond to after-hours Safe2Tell reports (which is when police officers are more likely to be the responders to a serious Safe2Tell report) because SROs generally work school hours.

Misuse of Safe2Tell. While we observed important instances where Safe2Tell connected youth to needed mental health resources, we also heard about and observed instances where parents and students misused Safe2Tell. Some part of this misuse may stem for the language regarding what to report mentioned earlier. "Harmful behaviors" can encompass quite a lot, and one mother we spoke with shared that she used Safe2Tell to report her own daughter's vaping. This is potentially an inappropriate or unnecessary use of Safe2Tell. Instead, it may have been more effective for the mother to tell her daughter's school counselor or principal, if she wants the school to know (perhaps to monitor the daughter for vaping behavior at school).

Several times during our observations, Safe2Tell was used to report kids having parties or gatherings despite COVID restrictions. This is an inappropriate use of Safe2Tell. Youth also shared that sometimes peers used a Safe2Tell report to bullying each other, though we did not observe many instances of Safe2Tell being used in this way. It is possible it happened but was dismissed before arriving at any meetings we observed (where Safe2Tell tips were reviewed and triaged).

While we ultimately see value in Safe2Tell despite its downsides, it is important to ensure that youth do not use it to harass each other. One student who perceived Safe2Tell to be "awful" and "all lies," stressed that Safe2Tell made her feel less safe at school. She explained:

I mean obviously, there are going to be people that are petty and weird...And they would be like, "Oh, there's like cocaine in this girl's backpack." And then they would pull her from class and search your backpack. And she's like, "Are you kidding me?" Someone who's probably just mad at me, you know? And so Safe2Tell was so stupid. It was so counterproductive. And then people felt less safe at school...because like people were making stuff up and then nothing was like...I know that [Safe2Tell had] good intentions and I know that it's saved a school student somewhere in [at a neighboring high school]...[But] for my

school, it did not work. I really hated safe to tell. I could have talked about that forever.

The student above is not alone in her concerns. Some students complained of having Safe2Tell called on them and disliking the situation; being inappropriately “Safe2Told” on by a classmate; and being bullied due to being falsely accused of using Safe2Tell to “tell on” someone else. While we observed rare instances of Safe2Tell being used inappropriately (by adults and students), in general, we still feel this is not a major concern that emerged from our research. However, these misuses, along with equity concerns, must be guarded against for Safe2Tell to be a positive influence on student well-being. Additionally, for Safe2Tell to remain a trusted part of the safety net, raising awareness about its appropriate use and discouraging bullying or harassment are vital. One parent, for instance, recalled a story in which someone used it to report her daughter being drunk, “and then the vice-principal calls me and say, ‘[your daughter’s] really drunk, she’s about to drive.’ And, I’m like, ‘Well no, she’s in the car with me right now.’” Another parent echoed this concern, worried that it was being used to make “false reports...because it’s anonymous to create hassles and issues and embarrassment.” Notably, she continued on, understanding that it was a useful tool: “I’ve thought in my own mind, ‘what would I do if I was the administrator in charge?’ Do you take that tool away? Maybe? I don’t know. That’s a tough one.” Like counselors or trusted adults more generally, Safe2Tell is only as good as those who might use it trust in its ability to help and not hurt. It is also only as good as the helpers who show up to help the person in need.

III. The Role of Families

Families play an important role in suicide prevention in schools and communities through several mechanisms.

...In the Production of School Cultures. First, families help set school’s agendas, priorities, and cultures. For many families, they wanted schools to prioritize suicide prevention and mental health promotion. Ninety-seven percent of parents and legal guardians from our surveys agreed that schools should be involved in suicide prevention; 99 percent agreed that schools should create positive social and emotional environments for students; 97 percent agreed schools should intervene when a student is in a mental health crisis; and 96 percent agreed that schools should understand the personal struggles students may be facing outside of school. Additionally, 83 percent of parents felt it was very important for schools to include mental health in their curriculum (with an additional 14.6 percent saying it was ‘somewhat important’); 89 percent said it was very important for schools to include life skills and building resilience in school curriculum, and 78.4 percent said it was very important for suicide to be addressed in school curriculum. Interestingly, families did not want talking to their children about suicide to be their

Figure 1: Most parents worry about their child's mental health

responsibility. Only 8 percent of family respondents said that they agreed that parents should talk to their children about suicide. They were significantly more comfortable with schools taking that on. Finally, many families reported serious concern about youth mental health. Over 90 percent of family respondents in our sample worry about their child's mental health, with 42 percent of respondents worrying "a great deal" or "a lot" (Figure 1). There was no statistically significant variation in any of these beliefs across schools.

While most parents endorsed a focus on mental health, there was a minority that believed schools should leave mental health to parents. Specifically, in our survey data, 28.2 percent of parents and legal guardians endorsed the idea that schools should leave mental health in the hands of parents. This pattern did vary significantly between schools. The school with a high rate of staff who felt mental health belonged in the hands of parents also had a high rate of parents endorsing this idea (28%), suggesting a synergy of beliefs. However, a second school, whose staff did not endorse this idea and who housed a whole-child educational philosophy, had an equally high rate of parents who endorsed the idea that mental health should be left to parents. A third school had significantly fewer parents who endorsed this idea. Parents from this third school (which is characterized by a whole-child philosophy) also agreed more than parents at the other two schools that their school could support student mental health through suicide risk assessments and accommodations.⁶ While not statistically significant (likely due to the small subsample size), among the 211 parents who had a suicidal child, more parents from this third school felt very satisfied with their schools mental health supports than parents at the other two large schools (34 percent compared to 22-23 percent, Pearson chi-square= 9.10, p-value < 0.17).

There are two things worth noting about these patterns. First, in general, parents want schools to support student mental health and well-being, through their curriculum and mental health safety nets. Second, schools are reflections of their parent communities. In schools where parents are less enthused about schools supporting student mental health, staff are also often less enthused. This is a well-known effect in the education literature – that schools mirror communities – and is called a "selection effect." Essentially, families select schools that match their cultural values, beliefs, and social identities, and then when children from those families enter the school they contribute to maintaining that culture.

This effect was very obvious in our qualitative interviews, particularly when we asked parents and students why they chose their high school. Parents and their children were often drawn to schools precisely because of their cultures and reputations. "Though the general atmosphere and environment of my school is at least reported to be a lot more toxic and hard to be in, and it's a lot more pressure and academically it's more rigorous," one teenager explained, "[that's actually] probably the reason I ended up going there. Just, because I wanted to have a better chance at college and just a general future, because I think especially that would be more impressive on a college application." This student valued academics more than anything, and thus was willing to put up with extra pressure and rumors of a toxic culture to attend the school they perceived to be more rigorous.

⁶ Note, when breaking down family beliefs by schools using our survey data, we only have sufficient statistical power to examine differences between three of the four schools. Thus, one school is excluded from these analyses, though in general it matches the "third school" discussed here.

Parents also emphasized the importance of academics when selecting a school: “We had primarily been in schools that were very highly rated in terms of metrics,” a parent explained, and so when it came time to choose a high school, she once again “look[ed] at benchmarks and all of those indicators.” This just made sense to this mother, after all, she shared, “Most of my kids' lives, they've gone to schools that have been very highly rated in academics.”

