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Empowering Youth to Prevent Suicide

By Megan Blanco and Holly Wilcox

Emergency room visits for 12- to 17-year-olds suspected of attempting suicide increased 31 percent during the pandemic, according to the U.S. Centers for Disease Control and Prevention (CDC). This trend was especially pronounced for girls, whose ER visits after suspected attempts were 50.6 percent higher in the winter of 2021 than during the same period in 2019.[1]

Several states are using the federal Coronavirus Aid, Relief, and Economic Security Act and the Elementary and Secondary School Emergency Relief Fund to address the mental health impacts of the pandemic. And many state boards of education were already addressing youth suicide prevention through a range of strategies.[2] A 2020 NASBE report stressed the importance of a model youth suicide prevention policy as part of a cross-sector state suicide prevention strategy.

To increase the impact of state and local strategies, state leaders may also consider policies directed at equipping students to help peers struggling with suicidal thoughts. Students also need to know when and how to seek help when they themselves are struggling or in crisis.

IMPORTANCE OF PEER SUPPORT

Most adolescents experiencing depression do not receive professional help.[3] Many report that if they were to experience a mental health problem, they would first turn to a friend.[4] Through exposure to evidence-based programs to empower and equip youth to assist peers, students can recognize the symptoms of mental distress in friends, learn how to involve a trusted adult or seek professional help, or ask their peer directly about whether they are having suicidal thoughts. In addition to being well placed to detect symptoms, peers can be a trusted source of information and support. A recent review of programs found that school-based peer-to-peer programs were effective at preventing student suicide attempts.[5]

PEER-TO-PEER TRAINING

A classroom-based program, teen Mental Health First Aid, teaches adolescents how to identify and respond to mental health distress and substance use in peers or friends. This Australian program increased adolescents' recognition of peers at increased risk of suicide and improved confidence in supporting a suicidal peer.[6] It has been adapted for implementation in the United States, with pilots in 50 schools. New Jersey is using COVID-19 recovery funds to support the program's use.

CDC highlights the Good Behavior Game (GBG) and the Youth Aware of Mental (YAM) Health Program as effective classroom programs. YAM encourages students to solve mental health dilemmas using role play and to build skills for managing mental health problems. In a large randomized control trial, those who received the program made 55 percent fewer suicide attempts and had 50 percent fewer cases of severe suicidal ideation compared with the control group over one year.[7] By rewarding teams for avoiding off-task and disruptive behaviors, GBG promotes classmates' interest in encouraging team members' positive behaviors. The program has been associated with reduced suicidal ideation and attempts.[8]

Originating in Utah, the Hope Squad program trains school-based peer support teams and has scaled nationally. Team members watch for at-risk students, provide friendship, identify suicide warning signs, and seek help from adults. The program is now in more than 950 schools across 31 states and Canada.

ADULT SUPPORTS

Schools enhance student mental health through early identification of those at risk, evidence-based prevention programs, assessment of suicide risk, mental health services, referral to community-based providers, and support to the entire school community in the aftermath of suicide.[9] Multi-tiered systems of support in place in many schools encompass counseling services, school climate improvement, mentoring, and other activities key to prevention.

Health Education. Universal prevention programs that move beyond identification of youth experiencing suicidal ideation toward reducing risk factors and enhancing protective factors are critical to suicide prevention and benefit all students' mental health. Such programs can enrich health education curricula and build social and emotional skills. By offering the curriculum to the entire student population, schools avoid stigmatizing individuals who appear to be at risk. Universal programs also mitigate problems in asymptomatic students that might otherwise arise later. Embedding these programs in health education class is an appropriate way to ensure their sustainability.

Task Forces. Several states have implemented multipronged approaches to suicide prevention. In Wisconsin, a bipartisan task force led by the state legislature conducted a listening tour with stakeholders, evaluated state resources for suicide prevention, and identified opportunities to target and assist at-risk individuals. As a result, the legislature instituted targeted programs, such as requiring that student identification cards include contact information for suicide prevention hotlines, and dedicated funding streams, including grants for peer-to-peer suicide prevention programs in high schools.

Social and Emotional Learning. According to the Collaborative for Academic, Social, and Emotional Learning, more than

20 states have comprehensive preK-12 social and emotional learning standards.[10] Providing teachers with targeted, grade-appropriate learning standards—along with professional development, leadership support, and tools—is one means of building student agency and understanding of emotional wellness. States have also begun to require mental health education for students, with Florida requiring students in grades 6-12 to receive at least five hours of instruction. New York, New Jersey, and Virginia also require mental health education as part of health education.

Access to Services. Students spend most of their day at school, making it the most convenient place to deliver mental health education and services. Providing safe, private onsite spaces for speaking with trained counselors, social workers, and school psychologists reduces barriers to seeking and receiving mental health support. A school thus removes transportation and logistical challenges while also embedding a trusted adult in efforts to ensure continuity of care.[11] When on-site services are not an option, schools should arrange for timely referrals to local agencies or provide time and space for telemedicine visits.

