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Current needs and response to suicidal behavior at the elementary school level: A survey of Virginia school psychologists

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Current Needs and Response to Suicidal Behavior at the Elementary School Level: A Survey of Virginia School Psychologists

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Abstract

While minimal information on suicidal behavior at the elementary school level is available, a review of the existing literature demonstrates the erroneous belief that children lack the developmental maturity to understand the concept of death and suicide. To better understand prevalence rates of suicidal behavior in elementary school-aged children, interventions offered to those children, reported levels of practitioner competence, and overall preparedness of elementary school personnel in appropriately addressing suicidal behavior demonstrated by their students, the researcher surveyed 155 Virginia school psychologists. Results from the online survey revealed that while suicidal behavior in elementary school-aged students is rare, school-based professionals do believe that these students are at-risk for experiencing or demonstrating such behavior. Furthermore, school psychologists largely depend on school counselors to lead intervention efforts and communicate valuable information with them. While there are many needs in elementary schools, Virginia school psychologists have expressed the need for additional training opportunities in addition to establishing strong crisis response plans to respond to concerns as soon as possible.

Keywords: suicide, children, elementary school, school psychologist

Introduction

In the year 2000, approximately one million people in the world died by suicide. This figure, on average, represents one death every 40 seconds (World Health Organization, 2005). Fortunately, mental health issues have seen an increase in public awareness, acknowledgement, and support in our society. Unlike many developing countries in the world, the United States of America has the funding and education available to treat mental health concerns and disorders, yet suicide remains the third leading cause of death among people aged 15-34 years in this country today (World Health Organization, 2005; Miller, Eckert, & Mazza, 2009). Further defining this movement has been the attention focused on youth suicide. Highly publicized deaths of children as the result of bullying have defined the mental health movement in this country over the past decade. The mental health community has welcomed this attention as suicide is the fifth leading cause of death in those aged 5-14 (Miller et al., 2009).

History of Youth Suicide Prevention

Suicidal behavior in children is not a new phenomenon, as records exist supporting 100 years of youth suicide prevention. In 1910, Sigmund Freud, Carl Jung, and Alfred Adler (among others) met in Vienna, Austria to discuss the alarming increase of youth suicide. While this is a helpful marker in the history of suicide prevention among children and adolescents, the past 100 years of suicide education, prevention, and intervention has not solved this devastating problem; in fact, it has worsened (Miller, 2010).

The rate of suicide among pre-pubertal children and adolescents increased 120 percent from 1980-1992 (Roche, Giner, & Zalsman, 2005). Furthermore, 94 years

elapsed following the first documented meeting on youth suicide before Congress passed the nation's first youth suicide prevention bill. In 2004, the Garrett Lee Smith Memorial Act was signed into law stating that the United States government supported the notion that youth suicide was a tragedy and early intervention and prevention activities were national priorities (Miller et al., 2009).

Prevalence Rates in Virginia

A rise in mental health awareness has shed light on the prevalence of suicide among all people, yet it continues to remain a public health concern. As years passed, this awareness experienced a downward extension with narrowed focus on our nation's youth. A comprehensive view of youth suicide is important to examine before narrowing focus on the 5-12 age group targeted in this study. Due to minimal scholarly emphasis on suicidal behavior in children, it is important to capture the general trend to better understand such behavior in this non-traditional population.

In a look at youth suicide in Virginia over a ten-year period (1999-2009), the Virginia Online Injury Reporting System found 68 suicides occurred among Virginia youth aged 10-14. While no suicides are reported in this time frame for children ages 1-4 and 5-9, there are reports of self-injurious behaviors in these age groups resulting in hospitalization. Seven children aged 1-4 and 38 children aged 5-9 were hospitalized for self-inflicted injuries during this ten-year period. Hospitalization as a result of self-inflicted injuries in 10- to 14-year-olds increased dramatically with 1,465 youths affected (Virginia Department of Health, 2012). More recently, the Virginia Department of Health (VDH) determined that, on average, two Virginia youths die each week from suicide (2011).

To construct research questions designed for school psychologists in the state of Virginia, the researcher contacted several state employees to explore current efforts in youth suicide prevention. In addition to receiving links to suicide programs targeting elementary school students, employees from VDH and the Campus Suicide Prevention Center of Virginia connected the researcher to several professionals from across the country who asked that any helpful information discovered be shared, as they too were interested in the subject of suicidal behavior at the elementary level. Such requests further emphasize the need for increased attention and resources, as other professionals are interested and have requested more information on this topic.

Anecdotal Evidence

While empirical research on suicidal behavior in elementary-aged students is sparse, anecdotal reports support the notion that young children do have thoughts of suicide and can act on them. In illustration, a school and community in southern New Jersey were shaken when a 10-year-old was found dead in his home in an apparent suicide. Lessons learned from the administration led them to write an emotional and solemn article giving advice to other schools (Salimena & Brooks, 1990). In 1997, an 11-year-old asked his school librarian for a book on suicide. When questioned further, he revealed that he was intending to commit suicide later that day (McArthur, 1997). Finally, a Texas school system found itself in the midst of a legal battle when an eight-year-old boy jumped from a two-and-a-half story campus balcony in a suicide attempt following relentless bullying from classmates (O'Hare, 2010).

Despite these reports, administrators, teachers, parents, and legislators do not believe suicidal behavior in elementary-aged children is of concern (Barnes & Zablotny,

2011). Available prevalence rates from national organizations such as the Centers for Disease Control and Prevention (CDC) and the American Foundation for Suicide Prevention (AFSP) make it easy to justify narrowed focus and resources on the population with a "significant" rate of suicidal behavior. For example, when examined by age, this organization reports the 5-14 age group has the lowest suicide rate. Furthermore, this same age group is most stable in rate changes across time (AFSP, 2011).

Scope and Significance

Examining the rates of suicide by age is helpful when examining trends across time; however, to understand the gravity of suicide, it is helpful to present concrete numbers. In 2008, 215 children aged 10-14 died by suicide, a rate of 1.07 percent. In comparison, 1,604 adolescents aged 15-19 died in the same year, a rate of 7.42 percent (AFSP, 2011). Clearly, there is a sharp increase in rates of suicide between children aged 10-14 and those aged 15-19. While these numbers support the need to focus on suicide prevention in adolescents, the lack of information provided on children less than ten-years-old sends an inaccurate message to concerned parents, teachers, and mental health advocates: children younger than 10-years-old do not have thoughts of suicide.

While school psychologists and other mental health professionals are more aware of the realities of suicidal behavior in all populations of people, even they are misinformed about the history of research supporting suicidal behavior in pre-adolescent children.

Suicidal Behavior in Children

Prevalence rates. Suicide is rare in childhood and early adolescence, yet it does occur. Westefeld et al. (2010) report 56 children aged 12 or younger died by suicide in

2006. The completion of suicide is only one behavior among a continuum of others including suicidal ideation, suicidal intent, and suicide attempts. Therefore, suicidal behavior (thoughts of suicide, intentions at the time of a suicide attempt of a wish to die, and self-injurious behavior intended to cause death) is a group of behavior much larger than suicide alone (Miller & Eckert, 2009). In fact, such suicidal threats and attempts by pre-pubertal children are very common and should be taken seriously as a study conducted by Shaffer (1974) found that 46 percent of children aged 14 and under had previously discussed, threatened, or attempted suicide before their deaths.

Cognitive development. A hurdle in overcoming limited conversations about suicidal behavior in young children is the belief that they may be protected from suicide due to their level of cognitive development and maturity. As a result, many believe it is difficult for children to plan a successful suicidal act and develop feelings of despair and hopelessness (Shaffer & Fisher, 1981). This view is popular among parents, teachers, and administrators (Barnes & Zablotny, 2011). Among psychologists, however, it is contentious despite evidence supporting children's well-developed cognitions surrounding death.

Normand and Mishara (1992) focused on students' understanding of suicide and death through interviews with children aged 5-11 in first, third, and fifth grades. Ultimately, they discovered that the concept of suicide was related to children's development of the concept of death, not age or grade level. While this study provided valuable information about how and when children comprehend the concepts of death and suicide, it was limited by a practical constraint: knowledge of the word "suicide." If a child did not know the meaning of the word "suicide", the interview was discontinued.

As a result, this limited the investigation with younger children (age 5-7) who did not understand the word.

Often, people associate a child's understanding of the word "suicide" to his ability to understand the concept of purposely ending his life. Therefore, it is concluded that if a child does not know the word "suicide", he does not have the cognitive ability to understand (and therefore act) on suicidal thoughts. In (erroneous) support of this belief is empirical evidence that many children do not understand the finality of death (Roche et al., 2005). While it is true that children often do not possess the cognitive maturity necessary to understand the irreversibility of death, this fact does not support children's inability to act on suicidal thoughts. In fact, it is argued that such young children are even more susceptible to acting on thoughts of suicide as they do not fully comprehend the consequences of such actions. Despite such statements and beliefs, many developmental specialists now agree that suicidality is the intent to cause death or self-injury regardless of the child's ability to understand lethality or outcomes (Pfeffer, 2011).

In an effort to expand his original study, Mishara (1999) used alternate wording with children who did not understand the meaning of the word "suicide" and instead used the phrase "killing oneself" or "taking one's life." In this study, interviews were conducted with 65 public school children in grades 1-5 concerning their understanding of death and suicide. While there were significant individual differences among the children, most first graders had a good understanding of the concept of death, with increased understanding in higher grade levels. With regard to suicide, only one of the first graders and seven of the 11 second graders understood the word suicide, while only one of the third and fourth graders did *not* know the meaning of suicide. Furthermore, all

of the children who knew about suicide were able to name at least one method of committing suicide.

Risk Factors

Biological, social, and environmental factors affect the demonstration of suicidal behavior in children. In Pfeffer's (2011) discussion, she includes several warning signs to note in this population. Among these signs are children's previous experiences with suicidal behavior, the presence of mood, anxiety, conduct, or psychotic disorders, exposure (first- or second-hand) to violence, and addictive disorders in parents or caregivers.

A 2005 study examined suicidal ideation among 1,051 maltreated eight-year-olds and found suicidal ideation in 9.9 percent of participants. Thompson et al. utilized pooled data from the Longitudinal Studies on Child Abuse and Neglect (LONGSCAN) where maltreated children (or those at risk for maltreatment) were given assessments at ages four, six, and eight to examine their functioning in several domains. The researchers found that compared with children who are at risk for maltreatment, children who have experienced maltreatment are twice as likely to report suicidal ideation by age eight. Furthermore, while the researchers cite few studies examining suicidality in children younger than 12 years (and with limited generalizability in those that do), they conclude that factors associated with suicidality in younger children are similar to those in adolescents (Thompson et al., 2005).

In Riesch, Jacobson, Sawdey, Anderson and Henriques' (2008) article, the authors describe how the Social Disintegration Model was used to study the intra-personal, interpersonal, and peer network characteristics that influence suicide ideation in children

aged 9-12 as natural disposition affects level of risk in demonstrating suicidal behavior. The researchers found that youth who expressed suicidal ideation reported less cohesion with peers, open communication, supervision, and family caring. These children also reported feeling less connected to school and utilizing internalizing behaviors frequently. In addition to focusing on the underlying characteristics and experiences of children endorsing suicidal thoughts, the initial finding of the research revealed significant concerns. Of the 179 participants, 16 reported they had thought of killing themselves, a rate of just over 11 percent.

