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Suicidal Behavior Among Elementary School Students and Current Needs in Prevention
Practices: A Survey of Virginia School Counselors

Maranda VanDyke

A thesis submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

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Abstract

Most of the research on suicidal behavior has focused on the middle and high school level, and an extensive review of the literature shows that more information is needed on the current needs and prevention practices at the elementary school level. In Virginia, school psychologists rated school counselors the top professional in elementary schools to lead suicide intervention and prevention efforts. Due to this, the current study examined 161 Virginia school counselors' responses to an online survey to further explore intervention and prevention efforts among school professionals. Both school counselors and school psychologists noted that receiving additional training and having established crisis plans are important in regards to suicidal behavior. While both professionals agree that suicide at the elementary level is something that should be taken seriously, the results found that open communication and discussion among professionals is an area that could be improved.

Introduction

In 2010, there were 38,364 suicides in the United States which made suicide the tenth leading cause of death for all ages (Murphy, Xu, & Kochanek, 2013). When looking directly at youth between the ages of 10 and 24, suicide is the third leading cause of death resulting in approximately 4,600 lives lost each year (Center for Disease Control and Prevention, 2014). **Suicide** is a fatal, self-inflicted act with the explicit or inferred intent to die, but that is only one component among a spectrum of other suicidal behaviors. Thoughts about or an unusual preoccupation with suicide is known as **suicidal ideation** (Miller & Eckert, 2009). Suicidal ideation was reported in 14.5% of 9th to 12th grade students in the United States in 2007 (Cash & Bridge, 2009). **Suicidal intent** refers to the level of commitment to taking one's own life. Additionally, **suicide attempt** is the self-injurious behavior conducted for the intent of killing oneself (Miller & Eckert, 2009).

Youth suicidal behavior is not a new trend. The first official record of a meeting among prominent mental health professionals regarding youth suicide was in 1910 in Vienna, Austria. Sigmund Freud was the chair of the symposium and many other distinguished psychiatrists from the Vienna Psychoanalytic Society were in attendance as well (Miller, 2010). Although we have had over 100 years to gain experience and expertise in suicide prevention, there are still an unsettling number of suicide rates. From 2003 to 2004, the suicide rate among those younger than 20 increased by 18% which was the largest single-year change in the past 15 years. It has been suggested that internet social networks, suicide among young U.S. troops, and higher rates of untreated depression due to black box warnings on antidepressants may be contributing to this increase (Cash & Bridge, 2009). However, there is no typical youth suicide, and it is

important to note that a complete understanding of youth suicidal behavior requires awareness of a broad range of variables.

Risk and Protective Factors

There are numerous risk factors that are associated with youth suicide. A previous suicide attempt as well as a family history of suicide puts a child at greater risk for suicidal behaviors in the future. Additionally, a psychiatric disorder is present in up to 80-90% of adolescent suicide victims and attempts. Major depressive disorder, bipolar disorder, conduct disorder, and substance use disorders put youth at a higher risk. Other risk factors that have been found include personality disorders, availability of lethal means, loss of a parent, family discord, physical or sexual abuse, lack of a support network, and dealing with homosexuality in an unsupportive family or community (Cash & Bridge, 2009). Additionally, suicidal behaviors have been found to increase when stressful life events emerge (Walsh & Eggert, 2007).

Of particular interest to those who work in schools, youth experiencing school difficulties are known to be at an increased risk for suicidal behaviors. Walsh and Eggert (2007) found that out of the students who were experiencing academic and/or behavior problems in school, those who were at risk for suicide reported higher levels of all risk factors and lower levels of protective factors. Another current and important issue in the schools concerns bullying. It has been reported that youth who partake in bullying are at risk for later suicidal ideation, suicide attempts, and deaths by suicide (Borowsky, Taliaferro, & McMorris, 2013). Suicidal behaviors frequently emerge when multiple risk factors are present (Beautrais, 2000). Of course, suicidal behaviors and tendencies are

very complex and all of these risk factors may be influenced by social, cultural and contextual factors.

Various factors that are associated with moderating or lowering the risk of suicide among youth. Perceived parental and family connectedness, caring relationships with nonparental adults, school connectedness, academic achievement, and perceived safety at school have been found to be important protective factors against adolescent suicide attempts (Borowsky et al., 2013). Suicide intervention efforts can hopefully be increased when practitioners have a better understanding of the elements that may serve to lower or increase the risk of suicide.

Child Suicide Classification Issues

It is important to note that the accuracy and validity of official suicide rates have been brought into question and are likely underestimated in youth. For example, youth deaths that are ruled as single-driver deaths, undetermined causes of death, and poisoning might in fact be suicides (Mohler & Earls, 2001). Research has also shown that while children display less suicidal ideation and self-harm than adolescents, children use methods that have a higher lethal risk. For example, adolescents were more likely to try to overdose from medication and misuse drugs and alcohol, while children were more likely to resort to less intricate but extremely dangerous strategies such as attempted hanging or strangulation (Sarkar et al., 2010).

Another classification issue that arises when discussing child suicide is that self-inflicted deaths in children are sometimes not categorized as suicide due to a belief that children do not fully understand the effects of their actions. Therefore, that leads some to

say that children are incapable of committing suicide, even if their self-harm or unsafe behavior resulted in death. Mishara's (1999) research suggests that although very young children may not recognize the word "suicide," many understand the concept of killing oneself. Most children also understand that death is final and it is quite rare for them to believe that someone could come back to life. Additionally, it was found that children not only understand the concept but they also are able to name at least one way to commit suicide.

Prevention and Intervention Practices

From 2004 to 2008, 540 Virginia youth aged 10-24 years old committed suicide. It is much more difficult to find suicide rates for children younger than 10 years old (Virginia Department of Health, 2012). The Virginia suicide prevention guidelines state that all licensed school professionals are responsible for identifying and reporting students at risk of suicide. Those who are responsible for assessing imminent risk in regard to suicidal ideation include school psychologists, school counselors, school nurses, and school social workers. School professionals who have not received adequate training in assessing suicidal risk (such as teachers) are expected to report a student's suicidal intent to a licensed school professional. Licensed school professionals are also responsible for contacting the parents and the Department of Social Services if appropriate (Suicide prevention guidelines, 2003).

Criteria to assess the suicide risk of students are outlined in the guidelines, with distinctions noted for younger and older children. Examples of criteria to examine in a suicide risk assessment are the student's communication of suicidal intent, gender,

history of expressed thoughts or attempts, plan, support system, loss, substance abuse, history of impulsive behavior and mental illness, and recent uncharacteristic behavioral change (Suicide prevention guidelines, 2003). These guidelines are put in place as a reference for licensed school personnel, but it is also important to look at what the actual suicide prevention and intervention practices are in the schools.

Much of the research on suicidal behavior in the schools has focused at the middle and high school levels. Although adolescents and young adults have higher prevalence rates of suicidal behaviors, that does not undermine the importance of investigating these behaviors at the elementary level. Additionally, the fact that children are more likely to engage in highly lethal suicidal attempts makes it even more essential to focus on best practices in suicide prevention at this level. Since there has not been a great deal of research in this area on elementary-aged children, it is important to investigate the current suicide prevention and intervention practices in elementary schools. While research has shown that the prevalence rates of suicidal behavior at the elementary level are low, the students who do demonstrate this type of behavior deserve to receive adequate services. It is vital for school personnel to learn what is happening and what could be improved at the elementary level in order to provide the best services possible for the children.

School psychologists. Cutchins (2013) surveyed 155 Virginia school psychologists to examine the current needs and responses to suicidal behavior at the elementary school level. It was found that the average prevalence rate for suicidal behavior in elementary school-aged students was .3%. Although this rate is low, it is also important to note that gaps were reported in relation to crisis planning, response, and communication among school employees. For example, although 83% of the school

psychologists reported that risk assessment is an integral part of suicide intervention, only 19% noted that they use risk assessment to address the needs of identified students.