For some parents, their child’s ability to fit into the school culture or the warmth and emphasis on belonging for all influenced their school selection. A parent of a child who attends the school with the intense culture of belonging cited that culture as central to their decision to send their child there:

One of the things I love about our school and this hit home to me when my son was just deciding between two high schools...The principal was so open and welcoming and she said, this is not the place for you if you are uncomfortable with people with blue hair. Or people who don't look like you...This is a place where you have to feel comfortable with everything and we strive for that.

This process of parents and students choosing schools because of their reputations likely has spillover effects. When ideal typical students and their parents are primarily concerned about academics, they create cross-pressures for staff who may be interested in changing the culture or the workings of the MTSS; it can make it more difficult to divert resources that have long supported strictly academic programs or to modify these programs to include mental health and suicide prevention because they appear to diverge from the mission families may believe the school is supposed to be realizing.

While selecting the social context that becomes the primary social contexts of our children’s lives matters, it is also critical to realize that this effect is not deterministic. Students and families grow through their experiences in schools and their communities, including when they experience collective traumas or challenges at school (e.g., school shootings, suicides, other student deaths, or the COVID-19 pandemic). These moments, while difficult, can also offer opportunities for change and growth. Additionally, we did see examples where school staff held different beliefs than parents in the example of the school where staff are more willing to take on mental health than parents perhaps think is ideal. What is clear is that families and students matter to school cultures. School cultures are not solely produced by the professionals who work in the buildings.

...In Connecting Youth to Help. The second major way that families matter to school-based suicide prevention is that families can choose to turn to the school for help and support, communicating their child’s needs, or they can keep quiet. In previous sections we saw powerful examples where parents reaching out to schools seriously helped their children (e.g., the case of Timothy). We also saw instances of parents who reached out and didn’t find the information they needed, which increased their stress during a painful crisis. But one profoundly clear finding from our family survey is that parents do not think of turning to schools as a source for mental health supports as often as might be ideal. Families are more likely to turn to mental health providers, pediatricians, or friends and family than they are to turn to schools.

This pattern also appeared when parents had a suicidal child. Almost half of parents did not tell the school that their child was suicidal (though 14 percent reported that the school already knew). This creates potential barriers to how effective the school’s mental health support systems and suicide prevention efforts can be. Some of this hesitancy is likely due to gaps in knowledge about what schools can provide that we discussed previously. But, some of it may also be due to other factors like their child’s resistance to getting help, parents not knowing how to get help, or not knowing or believing that the school can help. Regardless, greater communication between parents and school staff would undoubtedly improve the school’s ability to help provide support and prevent crises from escalating. As one staff member relayed: “Parents NEED to be a part of the solution if anything is going to change for the better.”

...Generating Pressure. We spent significant time discussing with community youth the sources of mental health problems. And youth across schools in the community were clear - youth feel tremendous pressure to conform to (often high) expectations. Families play an important role in generating and reinforcing this pressure, though youth also felt the pressure from schools and the community writ large. When Celia, for example, commented that it is stressful to be in a school that is so “academically driven,” her sister Alexandra was quick to point out their parents’ influence. Alexandra explained their parents’ emphasis on “straight A’s” mattered. She elaborated, “our parents...the thing that they’re strictest about is grades.” Similarly, an alumni of the schools recounted how upset her parents were when she earned one B in middle school. Most students describe “piles of homework,” no free time, and expectations to juggle multiple AP or IB classes. One young woman, we call Luna, shared that she believes that the generational difference in access to the internet has contributed to adults having unreasonable academic expectations.

Students are also acutely aware of Front Range Public School’s reputation for academics, which added another layer of pressure to live up to the community’s high bar for success. While some students describe community or school norms that reinforce or contribute to this pressure, many youths worried their parents would think less of them if they did not maintain high GPAs and complained of parental expectations surrounding straight A’s. Importantly, this parental pressure factors into whether youth feel they can tell their parents they are struggling.

Not surprisingly, the feelings of pressure and resulting distress was amplified by anxiety about the future. Students worry about their grades and extracurriculars in relation

to getting into a “good” college. Avery says much of the pressure around grades is because adults believe “that if you don't get straight A's and if you don't do this, then you're not going to have a great future.” Similarly, Mila describes the difficulty of being a teenager with so much going on, when parents do not seem to understand this pressure. Seemingly, students struggle to enjoy themselves or do what is best for them in the moment because their accomplishments are so oriented toward the future.

IV. The Role of Mental Healthcare

In our survey data, both parents and staff stress that access to mental healthcare and increasing the number of available mental health therapists and clinicians are critical to diminishing youth suicide. For both groups, it was one of the most popular responses. Additionally, for parents whose child had gone through a suicidal crisis, the most common barrier they noted - after their child being resistant to getting help – is a lack of access to treatment. About 19 percent of parents report that lack of access to treatment was a barrier (Figure 3). Parents we

interviewed reported it was challenging to figure out how to get professional support for one's child. One parent reported that it “is difficult to navigate [mental health supports] in the community. I believe the schools are working to do more but accessing true help outside of the District can be difficult and frustrating.” Indeed, the District has a staff member whose job is to help connect families to therapists and

other resources. However, even though it's frankly amazing that the district has devoted resources to this position, it's still not enough. This staff member is frequently busy and the perception among staff in the district is that she does not have enough time to address all student needs. Thus, schools focus on sending her only the neediest cases.

Families of children who experienced a suicidal crisis often brought up that there were not “enough beds” – meaning pediatric psychiatric hospital beds – in local hospitals. Hospitals were regularly full, causing families to have to change hospitals (e.g., from the hospital with the emergency department they initially went to to a different hospital). “One thing I have learned,” a mother shared, reflecting on her experience hospitalizing her daughter, “is there are not... – and I don't think it's unique to Front Range, but there are not enough beds...There's nowhere for [people who need help] to go. And if they do go, they have to get out quick because yeah [someone else needs the bed].” Another mother shared a similar experience with her son. “The state of mental health support from a medical standpoint,” she declared, “is a travesty. It's probably not just Colorado; I think it's as a nation, but it's horrible.” She continued:

Figure 3: For parents whose child had suicidal thoughts or had attempted suicide, one third did not report any barriers to seeking help; for those who did, child's resistance and a lack of access to treatment were main barriers.

And, you know, that was really hard, because as a mom, you know that your son's gone through this traumatic event. You know that he's behaving really weird. I'm trying to find some help. The school isn't telling me anything. Yet, I can't find the support. I don't know where to go. So you're just talking to people, but it is the kind of thing that, I don't think there's the same stigma here. But I think it's like, if I were to say, 'I know your husband had cancer. Who was his doctor and did you like him?' They would be much more comfortable telling me that answer than if I said, 'I know your husband's super depressed and he has a good therapist...who is [your therapist]?' That is still a very different conversation.

Despite her hesitation, she did ask people bluntly about their therapists. "But then, anyone that said yes ['I have a great therapist' then the therapist], they're not taking new patients. [ironic laugh]."