Risk factors for suicidal behavior among children should be taken seriously. Even if such factors do not have an immediate and visible impact on students, they can impact later emotional development and functioning. For example, Roche et al. (2005) state many factors lay dormant until puberty, which could account for the drastic increase in suicidal behavior between childhood and adolescence.

School personnel can identify children who are maltreated, are exposed to violence, have minimal supervision, and express internalizing behaviors in concerning ways. Many of the risk factors for suicidal behavior are similar to those for other externalizing concerns: conduct problems, eating disorders, and bullying; yet, the stigma attached to suicide hinders the attention and services these children receive. As a result, important questions are raised regarding the minimization and marginalization of mental health services in schools.

Minimizing Factors

Many factors exist that potentially minimize the severity of suicidal behavior at the elementary level. Several overwhelming challenges that parents and mental-health

professionals face in addressing the issue include ignorance, fear, denial, trust, and system failures (Barnes & Zablotny, 2011). Alone, and in combination, these factors impact an adult's ability to fully comprehend the severity of risk when children demonstrate suicidal behavior.

In addition, records of preadolescent suicide may be an underestimation of the actual prevalence rate due to tendencies to underreport or misinterpret suicide as an accidental death (Mishara, 1999; Westefeld et al., 2010). Shaffer and Fisher (1981) examined suicidal behavior in children and adolescents using an epidemiological approach to compare age groups. The results of this study revealed a moderate underrepresentation of suicide among 15- to 19-year-olds and a very considerable underrepresentation of suicide in 10- to 14-year-olds.

Further supporting this claim is Rosenthal and Rosenthal's (1984) belief that suicides among preschoolers are unrecognized due to the incredulity of parents and physicians. In fact, the Suicide Prevention Center of Los Angeles estimated that up to 50 percent of all child and adolescent suicides are disguised as accidents (Toolan, 1974).

While evidence exists supporting the presence of minimizing factors in many school systems and organizations, other systems have taken advantage of public and private funds to develop and utilize risk reduction programs with elementary-aged children. Riding the Waves and the Good Behavior Game are two examples of such systemic efforts (Youth Suicide Prevention Program, 2011; Embry, 2011).

Current Intervention Efforts

Riding the Waves is a developmentally appropriate program designed to address healthy emotional development, depression, and anxiety in fifth grade students. As a

result of state death and injury data indicating an emerging trend of dangerous behavior in younger students, the curriculum was developed by the Youth Suicide Prevention Program of Washington State and is funded by a two-year grant from an anonymous private funder. Among the skills covered in the 12 short (20-40 minute) lessons include relaxation techniques, understanding and expressing emotions and feelings, positive self-talk, helping friends, and journaling (Youth Suicide Prevention Program, 2011).

Through discussions with Virginia Department of Health employees and other professionals in response to the researcher's request for more information on suicidal behavior at the elementary level on the national suicidology listserv, the Riding the Waves program has been highly regarded and recommended as a training resource. Though suicidal behavior is not specifically addressed in the program, it aims to build resiliency in its young participants.

A similar and equally regarded and recommended program that fosters resiliency in young students is the Good Behavior Game (GBG). The GBG is significantly older than Riding the Waves as it was first developed in the 1960s (Wilcox, Kellam, Brown, Poduska, Ialongo, Wang, & Anthony, 2008). Despite its age, it is one of two initiatives that has been specifically named as a sponsored program in the history of the federal government and has shown a change in life course by young adulthood when implemented with first- and second-grade students (Embry, 2011). Through participation in regular teamwork, the GBG teaches voluntary control over inhibition, leading to regulation of maladaptive thoughts and behaviors (Embry, 2011; Wilcox et al., 2008).

In an epidemiological study conducted by Wilcox et al. (2008), the researchers examined the effectiveness of the GBG in two first- and second-grade classrooms on

suicidal ideation and suicidal attempts by young adulthood. Results supported the hypothesis that students in GBG classrooms experienced lower incidence of suicidality in childhood, adolescence, and young adulthood as data revealed half the lifetime rates of suicidal ideation and attempts in GBG classrooms in comparison to matched controls.

The implementation and success of Riding the Waves and the GBG in our nation's schools is representative of progress (with regard to recognizing and addressing suicidal behavior at the elementary level) on a national scale. In other words, a population in the mental health and educational communities exists that views suicidal behavior among pre-adolescent children as concerning. These professionals have sought information and interventions to address the problem on local and state levels; however, advocacy and support of such needs is fleeting and programs remain isolated in the context for which they were developed. Therefore, information, ideas, and success are contained, making the elimination of stigma, ignorance, and fear arduous and time consuming.

Summary

A review of the literature demonstrates the erroneous belief that children lack the developmental maturity to understand the concept of death and suicide. This research shows that eight- and nine-year-old third graders have a well-developed understanding of death, suicide, ideas of how to act on those thoughts, and access to resources to do so (Mishara, 1999). While national prevalence rates do not depict suicidal behavior in elementary school students as rampant, each story of a child who dies by suicide is tragic (Westefeld et al., 2010). Despite the small number of children who attempt and complete the act of suicide, the number of children who exhibit suicidal behavior is of concern, as

these children are at an increased risk to act on these thoughts as they mature and gain greater access to possible resources (Pfeffer, 2011).

Suicide and suicide attempts are not unheard of in pre-pubertal children, yet professionals, including school psychologists, have been slow to recognize this fact (Toolan, 1974). Contributing to a delayed response from professionals is the tendency for such behavior to be minimized as underreporting has been identified as an area of concern (Shaffer & Fisher, 1981). To remain safe following such thoughts and behaviors, children need the help of adults (Embry, 2011). Resources are available to administrators and mental health advocates, as intervention programs exist supporting the efficacy of classroom-wide prevention efforts.

A refusal to accept the reality of preadolescent suicidal behavior is dangerous and reflects ignorance, denial, and fear on the part of parents, administrators, and clinicians (Barnes & Zablotny, 2011). Ethically, the issue must be addressed to maintain best practice guidelines and standards in all fields of education and psychology.

Research Questions

Through a review of the literature and discussions with state and local personnel, the researcher in the current study surveyed school psychologists in Virginia for 1) increased understanding of prevalence rates regarding suicidal behavior in elementary school-aged children, 2) interventions offered to those children, and 3) reported levels of competence in helping children and their families get appropriate support services. Ultimately, the researcher examined 4) the preparedness of elementary school personnel in appropriately addressing suicidal behavior exhibited by their students.

Methods

Participants

Participants included 155 school psychologists employed in public schools in the state of Virginia. To capture adequate recall before beginning a new academic year, an email was sent in August 2012 to 683 school psychologists in Virginia 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 (see Appendix A). Thirty-four email addresses were not valid; therefore 649 school psychologists received an invitation to participate in the study.

Consenting volunteers connected to the survey through a hyperlink included in the email. Those school psychologists who voluntarily responded to the electronic survey and served at least one elementary school in their history of practice were included in data analysis. Of the 649 school psychologists contacted, 155 participated in the study, a 23.8% response rate.

Measures

A 21-item survey was developed by the researcher to answer the research questions (see Appendix B). Qualtrics, an Internet-based program for generating surveys, was utilized to create, collect, and store survey items and responses. Twelve survey items and three open-ended questions were developed to specifically address the four research questions. Six additional survey items were included that did not address the four research questions.

Survey items 4 and 5 addressed research question one, “Increased understanding of prevalence rates regarding suicidal behavior in elementary school-aged children.”

Survey items 7, 8, 9, 10, and open-ended question 19 addressed research question two, "Interventions offered to elementary school-aged children demonstrating suicidal behavior." Survey items 1, 11, 12, 13, and open-ended question 21 addressed research question three, "Reported levels of competence in helping children and their families get appropriate support services." Survey items 17, 18, and open-ended question 20 addressed research question four, "The preparedness of elementary school personnel in appropriately addressing suicidal behavior exhibited by their students." Survey items 2, 3, 6, 14, 15, and 16 were not included in the analysis of responses within the framework of the stated research questions.

The James Madison University Institutional Review Board approved the survey before it was activated electronically. On average, it took participants 10-15 minutes to complete the survey.

Procedures

Prior to activating the survey, several school psychologists participated in the researcher's pilot study and revisions were made based on participants' feedback. The researcher then obtained email addresses for Virginia school psychologists employed in public schools through the Office of Student Services at the Virginia Department of Education. After successfully emailing 649 Virginia school psychologists, willing participants were able to access the survey at their convenience for the duration of the study. The researcher deactivated the survey after 30 days of accessibility. Once the study was completed, data were stored electronically.

Results

A variety of question formats were utilized to capture an accurate representation of participants' experiences with suicidal behavior in elementary school-aged students. Survey items were presented in multiple-choice style formats, checklist style answer choices, and Likert scale questions. The Qualtrics program automatically summarized descriptive statistics and frequency charts for these survey items (see Appendix C).

Responses to open-ended questions were examined for common themes across respondents. Repetition of ideas and similarities and differences between responses were two methods used in order to identify common threads throughout responses to all open-ended questions. The cutting and sorting technique (Ryan & Bernard, 2003) was utilized to organize and categorize the data. To qualify as a theme, the researcher determined that the response category must have generated at least 10% of total responses to avoid arbitrary decision-making and reporting practices.

It is also important to note that respondents were not limited to a single themed response per open-ended question. Therefore, it is possible that a response from one participant was sorted and recorded under multiple themes.

Research Question One

To address the research question regarding prevalence rates of suicidal behavior in elementary school-aged students, participants were asked, "In the 2011/2012 school year, approximately how many students were enrolled in each of your elementary schools?" The follow-up question stated, "Approximately how many students exhibited suicidal behavior as reported by/through parents, teachers, counselors, peers, and/or self-report in the 2011/2012 school year?" Results indicated that of the estimated 101, 275

students served in 2011/2012 by participating school psychologists in this study, approximately 317 exhibited suicidal behavior, an average prevalence rate of .3%. Eighty-three percent of school psychologists surveyed reported one or more experiences with suicidal behavior in elementary school-aged children in the 2011/2012 school year.

Research Question Two

Research question two was addressed through survey questions examining the interventions offered for students who exhibited suicidal behavior in the past. Checklist style answer choices were included to offer the participant several common social/emotional interventions for convenience and comparability. A free response section entitled "other" was also included to allow participants to describe the intervention(s) offered if other predetermined answer choices were not appropriate. An open-ended question regarding goals and content of delivered interventions was included to allow the participant to share narrative information with the researcher.

When 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?", 57% of respondents selected the school counselor and 39% of respondents selected themselves or another school psychologist. When 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", 97% of participants selected the school counselor, 90% selected the school psychologist, 69% selected administrators, 42% selected classroom teachers, 22% selected other school-based professionals, and 14% selected school nurses.