Although the mean for current levels of competence when addressing suicidal behavior was between “average” and “good”, 66% of respondents suggested that targeted suicide prevention training specific to elementary school-aged children would be beneficial in developing additional competency. Approximately 43% of the respondents noted that suicide prevention training is not offered to any of the staff in their elementary schools. School psychologists rated school counselors as the most likely school professional to directly intervene in suicide prevention and intervention efforts. Additionally, if a student was exhibiting suicidal behavior, the school counselor would most likely be the person to contact the school psychologist (Cutchins, 2013). Due to these findings, it is important to examine how school counselors respond to students demonstrating suicidal behavior and how effective communication efforts are between the school professionals.

School counselors. School counselors are often called upon to address mental health needs and coordinate and manage student mental health programs in the schools. This means that school counselors play a significant role in the prevention and intervention efforts for suicide. Although there has not been a lot of research conducted at the elementary level, King et al. (1999) found that only 38% of high school counselors believed they could recognize a student at risk for suicide. In comparison, 56% school counselors who had received Project SOAR (Suicide, Options, Awareness, and Relief) training reported they could recognize a potentially suicidal student (King, 2000). The difference between these two groups may be indicative of how valuable it is for mental

health professionals to have additional training in suicide prevention and intervention efforts.

School counselors who had a crisis intervention team at their school had higher self-efficacy regarding adolescent suicide. This suggests that having effective collaboration among professionals, such as using a crisis intervention team, is beneficial in regards to suicide prevention and intervention efforts (King, 1999). When looking at years of experience, school counselors who had been working for five years or less were found to be more knowledgeable about suicide intervention steps than those who had been counselors for six years or more. This may be because those who are more recently employed have recently graduated and can more readily recall information. Additionally, those who are recently employed may have received more suicide prevention training in their graduate program due to the increased awareness of this topic. Additional training in suicide prevention and intervention could help to strengthen knowledge in suicide prevention and intervention for all school counselors (King, 2000).

Collaboration among professionals. Collaboration and communication efforts between school professionals are essential when providing suicide prevention and intervention services. School professionals may include school counselors, psychologists, nurses, teachers, administrators, and social workers. While not all school professionals are trained to diagnose and treat suicidal students, it is recommended for them all to assist in identifying students at risk for suicidal behavior and conveying that information to a mental health professional, such as the school counselor or psychologist (King, 2001). All professionals can bring something important and unique to the table, so working

together in a team approach when addressing suicidal behaviors in students can help to foster collegial support, feedback, and opportunities for resource sharing (Ward, 1995).

Teachers spend a lot of time with their students, which lead them to play a key role in detecting students at risk for suicide. Teachers have identified a need for more direct training when it comes to risk factors for suicide and crisis response. When schools have well-defined crisis policies and procedures, along with communication of these procedures and collaboration across staff, teachers are more likely to participate in suicide prevention programs (Nadeem et al., 2011). Singer and Slovak (2011) found that 88% of school social workers have worked with suicidal youth. However, low levels of graduate-level training in working with suicidal youth were reported by the school social workers. Since many professionals should play a role in suicidal prevention and intervention efforts, it is evident that there is a need for more direct suicide prevention and intervention training for all team members.

Summary

Suicidal behavior among our youth is not a new trend and is an important topic to discuss. Although the literature shows that suicide is the third leading cause of death in youth between the ages of 10 and 24, it is difficult to find suicide rates for children younger than 10 years old (Center for Disease Control and Prevention, 2014). Much of the difficulty stems from the belief that children do not understand the finality of their actions, which has led to suicidal deaths being misclassified. However, research has shown that many children do understand the concept of killing oneself (Mishara, 1999). Although the prevalence rate for suicidal behavior in elementary school-aged students

found in Cutchins' (2013) research was low, it remains an important and serious topic to address. In Cutchins' (2013) study, gaps were found in relation to crisis planning, response, and communication among school employees which are all integral parts of the suicide prevention and intervention process.

Along with school psychologists, school counselors play a vital role in suicide prevention and intervention services. The research shows that school counselors who have had additional training in suicide and prevention efforts feel much more competent in regards to identifying and addressing suicidal behavior in students. Additionally, those who had a crisis intervention team at their school had higher self-efficacy (King, 2000). However, all of that research was conducted at a high school level which demonstrates the need for research at the elementary level. Collaboration is key when intervening with suicidal behaviors, as taking a team approach helps to foster support among professionals and gives them the opportunity to share valuable information. There is also a need for more direct suicide prevention and intervention training for all school professionals; this issue needs to be addressed in order to provide students with the best services possible.

Research Questions

The researcher surveyed school counselors in Virginia to compare their responses to the results of Cutchins' (2013) research with Virginia school psychologists. The research questions examined whether or not school counselors reported similar 1) prevalence rates regarding suicidal behavior in elementary school-aged children, 2) interventions offered to those children, 3) reported levels of competence when providing appropriate services to the children and their families, and 4) levels of preparedness by

elementary school personnel when addressing suicidal behavior in the schools.

Additionally, the researcher was interested in 5) the collaboration efforts among school professionals when providing services to children and their families.

Methods

Participants

Participants included 161 elementary school counselors employed in public schools in the state of Virginia. An e-mail was sent to 1,037 elementary school counselors in Virginia in September 2014 with information about the purpose of the study, consent to participate in the study, contact information for the researchers, and instructions on completing the online survey. A total of 142 e-mails bounced back or were undeliverable, therefore 895 school counselors received the invitation to participate in the survey. Volunteers who consented to take the survey responded electronically through a hyperlink that was included in the e-mail. After 15 days, the researcher sent a second prompt and the survey remained active for 30 days in total; the response rate for the survey was 18%. Only school counselors who served in at least one elementary school during the 2013/2014 school year were included in the analysis of the data.

Measures

In order to answer the research questions, a 25-item survey was developed by the researcher. Qualtrics, a web-based survey service, was used to create, collect, and store survey items and responses. Survey items 4 and 5 examine research question one, “Increased understanding of prevalence rates regarding suicidal behavior in elementary school-aged children.” Survey items 7, 9, 10, and open-ended question 20 address

research question two, “Interventions offered to elementary school-aged children demonstrating suicidal behavior.” Survey items 1, 11, 12, 13, 14, and open-ended question 23 look at research question three, “Reported levels of competence in helping children and their families get appropriate support services.”

Survey items 18, 19, and open-ended questions 21 and 22 address research question four, “The preparedness of elementary school personnel in appropriately addressing suicidal behavior exhibited by their students.” Survey items 6, 8, and open-ended question 24 examine research question five, “The collaboration efforts among school professionals when providing services to children and their families.” Survey items 2, 3, 15, 16, 17, and 25 will not be included in the analysis of responses because they were not within the context of the stated research questions. These questions address the amount of elementary schools the school counselors have served in their history of practice, whether they practiced at an elementary school during the 2013/2014 school year, their beliefs on whether suicidal behavior in children is a relevant issue for elementary schools, and their beliefs on whether children understand the concept of killing oneself. Additionally, one question allowed the respondents to share any additional thoughts they may have as they reflected on their experiences with suicidal behaviors.

Procedures

The researcher obtained e-mail addresses for school counseling division directors in Virginia through the Virginia Department of Education. E-mail addresses for Virginia elementary school counselors were obtained by contacting the directors and searching

individual school districts' websites for contact information. The researcher e-mailed the survey to the elementary school counselors in September of 2014, and those who took part in the research had access to the survey for the duration of the study. The survey remained accessible for thirty days. Once the survey was closed, the data was stored electronically.

Results

The survey items were presented in multiple-choice style formats, checklist style answer choices, and Likert scale questions. These items were summarized by descriptive statistics and frequency charts generated from the Qualtrics program. Open-ended questions were analyzed by looking for common themes among the responses. Each response had the potential to be sorted into more than one theme. Ryan and Bernard's (2003) cutting and storing technique was used to organize and categorize the results. To be consistent with Cutchins' (2013) research, the response category had to generate at least 10% of the total responses to qualify as a theme. Additionally, independent t-tests were conducted to compare the school psychologists' responses from Cutchins' (2013) research to the school counselors' responses in the current study to see if there were any significant differences among the responses on items that use ratings (10, 11, and 12). A chi square analysis was used to examine significant differences among the items that use categorical responses (6, 7, 8, 9, 13, 15, 16, 17, 18, and 19).