There are several things worth highlighting from this quote that were things we noted with other families. First, the search for a therapist is extraordinarily stressful for parents, during what is already a painful time. "I need help," this mother shared. And when she struggled to find it she shared, "It was scary...not knowing [how to help my child.]" Second, when parents have a hard time navigating something, like access to mental healthcare, they do turn to the schools. The schools are often overwhelmed with these kinds of requests, though they do try to help. Unfortunately, for this parent, her attempts to seek help from the school were unsuccessful. Third, while mental health stigma was not a major issue in this community, and many people see therapists and seek mental health help, there is still some discomfort about talking to people about therapists they might recommend. And even then, even once a great therapist or psychiatrist is identified, they often aren't available. These parents are correct in saying that this is not just the Front Range or even Colorado. Indeed, in some ways, mental healthcare access in this community is far superior to other parts of the state or USA. But that information – that this is a crisis everywhere – is hardly comforting for kids or families going through a crisis or in need of additional supports.

It is also worth noting that parents were correct in how hard it is to find psychiatric hospital beds for teens on the Front Range. We also interviewed professionals who worked in the mental healthcare system and they confirmed parents' perception. "[It] was my job [to find psychiatric hospital beds for teens in need]," one mental healthcare worker shared, "and that can be challenging." The healthcare worker explained:

A couple new [hospitals with psychiatric beds for teens] have opened, but the state mental health hospital, which used to have a children's unit, an adolescent unit, those closed years ago. So a lot of times what I see is people will sit in an emergency department and they're not getting treatment there. Like maybe they have a security guard so they're safe or whatever, but they're not getting mental health treatment.

These gaps in mental healthcare are unfortunate because when teens had access to a supportive therapist it could be a serious game changer for their well-being. One young woman, Patricia, ultimately sought out the support of a therapist after her stress over schooling escalated to uncomfortable levels. "She's very very helpful," Patricia shared. She helped teach Patricia strategies to channel her stress out of her body and perhaps most

importantly the therapist became a safe space where she could talk about anything. “We talk about anything and everything,” Patricia shared. Therapists often taught youth helpful skills, often tied to Dialectical Behavioral Therapy or Cognitive Behavioral Therapy (at least these are the two youth mentioned to us; they are both evidence-based therapeutic modalities that often help youth cope with suicidal thoughts, anxiety, and the like). Additionally, when we spoke to youth, they stressed – when we asked them how they would improve suicide prevention – the importance of access to mental healthcare. Many of our young respondents emphasized that there needs to be concrete, widely-known, and equitably available mental health resources for kids and teens. Cameron, one young respondent, cautioned that money is a huge barrier to suicide prevention: “I would say just lack of mental health resources for kids that don’t have parents that are willing to pay a \$100 for an hour of therapy [is a huge issue].”

V. The Role of Pediatricians & Primary Care Providers

Pediatricians, primary care providers, and family medicine doctors are considered critical parts of the mental health support system for families and children. In ideal circumstances, these doctors have long histories with families, full of opportunities to build trust and construct a deep understanding of their young patients’ lives and medical histories. As a result, these doctors are uniquely positioned to assess children’s needs regarding mental health and direct families towards appropriate mental health resources. Our survey data confirmed the importance of pediatricians to mental health safety nets. The vast majority of family respondents reported that if they were concerned about their child’s mental health, they would be very likely (59.2%) or somewhat likely (26.8%) to seek advice from their child’s doctor (Figure 2, above). Furthermore, about 68 percent of family respondents reported that their pediatrician or family doctor has discussed their child’s mental health with them.

However, it is worth noting that about one-third (32%) of respondents reported their pediatrician or family doctor did not discuss their child’s mental health with them, while about 4 percent do not have a pediatrician or family doctor, suggesting that a substantial minority of respondents are not accessing mental health care through their primary care providers. This represents a critical gap in mental health safety nets that reinforces family reliance on schools for mental health help. Families did not list schools as high on their lists of who they would turn to for help (Figure 2). Nevertheless, in practice, we found that when families had children experiencing mental health struggles the two institutions they turned to the most – especially when they had trouble navigating the mental healthcare system – are their schools and their doctor’s offices. So if one of these is weaker, the other inevitably must pick up the slack.

Additionally, during our qualitative interviews with parents who had had a child struggle with suicide or other serious mental health struggles, few discussed the role of their pediatrician without prompting, suggesting that pediatricians are not being used to their full potentials. We found two patterns among parents that may explain why pediatricians are less involved than they could be with mental health. First, parents are not always convinced that their pediatrician is qualified to advise them on mental health issues, and thus, parents prefer to skip directly to mental healthcare providers. The following

exchange between two parents whose child experienced an acute crisis reflect the uncertainty that many families face when considering the role of their pediatrician.

Father: Is any pediatrician known for going to for mental health issues?

Mother: It's your doctor, though. They're supposed to refer you to somebody if they...are concerned. Or notify the parents or something.

Father: That's the only thing [our pediatrician] would have been able to do anyway. He's not trained in that space. And if he started [messing] around in [mental healthcare], he's going to get sued by some[body].

Mother: No, but if the doctors, if they're forced to get into having some kind of a mental health, whatever education on top of that and they can start... I think that could be really promising.

Father: I guarantee this is what the doctor's reactions are going to be, 'Okay. So you're going to ask me to take on the function of being the kid's psychiatrist too? Which only adds more risk to what I do. I'm going to get no more incremental pay, more liability.

This brief discussion underscores how parents were not always confident about their pediatrician's expertise regarding mental health and sometimes drew firm lines between mental and physical health. For these parents, the question was two-fold: could their doctor even help with mental health treatment *and* would they want to help given the possible liabilities? These parents are not alone in pondering this. Recent decades have seen an emphatic push in the medical education and suicide prevention literature for doctors, but especially pediatricians and emergency medicine doctors, to become more proficient at mental healthcare. We've also seen efforts to diminish the strong divide between mental and physical healthcare. But these concerns remain.

Second, we also found that many parents who actually tried to seek help from their pediatricians found their child's doctor to be less than helpful. For example, one parent that we call Mary, who had to hospitalize her child for suicidal thoughts, did not find their pediatrician at all helpful when they needed help getting connected to long-term mental health resources. "It's really hard to connect with resources," Mary explained, "I wanted to get [my son] into counseling and the school has some connections with counselors, but it's kind of a list...I reached out to our church. I reached out to our family services team at work. They work with therapists with our [social program]. I mean, I was just searching anywhere, everywhere, trying to figure out who he should see, what kind of background they should have." Anna then asked the mother, "what about your pediatrician? [Did she consider turning to them for help?]" The mother replied, "Oh, well, we did go to the pediatrician. Yeah. I mean he asks kids some questions and he kind of was just like, 'So you're not going to kill yourself, are you?' I mean, it wasn't really a connection." In this instance, not only did the pediatrician fail to fulfill their role in the mental health safety net for a child already identified by a hospital as in need of serious mental health support post-hospitalization, but the pediatrician, in asking, "you're not going to kill yourself, are you?" is really revealing their lack of appropriate skills or training for navigating mental health. This is a terrible question to ask someone who is suicidal or in distress and goes against best practices because it biases how people will answer. The desired answer to the

question – “no, of course not” – is implied in the question itself, which stymies honest communication between healthcare provider and patient.