When asked, “If a student exhibited suicidal behavior in your elementary school(s), which interventions were typically offered? Check all that apply”, 96% selected parental notification, 93% selected a referral to an outside agency, 83% selected risk assessment, 65% selected individual counseling with the school counselor, and 40% selected individual counseling with the school psychologist.

To address the effectiveness of typical interventions (parental notification, referral to an outside agency, risk assessment, counseling with the school counselor, and counseling with the school psychologist) for elementary school-aged students exhibiting suicidal behavior, respondents were asked to rate these interventions on a scale of 1-5 (‘Not at all’, ‘Somewhat’, ‘Average’, ‘Good’, and ‘Excellent’). Fifty-one percent of respondents rated typical interventions as ‘Good’, 25% of participants rated the interventions ‘Average’, and 17% rated them ‘Excellent.’

In addition to survey items, the 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 included in the survey. Participants responded with four clear themes. Consultation with others (including parents) was mentioned 76 times (31%), direct intervention with the student was mentioned 59 times (24%), referral to an outside agency was mentioned 57 times (24%), and risk assessment was mentioned 46 times (19%). The only additional theme mentioned was additional training, which was mentioned four times (2%).

Research Question Three

To explore research question three, reported levels of competence in helping children and their families get appropriate support services, participants were presented

with Likert scale questions to measure self-reported competence regarding their roles in service delivery for elementary school-aged students who exhibited suicidal behavior in the 2011/2012 academic year. In addition, Likert scale questions were used to assess the participant's level of comfort, competence, and training in crisis management.

On a scale of 1-5 ('Not at all', 'Somewhat', 'Average', 'Good', 'Excellent'), participants were asked to rate how well their graduate programs prepared them to handle suicidal behavior in elementary school-aged children. Descriptive statistics revealed the mean response of 2.64 fell between the categories of 'Somewhat' and 'Average'; however, the mean of participants' *current* level of competency in providing services for children who exhibit suicidal behavior at the elementary level was 3.78, between 'Average' and 'Good' on the same scale.

When 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", 59% of participants responded, "Yes, another workshop experience", 32% responded, "Yes, Applied Suicide Intervention Skills Training", 32% responded, "Yes, other training not specified", and 15% responded, "No."

When asked in an open-ended format, "What would be helpful in developing additional competency for school psychologists regarding suicidal behavior at the elementary school level?", two clear themes were identified by respondents. Targeted suicide prevention training specific to elementary school-aged children was mentioned 83 times (66%) and the creation and/or existence of an established crisis plan was mentioned 14 times (11%). Additional themes included: more classes in graduate school (seven times, 6%), overall positive school climate (six times, 5%), real-life practice experiences

(five times, 4%), not sure (four times, 3%), using a multi-disciplinary team approach (three times, 2%), and the use of screening tools (three times, 2%).

When asked, "How many years have you been a school psychologist?", 41% reported 15 or more years, 28% reported 5-10 years, 20% reported 10-15 years, and 11% reported 0-5 years of experience.

Research Question Four

Research question four was addressed through the presentation of a series of questions regarding the current level of need for training and education for school-based professionals. Dichotomous response options and open-ended questions were offered to capture the participant's views on the current needs, response, and future directions of service delivery for addressing suicidal behavior at the elementary level.

When 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)?", 43% of respondents reported that suicide risk assessment training was not offered to any school staff in their elementary school buildings, 31% of respondents reported that some of their elementary schools have offered training, while 27% reported that all of their elementary schools offered such training.

The open-ended question, "What advice or suggestions do you have for other practitioners regarding suicidal behavior at the elementary school level?" revealed four clear themes. Taking all threats seriously was most frequently suggested and was mentioned 45 times (32%). Seeking training for yourself and others was mentioned 39 times (27%), having an established plan was mentioned 20 times (14%), and establishing frequent and open communication with others (including parents) was mentioned 18

times (13%). Additional themes included taking a team approach (eight times, 6%), good documentation (five times, 4%), school-wide mental health prevention services (five times, 4%), and gathering more information from the student (two times, 1%).

Ultimately, when asked, “Do you believe there is a current need for suicide prevention training in elementary schools?”, 55% of participants responded, “Yes, but there are other greater priorities”, 41% responded, “Yes, this is a priority”, and 3% responded, “No, this is not needed.”

Discussion

The results of this survey have provided valuable information to practitioners, trainers, and leaders in school communities regarding training, risk assessment, and collaboration among school employees when examining suicidal behavior in elementary school-aged students. While Virginia school psychologists confirmed that suicidal behavior in this specific population is rare, gaps in crisis planning, crisis response, and communication among school employees were identified.

Research Question One

As a review of the literature did not reveal an extensive number of studies or results reported of suicidal behavior in children less than 10-years-old, it was expected that prevalence rates of such behavior in children as reported by Virginia school psychologists would be low. Despite expected outcomes, it was important to the researcher to gain an increased understanding of these prevalence rates given that few studies include such numbers in their analyses. Without data, the ability to support or deny claims and programs in the school setting is weakened.

Indeed, this research further supports the claim that suicidal behavior in elementary school-aged students is rare. An average prevalence rate of suicidal behavior in .3% of elementary school-aged students as reported by Virginia school psychologists may be reason enough for some to regard this topic as irrelevant; however, stories of all children who die by suicide are tragic. Those who die by suicide as elementary school-aged students are so profound, painful, and unimaginable that prevalence rates do not need to be statistically significant for such events to dramatically impact a school and community.

In fact, rare acts of violence, to self or to others, are often those that shape public policy and drive future research and intervention efforts. The recent mass shootings in Arizona (2011), Colorado (2012), and Connecticut (2012) have highlighted how prevalence rates of horrific incidents do not have to be high for attention to be garnered and action to be taken to prevent future occurrences of such events. The rarity of suicidal behavior in our elementary schools should not be a disqualifying factor when considering allocation of time and resources. Instead, current data should be examined to take an aggressive approach to intervening with such young students.

Research Question Two

When elementary school-aged students do exhibit suicidal behavior, it is important to examine the type of interventions offered and the effectiveness of such interventions. It is not surprising that school counselors are rated as the school-based professionals most likely to directly intervene with or coordinate intervention efforts for children demonstrating suicidal behavior. When examining areas of expertise, school counselors and school psychologists are generally the most highly trained and educated in suicide prevention and intervention efforts. As elementary schools tend to have lower numbers of enrolled students as compared to middle and high schools in the same district, many school psychologists are not based in one setting. Therefore, school counselors are more likely to be physically present when suicidal behavior is suspected.

Given the nature of both professions, it is possible either professional has the training, skill set, and desire to lead the intervention team. The key to developing an effective response plan is preparation and ongoing communication. While this study did not examine aspects of crisis planning and role delineation, future studies may reveal the

importance of individualized crisis response based on the background and skill set of school employees.

When examining the effectiveness of interventions, Virginia school psychologists appear to be satisfied as 68% of respondents rated intervention effectiveness as either 'Excellent' or 'Good.' When examining the top choices for interventions, however, an interesting breakdown of scores appears. Parental notification, referral to an outside agency, and risk assessment were the top three answers chosen and are listed above in order of highest frequency. While each of these top three responses is integral to a successful intervention plan, the frequency with which each intervention was mentioned should be analyzed.

As Virginia school psychologists are required by law to immediately contact a parent/guardian of a student determined to be at imminent risk of suicide, it is understandable that parental notification was most frequently mentioned (Suicide prevention guidelines, 2003). Referral to an outside agency is often appropriate and should be considered when a student exhibits suicidal behavior; however, the range and severity of suicidal behavior can be great. Risk assessment allows professionals involved to determine which interventions should be implemented and which should not.

While risk assessment was chosen as a typical intervention by 83% of respondents when listed among a finite number of available interventions, it was listed by 19% of respondents when asked in an open-ended format about what steps they have generally taken to address the needs of identified students. This discrepancy in reporting suggests that while practitioners are aware that risk assessment is an integral part of crisis response, crisis teams may not have systematic procedures in place to ensure risk is

assessed consistently and with fidelity. Future research concerning the effectiveness and uniformity of risk assessment among school psychologists may reveal deficits in training or procedure that should be addressed at the district, state, or national level.

Research Question Three

Reported levels of competence in responding to suicidal behavior at the elementary school level is a critical indicator of need and a guide for future training opportunities for state and local personnel. Based on the Virginia school psychologists surveyed, the reported mean for level of competence in dealing with suicidal behavior in elementary school-aged students out of a graduate training program was between 'Somewhat' and 'Average'; however, the mean for current levels of competence was between 'Average' and 'Good.' As 89% of participants had more than five years of experience in the field, working experience likely accounts for some of the increased competence of respondents. In addition to work experience, 85% of respondents reported that they had attended a workshop outside of their graduate school experience related to suicide prevention with elementary school-aged students.

While this study did not examine reasons behind the changes of perceived competence by school psychologists following graduate school (more work experience versus a specific training opportunity), future research may help to determine which path proves most useful. Regardless, this study did ask participants what would be most helpful in developing additional competency in responding to suicidal behavior at the elementary school level. Targeted suicide prevention training specific to elementary school-aged children captured an overwhelming majority with 66% of respondents

mentioning it in a free response section. The second most frequent response was the establishment of a crisis response plan, which garnered 11% of responses.

Both of these responses are excellent recommendations for federal, state, and local personnel. Increased guidance, legislation, policy, and procedures for the development of a crisis response team and plan can be disseminated from a variety of sources. Increased pressure on all levels (local, district, state, and federal) will ensure schools are taking the initiative in seeking training opportunities, developing their own individualized plans, and implementing such plans with high fidelity and integrity.

Research Question Four

Current needs, response, and future directions of service delivery are important predictors in addressing the future needs of students demonstrating suicidal behavior at the elementary level. Currently, 43% of participants respond that suicide prevention training is not offered to any staff in their elementary school buildings. While rare in children of this age, suicide is still a matter of life and death. Consider this: if a student stops breathing, cardiopulmonary resuscitation (CPR) is performed. There must be CPR certified staff in school buildings; otherwise, the school district may face serious legal consequences if the child dies and the school was not adequately prepared to respond. While signs of danger may be less evident in a young child who demonstrates suicidal behavior, his or her life is still at risk. It is imperative that trained staff be present in the school building to respond to such crises when they occur.

Participants' most frequent suggestions for other practitioners in developing additional competency in responding to suicidal behavior in elementary school-aged students included taking all threats seriously, seeking additional training, having an

established plan, and increasing communication with others. Each of these suggestions can be addressed through comprehensive workshops and seminars. Until such opportunities are provided, however, practitioners can first help others to understand that all threats should be taken seriously. We know that children can and do have thoughts of suicide (Mishara, 1999). Refusing to acknowledge this fact is dangerous and can lead to serious consequences (Barnes & Zablotny, 2011).