Research Question One

Participants were presented with two questions to examine research question one, "Increased understandings of prevalence rates regarding suicidal behavior in elementary

school-aged children.” Out of the 106,978 students that were reported to be enrolled in the school counselors’ elementary schools during the 2013/2014 school year, 400 of them exhibited suicidal behavior, a prevalence rate of 0.37%. Cutchins (2013) research showed that school psychologists reported 317 out of 101,275 students (0.31%) exhibited suicidal behavior during the 2010/2011 school year. It is important to note that although the number of students who exhibited suicidal behavior increased, the number of students who attended school in Virginia did as well. Additionally, 100% of school counselors who responded to the question, “Approximately how many students exhibited suicidal behavior as reported by/through parents, teachers, counselors, peers, and/or self-report in the 2013/2014 school year?” reported at least one student exhibited suicidal behavior during the 2013/2014 school year at one of their schools.

Table 1

<i>Suicidal Behavior in Elementary School-Aged Children</i>		
	School Psychologists’ Response (Cutchins, 2013)	School Counselors’ Response
School Year	2010-2011	2013-2014
Number of students who exhibited suicidal behavior	317	400
Total number of students reported	101,275	106,978
Prevalence rate	0.31%	0.37%

Research Question Two

A series of questions were asked to examine the interventions that were offered to elementary school-aged children demonstrating suicidal behavior during the 2013/2014 school year. School counselors were asked, “If a student exhibited suicidal behavior in

your elementary school(s), which school-based professional was most likely the key person responsible for direct intervention with the student?" Eighty-nine percent reported myself or another school counselor, 6% reported the school psychologist, 1% reported the classroom teacher, 2% reported the administrator, 0% reported the school nurse, and 2% reported other. In comparison, Cutchins' research (2013) shows that when school psychologists were asked the same question about the 2011/2012 school year, 39% reported myself or another school psychologist, 57% reported the school counselor, 0% reported the classroom teacher, 1% reported the administrator, 0% reported the school nurse, and 2% reported other.

Table 2

Key Person Responsible for Direct Intervention

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
School Psychologist	39%	6%
School Counselor	57%	89%
Classroom Teacher	0%	1%
Administrator	1%	2%
School Nurse	0%	0%
Other	2%	2%

A chi-square test was performed to examine whether there were significant differences between the school counselor and school psychologist responses in relation to who was most likely the key person responsible for direct intervention. There was a significant effect depending on if school counselors or school psychologists responded to the question $\chi^2(4, N = 285) = 46.89, p < .001$. Although both groups indicated overall that school counselors were most likely the key person responsible for direct intervention,

school psychologists reported a significantly higher number of school psychologists being responsible. Only 6% of school counselors reported “school psychologists” while 39% of school psychologists reported “school psychologists”.

When school counselors were asked, “If a student exhibited suicidal behavior in your elementary school(s), which interventions were typically offered? Check all that apply,” 92% reported referral to outside agency, 76% reported individual counseling with the school counselor, 13% reported individual counseling with the school psychologist, 11% reported small group counseling, 98% reported parental notification, 85% reported risk assessment, and 8% reported other. When school psychologists were asked the same question by Cutchins (2013), 93% reported referral to outside agency, 65% reported individual counseling with school counselor, 40% reported individual counseling with school psychologist, 9% reported small group counseling, 96% reported parental notification, 83% reported risk assessment, and 7% reported other.

Table 3

Typical Interventions Offered by the School

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Parental notification	96%	98%
Risk assessment	83%	85%
Referral to outside agency	93%	92%
Individual counseling with school counselor	65%	76%
Individual counseling with school psychologist	40%	13%
Small group counseling	9%	11%
Other	7%	8%

Multiple chi square tests were conducted to examine any significant differences between school counselor and school psychologist responses. When examining which interventions were typically offered to students who exhibited suicidal behavior, school psychologists were significantly more likely than school counselors to report that individual counseling with a school psychologist was used, $\chi^2(1, N = 286) = 26.29, p < .001$. Additionally, school counselors were significantly more likely than school psychologists to report individual counseling with the school counselor was used, $\chi^2(1, N = 286) = 4.00, p = .05$.

Participants were asked to rate the effectiveness of the typical interventions that were offered to students who exhibited suicidal behavior in their school(s) on a scale of 1-5. The mean response for school counselors fell between the categories of “average” and “good”.

Table 4

Overall Effectiveness of Typical Interventions (1-5 Scale)

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Mean	3.79	3.90
Description	Between “average” and “good”	Between “average” and “good”
Standard Deviation	0.80	0.68

An independent samples t-test was used to compare school psychologists' and school counselors' responses. There was not a significant difference in how effective school psychologists perceived the interventions (M=3.79, SD=.80) and how school counselors perceived the interventions (M=3.90, SD=.68); $t(274.51) = 1.26, p = .21$.

An open ended question, “While knowing that each child who demonstrates suicidal behavior is unique, what have you done, in general, to address the needs of identified students?” was also included in the survey. Eight themes were found by examining the responses from school counselors. Collaboration or consultation with other professionals was mentioned 52 times (40.63%), parent contact was mentioned 62 times (48%), provide resources for parents and collaborate with parents was mentioned 45 times (35%), and individual or group counseling was mentioned 40 times (31%). Additionally, working 1 on 1 with a student was mentioned 32 times (25%), risk assessment/safety plans was mentioned 50 times (39%), referral to an outside agency was mentioned 42 times (32%), and follow-up with a student was mentioned 25 times (20%). When Cutchins (2013) asked the same question to school psychologists about the 2011/2012 school year, four themes were found. Consultation with others (including parents) was reported 76 times (31%), direct intervention with the student was reported 59 times (24%), referral to an outside agency was reported 57 times (24%), and risk assessment was reported 46 times (19%).

Table 5

What the Professional Has Done to Address Identified Students' Needs

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Parent contact	N/A	48%
Collaboration/Consultation with other professionals	N/A	41%
Provide resources/Collaborate with parents	N/A	35%
Consultation with others (including parents)	31%	N/A
Group counseling	N/A	31%
Direct work with student	24%	25%
Risk assessment	19%	39%
Referral to outside agency	24%	32%
Follow up with student	N/A	20%

Research Question Three

Multiple questions were asked to examine reported levels of competence in helping children and their families get appropriate support services. One question asked how many years they have served within their current profession. The mean response of 2.53 for school counselors fell between the categories of “6-10 years” and “11-15 years.” This is very similar to the school psychologists’ responses where the mean response of 2.90 fell between the categories of “5-10 years” and “10-15 years.”

One question asked the participants to rate on a scale of 1-5 how well their graduate training program prepared them to deal with suicidal behavior in elementary

school-aged students. Descriptive statistics showed that the school counselors' mean response of 2.83 fell between “somewhat” and “average”.

Table 6

<i>Level of Preparedness by Graduate Training Program (1-5 Scale)</i>		
	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Mean	2.64	2.83
Description	Between “somewhat” and “average”	Between “somewhat” and “average”
Standard Deviation	1.12	1.26

An independent samples t-test was used to compare the responses and there was not a significant difference in how the school psychologists perceived how well their graduate training prepared them to deal with suicidal behavior in elementary students ($M=2.64$, $SD=1.12$) and how school counselors perceived their training ($M=2.83$, $SD=1.26$); $t(295) = 1.40$, $p = .16$.

An additional Likert scale question had the participants rate on a scale of 1-5 how competent they feel in their role at the elementary level in providing and/or coordinating services for children who exhibited suicidal behavior. The mean response of 3.85 for school counselors showed that the responses fell between “average” and “good”.

Table 7

<i>Level of Competence in Providing and/or Coordinating Services (1-5 Scale)</i>		
	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Mean	3.78	3.85
Description	Between “average” and “good”	Between “average” and “good”
Standard Deviation	.99	.84

An independent samples t-test was used to compare school psychologists' and school counselors' responses to this question. There was not a significant difference in how competent school psychologists felt providing and/or coordinating services ($M=3.78$, $SD=.99$) compared to school counselors ($M=3.85$, $SD=.84$); $t(285.90) = .68$, $p = .50$.