FEDERAL SUPPORT

In January 2021, the U.S. Surgeon General issued a call to action to implement the National Strategy for Suicide Prevention, which can serve as a model for states' plans to prevent youth suicide.

In collaboration with the CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA) offers states direct funding, technical assistance, guidance, and tools to prevent youth suicide. SAMHSA operates the National Suicide Prevention Lifeline, though many states have developed their own call centers and text services. Through grants to schools and other child- and youth-serving organizations in 27 states, the agency also supports suicide prevention programs and services. CDC recommends social-emotional learning, connectedness through peer norm programs and community engagement, and safe reporting and messaging about suicide.[12]

CDC tracks national data on suicide attempts and risk factors for students in grades 9 through 12 through its Youth Risk Behavior Survey, administered biennially since 1991 in partnership with state education and health departments. Data are disaggregated by grade, race, ethnicity, sex, and sexual identity and reveal disproportionately high attempt rates by LGB youth. State boards can invite the state's survey coordinator to present findings at their meetings.

QUESTIONS STATE BOARDS CAN ASK

To support statewide youth suicide prevention efforts, state boards can ask the following:

- What do state data reveal about the prevalence of suicide and suicidal behaviors in school-aged children by county, age, and other characteristics?
- Does our state have a suicide prevention commission or task force? If so, how are we partnering with it? Are students included?
- Does our suicide prevention strategy include partnership with K-12 schools and evidence-based approaches in schools?
- Do our schools receive sufficient federal and state funding for suicide prevention programming? If not, how can we work with key stakeholders to request more funding?
- What opportunities do students have to learn about suicide prevention and how to access crisis services and other community supports?

Because suicide is the second leading cause of death for children ages 10 to 14 and because ideation and attempts among children and adolescents are on the rise, state boards will want to pursue all avenues to support students' mental health, including by enabling them to help each other.

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NOTES

1 Ellen Yard et al., "Emergency Department Visits for Suspected Suicide Attempts among Persons Aged 12–25 Years before and during the COVID-19 Pandemic—United States, January 2019–May 2021," *Morbidity and Mortality Weekly Report* 70 (2021): 888–94. doi: http://dx.doi.org/10.15585/mmwr.mm7024e1external icon.

2 Megan Blanco, "Developing Policy to Prevent Youth Suicide," *Policy Update* 17, no. 1 (Alexandria, VA: NASBE, March 2020).

3 Ramin Mojtabai, Mark Olfson, and Beth Han, "National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults," *Pediatrics* 138, no. 6 (2016), doi: 10.1542/peds.2016-1878.

4 Laura M. Hart et al., "Helping Adolescents to Better Support Their Peers with a Mental Health Problem: A Cluster-Randomised Crossover Trial of teen Mental Health First Aid," *Australia–New Zealand Journal of Psychiatry* 52, no. 7 (2018): 638–51, doi: 10.1177/0004867417753552.

5 J. John Mann, Christina A. Michel, and Randy P. Auerbach, "Improving Suicide Prevention through Evidence-Based Strategies: A Systematic Review," *American Journal of Psychiatry* 178, no. 7 (2021): 611–24.

6 Laura M. Hart et al., "Teen Mental Health First Aid as a School-Based Intervention for Improving Peer Support of Adolescents at Risk of Suicide: Outcomes from a Cluster Randomised Crossover Trial," *Australia–New Zealand Journal of Psychiatry* 54, no. 4 (2020): 382–92.

7 Janet C. Lindow et al., "Feasibility and Acceptability of the Youth Aware of Mental Health (YAM) Intervention in US Adolescents," *Archives of Suicide Research* 24, no. 2 (April-June 2019): 269–84. The trial included 12,000 students in 179 schools across nine European countries.

8 Holly C. Wilcox et al., "The Impact of Two Universal Randomized First- and Second-Grade Classroom Interventions on Young Adult Suicide Ideation and Attempts," *Drug and Alcohol Dependence* 95S (2008): S60–S73.

9 Feelings of connectedness at school is also key to buffering against behaviors related to suicide risk. Kelly Allen et al., "What Schools Need to Know about Fostering School Belonging: A Meta-Analysis," *Educational Psychology Review* 30 (2018): 1–34.

10 CASEL, "SEL Policy at the State Level," website, https://casel.org/systemic-implementation/sel-policy-at-the-state-level/.

11 See also National Association of School Psychologists, PREPaRE 3rd Edition Curriculum, N.d., for school crisis response training.

12 Deb Stone et al., "Preventing Suicide: A Technical Package of Policies, Programs, and Practices" (Atlanta, GA: National Center for Injury Prevention and Control, CDC, 2017).

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