Through open-ended questions and those questions with predetermined answer choices, Virginia school psychologists have clearly identified a need for additional training. Despite such responses, 55% of Virginia school psychologists in this study ultimately reported that while suicide prevention training was needed in elementary school settings, there were other greater priorities at the time. Forty-one percent of participants stated such training was needed and 3% of participants did not think it was needed. While this study did not examine need assessment in the elementary school setting, additional research examining such priorities would be helpful in determining the desired level of response regarding suicidal behavior as compared to other identified needs. Additionally, as this survey found that school counselors were more likely to be involved in intervention planning for identified students, it may be helpful to survey those professionals for differing perspectives on suicide prevention training at the elementary school level.

Additional Survey Questions

Several questions were included on the survey that were not associated with a specific research question but reveal valuable information from the Virginia school psychologists surveyed.

When asked, “Do you believe suicidal behavior is a relevant issue for elementary school(s)?”, 98% of participants responded “yes.” Only three participants, 2% of the population surveyed, did not think that suicidal behavior in children is relevant in elementary schools today; however, these findings have to be interpreted within the context of interest in the survey topic. Voluntary participation in this survey may reflect an established interest and concern with suicidal behavior in elementary school-aged students. As a result, the data may be skewed based on the willingness of the population to respond to a survey that likely reflects a current interest in this aspect of service delivery.

While 33% of participants think that students in Kindergarten through second grade understand the concept of “suicide” or “killing oneself”, 93% of respondents believed students in third through fifth grades do. Responses to these questions demonstrate that the majority of school psychologists in this study understand that elementary school-aged students can and do demonstrate suicidal behavior. Agreement among such professionals will help drive professional development opportunities in risk assessment and intervention techniques regarding suspected or observed suicidal behavior in young children.

When asked, “If a student exhibited suicidal behavior in your elementary school(s), who most likely contacted you?”, 40% of respondents selected the school counselor, 35% selected an administrator, and 16% selected the classroom teacher. Again, the importance of the school counselor’s role in the identification and delivery of services for a student demonstrating suicidal behavior at the elementary level is highlighted as one of primary importance. This further emphasizes the need to expand

this research to incorporate the role of the school counselor, taking their past experiences and current level of training regarding suicide prevention at the elementary level into consideration.

Limitations

There were several factors that could have altered the results of this research study. As the timing of this study did not allow for the researcher to contact participants until August, their ability to accurately recall events from the previous school year may have been impacted. In the future, contacting school-based professionals in mid-May to mid-June may have resulted in better participation and more accurate reporting practices. Variability of valid email addresses was another limitation in this study. While 683 email addresses were received, 649 proved to be current and valid. An increased number of valid email addresses may have increased participation in the research study. While these limitations could have affected the results obtained, they were not momentous enough to change the data significantly.

Finally, all results have to be interpreted within the context of interest in the survey topic. As participation in this study was voluntary, it is likely those who have an interest in this aspect of service delivery were more willing to participate in this study. As a result, responses may not be indicative of the overall population of school psychologists.

Conclusions

Taken together, this survey demonstrates that while suicidal behavior in elementary school-aged students is rare, school-based professionals do believe that these students are at-risk for experiencing or demonstrating such behavior. Furthermore, school

psychologists largely depend on school counselors to lead intervention efforts and communicate valuable information with them.

For some trainers and practitioners, the reality that school psychologists are not taking a lead role in responding to suicidal behavior in children is in major conflict with ideological beliefs surrounding the role and function of the school psychologist. Others accept the discrepancy between such beliefs and reality as one of the unavoidable and unfortunate realities of the limited time and resources of school-based professionals. As a result, one of the major conclusions of this survey has highlighted one of the most fundamental aspects in the profession of school psychology: defining the role of the school psychologist regarding mental health concerns in children.

For some in the field, defining our role is simple. If advocating for children is a top priority, we must first advocate for our own skills, knowledge, and training to make sure children get the services they need. As professionals, however, we must accept our own limitations and work collaboratively with others to achieve an attainable balance in service delivery given the realistic constraints of time, energy, and resources. Given these two often-competing considerations, it is important to reflect on multiple perspectives before reaching definite conclusions.

School counselors have valuable training and often know students, environments, and school buildings more intimately than school psychologists. When crises arise, we should not adamantly insist on taking the lead in responding to such situations, but should consider and recognize the expertise of others involved. As school psychologists, we know we have skill sets that may be unrecognized by parents, colleagues, and administrators. Is it not appropriate to assume that other school-based professionals do

too? On the other hand, we should not ignore or mitigate our own levels of competence and training in the areas of mental health and crisis planning and response.

Clearly the answer lies in balancing leadership, advocacy, time, resources, and individual circumstances. This is not a one-size-fits-all decision making process. Some school counselors will have a stronger background in responding to suicidal behavior in children than school psychologists. In other schools, this may be reversed. The key is to establish and nurture collaborative partnerships and communicate with those professionals with whom we share overlapping roles. Focusing on building those relationships with others in the school building and taking a team approach to crisis response will ultimately benefit the children for whom we so strongly advocate.

There are many needs in elementary schools. Virginia school psychologists have expressed the need for additional training opportunities and the establishment of strong crisis response plans to respond to suicidal behavior in children as soon as it arises. Together, school psychologists and school counselors can achieve the mental health awareness and response in schools that has been championed throughout various professional organizations and national media outlets. Seeking strong partnerships with school counselors at the district, state, and national levels will alleviate confusion and miscommunication around the overlapping mental health roles of these professionals in school buildings.

Appendix A

Email of Informed Consent

Hello,

My name is Kelsey Cutchins and I am a second-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 psychologists' report of suicidal behavior in elementary school-aged children.

My study involves surveying school psychologists 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 Kelsey Cutchins from James Madison University. The purpose of this study is to examine school psychologists' report 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, 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 approximately 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:

Kelsey Cutchins, M.A.
Graduate Student
Department of Graduate Psychology
School Psychology Program
cutchikr@dukes.jmu.edu

Debi Kipps-Vaughan, Psy.D., NCSP
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(540) 568-4557
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Questions about Your Rights as a Research Subject
Dr. David Cockley
Chair, Institutional Review Board
James Madison University
(540) 568-2834
cocklede@jmu.edu

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.qualtrics.com/SE/?SID=SV_d7ivvVkD0lK7eWE

Kelsey Cutchins — *08/5/12*
Name of Researcher — Date

Appendix B

Survey Questions

This survey is intended for those school psychologists who **currently serve, or who have, in the past, served one or more *elementary* schools**. If you do not, or have not served at least one elementary school in your history of practice, 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 psychologist?
    a. 0-5
    b. 5-10
    c. 10-15
    d. 15 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 psychologist in at least one elementary school, some questions are specific to the 2011/2012 school year.

3. In the 2011/2012 school year, were you practicing in at least one elementary school?
    a. Yes
    b. No

4. In the **2011/2012** 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 **2011/2012** 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 psychologist
        ii. Counselor
        iii. Classroom Teacher
        iv. Student
        v. Peers
        vi. Parent
        vii. Administrator
        viii. School Nurse
        ix. 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 psychologist
        ii. Counselor
        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 psychologist
    ii. Counselor
    iii. Classroom teacher
    iv. Administrator
    v. School Nurse
    vi. 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

10. On a scale of 1-5, how effective were the typical interventions offered to students exhibiting 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 exhibit 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
        ii. Yes, another workshop experience
        iii. Yes, other training not specified
        iv. No

14. Do you believe suicidal behavior in children is a relevant issue for *elementary*

school(s)?

a. Yes
b. No

15. Do you believe *elementary* school students, **in Kindergarten through second grades**, understand the concept of "suicide" or "killing oneself"?
    a. Yes
    b. No

16. Do you believe *elementary* school students, **in third through fifth grades**, understand the concept of "suicide" or "killing oneself"?
    a. Yes
    b. No

17. 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. No, suicide risk assessment training was not offered in any of my elementary school buildings

18. 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
    c. No, this is not needed

The following three 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 psychologists' responses to suicidal behavior in elementary school-aged students. All information is valuable and appreciated. Thank you for your continued participation in this study.

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

20. What advice or suggestions do you have for other practitioners regarding suicidal behavior at the elementary school level?

21. What would be helpful in developing additional competency for school psychologists regarding suicidal behavior at the elementary school level?

Appendix C

Qualtrics Survey Results

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

#	Answer		Response	%
1	0-5 years		17	11%
2	5-10 years		44	28%
3	10-15 years		31	20%
4	15 or more years		63	41%
	Total		155	100%

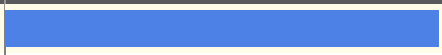
Statistic	Value
Min Value	1
Max Value	4
Mean	2.90
Variance	1.13
Standard Deviation	1.06
Total Responses	155

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

#	Answer		Response	%
1	1		5	3%
2	2		11	7%
3	3		20	13%
4	4		15	10%
5	more than 4		103	67%
	Total		154	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	4.30
Variance	1.30
Standard Deviation	1.14
Total Responses	154

3. While most questions in this survey are inclusive of your time as a practicing school psychologist in at least one elementary school, some questions are specific to the 2011/2012 school year. In the 2011/2012 school year, were you practicing in at least one elementary school?

#	Answer		Response	%
1	Yes		141	91%
2	No		14	9%
	Total		155	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.09
Variance	0.08
Standard Deviation	0.29
Total Responses	155

4. In the 2011/2012 school year, approximately how many students were enrolled in each of your elementary schools?

Elementary School #1	Elementary School #2	Elementary School #3	Elementary School #4
585	600	500	
700+	700+		
450			
350	240		
598	503		
561	541	297	
1000			
850	500		
500	550	400	
200	250		
250	190	165	150
600	500		
700			
1300			
875			
800	400		
over 500	around 300		
580	260	650	
700	950		
500			
400	300		
800	600	500	700
600	300	300	450
500	350	350	650
300			
600			
750			
775			
350	475		
500			
700			
600	400	700	750

1200	1000	700	
500	500		
325	344		
526	494	201	126
1100	780		
400	200		
500			
400			
450			
500			
500	years ago...don't remember	years ago...don't remember	years ago...don't remember
525	495		
475	475	300	
700			
392	424		
410			
200	300	250	
400	200		
660	550	680	
450			
700			
180	180	450	250
350+	350+		
650	500	500	
780	800		
425			
425			
200	200		
500	250	250	
400	300		
250	225	470	
300	450	550	
800			
260	250		

400	400	350	350
855			
550			
400	400		
385			
450			
703			
800			
500	750		
850			
500	150	120	70
300			
575			
700			
600			
499	391		
950	800		
700	600		
850	700	700	
800	800		
600	380		
750			
400	600	600	
400	250	400	400
500	500	500	
725	550		
600			
700	800		
550	550		
550	550		
500	400		
500	500		
850	700		
750			
500			

Statistic	Value
Total Responses	140

5. 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). Approximately how many students exhibited suicidal behavior as reported by/through parents, teachers, counselors, peers, and/or self-report in the 2011/2012 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.

