Lives Worth Living

DEDICATION

This book is for those who lost their lives to suicide, those with lived and living experience, loved ones and families, and all those dedicated in the pursuit of suicide prevention.

Lives Worth Living

Applying Zero Suicide as a Prevention Approach for Schools

Stephen Sharp
Perri Rosen

CORWIN

CORWIN

FOR INFORMATION:

Corwin
A Sage Company
2455 Teller Road
Thousand Oaks, California 91320
(800) 233-9936
www.corwin.com

Sage Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

Sage Publications India Pvt. Ltd.
10th Floor, Emaar Capital Tower 2
MG Road, Sikanderpur
Sector 26, Gurugram
Haryana - 122002
India

Sage Publications Asia-Pacific Pte. Ltd.
18 Cross Street #10-10/11/12
China Square Central
Singapore 048423

Printed in the United States of America

ISBN 978-1-0718-7609-1

This book is printed on acid-free paper.

Vice President and Editorial Director: Monica Eckman
Senior Publisher: Jessica Allan
Senior Content Development Editor: Mia Rodriguez
Senior Editorial Assistant: Natalie Delpino
Production Editors: Amy Schroller; Neelu Sahu
Copyeditor: Colleen Brennan
Typesetter: C&M Digitals (P) Ltd.
Cover Designer: Janet Kiesel

25 26 27 28 29 10 9 8 7 6 5 4 3 2 1

Contents

For downloadable resources related to *A Lives Worth Living: Applying Zero Suicide as a Prevention Approach for Schools*, please visit the companion website:
companion.corwin.com/courses/LivesWorthLiving

Foreword

We hold no greater responsibility as a society than to protect our children and give them the chance to thrive. To borrow a phrase from the Talmud: *The world endures only for the breath of schoolchildren.* Taken literally, those breaths, the lives of children, are what sustain our humanity. When they are attending school, children spend nearly as much of their waking time in classrooms and hallways as they do at home. School years, meant for growth, learning, and opportunity, have also become a time when too many young lives are affected by suicide. Every year in the United States, nearly 2 million adolescents attempt suicide. Every year, nearly 6,500 families lose a child in this age group to suicide. Behind each number is a name, a family, and a future that could have been different if someone, somewhere, had recognized the signs and known how to respond.

For me, the lesson is clear: Suicide is not fate. It is preventable. And prevention becomes possible when schools, health systems, and communities see it not as a peripheral initiative, but as a core responsibility. That is why we created the "Columbia Protocol," formally known as the Columbia Suicide Severity Rating Scale (C-SSRS), to give people at every level of society a simple, evidence-based tool to detect risk and act before tragedy unfolds. What began as a set of simple questions that anyone, anywhere could use has become a movement adopted by schools, health systems, the military, and nations across the globe. The Zero Suicide framework carried this momentum into healthcare, proving that systemic commitment can reverberate and change outcomes on a vast scale.

What excites me about *Lives Worth Living* is that it brings this vision into the very center of children's daily lives: their schools. Stephen Sharp and Perri Rosen show us that suicide prevention is not an "extra" program piled on top of everything else educators are asked to do. Instead, they demonstrate how prevention can be woven into the existing school structures and culture. Their framework of "LEAD, EDUCATE, IDENTIFY, ENGAGE, CARE, CONNECT, and IMPROVE" aligns seamlessly with Multi-Tiered Systems of Support (MTSS) and provides schools with a practical roadmap to act with intention, compassion, and effectiveness.

This book provides a fundamental shift in our thinking because it moves suicide prevention upstream. It shows that the daily practices of schools aimed at increasing

connectedness by building belonging, teaching coping skills, engaging families, and fostering resilience are not ancillary to suicide prevention, they *are* suicide prevention. This book is written in the best humanistic traditions that elevate youth voices and remind us that students are not passive recipients of education and care. They are partners and leaders in shaping school cultures of safety and support.

History proves that systemic change saves lives. Fire alarms, drills, and sprinklers ended deaths from school fires. National safety measures like seatbelts in cars and mandatory handwashing drastically reduced deaths from car crashes and medical procedures. In the same way, we can build heartfelt systems that extinguish youth suicide. With intention and collective will, we can create environments where every student feels seen, heard, valued, and connected, and where the audacious but necessary goal of "zero suicides" moves within reach.