Another mother shared a similarly concerning interaction with a pediatrician, following her child’s mental health crisis: “My pediatrician is so uncomfortable with [mental health crises], it’s not funny. She had [my daughter], when [my daughter] was in crisis, sign a document, that she wouldn’t hurt herself.” This is actually deeply concerning because having a child sign a no-suicide contract is *not* an accepted best practice for mental healthcare. It could even harm the child because it shuts down conversations about how a child is really feeling and essentially forbids children from discussing certain forms of distress. It essentially makes it unsafe for children to raise their suicidal thoughts honestly within their doctors. Dr. Stacey Freedenthal, a Denver-area clinical social worker, professor, and expert on working with suicidal patients, offers an excellent brief summary of why the practice of so-called no-suicide contracts is not acceptable in her blog, *Speaking of Suicide*.⁷ Similarly, if parents, doctors, etc, would like to educate themselves, we recommend this podcast,⁸ discussing this and other issues with Dr. Katie Gordon, clinical psychologist and author of the *Suicidal Thoughts Workbook* (2021).

Pediatricians not using best mental health practices are not isolated incidents in our data. Additionally, interviews with mental health workers who support youth experiencing suicidal crises also felt that pediatricians are not a very active part of the mental health safety net. Francine, a mental health worker in Front Range, expressed her frustration with pediatricians: “I think pediatricians are so afraid of mental health issues and they get like what, four hours of training for mental health stuff in their training? And, usually, they are just like, ‘go somewhere else for it.’ It would be great if we could collaborate with pediatricians more often. Pediatricians usually do not want to prescribe psych meds.” While she says, “[she] can’t blame them” – this kind of work is hard and takes training – she also felt that it created weaknesses in mental health safety nets for youth.

Despite these negative experiences, pediatricians can play an important role in mental health safety nets. And when pediatricians come through for families and children, their support is extremely powerful. The older brother of one child told his mom, upon hearing that his younger sibling was exhausted and sleeping around the clock – signs he took to be indicative of possible depression, “you need to call the pediatrician right now.” The mother did, and the pediatrician was immediately responsive, clarifying whether the child was in crisis or whether an appointment ASAP with the pediatrician would be sufficient. “They were awesome,” the mother shared, “we got an appointment [immediately], [and after seeing the child] the pediatrician’s like, he needs [more than] medicine, he needs to have a therapist *and* take medicine.” Every step of the way the pediatrician was integral to walking this family through supporting their child with mental health issues and connecting that child to appropriate specialized care, while remaining an integral and effective part of the treatment process.

One local pediatricians’ office includes behavioral health in their practice. This means that they have counselors or therapists on staff, in the office, who can be quickly

⁷ <https://www.speakingofsuicide.com/2013/05/15/no-suicide-contracts/>

⁸ Suicide: The Most Known Unknown: A Dialogue with Dr. Kathryn Gordon, Podcast hosted by Dr. Xavier Bonilla
https://open.spotify.com/episode/3fB1b9E3D1WmrVxh3KTgOr?si=PHuQTS2wQioA0hISWcGXlg&dl_branch=1

deployed when concerns arise. This is a model that parents we interviewed found very supportive and functional. One parent that we spoke with experienced a suicidal crisis with her daughter, and her first step was to call her pediatrician's office:

We were with Front Range Pediatrics [the group with integrated behavioral health] and one thing that struck me is we were all three of us were sitting in my car and we called Front Range Pediatrics, [and they had a] health behavior helpline [we could call] to say, 'Hey, should we bring her in or what do we do?' ...we got...onto the line with a counselor, a behavioral health counselor at Front Range Pediatrics and he was asking different questions [than I expected]. It was on speakerphone and my daughter was answering them really openly with both my husband and I there. And he said, you know, 'I think you need to come into the emergency room.' My husband said, "you know, hey, so I have a question for you, so instead of doing that, like what if we just take her home and just kind of monitor her at home and hang out with her?' And before he could answer, our daughter said, 'I need to go.' And then the guy on the phone said, 'I think you need to come. I don't think this is a close case.' So, we went to the emergency room, by our house.

As this family experienced, knowing the precise questions to ask, and how to ask them, to elicit important information from youth is a valuable skill for someone in a pediatrics office to have. This helpline immediately connected this family to trusted experts who knew how to handle the situation and advised them on the next steps necessary to keep their daughter safe.

In our data it became clear: pediatricians have a lot of power to either be amazing resources who change the experience of a mental health crisis for families, or they can be absent partners who don't even come to mind when a crisis emerges. Perhaps in the worst case, they can use practices that many consider harmful – such as no-suicide contracts. In an ideal world, we would ensure that all family medicine, internal medicine, and pediatric doctors (if not all doctors period) can support suicidal patients in their practices. Additionally, if pediatricians mention child mental health at every doctor's visit they may help reinforce their role in mental health safety nets for families. These strategies would strengthen the mental health safety nets in communities and possibly alleviate some of the intense burden on schools to support student well-being.

Pediatricians and family medicine doctors should also ensure they stay up to date on mental health promotion and suicide prevention (Breslin, Balaban, and Shubkin 2020), including but not limited to effective, noncoercive safety planning (Nuij et al. 2021), restricting access to guns and medication (i.e. means safety and restriction) (Daigle 2005), among other strategies. Importantly, pediatricians and other family medicine doctors need to have distinct strategies for children in crisis and more general upstream strategies for promoting mental health or catching signs of struggle early. Including a mental health therapist or behavioral health therapist in the clinic staff would help pediatricians accomplish these goals and ensure they provide gold-standard care for their patients. They should also have comprehensive lists of local and state resources for families who need more specialized support for their children. Because families noted that wait times for psychiatrists who see children are extremely lengthy, physicians that treat children and youth should do continuing education to ensure they are comfortable and capable of

prescribing and managing psychiatric medications. While this may not be ideal, the national shortage of child and adolescent psychiatrists is severe and enduring (Thomas and Holzer 2006; Findling and Stepanova 2018). Thus, there may be few other options to address critical gaps in mental health safety nets for children. This is in line with broader calls in the literature to increase the role of pediatricians and emergency medicine physicians in suicide prevention (Hoffmann and Grupp-Phelan 2020; Breslin, Balaban, and Shubkin 2020).

VI. The Role of Faith Communities

As a substantial literature would predict, students and families who participated in a faith community found these communities powerful sources of support, healing, and belonging. As one young man that we call Connor explained, “I went through something...last year, I was deciding on my sexuality...my mom said, ‘well just know that no matter what we’re going to love you,’ and then I felt the same way about my religion, like God loves you no matter what.” This made Connor feel like his exploration was essentially no big deal, that he could just be who he wanted to be. Which ultimately, he decided was heterosexual. Feeling loved by God, as Connor did, helped people weather the rough times. As one adolescent explained, “Personally, I pray every day. I do feel like I have a strong relationship with God, and that’s something that I carry with me and think about when I am in hard times. That’s where I stop and take a step back and focus on that more than anything else.” And yet, despite these clear positive ways that faith communities help youth mental health, we found two places where faith communities could improve their contributions to mental health safety nets.