Elementary School #1	Elementary School #2	Elementary School #3	Elementary School #4
0	1	0	
1	1		
7			
15	4		
1	1		
0	0	0	
1			
2	1		
1	1	0	
0	0		
0	0	0	0
3	1		
0			
6			
3			
8	2		
0	1		
2	0	2	
0	1		
0			
0	0		
4	1	1	0
3	0	2	0
2	0	1	0
1			

1			
6			
2			
0	1		
3			
2			
2	1	3	0
0	0	1	
0	2		
4	2		
1	1	0	0
2	0		
0	1		
3			
3			
1			
3			
1	not sure	not sure	not sure
1	2		
2	0	0	
2			
1	3		
0			
3	7	2	
5	3		
3	2	4	
0			
3			
0	1	1	2
2	1		
5	1	2	
1	2		
2			
5			
1	1		

2	0	0	
0	0		
0	0	2	
1			
2			
0	0		
1	1	1	2
10			
0			
4	5		
5			
1			
2			
5			
4			
0	1	1	0
3			
0			
5			
3			
3	2		
1	1		
3	1		
1	2	0	
3	2		
6	3		
1			
5	8	6	
0	0	0	0
0	0	0	
0	0		
1			
2	1		
1	0		
1	0		

0	0		
1			
0	2		
0			
1			
	1		

Statistic	Value
Total Responses	140

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

#	Answer		Response	%
1	Another school psychologist		1	1%
2	Counselor		57	40%
3	Classroom Teacher		23	16%
4	Student		2	1%
5	Peers		0	0%
6	Parent		6	4%
7	Administrator		49	35%
8	School Nurse		0	0%
9	Other		4	3%
	Total		142	100%

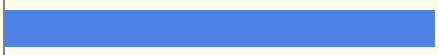
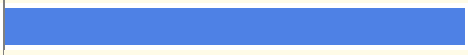
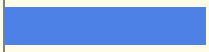
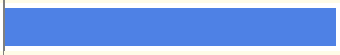
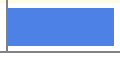
Statistic	Value
Min Value	1
Max Value	9
Mean	4.27
Variance	5.78
Standard Deviation	2.40
Total Responses	142

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?

#	Answer		Response	%
1	Myself or another school psychologist		56	39%
2	Counselor		82	57%
3	Classroom Teacher		0	0%
4	Administrator		2	1%
5	School Nurse		0	0%
6	Other		3	2%
	Total		143	100%

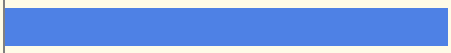
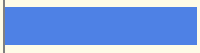
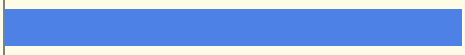
Statistic	Value
Min Value	1
Max Value	6
Mean	1.72
Variance	0.71
Standard Deviation	0.84
Total Responses	143

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.

#	Answer		Response	%
1	Myself or another school psychologist		130	90%
2	Counselor		139	97%
3	Classroom teacher		61	42%
4	Administrator		100	69%
5	School Nurse		20	14%
6	Other		32	22%

Statistic	Value
Min Value	1
Max Value	6
Total Responses	144

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

#	Answer		Response	%
1	Referral to outside agency (ex: Community Services Board)		134	93%
2	Individual counseling with School Counselor		94	65%
3	Individual counseling with School Psychologist		58	40%
4	Small group counseling		13	9%
5	Parental notification		138	96%
6	Risk Assessment		119	83%
7	Other		10	7%

Statistic	Value
Min Value	1
Max Value	7
Total Responses	144

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

#	Answer		Response	%
1	Not at all		0	0%
2	Somewhat		9	6%
3	Average		36	25%
4	Good		73	51%
5	Excellent		24	17%
	Total		142	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.79
Variance	0.64
Standard Deviation	0.80
Total Responses	142

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?

#	Answer		Response	%
1	Not at all		24	16%
2	Somewhat		48	32%
3	Average		44	30%
4	Good		24	16%
5	Excellent		9	6%
	Total		149	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.64
Variance	1.25
Standard Deviation	1.12
Total Responses	149

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 exhibit suicidal behavior?

#	Answer		Response	%
1	Not at all		1	1%
2	Somewhat		15	10%
3	Average		41	28%
4	Good		50	34%
5	Excellent		41	28%
	Total		148	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.78
Variance	0.98
Standard Deviation	0.99
Total Responses	148

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.

#	Answer		Response	%
1	Yes, Applied Suicide Intervention Skills Training		50	32%
2	Yes, another workshop experience		91	59%
3	Yes, other training not specified		49	32%
4	No		23	15%

Statistic	Value
Min Value	1
Max Value	4
Total Responses	155

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

#	Answer		Response	%
1	Yes		152	98%
2	No		3	2%
	Total		155	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.02
Variance	0.02
Standard Deviation	0.14
Total Responses	155

15. Do you believe elementary school students, in Kindergarten through second grades, understand the concept of "suicide" or "killing oneself"?

#	Answer		Response	%
1	Yes		51	33%
2	No		104	67%
	Total		155	100%

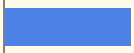
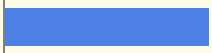
Statistic	Value
Min Value	1
Max Value	2
Mean	1.67
Variance	0.22
Standard Deviation	0.47
Total Responses	155

16. Do you believe elementary school students, in third through fifth grades, understand the concept of "suicide" or "killing oneself"?

#	Answer		Response	%
1	Yes		140	93%
2	No		11	7%
	Total		151	100%

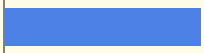
Statistic	Value
Min Value	1
Max Value	2
Mean	1.07
Variance	0.07
Standard Deviation	0.26
Total Responses	151

17. 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)?

#	Answer		Response	%
1	Yes, in all elementary schools in which I've worked		41	27%
2	Yes, in some elementary schools in which I've worked		47	31%
3	No, suicide risk assessment training was not offered in any of my elementary school buildings		66	43%
	Total		154	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	2.16
Variance	0.67
Standard Deviation	0.82
Total Responses	154

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

#	Answer		Response	%
1	Yes, this is a priority		64	41%
2	Yes, but there are other greater priorities		86	55%
3	No, this is not needed		5	3%
	Total		155	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.62
Variance	0.30
Standard Deviation	0.55
Total Responses	155

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

Text Response
regular counseling (with parental consent), regular check-ins with students and staff working with identified students, counseling groups
Provide direct assessment and intervention to the child, while immediately contacting the parent so the child could recieve services and perhaps medication from the providers in the community as well.
Provide outside resources to parents and communicate with couseling personnel, provide individual counseling for a time period
It is difficult to provide sufficient counseling in the school setting so it has been imperiative that the parents are aware of the risk assessment and the necessity to have issues addressed by outside resources.
Maintain contact with parents and outside agencies. Frequently check in with student and teacher. Refer student to weekly counseling sessions with guidance. Refer to therapuetic day treatment services. Keep administrators abreast of situation
Increase parent awareness Build a relationship with targeted students so that they feel they have someone to talk with when issues arise
referred to mental health agencies in the area, spoken with parents, identified point-of-contact in the school for referral to the Family Assessment and Planning Team to draw information/assistance from outside agencies in the area, notified teachers of the need for close observation and notification of select personnel within the school if behaviors are observed.
Risk assessments, work with parents, daily check-ins
Determined risk through interview, Notified parents, Consulted with teacher and administrator, Provided referrals to outside agencies. Administrators and I have developed a letter to parents indicating we have talked to parents and provided referrals.
-risk assessment with child -phone call or in person discussion with parent -discussion with teacher, counselor, administrator, school psychologist colleague and/or social worker -documentation of discussion and suggestions to parents -providing a list of mental health providers in the community -meeting with parent and educational staff for re-entry to school to determine what interventions need to be put into place for the child (group counseling, one-on-one counseling, morning check in/afternoon check out to assess mood, referral to the school-based mental health counselor, etc.)
When we have an identified student who is demonstrating such behavior we have successfully used a multi-disciplinary approach to address the student and family needs. The team approach is extremely helpful in the assessment, documentation, intial intervention, working with the family, making community resource contacts, and then with long term support within the school setting.
Initial referral involves risk assessment, follow through with teachers and parents, and then referrral on for those deamed to be in immediate crisis I have also provided

counseling for both short term and long term cases in the past.
I have assessed the student for potential risk, spoke with parents both on the phone and in person, and linked the families to agencies that could help them if there did indeed appear to be some risk. I also conducted follow-up after whatever intervention was suggested (where it may have occurred or not)
Our mandate it not to do therapy. In fact, we are specifically told that "therapy" is not appropriate in a school setting. I agree with that policy. I see my role as screening, gathering info, and communicating with whomever I must to make sure the student's issues are taken seriously and dealt with appropriately. I give out appropriate referrals for therapy and make sure that interventions take place.
crisis counseling, referrals for long-term counseling
I, personally, have never had an instance of suicide or threatened suicide in any of my elementary schools. This being the case, I am not naive to the possibility of it occurring one day. I think we, as a school system, do a good job at intervening at the first sign of emotional instability.
clinical interview.
As a previous mental health professional for 15 years, I have a unique level of expertise in handling suicide assessment and intervention in an elementary age population. I am called upon more than most school psychs to consult in cases of this nature but my interevention is tailored to what is legally appropriate and permitted in a school/educational setting. I often help the counselors in talking over issues but rarely have much direct intervention with the children, as this is moving out of a bound that is considered typical or legitimate for Va school psychs.
My role is to coordinate services with school personnel and outside agencies.
I have consulted with the school counselor and classroom teacher on ways to assist in deescalating high-risk behaviors.
one-on-one conversation, risk assessment and follow up
Informed parents and guided them through resources available to help their child. There are always individual sessions with the student when he or she returns to school.
assisted parents in getting them into counseling
Determine the level of threat (e.g. is there a plan? is there an ability to carry out the plan?). Consulting with school staff who know the student better to determine the level of threat. Consultation with parents. Encourage the participation of outside agencies (community services board) to determine threat level and need of services.
Call parents, conduct a risk assessment, involve collateral agencies (Risk hotline, CPS sometimes), notify supervisors, and follow thru with paperwork and contact with child/family
offered individual therapy worked with parents referred to outside agency worked with classroom teacher worked with other school staff
Contact parents- risk assessment-refer out
Provided risk assessments and follow up when the child returns to school Provided