Lives Worth Living is both a roadmap and an inspiring call to action. It provides schools and communities with the tools to meet this urgent need with courage and hope. I am deeply grateful to the authors for their vision and dedication, and I urge every educator, policymaker, and community leader to take their message to heart. In the end, the breath of the schoolchildren is not only what sustains the world, but also what reminds us of the future we are called to safeguard.

Kelly Posner Gerstenhaber, Ph.D.
Columbia University Department of Psychiatry
Founder & Director, The Columbia Lighthouse Project

Acknowledgments

Thank you to . . .

Bekah and Olive for their partnerships and voices and for sharing their unique journeys of resilience and recovery. Your stories are a powerful reminder to schools of their role in this essential work.

Aevidum, the amazing students, and educators for their leadership in suicide prevention and depression awareness by letting others know, "I've got your back."

The Zero Suicide Institute at Education Development Center for the integral work transforming behavioral health systems and for serving as a model for our work in schools.

The Pennsylvania Garrett Lee Smith (GLS) Youth Suicide Prevention Grant team for collaboration in applying Zero Suicide across multiple systems in support of youth and families.

PUBLISHER'S ACKNOWLEDGMENTS

Corwin gratefully acknowledges the contributions of the following reviewers:

Debra Paradowski
Administrator
Mukwonago High School
Mukwonago, WI

Kim Watson
K–6 Elementary School Counselor
Constitution Elementary, Deer Valley Unified School District
Phoenix, Arizona

About the Authors

Stephen Sharp is a school counselor and best-selling author. He has worked to provide students with the knowledge and skills to be healthy and successful in the 21st century. Stephen has served on the governing boards of his local, state, and national school counseling organizations. Stephen completed his M.Ed. at Millersville University of Pennsylvania and his B.A. at Lycoming College.

Steve is a co-founder of the Leadership Summit, a community-based social justice network to provide students with the language and tools to understand and combat the many forms of oppression.

Stephen is a Nationally Certified School Suicide Prevention Specialist and worked with the Commonwealth of Pennsylvania to pilot an electronic behavioral health screening for schools. He works tirelessly across the nation to provide education and training on mental health, substance abuse, and inequality.

Stephen frequently presents and writes on school counseling practice, leadership, technology, emerging career skills, mental health, and race in education. Stephen was named the 2017 Pennsylvania Middle School Counselor of the Year.

Dr. Perri Rosen is a nationally certified school psychologist, licensed psychologist, and certified special educator. She received her M.S.Ed. in human development from the University of Pennsylvania and her Ph.D. in school psychology from Temple University.

With over 10 years of experience in mental health and suicide prevention and over 20 years of experience in education, Dr. Rosen has worked at both state and local levels to support students, educators, and school systems. She has helped lead multiple federally funded grants and initiatives focused on youth mental health and suicide prevention in schools, other youth-serving systems, and state government.

Dr. Rosen is passionate about supporting schools to meet the mental health needs of all students through multi-tiered and comprehensive approaches. She has helped develop and provide training, technical assistance, and guidance to schools on suicide prevention policies and procedures, crisis response and postvention, and cross-systems collaboration. Dr. Rosen has co-authored peer-reviewed research articles on various topics, including universal mental health screening, suicide prevention training for educators, and comprehensive school-based suicide prevention.

Introduction

A spark took nearly a hundred children's lives and changed everything. In 1958, a fire burned its way through Our Lady of the Angels, an elementary school in Chicago. Following the deaths of nearly 100 students and staff, there was mourning and recovery. What also followed was sweeping changes for both public and private schools. The sweeping policies and practices gave rise to commitments of safety. Fire protection emerged not simply from hoses and extinguishers but also from layers of safety monitoring, inspection, and procedures, invisibly integrating fire safety into nearly every building's culture.

Last year, no students died in school fires in the United States. No flames touched their bodies. Smoke seldom even kissed their skin. If a fire alarm rang through the halls, students and staff walked out of their classrooms in an orderly way, likely to a nearby parking lot, as the building was checked, students were accounted for, and the school routine was reestablished. Despite nearly 3,400 school property fires in the most recent data from the National Center for Fatality Review and Prevention (2025), there were no student deaths in school fires.

In recent years, students haven't died by fire in schools. They are far more likely to die by their own hand. According to national data, there was a greater than 60% increase in deaths by suicide for youth ages 10 through 24 in the decade and a half between 2007 and 2021 (Curtin & Garnett, 2023). The suicide rate for ages 10 to 14 tripled during the same window to almost 600 student deaths (Centers for Disease Control and Prevention, n.d.; Curtin & Garnett, 2023).