The first is that few families, even families who report attending religious services, thought to turn to their faith communities for help supporting the mental health of their children. Only 29 percent of religious families, report that they would be “very likely” to seek support from their faith community if they were concerned about their child’s mental health. While this is higher than non-religious families, it’s still a minority. Additionally, 10 percent of religious families said they are “very *unlikely*” to seek support from their faith community, suggesting a barrier exists in at least some faith communities to engaging in mental health promotion or suicide prevention. These findings match our interview data, where few parents report seeking or receiving help from their faith community. Those who do reach out to religious leaders, like Mary above, rarely encounter substantial support there. Youth also sometimes report that they feel their faith community explicitly scold them for trying to talk about their mental health problems. “They never talked about mental health,” Sam, a teenager, shared. “A lot of the people at church were like, ‘Just pray harder. You’re not praying hard enough.’” Sam learned to keep her mental health struggles, including her eventual hospitalization to herself. She feels very unsafe talking about her experiences in her youth group and feels ostracized for having a mental health problem. “Some of [the girls in my youth group] completely stopped talking to me [after I came back from my hospitalization] and were just terrified to talk to me” Sam shared, with tears in her eyes. From Sam’s perspective, the youth group leaders -who she tried to speak to- didn’t help. Ultimately for this young person trying to figure out who she was and how to be in this world, her faith community became a place of silence and stress since her experience

contradicted what was okay to bring to the group. This is a missed opportunity to educate the entire group about mental health and ensure that all topics are safe to discuss.

The second way faith communities do not contribute to mental health was through strict cultural norms about good kids and good people of faith. While Connor experienced powerful support as he questioned his sexuality from his love of God, other youth who identified as gay, lesbian, bisexual, transgender, or questioning who encountered negative messages from their faith communities, really struggled. When we asked Arden, a teenager, what were some of the sources of stress in her life, she immediately said, “Depression and anxiety, mental health stuff...Being surrounded by very religious people. When I was raised in a home with religion, I didn’t really have a good effect on me, because a lot of my pastors were very not good people, and were very like, ‘we need to kill the gays’. And I’m just like, I don’t know about.” While Arden is likely exaggerating exactly what her pastors said, she clearly feels she received homophobic messages from her religious community. Because she herself identifies as gay, this scenario is quite stressful, even after she left her own faith community. She worries that any Christian person she meets thinks she is wrong just because she experiences same-sex attraction. The experiences of Sam, Connor, and Arden are all representative of a broad trend in the literature – feeling you belong to your faith community is a wonderfully protective experience, while feeling cast out is painful (Cotton et al 2006; Gattis, Woodford, and Han 2014). For this reason, especially as the world confronts unprecedented rates of youth suicide, faith communities should carefully craft messages that diminish how often youth feel painful exclusion from a community that matters to them.

Collectively, these findings suggest that faith community involvement in mental health is a place for potential growth in this community. Faith communities can serve important roles in mental health promotion and suicide prevention by including suicide prevention in their missions and honoring their message to be one of inclusion, openness, and unconditional support. There are also trainings developed specifically for faith communities, such as Colorado-based LivingWorks Faith,⁹ for faith communities that want to grow in this direction.

Advice for Adults from Youth

In this section, we review ideas for improving suicide prevention from youth themselves. One of the first things that youth made clear is that it is critical adults listen to them and take their concerns seriously. Adults, according to youth, grew up in a different time, and therefore, we do not always understand the intricacies of what it is like to grow up today. Youth admonish that these differences require adults to “just listen” to youth. No issue seems more relevant to youth than being heard. Related to this, adults should be careful to avoid responses like “I know what you are going through” or “It will get better, you’ll see,” when youth are looking for empathy and, sometimes, a place to vent. The response that things will be better sometime in the future can be pretty infuriating for youth. It can feel patronizing or, worse, like the solution is just for them to suffer for several years rather than having adults rise to the occasion and immediately make the world better for youth. If an immediate solution is not possible, at least validating youth’s experiences

⁹ <https://www.livingworks.net/faith>

and conveying that they *deserve* a better world is more helpful. There are some moments when adults should take action, such as a suicidal teen or a teen with substance problems. In those instances, it is still critical for adults to continue to listen to youth voices and concerns. Partnering with youth whenever possible and respecting and taking their concerns seriously will build trust. Though it is of course better to have these things be permanent features of adult-youth relationships, so that that trust can be relied on during a crisis or difficult conversation.

The second suggestion for suicide prevention that youth have is that they feel like they should be included in assessing the quality and effectiveness of mental health support systems. They are not just the primary customers but also recognize themselves as members of the system, too. Youth put much effort into supporting their friends, promoting their friends' mental health, and keeping their friends safe. In response to a similar youth request, the District began a youth advisory board for mental health concerns during our fieldwork. The youth on this board developed recommendations and ideas for the District, including valuing social-emotional skills on report cards (so that they are valued more heavily, like grades), revitalizing school counseling departments to make them more welcoming and relaxing, and improving District-wide sensitivity to gender diversity. Importantly, this group, at least for the students who participate, provides an important setting for youth concerns to be heard and for youth's ideas to be leveraged to improve mental health promotion and suicide prevention. We strongly recommend continuing this work and ensuring that students from all schools and diverse social identifies or demographics are included.

The third suggestion youth have for adults is that mental health should be prioritized year-long, rather than during the autumn months. Focusing on mental health year-long and implementing strategies, such as 'social media fasting' and 'random acts of kindness' weeks, could ensure that coping techniques become stabilized instead of seasonal. As Harper said, "We don't have really anything in March or in February and stuff like that, months in that time of the year. It's empty. People have lost all that. When you're walking around, no one is genuinely asking 'how are you?' They're just going through their day." It is worth noting that Sources of Strength is a program present in all of these schools and offers year-round activities to promote a culture of mental health. While Sources of Strength and other school organizations often did creative events or projects to get their message out, many students did not participate. Working to ensure Sources of Strength has the maximum impact possible through visibility and inclusion is likely a good strategy to address youth's suggestion that suicide prevention and mental health promotion not be restricted to certain periods.

Youth's fourth suggestion is incorporating "mental health" into established school programs, like seminars and assemblies. Some students felt these moments were an opportune time to prioritize youths' wellbeing and to teach them coping skills and academic skills. Schools did, of course, sometimes host mental health seminars and assemblies, and they were not always popular. Messaging always matters with mental health, so these options should be chosen carefully.

Students' fifth suggestion is that, in addition to being advised to seek counseling or utilize Safe2Tell, they should be taught about the warning signs of suicide and about what to do when a friend is in crisis:

I think that's the main thing is just, we need more information you need videos and statistics and more than just the Safe2Tell number on the back of our IDs and we, a whole week even, even though it sounds cliché, you know, like... a lot of the high school is gonna be like oh great it's Suicide Prevention Week, again, you know, we're having celebrations about death, you know, kind of things. It's more about we just, we need the information we need to know what to do. Because when you panic and your brain stops functioning the way it needs to, because of the panic, then you could end up doing something that hurts your friend more than it helps them. (Gianna, a junior)

Sixth, many youth felt that drug and alcohol use and abuse were significant problems and tied substance use to their understandings of suicide in the community. Consequently, our respondents drew a direct link between drug use and their friend's struggles, and alumni from several schools attributed substance use as directly tied to several suicides. Particularly, our young adult interviewees spoke about this at length, and both in a general sense and about specific friends. Sian said, "definitely drugs, drugs, drugs play a huge part [in my friends' suicides]. And no one wants to acknowledge that...almost every death has had to do with drug use." This was corroborated by other alumni. Sian continued, "Some of them were involved in drugs, not just in the moment that they committed [sic] suicide." One of the complexities surrounding adolescent drug use is that it is often used as a mechanism to relieve the pressure teens face in and out of school. This coping can then amplify mental health issues, increase those pressures as teens may fall behind in school, and shift from use to abuse. Regardless, youth wanted more attention and resources devoted to supporting this aspect of mental health challenges in the community.