outside community resources to the parent, as well as crisis mental health resources for immediate screening
The primary actions were to identify the severity of intent and the plan of action the student has to complete a suicide.
Conduct brief, focused counseling sessions focusing on intent, then events/feelings leading up to suicidal thoughts, then working on resiliency for the next time such events/thoughts/feelings occur.
Communicate with school staff, especially classroom teacher and counselor to make sure student needs are met.
Encourage parents to get family counseling help.
Make sure that the parent was informed immediately of the concerns. Assist the parent in securing private psychotherapeutic support for the student, or in one case, resources for dealing with grief after the death of a parent. Let the teacher, counselor and administrators know the situation so that the student could be monitored closely. Encourage close communication between the home, school, and private professionals to insure that consistent measures were implemented to support the student.
Pushed for students and their families to get appropriate treatment in the private sector and school.
Developed a system of support using school counselors, administration and additional staff with some background in mental and medical health to be aware and available in the event of a referral. School based crisis team is reviewed and updated annually.
Parent contact, referral to outside agencies/therapists, individual counseling.
Interviewed student, consulted with administration, advised parents, follow-up with outside agency, follow-up with student upon return to school, consult with school counselor
Administration was notified, risk assessment completed, parent notified, outside referral or contact with existing psychologist, follow up with student
Using a case management approach, make sure that the student's needs are being met holistically--family, academic, behavior and social skills deficits.
I adminsiter the SIQ or SIQ-JR and make appropriate referrals. I ensure the student is closely moniotored until released to a parent or guardian, unless the reason for contemplating suicide is abuse or negect in which case I contatct social services.
At the elementary level, we try to involve parents and assist them, if necessary, in obtaining outside counseling.
immediate assessment to ensure safety Prompt parent notification and possibly a safety plan
My general protocol is to do a risk assessment, contact the parent, and, if appropriate, refer to our local CSB for further assessment/intervention.
I meet with identified students and conduct an extensive clinical interview/threat assessment and provide them with opportunities to rate their feelings/behaviors compared to normative data (e.g., BASC-2 Self-Report). I then share the results (after informing the

child) with administrators, teacher(s), and parent(s) in order to determine next steps, i.e., keeping the child "on watch" (not unattended), meeting with the school counselor, obtaining an appointment with an independent psychologist or psychiatrist, contacting the hospital, or consulting with another agency.
In a school system where I previously worked, school psychologists were required to attend training regarding suicide (K-12). We were then required to present to the entire faculty information regarding suicide for students. The presentations vaired depending on the school (i.e., one presentation for elementary and a different presentation for middle/high schools). Information included in these presentations: statistics, signs, symptoms, specifically how teachers should intervene, and steps that could be taken to address the students' needs.
Frequent student check-ins, allowing students to visit myself or the counselor when feeling particularly down, counseling (both individually and in small groups), referrals to outside agencies, frequent parent communication
In my experience, division policy to a large degree directs intervention along with staffing. Since school counselors in our division are based in every school and school psychologists travel between schools, counselors are often the first line of defense but call the school psychologist for consultation. When a concern is brought to either of our attention, we complete an immenint risk assessment to gauge if there is a legitimate threat of self harm. If there is concerns because of behaviors, statemtments, plans, etc., we contact parent to make sure the child remains safe until an evaluation through the CSB can be conducted. A follow up plan is devised on how the child will be monitored and student and family are informed of additional resources (ie availability of counselor/psychologist, outside referrals, etc.). Student may also be referred to the child study team to develop supports if there is academic impact and monitor progress or refer for evaluation if an educationally relevant disability is suspected.
We typically address suicidal children with a team approach, using the Guidance Counselor and School Social Worker as well as the school psychologist. We attempted to discover what issues were driving the student to feel the need to exhibit suicidal behavior and then tried to address those issues, either directly or indirectly.
Referral to outside mental health agency.
Look at the bigger picture, academics, self-concept, coping strategies, family supports, and social skills. Try to address the needs that might be triggering the negative feelings
Usually I am contacted by the school counselor. Together we accessed the student risk, contacted the parents, and as well referred the student to an out patient local agency for further assessments. Upon the student returning to school, the school intervention team meet and review the plan recommended by the outside agency. Develop a plan for the school, as well monitor the student. Further referrals are made if needed.
Generally begin with an assessment of the situation to determine the meaning of what was said or written. Complete risk assessment as necessary and notify parents of next step whether that be emergency room visit or visit with another therapist outisde of the school setting.
Student interview, contact parent, assist parents in contacting mental health services,

consultation with outside, school counselor, teacher and administrator for background information and pattern of behavior.
Risk assessment Consultation with parent/guardian Referral to outside agencies Periodic follow-up with parent/child/teacher
While we do not provided "therapy" in the schools, frequent contact (daily) of the student from the school counselor and me is coordinated. Parents are brought in initially and given resources for follow-up from their private provider with on-going follow-up from the school. We obtain written permission to talk with the outside therapist.doctor. In addition, the adminstration and teacher are in the loop. The teacher is provided with information about depression/behaviors to look for and is aware that he/she can contact a support person at any time. Risk assessments are done for students who are displaying significant behaviors.
Risk assessment and referral to outside agency, and counseling
Contact and consult with parents, refer to community based services, consult with teacher to monitor emotional status in school, direct counseling with student
My role was to provide support to other staff. I had very little contact with the student while the counselor worked with the child.
Referrals made to emergency rooms, day treatment/mental health providers, parents. Frequent communication with parent, mental health providers
Provided close monitoring, individual counseling, and frequent communication with parents and outside mental health provicers.
Counseled with student, discussed behaviors with parents, and served as a liason when outside agencies were involved. Also Helped schools to maintain appropriate safeguards with regards to risk assessments and documentation.
Request a risk assessment Contact parents Connect them with the school based therapist that is from the local community services board
Little. Last year I served 16 schools, 9 of which were K-5 as well as an alternative program that also served children beginning at the Kdg level. Most schools have CSB employed people serving as counselors, and the majority of elementary school aged kids exhibing concerns were served by an outside agency. My role was to run around and make sure that the threats were addressed by the outside agencies.
My focus has been on making sure supports are in place to keep the child safe in the short-term and to help families connect with resources to address longer term mental health needs.
Risk Assessment and monitoring Counseling Referral and assistance to famillies to access outside agencies
Helped with initial screenings and notified parents/help made referrals for more thorough risk assessments and treatment plans. I also have helped with re-entry plans.
Provided training to all teachers regarding what to do if a student might be suicidal.
I several of the schools I served, I worked with the school counselor and developed a "screening form" of sorts which help to identify students who may have been at-risk.

Threat/Risk assessment Parent contact Child study meeting to develop an intervention plan
Open communication and a trusting relationship with the parent. Frequent communication with the classroom teachers.
work directly with the student, consult with teacher, parent, counselor, ongoing monitoring
With elementary students whom we have identified as at risk for suicide we meet with the parent to make sure they are accessing mental health services and then discuss what interventions we can provide at school: cutting back on work requirements to ease stress, offering individual counselingn with either myself or a guidance counselor, cutting back on homework to relieve stress at home, and possibly including the child in a group counseling (We've never had a suicide group counseling but could include the child in a "family changes" group or "friendship" group if those are relevant to the child's emotional needs.)
Risk assessment is the primary concern. Followed by contacting appropriate people close to the student and developing an intervention plan (which sometimes contains counseling).
I have not had experiences with suicidal elementary students at this time. however, i am aware that the potential exists.
-provided a risk assessment and then followed up with specific intervals based on the plan - have provided consultation to other school staff such as counselors or nurses, or administrators and teachers
conducted in depth interviews with the student, teachers, and parents
Help understand the issues and provide referral to appropriate outside agencies, try to understand family dynamics that may be at play, help provide both the student and the family support
Previously taught school guidance staff using the ASIST model. Developed district-wide suicide intervention protocol. Home intervention for suciide risk assessment Worked with community providers to ensure continuity of serivces
talked with parents and student, referred to outside agencies, referred to counseling in school, completed a threat assessment
I have contacted parents and provided referrals to outside agencies. (community service board/etc.) I have also consulted with teachers and child study teams to align school-based supports. I have provided short-term individual counseling when indicated, and typically follow-up with the student and family over time.
Student interview in all cases. If further referral was needed they have been referred to the local CSB for additional assessment.
parent notification, referral for outside support, recommendation of mental health assessments, risk evaluation
The crisis team has gathered to determine the next steps. The team usually includes students gaurdian, any outside agencies involved, counselor, administrator, school psych and/or school social worker, and teacher. We would help to make a plan to transition the

student back to school after an incident and risk assessment was conducted. The transition plan would be dependent on the level of assessed need (attempt and hospitalization vs ideations). Check in check out plans were implemented, scheduling of counseling sessions, and coordination with parents for outside services (i.e. sometimes FAPT services or in-home counseling was provided).
Collaborate with parent, teacher, counselor, physician and school administrators to help determine an appropriate plan for intervention.
Communicate with school counselor, teacher and social worker about student needs
Contacted the parents, risk assessment, alerting administration and the school counselor
Counseling, consultation, conferences, referrals to outside agencies
Counseling, consultation, parent conferences. referrals to outside agancies
Provide information to parents regarding available community resources, education regarding suicidal ideation and depression, provide students with support when needed.
I am often notified informally after the fact since I am split between several buildings. It is often the school counselors that take on a more direct role in working with the students and families.
I administer the SIQ and have trained guidence counselors to administer and score it in my absence. I've also told counselors on to use the score as an "absolute" but to judge it in the context of the child's overall mental state.
parental contact, coordination of risk assessment and possible services within the community, notifying administrator, counselor, and teacher, arranging for counselor to work with the child individually
Unfortunately, there was no prior behaviors and the child did complete the suicide attempt.
Imminent risk assessments, parent contact, and connecting students with outside agencies to provide more intensive therapy.
I share outside resources with parents, have face-to-face conferences with parents to help them understand the seriousness of their child's issues, have taken students for in-take evaluations at the local mental health clinic, provide consultation with their teacher and act as a liason w/the child's outside provider.
Identified specific people that they can go to should they have such thoughts. Helped the child understand that it is normal to go through periods of feeling down but there are strategies they can use to think about things differently that can help to overcome these feelings. Basically, helping the child to see that there are other ways of dealing with problems. I was amazed how often the kids thought their parents would be upset with them. It seemed helpful just opening the lines of communication between parent and child.
Completed a risk assessment to determine level of threat, referred to outside evaluation/counseling if necessary, talked with teacher to increase awarness of behaviors and what to "watch" for, and met with parents/staff to keep up to date on the student's progress and identify any needs.

primarily risk assessment and consultation with the school counselor who knows the kids well and is on campus every day whereas i am only there once a week
We follow a rubric for intervention that we have developed and modified over the past 25 years. All new staff are required to attend a suicide intervention training to learn how to identify and their responsibility to report to the appropriate staff.
I, along with the administrator and counselor, contact the parents, facillitate a suicide assessment/follow up with the local mental health agency and oversee follow up care at the school site (depending on student needs).
Initially, provide risk assessment in school. Next, consult with parents and, when appropriate, teachers, and provide referrals to community resources as well as offer individual counseling in school to address any factors that may be related to the suicidal thoughts/behavior/intent.

Statistic	Value
Total Responses	124

20. What advice or suggestions do you have for other practitioners regarding suicidal behavior at the elementary school level?