When school counselors were asked, “Have you participated in additional training (beyond your graduate program) with regard to suicide prevention for elementary school-aged students? Check all that apply,” 37% reported Yes, Applied Suicide Intervention Skills Training (ASIST), 40% reported Yes, another workshop experience, 28% reported Yes, other training not specified, and 21% reported no. When school psychologists were asked the same question by Cutchins (2013), 32% reported Yes, Applied Suicide Intervention Skills Training, 59% reported yes, another workshop experience, 32% reported yes, other training not specified, and 15% reported no.

Table 8

<i>Participation in Additional Suicide Prevention Training</i>		
	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Yes, Applied Suicide Intervention Skills Training (ASIST)	32%	37%
Yes, another workshop experience	59%	40%
Yes, other training not specified	32%	28%
No	15%	21%

Multiple chi square tests were conducted to examine significant difference in the responses provided by the school counselors and school psychologists. The results showed that significantly more school psychologists reported attending “another workshop” compared to school counselors, $\chi^2(1, N = 304) = 11.10, p = .001$.

When school counselors were asked, “Which proves more useful in your perceived competence in providing and/or coordinating services for children who exhibited suicidal behavior”, 55% reported more work experience while 45% reported a specific training opportunity. Those who chose “a specific training opportunity” were asked to explain their answer. Out of those who reported “a specific training opportunity”, 30% of school counselors noted Applied Suicide Intervention Skills Training (ASIST) specifically.

The open-ended question, “What would be helpful in developing additional competency for school counselors regarding suicidal behavior at the elementary school level?” resulted in two major themes from school counselors. Additional training targeted at the elementary level was mentioned 76 times (68%) and having a set of

policies/procedures in place was reported 14 times (13%). The results from Cutchins (2013) research with school psychologists produced very similar responses. School psychologists mentioned targeted suicide prevention training specific to elementary school-aged children 83 times (66%) and the creation and/or existence of an established crisis plan 14 times (11%).

Table 9

What Would Be Helpful in Developing Additional Competency

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Additional Training Targeted at the Elementary Level	66%	68%
Set of Policies/Procedures in Place	11%	13%

Research Question Four

Two questions that required categorical responses and two open-ended questions were asked to examine the preparedness of elementary school personnel in appropriately addressing suicidal behavior exhibited by their students. When school counselors were asked, “At any time during your work in an elementary school, was suicide risk assessment training provided to any school staff in your elementary school building(s)?” 28% reported yes, in all elementary schools in which I’ve worked, 10% reported yes, in some elementary schools in which I’ve worked, 8% reported yes, in one elementary school in which I’ve worked, and 53% reported no, suicide risk assessment training was not offered in any of my elementary school buildings. When school psychologists were asked the same question (Cutchins, 2013), 27% reported yes, in all elementary schools in which I’ve worked, 31% reported yes, in some elementary schools in which I’ve worked,

and 43% reported no, suicide risk assessment training was not offered in any of my elementary school buildings.

Table 10

Suicidal Risk Assessment Training Provided to Staff

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Yes, in all elementary schools in which I've worked	27%	28%
Yes, in some elementary schools in which I've worked	31%	10%
Yes, in one elementary school in which I've worked	N/A	8%
No, suicide risk assessment training was not offered in any of my elementary school buildings	43%	53%

A chi square test was conducted and found that school psychologists and school counselors reported similar responses in relation to if their schools provided suicide risk assessment training, $\chi^2(1, N = 302) = 3.35, p = .07$.

School counselors were asked, "Do you believe there is a current need for suicide prevention training in elementary schools?" and 62% chose yes, this is a priority, 29% reported yes, but there are other greater priorities, and 9% reported no, this is not needed. Those who chose "yes, but there are other greater priorities" were asked to list the greater priorities which resulted in two main themes. Focusing on prevention by teaching coping strategies and other skills was mentioned 12 times (38%) and trauma/other mental health issues were mentioned 15 times (47%). School psychologists were asked the same question by Cutchins (2013) and 41% reported yes, this is a priority, 55% reported yes, but there are other greater priorities, and 3% reported no, this is not needed.

Table 11

Current Need for Suicide Prevention Training at Elementary Level

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Yes, this is a priority	41%	62%
Yes, but there are other greater priorities	55%	29%
No, this is not needed	3%	9%

A chi square test was conducted to determine if school psychologists and school counselors had similar responses. School counselors were significantly more likely to state that suicide prevention training is a priority in elementary schools than school psychologists. However, school psychologists were significantly more likely to respond that there is a need for suicide prevention training but there are other greater priorities, $\chi^2(2, N = 304) = 23.51, p < .001$.

School counselors were asked the open-ended question, “Have you noticed any trends among elementary school students regarding suicidal behaviors? If yes, please explain,” and five clear themes were found. Mental health issues and other diagnoses were mentioned 13 times (11%), dysfunctional family system was mentioned 20 times (16%), lack of coping skills was mentioned 13 times (11%), students not understanding the gravity of the situation was mentioned 13 times (11%), and 39 responses indicated that no trends have been noticed (32%).

When school counselors were asked the open-ended question, “What advice or suggestions do you have for other practitioners regarding suicidal behavior at the elementary school level?” six major themes were found. Consultation and collaboration

with other professionals was noted in 16 responses (14%), seek out additional training was reported 14 times (13%), and take all threats seriously was noted 34 times (31%). In addition, parent notification/collaboration was noted 23 times (21%), have an established plan was reported 22 times (20%), and stay supportive/maintain students' trust was noted 15 times (14%). When Cutchins (2013) asked school psychologists the same question, four themes were established. Take all threats seriously was mentioned 45 times (32%), seek training for yourself and other was noted 39 times (27%), having an established plan was reported 20 times (14%), and establish frequent and open communication with others (including parents) was mentioned 18 times (13%).

Table 12

Advice for Other Practitioners Regarding Suicidal Behavior at the Elementary School Level

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
Consultation and collaboration with other professionals	N/A	14%
Seek out additional training	27%	13%
Take all threats seriously	32%	31%
Parent notification/collaboration	N/A	31%
Have an established crisis plan	14%	20%
Stay supportive/maintain students' trust	N/A	14%
Establish frequent and open communication with others	13%	N/A

Research Question Five

Two categorical and one open-ended questions were asked to school counselors to examine collaboration efforts among school professionals when providing services to

children and their families. School counselors were asked, “If a student exhibited suicidal behavior in your elementary school(s), who most likely contacted you?” One percent responded another school counselor, 0% reported school psychologist, 67% reported classroom teacher, 16% said it was a student self-report, 8% responded peers, 2% reported parent, 4% reported administrator, 0% reported school nurse, and 3% responded other. When school psychologists were asked the same question (Cutchins, 2013), 1% responded another school psychologist, 40% stated the school counselor, 16% reported the classroom teacher, 1% stated the student, 0% reported peers, 4% reported the parent, 35% responded administrator, 0% stated the school nurse, and 3% responded with other.

Table 13

Person Most Likely To Contact Professional if a Student Exhibited Suicidal Behavior

	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
School Counselor	40%	1%
School Psychologist	1%	0%
Classroom Teacher	16%	67%
Student Self-Report	1%	16%
Peers	0%	8%
Parent	4%	2%
Administrator	35%	4%
School Nurse	0%	0%
Other	3%	3%

A chi square test was conducted to determine if there was a significant difference in who contacted each profession when a student exhibited suicidal behavior. The results show that teachers and students were significantly more likely to contact the school

counselor while an administrator was more likely to contact the school psychologist, $\chi^2(7, N = 282) = 162.67, p <.001$.

When school counselors were asked, “If a student exhibited suicidal behavior in your elementary school(s), which school-based professionals traditionally worked together to provide needed services? Check all that apply,” 98% reported the school counselor, 55% reported the school psychologist, 48% reported the classroom teacher, 76% reported an administrator, 25% reported the school nurse, and 26% reported other. Out of the school counselors that reported “other”, 41% reported that a social worker was part of the team, 16% reported parent, 24% reported a community service board counselor, 3% reported a school resource officer, 3% reported a special education teacher, 3% reported a behavior support therapist, 3% reported a Title 1 coordinator, and 8% reported using outside or private resources.

In comparison, when school psychologists were asked who was part of the team, 90% reported myself or another school psychologist, 97% reported the school counselor, 42% reported the classroom teacher, 69% reported an administrator, 14% reported the school nurse, and 22% reported other (Cutchins, 2013).