One final aspect of suicide prevention that we observed and heard from youth is regarding the school's culture about diversity and mental health stigma. On the one hand, we saw that some schools worked hard to foster a sense of belongingness—something we discuss in greater detail in a previous section—and focused positive attention on all of their students. However, we also heard from many students that the "average" kid could be occasionally lost in the shuffle between the focus on the most ideal typical youth and those who were visibly struggling. Youth also wanted attention focused on mental health stigma. In some school particularly, youth felt that mental illness or mental health problems were stigmatized. Addressing that could help encourage help-seeking. Many of the other ideas youth had (listed above) would help address mental health stigma and would help make conversations around mental well-being more routine.

Limitations

While this study provides an unprecedented and comprehensive view of how schools, districts, and their communities work to prevent youth suicide, this study is not without limitations. Our first and perhaps most obvious limitation is that our in-person data collection was interrupted by the COVID-19 Global Pandemic. While 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 we could not be in the community. Research restrictions required that we conduct all research procedures online. This is important context for this study and may have impacted our ability to reach hard-to-reach populations. However, the schools and the District were extremely generous at including us

online in all possible aspects of schooling. This is in part because many school and District staff got to know us during our earlier in-person fieldwork. 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 is that our sample of family respondents is more socioeconomically privileged than the general population of District parents. For example, when we compare our family survey data to data from this District from the National Center for Education Statistics, our sample reports a higher education level than the district's parent population (though our sample's median household income generally matches NCES data). As a result, the concerns of less privileged parents may not be as well captured by this data. This pattern is likely tied to our limited time in person in the community. Thus, the District should be cautious about using these findings to make policy decisions without pursuing additional input from parents who did not respond. We also had a higher response rate from mothers and white parents, than father's and parents of color.

Our third limitation is that we had a significantly more difficult time recruiting youth participants after the pandemic started. As a result, we do not include as many youth voices as we may have liked. Additionally, youth's lives are quite disrupted by the pandemic, which may skew some of their responses. The vast majority of our data with youth, however, comes from the period prior to the pandemic. This means that we are not well equipped to understand youth's experiences of the pandemic, as that was largely beyond the scope of our study.

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.

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, further illustrating 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 12.

References

- Breslin, K., Balaban, J. and Shubkin, C.D., 2020. Adolescent suicide: what can pediatricians do?. *Current opinion in pediatrics*, 32(4), pp.595-600.
- 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, U. 1979. *The Ecology of Human Development*: Harvard University Press.
- Calarco, J.M. 2020. "Avoiding Us Versus Them: How Schools' Dependence on Privileged "Helicopter" Parents Influences Enforcement of Rules." *American Sociological Review* 85(2):223-46.
- Cha, C.B., P.J. Franz, E.M. Guzmán, C.R. Glenn, E.M. Kleiman and M.K. Nock. 2018. "Annual Research Review: Suicide among Youth – Epidemiology, (Potential) Etiology, and Treatment." *Journal of Child Psychology and Psychiatry* 59(4):460-82. doi: 10.1111/jcpp.12831.
- Curtin, SC., M. Warner and H. Hedegaard. 2016. *Increase in Suicide in the United States, 1999-2014. NCHS Data Brief No. 241*.
- Daigle, M.S., 2005. Suicide prevention through means restriction: Assessing the risk of substitution: A critical review and synthesis. *Accident Analysis & Prevention*, 37(4), pp.625-632.
- Eder, D., C.C. Evans and S. Parker. 1995. *School Talk: Gender and Adolescent Culture*. New Brunswick: Rutgers University Press.
- Findling, R.L. and Stepanova, E., 2018. The workforce shortage of child and adolescent psychiatrists: is it time for a different approach?. *Journal of the American Academy of Child & Adolescent Psychiatry*.
- Franklin, J. C., J. D. Ribeiro, K. R. Fox, K. H. Bentley, E. M. Kleiman, X. Huang, K. M. Musacchio, A. C. Jaroszewski, B. P. Chang and M. K. Nock. 2017. "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research." *Psychol Bull* 143(2):187-232. doi: 10.1037/bul0000084.
- Gilbert, K. L., & Ray, R. 2016. Why police kill black males with impunity: Applying public health critical race praxis (PHCRP) to address the determinants of policing behaviors and "justifiable" homicides in the USA. *Journal of urban health*, 93(1), 122-140.
- Gordon, K.H. 2021 *The Suicidal Thoughts Workbook: CBT Skills to Reduce Emotional Pain, Increase Hope, and Prevent Suicide*. New Harbinger Publications.
- Hallett, T. 2010. "The Myth Incarnate: Recoupling Processes, Turmoil, and Inhabited Institutions in an Urban Elementary School." *American Sociological Review* 75(1):52-74. doi: 10.1177/0003122409357044.
- Hoffmann, J.A. and Grupp-Phelan, J., 2020. Advocacy Opportunities for Pediatricians and Emergency Physicians to Prevent Youth Suicide. *Clinical Pediatric Emergency Medicine*, 21(2), p.100776.
- Joe, S. and H. Bryant. 2007. "Evidence-Based Suicide Prevention Screening in Schools." *Children & Schools* 29(4):219-27. doi: 10.1093/cs/29.4.219.
- Joiner, T. 2005. *Why People Die by Suicide*. Cambridge: Harvard University Press.
- LeCount, R. J. 2017. More Black than Blue? Comparing the Racial Attitudes of Police to Citizens. *Sociological Forum*, 32(S1), 1051-1072. doi:10.1111/socf.12367
- Monk, E. P. 2019. The color of punishment: African Americans, skin tone, and the criminal justice system. *Ethnic and Racial Studies*, 42(10), 1593-1612. doi:10.1080/01419870.2018.1508736