Text Response
While it may be an infrequent issue, it is something to keep aware of, therefore it is important to keep relevant skills & knowledge current.
I believe it is essential to educate the teachers about warning signs to watch for (i.e writings and drawings, observed behaviors, etc). Even though elementary school children are young, they do have problems and are impulsive. They also do not have strong problem solving skills and may engage in dangerous behaviors that could potentially be deadly.
Involve as many resources as you can to provide assistance and encourage parents to view the information objectively and seriously
To recognize that while K-2 might not understand the whole concept of killing oneself (as in you do not get to see your mom ever again if this happens), statements reflecting this type of thinking still indicate serious issues that need to be addressed.
Children need to be monitored , any incident should be taken seriously, teachers need to be informed on what to look for and explained that when in doubt error on the side of caution every time
Always take behavior seriously. Document all contacts and interventions used. Maintain contact with parents, outside agencies, administrators, student and teachers.
Set up your procedure for staff to follow if they encounter these behaviors and train the staff on the steps to follow in the event of this event. This procedure should include notification of parents, your principal, your guidance counselor, and your local mental health emergency services number. Make sure that the school psychologist and other first responders in the school have been attended Applied Suicide Intervention Skills Training (ASIST).
take all threats seriously initially
Be sure school staff knows what is suicidal behavior and what to do when they observe it.
-take it seriously and talk through what it means to commit suicide - in my experience, some students understand the concept, many do not - regardless, you need to break it down as that it is a permanent solution that has consequences not only for them, but also for their families -have a strategy for risk assessment and documentation in place
The most important thing is to educate teachers and staff what the signs of suicide/depression/other mental illness are. Then teaching them what to do, how to report, when to report, and local policies related to students demsontrating such concerns. Then next is to use PBIS as a platform to build positive attidudes, resiliency, and social connectedness as a prevention measure.
Also investigate and assess students who are referred because of sucidal behaviors. Follow state or local policy for handling assessment, intervention and referrals for students. Get trained in a specific program and/or update your training over time.
It does exist, and it should be taken as seriously as for other age groups

Depression screening and inservicing of teachers regarding depression and suicide are key in identifying issues early and dealing with them proactively. People should know also that ANY suicidal statement or gesture should be taken seriously.
Take it seriously
take threats seriously, training for teachers and staff
I think a multi-faceted team approach is certainly best practice. Pulling together parents, teachers, administrators, counselors, psychologists, and outside agencies to problem solve and brainstorm a plan going forward is critical. Consistency across service providers is key in any challenging issue that comes up with children this young.
I think having some experience and training made available to teachers is a very good idea. I also think that school counselors should be doing this more regularly than School Psychs and we should be more of an advocate than an intervention specialist.
Take comments, drawings, etc. seriously and investigate them.
A risk assessment is the first step in addressing the problem.
be aware that it is possible. behaviors are different at this young age. they don't understand the finality of it though.
All suicidal behavior needs to be taken seriously as the child is crying out for help.
Make the distinction between making a threat and posing a threat
Erring on the side of caution is best - if you have concerns, share them with other professionals in your building. Use a consultative team model for determining threat levels.
Stay calm, help parents thru this with plan and even accompany them to next step if needed, be hopeful--sometimes this crisis starts putting supports into place. Get to know every support person available in your school as well as those in community. The first week you start your job, know your policy and if your training or expertise tells you that there may be holes in the policy, work to change it.
get good specific training work with admin.to help prepare staff awareness present clear procedures for staff
Follow up to confirm parents followed through with outside help.
Watch out for red flags or warning signs in all children
Create a solid plan of action, i.e. a response tree, who should be notified, and what action will take place if a student threatens or exhibits suicidal tendencies.
Be calm, talk to the child, don't panic, and be ready to call on your supports.
It does not always manifest itself as it does in later years an is not always as overt in young children.
Helping teaching staff understand the need to report suspicion of suicidal thoughts/intentions so that evaluation can be done.
Don't assume that young children cannot be extremely depressed.
Listen, don't discount behavior. Address it.
Develop more developmentally appropriate and language friendly methods in interacting

with elementary students to gain more information about their state of mind. Use educational materials regarding feelings and the range of mild to severe that provide more concrete, realistic examples for them to be able to rate their current and previous emotional states.
Don't be afraid to ask the question, "Are you thinking of killing yourself?" Follow up with questions regarding potential plans. Consider protective factors that may be used in developing a student agreement form, as part of counseling, etc.
Gain an understanding of the child's awareness of finality/death resulting from suicide in the framework of their cognitive development, particulary with K/1 students. Dig deep to determine their intent, as they might only want to "kill" themselves to visit a recently passed love one believing they will then return to their current life. This situation might not call for crisis intervention as it would if they had an understanding. The older children who understand the ultimate outcome need to be treated as anyone would and constant supervision and immediate crisis intervention should ensue.
Make sure that everyone knows the steps involved in reporting suicidal behavior and thoughts and to take these thoughts seriously, but not to overreact. There is a current trend to throw out words such as "I'm going to kill myself" with adults and students. This needs to stop so we can make sure it is not ignored when there is a true problem.
Consider all threats as serious even if the risk of suicide is not imminent.
Become acquainted with the signs of suicidal ideation.
Advocate for district-level support for teacher training at all schools, every year. Consider co-leading the training with the school counselor to build relationships with teachers, and make it understood that you are a resource any time there is a concern.
Don't think that just because the children are young that they are immune from suicidal behavior/thoughts. In discussions, be frank and honest, keeping in mind the developmental age of the student.
Although most elementary cases are "cries for help", take each case seriously and do not be afraid to ask the important questions and get involved.
Make sure to have a clear understanding of what "suicidal behavior" looks like for elementary students, know the risk factors, know the signs/symptoms of a child who may be considering suicide, know community resources, and be able to speak with teachers and parents generally and specifically about suicide.
Have a positive and open relationship with the counselor, principal, and school nurse in your building. These people are key in our suicide threat assessments. Having face-to-face conversations with parents has been more beneficial than trying to speak with parents over the phone about their child's suicidal ideations.
It is important ot consider the developmental level of children but also error on the side of taking suicidal behavior as servious even at the elementary level.
First, it is necessary to regularly remind all staff members of our obligations to follow up on suicidal threats and ideation, even if it does not appear to be serious, immediately and with concern for the safety of the child. It is very important that the parent be notified about this type of behavior, even if, after talking to the student and doing a risk

assessment, it appears to have been an idle threat. Notification should be direct (phone call) and not throught a note sent home with the student! Always be prepared to address suicidal behavior - keep necessary forms and documentation with you at all times.
Always take threats seriously.
look at available resources that can be utilized. Develop an adequate screening device as well as an efficient process.
My county take suicide prevention pretty seriously. Psychologist are responsible to offer training to new teachers, as well any one else interested in training about suicide prevention.
Never ignore any questionable behavior or comment. Children as young as three or four have been known to complete suicide.
Always contact parents to inform them of your concerns regarding suicidal behavior. If you believe the student needs to go to mental health or the hospital, advise the parent and ask them to sign a statement indicating that they were made aware of your concerns and will take them there. If you feel the parent may not follow through, ask mental health services to come out to the school. When interviewing the student it is always helpful to have two people in the interview, one to stay with the child and one to make calls, etc. and both can document the interview.
Education of staff Competency in risk assessment
It is probably optimal to address depression and anxiety at the school level, providing staff with information regarding behaviors and school resources. We also try to stay aware of students who may be vulnerable due to risk factors- family history, bullying issues,etc- and monitor them.
Communication with parents and staff and counseling/support for student
Best to deal with directly and immediately and to make sure parents understand the seriousness of the concerns
It is imperative to form good relationships with school staff and community providers.
Make sure that there are several available staff members with suicide training, and keep all members in the loop about the child. Have team members ready to respond to multiple students and have training about death.
Err on the side of caution. Refer quickly to community mental health/emergency room for assessment of inpatient needs. Always, always work within a team framework which includes open and frequent communication betweeen guidance counselor, teachers (who need to know), parents, mental health providers.
Students understanding of and communication of suicidal behaviors varies greatly from that of adolescents.
Take all threats seriously, be avaialbe to your teachers who may have concerns, and help your staff to be informed of warning signs to look for.
Always report it!
Learn about the community resources that are available to address this issue. Look at the bullying policies in your district and become a proactive part of any anti-bulling

measures. Also, continue to support social skills training for all children.
Monitor indentified students closely until risk resides.
Awareness training for all staff who interact with students to provide a wide "screen" or "net" so that we do not miss anyone.
Provide training to all personnel.
A knowledgeable staff is an effective staff.
Make sure that a person who is trained to do a risk assessment is notified rather than only telling the student's parents or blowing it off because the child is young.
Trust your instincts. If a student uses words or actions that indicate suicidal ideation, they are communicating that they are in some sort of trouble or pain. It may not be to the level of an imminent suicide attempt, but they are definitely telling you something that needs immediate attention/intervention.
take it seriously, it can be an indication that the student is experiencing pain in some way, which needs to be addressed (even if it is not a real threat of suicide)
If you have a parent who is reasonable and truly cares about their child then they are willing to follow your advice/recommendations on helping the child but if the parent is unreasonable, quick to blame others, or uninvolved then it becomes much harder. You know have to decide whether to contact social services if you think a parent will not follow up on help for their suicidal child.
Do not be afraid to ask for help!
- take the behavior seriously since many times adults think elem age children are too young to really consider this, but there are some children who do
to take suicial threats seriously even in small children, these are often a cry for help
It helps to work closely with other school based staff (e.g., guidance counselor and school social workers) who also have training in mental health to support the child at school and also with obtaining outside treatment
Increased stress and pressures, inc. younger parents and economic stress, has lead to an increase
Suicidal behavior should be taken seriously at any age and investigated thoroughly.
Have a specific procedure in place that is consisent across schools in your division.
know the warning signs, collaborate with stall about warning signs, be fully aware of and follow procedures of school district
Practicioners may want to ensure that staff are trained and competent with the signs and warnings of sucidial behavior at the elementary school level. I think a lot of people may be surprised to find that students that age think about suicide or make threats. Also, the behaviors and symptoms of depression in younger children manifest differently than the symptoms and behaviors in adolescents/adults.
Just because they are young does not mean that they don't think about suicide or get deeply depressed.
Assess understanding of death

Always take a student seriously
Take all threats seriously
Take all threat seriously
Stay informed and always err on the side of caution.
Be sure to make school-based staff aware that you are a resource for helping address these issues.
Empower counselors. I often have to tell folks that they might have ot interviene, if I am absent.
all suicidal ideation should be taken seriously and provided good follow-up
ALways be aware of changes in the behaviors of your students. There is no one "type" of student who commits suicide. It can be one of your "best" students academically not always the most "troubled" child.
School psychs can provide knowledge to teachers and other professionals on signs and procedures to follow.
I do think that it is an issue that we need to talk more about as most suicide prevention strategies are geared toward the middle and high school level. I would simply suggest that new practitioners consider that it does occur and keep that in mind when working with young children.
It's important to take all suicide threats seriously but not to overreact. It's important to remain calm and make the child feel comfortable discussing their feelings. Sometimes staff can become emotional and escalate the situation. This also increases the prevalence of making suicidal statements for attention.
Take it seriously and make sure that the parents take it seriously as well.
take it seriously and encourage teachers/administrators to take it seriously (suicidal thoughts in young children is an idea that is hard to grasp so many times people think the kids are doing it for attention).
If training is not provided as noted above, ask that this be provided to all new staff.
View this behavior as a serious issue, document parent notification and make sure to initiate a contact meeting with mental health services.
When you determine that a child isn't in imminent risk, do not let that be the end of your involvement...offer services/referrals to address whatever factors led to the incident (in other words, just because a child isn't an immenent risk does not mean that they don't need help. Provide help so that, hopefully, they don't become and imminent risk)
Keep staff and parents informed as much as possible.
Must impress upon others the need for immediate and subsequent attention to the issue / Usually an indication of something more complex, so don't oversimplify the issue
It is important to have a division wide system of procedures for consistent risk assessment and delivery of services. This should be designed by qualified mental health providers within the school system.