Table 14

<i>Which School-Based Professionals Traditionally Worked Together</i>		
	School Psychologists' Response (Cutchins, 2013)	School Counselors' Response
School Counselor	97%	98%
School Psychologist	90%	55%
Classroom Teacher	42%	48%
Administrator	69%	76%
School Nurse	14%	25%
Other	22%	26%

Multiple chi-square tests were conducted to examine significant differences in the responses. School psychologists were significantly more likely than school counselors to indicate that a school psychologist was part of the team that worked together to provide services to students who exhibited suicidal behavior, $\chi^2(1, N = 286) = 45.04, p < .001$. Additionally, school counselors were significantly more likely than school psychologists to indicate that the school nurse was a part of the team, $\chi^2(1, N = 286) = 5.97, p = .02$.

School counselors were also asked the open-ended question, “What would be helpful in enhancing collaboration efforts between school-based professionals regarding suicidal behavior at the elementary level?” and four clear themes were found. Within the responses, 34 school counselors mentioned all staff should receive training (34%), 16 mentioned having a set procedure in place (16%), 10 mentioned taking a team approach to risk assessment (10%), and 14 mentioned open communication and discussion (14%).

Discussion

Although rare, suicidal behavior among elementary school aged children is serious and does occur. Understanding different views on this topic is a helpful first step in directing the process of collaboration among professionals in this area. All professionals within a school system have different strengths and viewpoints in relation to suicidal behavior. Knowing and understanding different professionals' assets can give us a better idea of how to best help children exhibiting these types of behaviors in school. Comparing school counselors' and school psychologists' perspectives will give us more knowledge on how to share roles and work together if a student exhibits suicidal behavior.

Research Question One

As expected, the prevalence rates regarding suicidal behavior in elementary school-aged children was low. School counselors reported that 0.37% of elementary school children exhibited suicidal behavior during the 2013/2014 school year which means that 400 students demonstrated some type of suicidal behavior. Even though the prevalence rate is low compared to how many students were enrolled in Virginia, the fact that 400 elementary school students demonstrated some type of suicidal behavior is concerning. Even more alarming is that every school counselor who responded to this survey item noted that at least one student exhibited suicidal behavior at their school during the 2013/2014 school year. When Cutchins (2013) asked the same question to school psychologists during the 2010/2011 school year, it was reported that 317 students (prevalence rate of 0.31%) exhibited suicidal behavior. It does not appear that suicidal

behavior at the elementary level is decreasing in any way; these numbers show that suicidal behavior at the elementary level is something that does occur and is something that should be taken seriously. It is important for professionals working with the students to know best practices and have a set procedure in place for suicidal prevention and intervention services even though it is something that does not happen often.

Research Question Two

A number of interesting observations were made while comparing the responses from school counselors and school psychologists regarding interventions that were offered to elementary school-aged children demonstrating suicidal behavior. It is obvious that the school counselor appears to be the most likely the key person responsible for direct intervention. Notwithstanding, school psychologists and school counselors have different views concerning how often the school psychologist is the key person responsible. While 39% of school psychologists reported that the school psychologist was most likely the key person responsible, only 6% of school counselors reported school psychologists. There appears to be discontinuity in perceptions of responsive actions between counselors and psychologists.

While the mean response from school psychologists and school counselors noted that the effectiveness of the interventions they use are between “average” and “good”, there were some differences when comparing which interventions were reported. A large majority from both professions reported that referral to an outside agency, parent notification, and risk assessment are interventions that are typically used when a student exhibits suicidal behavior. The area where school psychologists and counselors appeared

to differ was individual counseling. Although both professions reported a higher number of school counselors providing counseling services, 40% of school psychologists said that individual counseling with a school psychologist was used and only 13% of school counselors reported that individual counseling with a school psychologist was used.

The difference in reports from the school psychologists and school counselors could be due to a number of reasons. Although school psychologists may be providing direct intervention services to students, school counselors may not be aware of their involvement. Many school psychologists are central office based and split their time between different schools while school counselors are typically stationed at one school. The fact that psychologists may not be engrained in the school like the counselors could contribute to other school professionals not knowing the psychologists' level of involvement with the students.

Additionally, the fact that school counselors and school psychologists sometimes work with different populations could be a contributing factor to the difference in responses. If a student exhibited suicidal behavior during a special education evaluation, the school psychologist may be the key person responsible for providing interventions. A school counselor may be the one providing services if the suicidal behavior were to happen during the regular school day. If the schools did not take a team approach to suicide intervention and prevention, then the school psychologist and school counselor may not be aware of each other's individual roles with the students.

Regardless of the scenario, it is apparent that better communication is needed between professionals when providing services to students. When professionals build

relationships with each other it can give them a better understanding of each other's roles and skill sets. In turn, intervention efforts can be strengthened by the increase of collaboration among professionals.

School psychologists and school counselors were given the chance to respond freely to a question examining what each professional has done to address the needs of identified students. The percentage of school psychologists and school counselors who reported administering risk assessment was low compared to how many reported it was offered by the school. Although 83% of school psychologists and 85% of school counselors said the school offered risk assessment, only 19% of school psychologists and 39% of school counselors noted that they performed risk assessment. School psychologists and school counselors are typically thought of as the mental health professionals within a school system, so it is surprising to find that they may not be providing risk assessment. Virginia's suicide prevention and intervention guidelines suggest that school professionals who have not received adequate training in assessing suicidal risk should report the suicidal intent to a licensed school professional. In turn, the licensed school professional should be the one to do the risk assessment. Assessing suicidal risk is not an easy task and something that should not be taken lightly. It is very important for teachers and other school professionals to be able to identify and report suicidal behavior, however, assessing the risk of suicide should be conducted someone who is trained to do so.

Research Question Three

Examining the school psychologists' and school counselors' reported levels of competence in helping children and their families get appropriate services is an important step in examining how to best help school professionals feel prepared. Both school psychologists' and school counselors' mean response in relation to how well their graduate training program prepared them to deal with suicidal behavior in elementary school-aged students was between "somewhat" and "average". This suggests that graduate level training is important but may need to be supplemented in order to feel more competent when providing suicide prevention and intervention services. When looking at how many years the psychologists and counselors have been practicing, the mean response fell between "5-10 years" and "10-15" years for psychologists and between "6-10 years" and "11-15 years" for counselors. More research and awareness about suicidal behavior at the elementary level has been conducted in recent years; perhaps if the mean demographic of those who took the survey was less than 5 years, more would have felt that their graduate level training better prepared them.

When looking at which proves to be more useful in providing and/or coordinating services for students who exhibited suicidal behavior, 55% of school counselors reported more work experience while 45% reported a specific training opportunity. It appears that school counselors believe that additional training opportunities and additional work experience are about equally important. Although work experience is something that comes with time, training opportunities are something that are within the professionals' control. School counselors were allowed to elaborate further if they chose "a specific training opportunity" and 30% mentioned Applied Suicide Intervention Skills Training

(ASIST) specifically. Research has shown that ASIST can be a helpful training opportunity for those who are looking to increase their knowledge, attitudes, and skills of suicide first aid with the general population (Rodgers, 2010).

When looking directly at whether or not school psychologists and school counselors have participated in additional training, one main difference was noted. While about the same percentage of counselors and psychologists reported attending ASIST or another training not specified, a significantly higher number of school psychologists reported attending another training experience. Although school counselors were the most likely school professional to intervene when a student exhibited suicidal behavior, the survey responses suggest that school psychologists have more training in suicide prevention and intervention. Since school psychologists may not always be the person to directly intervene, they could use their training to provide professional development opportunities to school counselors and other school staff. Providing professional development opportunities would potentially allow school psychologists to use their own training to help increase other school professionals' competency.

According to the survey responses, school psychologists' and school counselors' competence levels were between "average" and "good" when providing and/or coordinating services to children who exhibit suicidal behavior. However, 66% of school psychologists and 68% of school counselors reported that additional training targeted at the elementary level would be helpful in developing additional competency. Additionally, 11% of school psychologists and 13% of school counselors believe that having a set procedure in place would help to develop competency.