- Mueller, A.S. and S. Abrutyn. 2016. "Adolescents under Pressure: A New Durkheimian Framework for Understanding Adolescent Suicide in a Cohesive Community." *American Sociological Review* 81(5):877-99.
- Noddings, N. 2005. "What does it mean to educate the whole child?." *Educational leadership* 63, no. 1 (2005): 8.
- Nuij, C., van Ballegooijen, W., de Beurs, D., Juniar, D., Erlangsen, A., Portzky, G., O'Connor, R.C., Smit, J.H., Kerkhof, A. and Riper, H., 2021. Safety planning-type interventions for suicide prevention: meta-analysis. *The British Journal of Psychiatry*, pp.1-8.
- Rios, V. M. 2011. *Punished: Policing the lives of Black and Latino boys*: NYU Press.
- Rosin, H. 2015. "The Silicon Valley Suicides: Why Are So Many Kids with Bright Prospects Killing Themselves in Palo Alto?" *The Atlantic*.
- Shankland, R. and E. Rosset. 2017. "Review of Brief School-Based Positive Psychological Interventions: A Taster for Teachers and Educators." *Educational Psychology Review* 29(2):363-92.
- Shedd, C. 2015. *Unequal city: Race, schools, and perceptions of injustice*: Russell Sage Foundation.
- Singer, J.B. 2017. "Identifying and Responding to Suicide Risk in Schools." *Psychiatric Annals* 47(8):401-05.
- Singer, J.B, T.A Erbacher and P. Rosen. 2019. "School-Based Suicide Prevention: A Framework for Evidence-Based Practice." *School Mental Health* 11(1):54-71.
- Spencer, M.B. 2007. "Phenomenology and Ecological Systems Theory: Development of Diverse Groups." *Handbook of child psychology* 1.
- Spillane, J.P., L.M. Parise and J.Z. Sherer. 2011. "Organizational Routines as Coupling Mechanisms:Policy, School Administration, and the Technical Core." *American Educational Research Journal* 48(3):586-619. doi: 10.3102/0002831210385102.
- Thomas, C.R. and Holzer, C.E., 2006. The continuing shortage of child and adolescent psychiatrists. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(9), pp.1023-1031.
- White, K. M. 2015. The salience of skin tone: effects on the exercise of police enforcement authority. *Ethnic and Racial Studies*, 38(6), 993-1010. doi:10.1080/01419870.2014.952752
- Wyman, P.A. 2014. "Developmental Approach to Prevent Adolescent Suicides: Research Pathways to Effective Upstream Preventive Interventions." *American Journal of Preventive Medicine* 47(3):S251-S56. doi: <https://doi.org/10.1016/j.amepre.2014.05.039>.
- Wyman, P.A., C H. Brown, M. LoMurray, K. Schmeelk-Cone, M. Petrova, Q. Yu, E. Walsh, X. Tu and W. Wang. 2010. "An Outcome Evaluation of the Sources of Strength Suicide Prevention Program Delivered by Adolescent Peer Leaders in High Schools." *American Journal of Public Health* 100(9):1653-61.

Appendix A: Methodology

The data in this report were collected between October 2018-June 2021. We remain grateful to Front Range School District, who sent email invitations to all staff, students, and parents to participate in the study multiple times a year. The data collected fall into three

different categories: interview data, observational fieldwork data, and survey data. Each category is described briefly below.

Data

The research team completed **192 total interviews**, broken down into the following categories: **37 youth, 50 school staff, 101 parents, and 4 community mental health providers**. All interview protocols were offered in both English and Spanish; however, all interviews were conducted in English. Interviews were only conducted with individuals who volunteered for them, and those who volunteered were given the opportunity to participate in a focus group with other individuals they selected rather than an individual interview if they preferred. During an interview/focus group, a member of the research team asked questions related to the following themes listed below. These themes varied depending on who was being interviewed (i.e., a student versus a parent): 1) life/professional histories, 2) perceptions of communities and schools, 3) the mental health support system in a school and an individual's experience with it, 4) trusted adults, 5) an individual's social networks, 6) experiences with social media, 7) experiences with exposure to suicide and beliefs about suicide, 8) pressures the school faces, 9) larger community culture and resources and challenges in community, and 10) suggested solutions for supporting and protecting youth. These interviews were particularly useful for uncovering important, but hard to observe aspects of day-to-day life and experiences, such as how youth feel about seeking help or how folks feel about their school. Interviews with staff and professionals provided insights into the workings of the mental health safety nets within schools and individuals' roles within them. Interviews/focus groups were digitally recorded, transcribed by professional transcribers, and reviewed by the research team for accuracy. All identifying information in interview transcripts were replaced with pseudonyms, consistent with our community agreement and Human Subjects protocol.

The research team also conducted 22 months of **fieldwork**, from August 2019-June 2021. Fieldwork is the gathering of information through observations about something in a real, natural environment – in our case, most often schools were the natural environment. During fieldwork observations, members of the research team took extensive fieldnotes of what was happening, what was said, and who was interacting with whom. We omit all identifiable information from our fieldnotes. For example, there are no names of people or places in our fieldnotes. Before the onset of the COVID-19 pandemic, and with permission, members of the research team conducted fieldwork at school events, including classes, extracurriculars, dances, cafeterias, graduations, and school “showcase” nights in person. These observations provided an excellent opportunity to observe differences in belonging and inclusivity among students, cliques and status hierarchies, and relationships between students and adults. Members of the research team also conducted observations of the weekly meetings of administrators, faculty, and staff where they addressed school business, along with student intervention team meetings (SIT) and professional learning communities (PLCs). The schedules of these meetings varied at each school, but each one we attended provided insights into the negotiations schools need to make about their priorities, concerns, and decisions. Members of the research team conducted fieldwork at these meetings prior to, and during the pandemic, as these meetings transitioned to online platforms. We were also able to observe the organizational goals of the schools in these meetings, especially as those goals relate to student academics and student mental health

and wellbeing. Members of the research team also observed community events, such as fundraisers, events where the priorities of schools were being discussed (such as school board meetings), and events in key community spaces, such as religious organizations. Similarly, members of the research team observed these events prior to the pandemic, and during the pandemic when these events occurred in an online format. In sum, during this fieldwork, **the research team observed the work of 273 school and district staff members, and completed over 350 observations, which created approximately 2,000 pages of fieldnotes.**

Finally, the research team conducted **two** different **surveys** in the LPS community, one with families of students and one with school staff. The surveys were offered in English and Spanish in a format that was accessible for individuals who use either screen readers or who are vision impaired. Additionally, respondents could take the survey by phone.

The family survey occurred in December 2020 through January 2021. The confidential family survey was designed to ask parents and guardians about their comfort in talking about suicide with youth, their willingness and desire to receive various trainings, their expectations for schools, and their beliefs about mental health. The staff survey asked staff about their experiences with the mental health support system in their schools, their willingness to contribute to suicide prevention protocols in schools, their philosophy of education, and other topics. We also collected data on perceptions by parents, legal guardians and staff on whose responsibility it is to prevent suicide in schools. These surveys elicited broad views of both family and staff opinion and experiences, and allow us to confirm or challenge the themes in our interview and fieldwork data. We had **1,230 parents** respond to the family survey, nine of whom used the Spanish-language survey, and we had a good proportion of parents responding from each school. We do not know the exact number of parents who received the invitation to take the anonymous survey from the school district; however, if we compare the number of parents who took the survey from a particular school to the size of the student population we can estimate an upper bound for the survey response rate per school. If we assume all students had two parents or legal guardians invited to take the survey, dividing this number by 2 provides a lower bound estimate of the response rate. Overall, these analyses suggest that our response rate was between 12% and 23%.

The confidential staff survey occurred in March-April 2021. All school and district staff members in this district were invited to participate, and **1,004** responded to the ten-minute survey. The survey was designed to help us better understand how staff work to prevent suicide and promote mental health at school. School staff members make up 88.9 percent of respondents and district staff members make up 11.1 percent of respondents. We had 287 high school staff respondents, with excellent and proportionate representation across the high schools. People in our survey held diverse occupations in the district and the schools, from leadership roles to teachers to district and school mental health staff to janitors to security personnel. For the staff survey, we had an outstanding response rate of approximately 75% of district and school staff members. To accommodate that, we provided staff with open and closed ended survey items and received rich data on how staff feel about their abilities and willingness to engage in suicide prevention.