Statistic	Value
Total Responses	118

21. What would be helpful in developing additional competency for school psychologists regarding suicidal behavior at the elementary school level?

Text Response
Recognizing signs in younger children, as they are sometimes different than the symptoms & behaviors in older children.
Continuing training in suicial prevention should be providing throughout grad programs and throughout their professional career.
observation of suicidal ideation interviews whenever possible
Better understanding of building wrap around services so support in school is relevant to outside agency intervention.
exposing school administration the role the school psychologist should play in intervention - it also is much more difficult when you are not school based but rather central based with no provided space at schools you remain an outsider no matter how well accepted you are within the school
Training on how to complete risk assessment at the elementary level
They should receive ASIST training as a part of their graduate programming.
a specific course in risk-assessment and threat assessment and interventions to go along with them
Training in suicide risk assessment for that age group
-have discussion about it in graduate school -have an awareness that some populations may be more prone to suicidal ideation - for example, I work with military families and the kids are aware that there have been multiple soldier suicides on post
I think at times, certain aspects of mental health issues can be overlooked. SOL's, RTI, academics, and other programs tend to be the primary issue for many psychs. In addition, the frequency may not be high for issues related to sucide threats. I believe regular training and review of suicide prevention, assessment, and intervention procedures and guidelines is crucial. This is the same for threat assessment and crisis management and intervention. Additionally, the focus should be that any kind of sucide prevent, assessment, and intervention should be linked in a larger continuum of overall prevention/safety within the school. Again this should be applied to threat assessment and crisis intervention.
Training in programs that provide comprehensive assessment and intervention with students who are at risk for sucidial behavior.
Understanding what this age group does or does not understand in regards to the permanency of their lives, and their understanding of what death actually means
Perhaps a refresher on lethality assessment techniques and an emphasis on having a concrete course of action in place before incidents occur. It is hugely important that such responsibilities are shared with other school staff, as psychologists are not always in the building. Social workers and school counselors should be equally familiar with the established procedures.

Trainings focused on elementary age students as opposed to secondary age students.
ASSIST training was beneficial for improving confidence in crisis counseling
I think understanding, more clearly, the behaviors associated with suicidal ideation or depression in general in children this young would be helpful. The behaviors exhibited by K-2 is certainly different than in any other age group.
Training requirements as part of recertification would be a good notion, but considering the nature of it being clearly a higher incidence issue for high school and middle school levels, maybe just making training available - online - would be a good state wide initiative.
Updates on strategies every year or so.
Trainings that focus on signs and symptoms. I also think school psychologists should conduct assessments of at-risk students with regard to suicide ideation and depression as a preventative measure.
awareness of warning signs
Workshops or seminars addressing this issue.
How to walk the young folks through their statements, thoughts, planning, etc ... The probing questions, that with experience the ease of exploring this increases
The ASIST trainings I've attended have been very helpful.
Continue to attend trainings and examine crisis plans yearly
get more specific training foster team assessment approach
Basic training on risk factors, red flags, protocol to follow when hear threats of suicide or comments from other students
Integrating training into an overall crisis model, i.e. training for in-school crisis situations.
Training in specific developmental periods and attitudes about death, depression, etc..
More awareness of behaviors associated with suicide in young children.
DK
Checklist of risk factors. Inservice training.
Training is available.
More research utilizing developmental and early childhood cognitive development to better understand children's understanding and expressions of these topics. Tools that are designed to be used with k-5 students using more pictorial or media tools and/or to account for language development and vocabulary when assessing and discussing these topics. Bibliotherapy, rating scales or videos that are tailored to age 5--11 years old.
Every school psychologist should have additional training in suicide assessment.
More training in graduate school, but also more opportunities during practicum/internship in high school. That is where I have gained the bulk of my experience.
Workshop offered to provide refresher since we don't deal with this often.
The PrePare training is excellent and should be required for all school psychologists,

counselors and support personnel.
Specific training in counseling
In our county, nothing. Our school psychologists are highly trained. For others, I would say intensive training.
My graduate school provided good training in this area.
A standard risk assessment protocol would be useful as a starting place (knowing that each child/situation is different and requires individualized assessment).
More training on prevention, how to raise awareness amongst teachers and other staff, how to handle specific cases, and counseling strategies.
Current data, current research, practice as part of a counseling or mental health intervention class.
Having more classes devoted to the topic. In my school psych classes, we maybe spent one class (or half of a class) talking about suicide risks and suicide threat assessments.
Aj summary of developmental expectations/cognitive development of typically developing children and how that corresponds to suicide risk assessment at the various stages and summary of effective research based interventions.
One of the most meaningful experiences I had during training was a presentation by the parent of a third grade student who had committed suicide. It can and does happen. Hearing these sad stories helps all of us stay alert to the risk,even among our younger students. School psychologists who are new to a community need to be familiar with procedures, etc. for involuntary committments and for involving child protective services if indicated.
Specific issues experienced at that age level leading to suicidal behaviors.
Have a class or having the topic covered during training
I do not think so. I think we are well trained and there is no need for additional training.
including work on how to conduct a risk assessment and how to determine suicidality, whether active or passive
Thorough training with role play.
Additional training in signs of depression Additional training in risk assessment
My school system is quite large and has frequent training/in-services opportunities that address topics including depression, self-harm, bullying, etc.
Additional training
Having a training workshop or DVD that psychologists can view
also be prepared for suicide in adults for possible staff/family incidents
Trainings like the ASSIST program
Training specific to behaviors communicating suicidality that may be unique for children at such a young developemntal level. Training regarding intervention strategies that may be more developementally appropriate than some of the more general intervention approaches.

Not sure. The specialized workshops and training provided (and required) by the school system has been helpful and sufficient.
School psychologists are in elementary schools 2 days a week on average; this leaves the burden of suicide assessment on the school counselors. I wish school psychologists had more time to devote to mental health in elementary schools!
More education about this topic would be a good place to start.
In our area, the major concern is availability of services for non-medicaid recipients. Kids who have a private insurance do not have easy access to mental health care; most travel out of state for up to two hours.
Specific training for pre-screening/risk assessment.
Our county is actually very good for training us at assessment/screening and training other staff for awareness.
Helping each local educational agency develop training for personnel to recognize the signs of suicide and training them regarding what they need to do if a student demonstrates signs of suicide.
Honestly, most of what I learned wasn't through trainings and workshops. My knowledge base came primarily from working on crisis teams with my colleagues and learning a lot from them. Of course I have learned some, too, from workshops etc, but the real life situations proved much more valuable for me.
?
My graduate training included very little training on suicidal behavior in children at any age. I think the media and the internet have contributed to this issue (i.e., the "contagious" nature of suicide), as well as the accessibility of weapons. Now this is something that I believe needs to be discussed, researched and taught at the graduate level. Child development courses should include more research on what children understand about death. Parent training on what they can do for their children. Addressing self-esteem and self-efficacy in elementary schools should be done as well.
continued professional development
I'd like a little more support on how to deal with parents who don't want to acknowledge that their elementary school child may be suicidal or are even combative with the school regarding a child's suicidal comments.
Training specific to elementary aged students.
- suggestions for revising suicide protocols at the elementary level as well as training on how to train general staff (such as teachers and administrators)
Undergoing training relevant to risk assessment and identifying suicidal behavior
Recognition of signs of depression which are different in elementary-aged students
I haven't ever been to a workshop focusing solely on elementary school suicidal behavior. I think it would be helpful if more workshops were offered.
Graduate level and school district training regarding specific interventions for working with students that have exhibited suicidal behavior (including ideation) would be helpful. Most staff are aware of warning signs but seem unsure what to do next.

Requiring all mental health related professionals in the schools to be trained in the same procedures.
greater training in risk assessment, workign with parents to find support for student, and workign with administrators to ensure the situation is taken seriously.
I think everyone should do ASIST it was really intensive and VERY beneficial for me. Also, maybe an opportunity to shadow or talk with mental health professional at the local CSB or hospitals, to look at the in-take/assessment process and to hear/see first hand expriences with elementary aged children experiencing suicial ideations.
Further understanding of moderate to severe mental health disorders
Uniform guidelines and procedures for how to react to certain presented risks
Regional workshiops
Have regional or statewide workshoips
Additional inservice training regarding risk assessment for young children.
Children at this age level often make self harm statements or act aggressively toward others rather than engaging in overt suicidal behavior. Self-harm statements and aggressive behaviors are the manifestation of other issues and becoming more adept at identifying these issues is important for school-based mental health professionals.
Specific training on behaviors at this level.
more information of the laws surrounding suicidality in children, knowledge of community-based services
More education in the specialist program. On-going education in the schools, conferences, counselors and school psychologists working in unity not just in time of crisis but before and after the suicidal attempt.
Additional training is always helpful!
Training in graduate school programs and workshops geared to helping younger children. However, I also think that you have to be particularly careful about how this is discussed with younger children because they don't cognitively understand the permanence of such an act and if there is too much attention placed it could plant a seed of an act that had never even been considered. In other words, I do not think that the large-scale, mass audience kinds of awareness discussions that we have at the high school level would be appropriate with elementary students.
Risk assessment training was the most helpful. Many suicidal referrals turn out to be transient. It is important to be able to quickly assess the children who need additional intervention versus the ones who don't. I think it would be helpful to have some trainings regarding what kinds of follow-up need to be done at the school level after a high-level suicide risk. I work in preschool now...but in my elementary school, our typical procedure was letting parents know...having parent and child sign a contract...asking parents to keep sharp objects put away and not leave child alone...and referring to outside agencies for counseling.
Additional training from local sources that are familiar with suicidal behaviors (i.e. local children's psychiatric facilities)

training on what suicidal behavior in young children looks like and how to explain suicide to them so they understand the finality and implications
Experienced staff should train and model appropriate intervention procedures. The team should review or debrief at the conclusion of an event to evaluate the actions that were taken.
Not sure
Statistical information on suicide at the elementary level, including causes, methods, etc., as well as mportant strategies on how to deal with this issue at such a young age.
Exposure to students while in treatment and in counseling situations / Thorough review of the body of literature which has existed since 1970's -- it's not a "new thing"/ see Dr. Cynthia Pfeffer's numerous articles and papers from 1970ish to mid-80's / In our networked age of digital technology, we assume that these kinds of things have not been carefully examined before, but there were articles, publications, and professionals addressing these kinds of issues long before the internet, and there is much there to be learned as well.
Professional development and opportunities for sharing resources among school and community mental health workers on identification of needs and supports that can be put in place.
inservice training for teachers
Training, as well as some semi formal risk measure.

Statistic	Value
Total Responses	115

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