Although school psychologists and school counselors appear to feel competent when providing services, their suggestions for developing additional competency are very beneficial. Many suicide prevention and intervention trainings, such as ASIST, are extremely valuable and provide evidenced based training on suicide first aid. Nevertheless, many of these workshops are targeted to work with the general population and not a certain age level or group. Training targeted at the elementary level could help increase competency when providing services by helping professionals navigate how to best approach this specific population. Providing targeted training is a specific recommendation and something that the local and state school officials may consider. Additionally, it would be appropriate for these trainings to be supported by the school psychology and school counselor professional organizations.

School counselors' and school psychologists' belief that having a set procedure in place would help to develop additional competency is a further consideration that local and state educational officials may want to consider. If a student exhibits suicidal behavior, it is important for the school staff to know how to appropriately proceed. The longer it takes for school professionals to determine how to proceed when this situation arises, the longer it takes to provide adequate services to the student. School crisis plans are developed to maximize responsiveness to crisis situations and support students in need.

Research Question Four

While it is important to feel competent while providing services to students, it is also vital to gauge the preparedness of elementary school personnel in appropriately

addressing suicidal behavior. Responses from a question within research question three indicated that 31 school counselors (21%) and 23 school psychologists (15%) have not participated in any additional training beyond their graduate program with regard to suicide prevention. School psychologists and school counselors are thought of as the mental health professionals within a school system; if they have not participated in additional training then it is not likely that others within the school system have had training either. While not all school professionals have the training or job responsibility to professionally assess suicidal risk, all school professionals are legally required to report suicidal behavior (Suicide prevention guidelines, 2003).

An additional question within research question four showed that 43% of school psychologists and 53% of school counselors reported suicide risk assessment training was not offered in any of their school buildings. If it is implausible for every school district to provide suicide risk assessment training at the school level, it is imperative for the mental health professionals to be trained. Having at least one school professional trained would allow them to provide professional developments to the rest of the school staff on best practice regarding suicide prevention and intervention services. Although it may not be an official training, knowing risk factors and their duties if the situation were to arise could prove to be very beneficial in strengthening competency and preparedness. Additionally, the Virginia Department of Health website provides access to free materials and training for suicide prevention and intervention.

School counselors were more likely than school psychologists to report that there is a current need for suicide prevention training in elementary schools. This may be because school counselors are most likely the ones who are providing direct intervention

services. School psychologists were more likely to report that suicide prevention training in elementary school is needed but there are greater priorities. Although school psychologists were not given the opportunity to elaborate on the greater priorities, school counselors who chose this option were able to explain what they believe was more important. Focusing on prevention by teaching coping strategies and trauma/ other mental health issues were believed to be a greater priority than suicide prevention training. However, both of these suggestions fall under suicide prevention training. While suicide prevention training may be thought of as learning what to do when someone exhibits suicidal behavior, it can also include knowing risk factors for suicidal ideation and providing services to students who are at risk.

When examining trends among elementary school students regarding suicidal behavior, school counselors noted mental health issues and other diagnoses, dysfunctional family systems, lack of coping skills, and students not understanding the gravity of the situation. Many of these trends fall under the category of risk factors for displaying suicidal behavior. Knowing risk factors for suicide, such as having mental health issues in combination with a dysfunctional family system, is an important part of suicide prevention services. Instead of thinking of these factors as being different and more important than suicide prevention, it could be beneficial to think of them as one in the same. Providing services to students who are at risk is just as vital as providing services to students who exhibit suicidal behavior.

School counselors and school psychologists were able to freely respond to a question which asked for advice for other practitioners regarding suicidal behavior at the elementary school level. Themes from both professionals included to seek out additional

training, take all threats seriously, and have an established crisis plan. All three of these suggestions could be summarized as being prepared in case the situation were to arise. School psychologists also mentioned establishing frequent and open communication with others while school counselors noted consultation, collaboration, stay supportive, and maintain students' trust. While being prepared is the foundation for suicide prevention, follow through and consultation are just as essential. Taking a team approach allows professionals to coordinate their expertise and work together in order to give the child the most appropriate services possible. Also, it is important for students to feel comfortable trusting adults in the school; this type of trust is something that can be built before a situation occurs.

Research Question Five

Collaboration and consultation were constant themes among school psychologists' and school counselors' responses. It is obvious that working with other professionals is something that both school counselors and school psychologists agree is important and a necessity, but further questioning provided information on how collaboration actually occurs in the schools. There were some differences when examining who most likely contacted each professional if a student exhibited suicidal behavior. School counselors were most likely to be contacted by student self-report and teachers while school psychologists were more likely to be contacted by a school counselor or administrator. Since most counselors are school based, it makes sense that teachers and students may go to them to report suicidal behavior. Additionally, if a school psychologist is based out of central office, it is also understandable that a school counselor or administrator would be the one to contact them.

Perhaps where consultation and collaboration are most crucial is when services are provided to children who demonstrate suicidal behavior. The Virginia Suicide Prevention Guidelines states that when a student exhibits suicidal behavior it is recommended to have a follow up meeting in order to determine needed interventions. Additionally, it suggests that the follow up is a team effort which can include school personnel, the parent/guardian, the child, and the child's mental health provider if appropriate (Suicide prevention guidelines, 2003). School psychologists' and school counselors' both noted that school counselors, school psychologists, classroom teachers, administrators, school nurses, and other school based employees may work as a team to provide services. However, school psychologists were significantly more likely than school counselors to report that a school psychologist was part of the team.

While 97% of school psychologists and 98% of school counselors reported that a school counselor was part of the team, 90% of school psychologists and only 55% of school counselors noted that a school psychologist was part of the team. Again, one reason the professionals' perspectives differ may be due to psychologists not seeming as present in the schools if they are not school based. Although psychologists may provide services to students, it may not be as obvious to other school personnel. Another possibility is that school psychologists may perceive being notified of suicidal behavior and providing risk assessment as being a role in the team that provides services. Alternatively, school counselors may perceive providing services to mean work such as individual or group counseling. Either way, it appears that there is not clear communication about exactly what each professional contributes to the team.

As suspected, when school counselors were given the opportunity to freely respond on what would be helpful in enhancing collaboration efforts, open communication and discussion as well as taking a team approach were mentioned. Although open communication appears to be something that was brought up continuously throughout responses, it definitely seems to be an area that could be strengthened in actual practice. Other suggestions included that all staff should receive training and having a set procedure in place. If all staff received training it would give them a better understanding of their roles during a crisis situation. Intervention efforts could then be enhanced by having set procedures in place which would allow school personnel to know exactly how to carry out their roles. The hope would be that in turn, these two recommendations would help enrich communication between school personnel and lead to more discussion surrounding suicide prevention and intervention efforts.

Additional Survey Questions

Additional questions were included in the survey to provide valuable information in regards to suicidal behavior at the elementary level. Research suggests that many young children understand the concept of killing oneself and that death is final. Still, it is important to know if professionals believe that children can grasp the seriousness of suicide as it may influence their intervention and prevention practices. While 94% of school counselors and 93% of school psychologists believed that students in third through fifth grade understand the concept of killing oneself, only 25% of school counselors and 33% of school psychologists believed the same for students in Kindergarten through second grade (Cutchins, 2013). It is apparent that both professionals believe that older students have the capacity to understand the gravity of suicide while many do not see

younger students as having that understanding. It is important to remember that although some may not believe that young students can understand the concept of suicide, those beliefs should not impact the integrity of prevention and intervention efforts.

School counselors were allowed to freely respond on thoughts that they had as they reflected on their experiences with suicidal behaviors. Many themes emerged that have already been discussed such as the importance of training and giving parents resources, taking all suicidal behaviors seriously, and how lack of coping behaviors and excessive stressors appear to be major risk factors. In addition to these themes, school counselors also mentioned that it is important to be caring towards students and advocate for them. Prevention services start with developing relationships with students as we know that having a caring relationship with nonparental adults is a factor that is associated with lowering suicidal risk in children.

Implications for the Future

School psychologists and school counselors provided many helpful ideas regarding suicide prevention and intervention services in schools. The following suggestions may help school professionals be better prepared and feel more competent when providing services to children who demonstrate suicidal behavior: seek additional training, establish a formal crisis plan, have a written document with everyone's roles and a flow chart of procedures, communicate interprofessionally, educate school and community on importance of mental health, and conduct follow-up meetings to assess intervention effectiveness.