Analytic Approach

Following a team ethnographic approach (Evans, Huising, & Silbey, 2016), all qualitative data was analyzed by at least two team-members to guard against bias in coding and interpretation. The data analysis was concurrent with data collection to allow us, as researchers, to pursue confirming and disconfirming evidence while in the field. We began analysis with open-coding of data for emergent themes and analytic coding, with codes drawn from our conceptual model and hypotheses (Deterding & Waters, 2018). These early codes provided structure for the process of interpretation and were re-evaluated as new data allowed us to confirm or reject early hypotheses. (To see these hypotheses, please refer to our conceptual model presented in Figure 1). To see the codes we used to evaluate these hypotheses, please see Table A. As data collection concluded in June 2021, we switched to fully-focused coding of themes that emerged as salient to our specific aims through earlier rounds of analysis. This multi-analyst, multi-stage coding approach produces a thorough scientific inquiry (Tavory & Timmermans, 2014). We also conform to best practices for qualitative data analysis and research design set forth by the National Science Foundation (NSF 2004).¹⁰ All qualitative data were coded and analyzed in NVIVO 12 (QSR International), a qualitative analysis software package. Survey data was analyzed using STATA 15 and SAS 9.4 data analysis software. Bivariate statistical tests (largely, chi-square tests) and multivariate logistic regressions were used with an alpha of .05.

Figure 1: Conceptual Model

¹⁰ Report from the Workshop on the Scientific Foundation of Qualitative Research: <https://www.nsf.gov/pubs/2004/nsf04219/nsf04219.pdf>

TABLE A: Summary of Data Analysis by Aim during PHASE 1			
Analytic Goal: INITIAL SCHOOL & COMMUNITY DESCRIPTIONS			
	OBSERVATION TARGETS	INTERVIEW QUESTIONS	INDEX ANALYTIC CODES
<u>Aim 1: Identify how school cultural systems facilitate youth MH.</u>			
	Classes (Core Subjects)	Youth, Parents & Staff:	Importance of Mental health
	Student Lunches	Describe the school (why did you choose it?)	Mental health stigma
	Extracurricular Events	Describe the ideal student.	Whole-Child Educational Philosophies
	School Celebrations	Explanations for mental health challenges.	Cultural Inclusion/Exclusion
	Parent Teacher Organization Meetings	Youth:	Prejudice (Racism, Homophobia)
	School Showcase Nights	Relationships w school adults, trusted adults.	Academic Pressure
	School Administrators Meetings	Friendships.	Connectedness
	Teachers Meetings (PLC)	Parents:	Trust between youth and adults
		Experiences with school staff.	Ideal youth
		School Staff:	School descriptions
		Importance of mental health.	Community pride
<u>Aim 2: Determine the organizational elements that enable schools to create MH safety systems that effectively identify, triage, and support vulnerable youth</u>			
	School Mental Health (MH) Team Meetings	Youth & Parents:	Organizational Goals
	School Admin Team Meetings	Experiences w help-seeking.	Identification & definition of student problems
	School Staff Meetings	School Staff:	Uncertainty in how to help
	Shadow School Staff, Admin, SRO	Experiences supporting students.	Discipline and consequences
	Shadow District MH Staff	Knowledge of the mental health safety system.	Youth disclosures of distress to staff and parents
	District MH Team Mtgs	Philosophy of education.	Discussions of Suicide
	MH or suicide prevention trainings		Character Evaluations (of parents, students)
	District Safety Team Meetings		Strategies to identify mental health problems
<u>Aim 3: Assess the components of communities that serve as barriers or enablers of schools' strategies to support youth MH and prevent S/SC</u>			
	Community MH/SP Mtgs	Youth & Parents:	Parents expectations of schools
	School Board Meetings	Help-seeking in the community.	Importance of Mental health
	Religious Organizations	School Staff:	Mental health stigma
	Discussions of Politics and Ballot Initiatives	Pressures from parents.	Cultural Inclusion/Exclusion
	Events Salient to Community Identity	Resources & funding.	Prejudice (Racism, Homophobia)
			Mental health resources

Author Bios

Anna S. Mueller, PhD, is the Luther Dana Waterman Associate Professor of Sociology at Indiana University Bloomington. She is the Principal Investigator of the Social Worlds & Youth Well-Being Study. Her research bridges sociology of education, medical sociology, and suicidology to identify better strategies to prevent youth suicide, especially in schools and doctor's offices. In 2020, she was recognized as one of Science News's [Top 10 Early Career Scientists to Watch](#) and with the [Edwin S. Shneidman Early Career Award](#) for her contributions to understanding youth suicide. Mueller's research has been funded by the National Science Foundation, the National Institute of Mental Health, the American Foundation for Suicide Prevention, and the Western Colorado Community Foundation, among others. Her research has received multiple awards for its contribution to knowledge, including from the American Sociological Association, the American Pediatrics Association, the Society for Science & the Public, and the American Association of Suicidology. Her work can be read in the *American Sociological Review*, the *American Journal of Public Health*, *Social Science & Medicine*, among others.

Sarah Diefendorf, PhD, is a Co-Investigator on the Social Worlds and Youth Wellbeing Study and a visiting scholar at Indiana University Bloomington. Diefendorf's research

interests lie at the intersections of gender, sexuality, religion, and health. Her research has been recognized with multiple awards for her contributions to knowledge, including the Early Career Award from the American Sociological Association Section on Sexualities. Her work can be found in *Gender & Society*, *The Journal of Adolescent Health*, *Sex Roles*, and other scientific outlets.

Seth Abrutyn, PhD, is Associate Professor of Sociology at the University of British Columbia. He is a Co-Investigator on the Social Worlds & Youth Well-Being Study. His research interests lie at the intersection of sociological theory, social psychology, the sociology of emotions, and mental health in an effort to better understand and explain youth suicide. His research has won several national awards for its contribution to science and his work can be found in *American Sociological Review*, *Sociological Theory*, *American Journal of Public Health*, and other scientific outlets.

Katie Beardall, MA, is a doctoral student in the Department of Sociology at Indiana University Bloomington and a graduate research assistant for the Social Worlds team. Her research interests are at the intersections of education, inequality, organizations, and culture. Her dissertation research focuses on post-secondary honors programs.

Robert Gallagher is a doctoral student in the Department of Sociology at Indiana University Bloomington and a graduate research assistant for the Social Worlds team. His research interests lie at the intersection of LGBTQ+ populations, mental health, and medical sociology.

J'Mauri Jackson is a doctoral student in the Department of Sociology at Indiana University, Bloomington and a graduate research assistant for the Social Worlds team. Her research interests lie in race/ethnicity, medical sociology, and mixed methodology.

Yingjian Liang, MA, is a PhD candidate at the Department of Sociology, Indiana University Bloomington and a graduate research assistant for the Social Worlds team. His research interests include social networks, culture, and sociology of work.

Hillary Steinberg, PhD, is the Health Services Research and Policy Postdoctoral Fellow at the AJ Drexel Autism Institute at Drexel University. She is also a post-doctoral research on the Social Worlds & Youth Well-Being Study. Her areas of interest include childhood and youth, health, identity, and gender. She currently studies the transition to young adulthood for autistic youth.

James Watson is a doctoral student in the Department of Sociology at Indiana University, Bloomington and a graduate research assistant for the Social Worlds team. His research interests lie in sociology of mental health, immigration, and race/ethnicity.

Hannah Worton is a rising master's student in the Department of Sociology at Indiana University, Bloomington and an undergraduate research assistant for the Social Worlds team.