Table 15

Suggestions for School-Based Intervention Regarding Suicide Prevention and Intervention Services

Seek training and workshops aimed at suicide prevention, intervention, and risk assessment
Establish a formal crisis plan
Have the crisis plan contain everyone's roles and a flow chart of procedures
Communicate interprofessionally regarding each other's roles and skill sets
Educate the school and community on importance of mental health services in schools
Conduct follow-up meetings to monitor progress and adjust interventions as necessary

Limitations

As with any research, there were limitations to this study. The current survey, along with Cutchins' (2013) survey, was sent to participants at the beginning of the school year. Since participants had to reflect on the previous school year for many of their answers, it may have been more difficult for them to recall past events. It may have been beneficial to conduct this survey at the end of a school year, however, the researcher wanted to be consistent with Cutchins' (2013) work and send out the survey at the same general time of year.

Participants who responded to the survey may be the counselors who are most invested in this topic. Professionals who do not have as much experience with or interest in suicide at the elementary level may have different practices than those who do. Additionally, a greater depth of information may have been obtained by conducting focus groups and interviews. Although surveys are a good way to get information from many people at once, conducting focus groups and interviews may have helped explain some of the differences between the school psychologists' and school counselors' responses.

Future research in prevention and intervention practices regarding suicidal behavior may benefit from delving deeper into the area of communication and collaboration among school professionals in this way.

Conclusions

A lot can be learned by comparing different mental health professionals' perspectives. As the current study and Cutchins' (2013) research noted, school counselors do appear to be at the forefront of intervention and prevention efforts in elementary schools. However, both school psychologists and school counselors mentioned that consultation, collaboration, and open communication are all important in working with a student who exhibits suicidal behavior.

Each professional has their own unique ideas, experiences, and training that contribute when working with students. In order to best serve the school population, each professional needs to be able to communicate effectively and know not only their role, but other's roles within the system. As psychologists may not be as deeply engrained in the school as the counselors, it is important for them to make their presence known and inform the school personnel regarding their knowledge and skills. As all school personnel have many demands, working together as a team is the most efficient and responsive approach to crisis intervention.

Both professionals agree that having an established crisis plan, receiving additional training, and taking all threats seriously are important factors regarding suicidal behavior at the elementary level. Not only would all of these suggestions help professionals know what is expected of them in the school, but it would also give them

better insight on how to deal with suicidal behavior at this level. Of course, all of this combined will not be nearly as beneficial if it does not come with open communication and discussion between practitioners.

It is important for each school professional to not only be an advocate for the students they work with, but to also be an advocate for mental health awareness in general. This may include giving parents resources, providing professional development opportunities for others, or making it known what types of services they can contribute. Before effective intervention and prevention efforts can be implemented, it is vital for others to understand the benefit of having mental health services in schools. School psychologists and school counselors working alongside one another can enhance these efforts which would result in better services for all children.

Appendix A

Email of Informed Consent

Hello,

My name is Maranda VanDyke and I am a third-year graduate student in the School Psychology program at James Madison University. To fulfill requirements to obtain my Educational Specialist degree, I am conducting a research project examining school counselors' reports of suicidal behavior in elementary school-aged children.

My study involves surveying school counselors in the state of Virginia. I am asking you to participate in my study by completing an online survey. I appreciate your consideration of this request and thank you in advance for your participation.

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Maranda VanDyke from James Madison University. The purpose of this study is to examine school counselors' reports of the current needs and response to suicidal behavior in elementary school-aged children. This study will contribute to the student's completion of her Educational Specialist degree.

Research Procedures

In this study, a link to an online survey (administered through Qualtrics) will be emailed to participants. If you choose to participate, the survey will ask you to provide answers to a series of questions regarding prevalence rates of suicidal behavior in elementary school-aged children, interventions offered to those children, current collaboration efforts, and your reported level of competence in this area of service delivery. Should you decide to participate in this anonymous research, you may access the survey by following the web link located under the "Giving of Consent" section.

Time Required

Participation in this study will require 10-15 minutes of your time.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study. Participants may experience mild psychological discomfort given questions about suicide. However, you have the right to skip any questions that may cause you such discomfort.

Benefits

There are no direct benefits for the participants in this research study. However, as a result of participation in the study, participants may help identify a current need that is not being adequately addressed in elementary schools. Further, participation in this study will contribute to and expand existing knowledge and research on preadolescent and youth suicide prevention.

Confidentiality

Data collected from the survey will be obtained anonymously and recorded via Qualtrics software (a secure online survey tool). No identifiable information will be collected from the participant and no identifiable responses will be presented in the final form of this study. All data collected will be held in strictest confidence and will be stored in a secure location accessible only to the researcher and her faculty advisor. Upon completion of this study, all information will be destroyed.

The results of this research will be presented to students and faculty members in the Department of Graduate Psychology at the annual Graduate Research Symposium. The researcher retains the right to use and publish non-identifiable, aggregated data. Final aggregate results will be made available to participants upon request.

Participation & Withdrawal

Participation in this study is voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences; however, once your responses have been submitted and recorded, you will not be able to withdraw from the study.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion, or you would like to receive a copy of the final aggregate results of this study, please contact:

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Questions about Your Rights as a Research Subject

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James Madison University
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Giving of Consent

I have read this consent and I understand what is being requested of me as a participant in this study. I freely consent to participate. The investigator has provided me with a copy of this form through email. I certify that I am at least 18 years of age. By clicking on the link below, and completing and submitting this anonymous online survey, I am consenting to participate in this research.

http://jmu.co1.qualtrics.com/SE/?SID=SV_e4LxiMObjXpitZr

Maranda VanDyke _____ 09-01-2014

Name of Researcher

Date

This study has been approved by the IRB, protocol # 15-0016.

Appendix B
Survey Questions

This survey is intended for those school counselors who **served in at least one elementary school during the 2013/2014 school year**. If you did not serve in at least one elementary school during the 2013/2014 school year, you may discontinue your participation in this research study at this time.

Furthermore, the researcher understands that information regarding suicidal behavior in elementary school-aged children may be based on your recall of events rather than collected or documented data. Thank you for your time and cooperation.

1. How many years have you been a school counselor?

- a. 0-5
- b. 6-10
- c. 11-15
- d. 16 or more

2. In total, how many *elementary* schools have you served in your history of practice (including current placements)?

- a. 1
- b. 2
- c. 3
- d. 4
- e. more than 4

While most questions in this survey are inclusive of your time as a practicing school counselor in at least one elementary school, some questions are specific to the 2013/2014 school year.

3. In the 2013/2014 school year, were you practicing in at least one elementary school?

- a. Yes
- b. No

4. In the 2013/2014 school year, approximately how many students were enrolled in each of your *elementary* schools?

- a. Elementary School #1
 - i. ENTER NUMBER
- b. Elementary School #2
 - i. ENTER NUMBER
- c. Elementary School #3
 - i. ENTER NUMBER
- d. Elementary School #4
 - i. ENTER NUMBER

Suicidal behavior: suicidal behavior includes a larger set of behaviors than suicide alone. Suicidal behavior includes suicide (a fatal, self-inflicted act with intent to die), suicidal ideation (serious thoughts of suicide viewed as a precursor to suicidal acts), suicidal intent (intentions at the time of a suicide attempt in regard to a wish to die), and suicide attempts (self-injurious behavior intended to cause death).

5. Approximately how many students exhibited suicidal behavior as reported by/through parents, teachers, counselors, peers, and/or self-report in the **2013/2014** school year?

Note: Please include all students with such concerns of which you were aware, regardless of your interaction with the student and/or family.

a. Elementary School #1

i. ENTER NUMBER

b. Elementary School #2

i. ENTER NUMBER

c. Elementary School #3

i. ENTER NUMBER

d. Elementary School #4

i. ENTER NUMBER

6. If a student exhibited suicidal behavior in your *elementary* school(s), who **most likely** contacted you?

a. DROP DOWN MENU

i. Another School Counselor

ii. School Psychologist

iii. Classroom Teacher

iv. Student self-report

v. Peers

vi. Parent

- vii. Administrator
- viii. School Nurse
- ix. Other (ENTER OTHER)

7. If a student exhibited suicidal behavior in your *elementary* school(s), which school-based professional was **most likely** the key person responsible for direct intervention with the student?

a. DROP DOWN MENU

- i. Myself or another School Counselor
- ii. School Psychologist
- iii. Classroom Teacher
- iv. Administrator
- v. School Nurse
- vi. Other

8. If a student exhibited suicidal behavior in your *elementary* school(s), which school-based professionals traditionally worked together to provide needed services? **Check all that apply.**

a. CHECKLIST

- i. Myself or another School Counselor
- ii. School Psychologist
- iii. Classroom teacher
- iv. Administrator
- v. School Nurse
- vi. Other (ENTER OTHER)

9. If a student exhibited suicidal behavior in your *elementary* school(s), which interventions were typically offered? **Check all that apply.**

a. CHECKLIST

- i. Referral to outside agency (ex: Community Services Board)
- ii. Individual counseling with School Counselor
- iii. Individual counseling with School Psychologist
- iv. Small group counseling
- v. Parental notification
- vi. Risk Assessment
- vii. Other (ENTER OTHER)

10. On a scale of 1-5, how effective were the typical interventions offered to students who exhibited suicidal behavior in your *elementary* school(s)?

1 (Not at all) 2 (Somewhat) 3(Average) 4 (Good) 5(Excellent)

11. On a scale of 1-5, how well did your **graduate** training program prepare you to deal with suicidal behavior in *elementary* school-aged students?

1 (Not at all) 2 (Somewhat) 3(Average) 4 (Good) 5(Excellent)

12. On a scale of 1-5, how competent do you feel in your role at the *elementary* level in providing and/or coordinating services for children who exhibited suicidal behavior?

1 (Not at all) 2 (Somewhat) 3(Average) 4 (Good) 5(Excellent)

13. Have you participated in **additional** training (beyond your graduate program) with regard to suicide prevention for *elementary* school-aged students? **Check all that apply.**

a. CHECKLIST

- i. Yes, Applied Suicide Intervention Skills Training (ASIST)
- ii. Yes, another workshop experience
- iii. Yes, other training not specified
- iv. No

14. Which proves more useful in your perceived competence in providing and/or coordinating services for children who exhibited suicidal behavior?

A) More work experience

B) Specific training opportunity (please explain)

15. Do you believe suicidal behavior in children is a relevant issue for *elementary* school(s)?

- a. Yes
- b. No

16. Do you believe *elementary* school students, **in Kindergarten through second grades**, understand the concept of “suicide” or “killing oneself”?

- a. Yes
- b. No

17. Do you believe *elementary* school students, **in third through fifth grades**, understand the concept of “suicide” or “killing oneself”?

- a. Yes
- b. No

18. At any time during your work in an elementary school, was suicide risk assessment training provided to any school staff in your elementary school building(s)?

- a. Yes, in **all** elementary schools in which I've worked
- b. Yes, in **some** elementary schools in which I've worked
- c. Yes, in **one** elementary school in which I've worked
- d. No, suicide risk assessment training was not offered in any of my elementary school buildings

19. Do you believe there is a current need for suicide prevention training in *elementary* schools?

- a. Yes, this is a priority
- b. Yes, but there are other greater priorities (LIST THE GREATER PRIORITIES)
- c. No, this is not needed

The following six open-ended questions will give you the opportunity to provide more information on your experiences with suicidal behavior at the elementary school level. This narrative will help the researcher draw comparisons and identify common themes among school counselors' responses to suicidal behavior in elementary school-aged students. All information is valuable and appreciated. Thank you for your continued participation in this study.

20. While knowing that each child who demonstrates suicidal behavior is unique, what have you done, **in general**, to address the needs of identified students?

21. Have you noticed any trends among elementary school students regarding suicidal behaviors? If yes, please explain.

22. What advice or suggestions do you have for other practitioners regarding suicidal behavior at the elementary school level?
23. What would be helpful in developing additional competency for school counselors regarding suicidal behavior at the elementary school level?
24. What would be helpful in enhancing collaboration efforts between school-based professionals regarding suicidal behavior at the elementary school level?
25. What observations or thoughts would you like to share as you reflect on your experiences with suicidal behaviors?

References

- Beautrais, A. L. (2000). Risk factors for suicide and attempted suicide among young people. *Australian & New Zealand Journal of Psychiatry, 34*(3), 420-436.
- Borowsky, I. W., Taliaferro, L. A., & McMorris, B. J. (2013). Suicidal thinking and behavior among youth involved in verbal and social bullying: Risk and protective factors. *Journal of Adolescent Health, 53*(1), S4-S12.
- Cash, S. J., & Bridge, J.A. (2009). Epidemiology of youth suicide and suicidal behavior. *Current Opinion in Pediatrics, 21*(5), 613-619.
- Center for Disease Control and Prevention. (2014, January 9). *Suicide prevention: Youth suicide*. Retrieved from http://www.cdc.gov/violenceprevention/pub/youth_suicide.html
- Commonwealth of Virginia, Board of Education. (2003). *Suicide prevention guidelines: §22.1 – 272.1 Code of Virginia*. Retrieved from http://www.doe.virginia.gov/boe/guidance/health/suicide_prevention.pdf
- Cutchins, K. R. (2013). *Current needs and response to suicidal behavior at the elementary school level: A survey of Virginia school psychologists* (Educational Specialist thesis). James Madison University, Harrisonburg, VA.
- King, K. A. (2001). Developing a comprehensive school suicide prevention program. *Journal of School Health, 71*(4), 132-137.

- King, K. A., Price, J. H., Telijohann, S. K., & Wahl, J. (1999). How confident do high school counselors feel in recognizing students at risk for suicide? *American Journal of Health Behavior, 23*(6), 457-467.
- King, K.A., & Smith, J. (2000). Project SOAR: A training program to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health, 70*(1), 402-407.
- Miller, D. N. (2010). A centennial milestone (1910-2010): 100 years of youth suicide prevention. *NASP Communiqué, 38*(5). Retrieved from <http://www.nasponline.org/publications/cq/mocq385suicide.aspx>
- Miller, D. N., & Eckert, T. L. (2009). Youth suicidal behavior: An introduction and overview. *School Psychology Review, 38*(2), 153-167.
- Mishara, B.L. (1999). Conceptions of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide and Life-Threatening Behavior, 29*(2), 105-118.
- Mohler, B. & Earls, F. (2001). Trends in adolescent suicide: Misclassification bias? *American Journal of Public Health, 91*, 150-153.
- Murphy, S. L., Xu, J., & Kochanek, K. D. (2013). Deaths: Final data for 2010. *National Vital Statistics Report, 61*(4), 1-118.
- Nadeem, E., Kataoka, S. H., Chang, V. Y., Vona, P., Wong, M., & Stein, B. D. (2011). The role of teachers in school-based suicide prevention: A qualitative study of school staff perspectives. *School Mental Health, 3*, 209-221.

- Rodgers, Philip. (2010). *Review of the Applied Suicide Intervention Skills Training Program (ASIST)*. Retrieved from <https://www.livingworks.net/dmsdocument/274>
- Ryan, G. W. & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, 15(1), 85-109.
- Sarkar, M., Byrne, P., Power, L., Fitzpatrick, C., Anglim, M., Boylan, C., & Morgan, S. (2010). Are suicidal phenomena in children different to suicidal phenomena in adolescents? A six-year review. *Child and Adolescent Mental Health*, 15(4), 197-203.
- Singer, J. B., & Slovak, K. (2011). School social workers' experiences with youth suicidal behavior: An exploratory study. *Children & Schools*, 33(4), 215-228.
- Walsh, E., & Eggert, L. L. (2007). Suicide risk and protective factors among youth experiencing school difficulties. *International Journal of Mental Health Nursing*, 16, 349-359.
- Virginia Department of Health (2012). *Suicide in Virginia: A review of suicide across the lifespan, 2004-2008*. Retrieved from <http://www.vdh.virginia.gov/ofhs/prevention/preventsuicideva/documents/2012/pdf/Virginia%20Suicide%20Report,%202004-2008.pdf>
- Ward, B. R. (1995). The school's role in the prevention of youth suicide. *Social Work in Education*. 17(2), 92-100.