In each passing year over the past two decades, a whole school building and its students essentially disappeared, not due to flames but to suicide. These deaths don't disappear or extinguish. Each resonates through families, schools, and communities. The trauma lingers and permeates like smoke throughout the school community. Schools are left scorched and smoldering, often unsure where to start in the repair and with fear that the embers might spark another death.

Bekah's Story

Middle school is the earliest memory I have of living with my untreated depression. I had lost interest in being a part of my cross country team, something that once brought me joy. I was putting in minimal effort towards my school work and into relationships with my family and supportive friends. I could feel myself changing, sinking. I didn't know what I was feeling or how to make it stop. I felt irritable, hostile. I was struggling with self harm, and I had begun to form an unhealthy relationship with food. I felt hopeless and worthless. The desire to be an active participant in my life diminished. I felt that the only thing that could relieve me from the ache of my depression was not being here anymore. 2014 was the first time I tried to take my own life; I was twelve. ●

Olive's Story

I'm sixteen years old and despite not having any serious disease or taking part in any risky behavior, I don't believe that I will live past eighteen. It's just this sense I have that I don't have a future, and it's terrifying because my parents and friends are starting to talk about college, and they expect me to know where I want to go and I don't know how to tell them that I just know that I am going to meet my untimely demise at some point between prom and graduation. ●

Despite the concerning rising numbers and the reality of the lived experience of students like Bekah and Olive, suicide is one of the most preventable forms of death. The challenge and charge to curb suicide deaths may likely feel as far reaching as ending deaths due to school fires did in the 1950s.

The spark that led to the change was a simple national commitment that no more children would die in a school fire. We can commit now to building a culture where no more children need to die by suicide.

This simple commitment, the aspirational goal that there will be zero suicides, has already emerged through behavioral health.

ZERO SUICIDE

Zero Suicide is both a framework and a roadmap for safer suicide care (Education Development Center, n.d.-a). It began more than a decade ago when a task force of nationwide experts came together to discuss how gaps and fragmentation within health care organizations could be improved for patients at risk of suicide. Research

has shown that the vast majority of people that attempt suicide saw a health care provider in the year before their attempt, and more than one-third of people visited a health care setting in the week before they attempted suicide (Ahmedani et al., 2015). Unfortunately, the health care system has not been known to consistently implement evidence-based and best practice approaches to suicide prevention, missing a significant opportunity to identify people at risk and save lives.

The concept of Zero Suicide is built upon seven components that create a comprehensive approach to suicide prevention in which an organization aspires to turn suicide into a "never event" (Education Development Center, n.d.-a). It is based on the belief that any individual that is connected to care should not die by suicide. In recognizing that not every single suicide can be prevented, striving for zero as an overarching goal sets a standard within an organization that suicide prevention is a priority. By implementing strategies across each of the seven components—lead, train, identify, engage, treat, transition, improve—organizations can move toward more systemic and sustainable change that has been shown to have desirable outcomes.

Since its inception, Zero Suicide has grown and expanded, and it has been adapted in a variety of ways and applied to the delivery of health care in other systems like corrections, tech companies, and foster care. One system it has not yet found its way to yet, however, is education. With suicide rates among youth rising significantly over the past two decades, and with recent research identifying highly concerning trends among LGBTQ+ youth and youth of color, specifically Black youth, it is essential to look more closely at the setting in which youth spend a majority of their time—schools. If the roots of Zero Suicide grew from missed opportunities within the health care system, the question is raised as to what opportunities are present in our schools that make them a prime setting to prevent youth suicide. The most obvious answer, that close to 100% of youth touch the educational system, provides a reasonable starting point.

In understanding Zero Suicide as systems change and acknowledging its potential to elicit a culture shift within a given organization, other comprehensive approaches that have been implemented in schools for decades may come to mind. Multi-tiered frameworks implemented in schools are all designed to enhance broad outcomes for all students. Schools that have embarked on the path of implementation know firsthand that these systems and structures take years to build. They are reliant on leadership support and teaming; training of staff to implement evidence-based practices; effective use of data to drive decisions in terms of identifying students in need of additional support; and parent, student, and community engagement. Lead, train, identify, engage. Conceptually, the key components of Zero Suicide align closely with these existing efforts, and it may seem like a natural fit. The challenge in bridging this concept, however, starts with helping schools to recognize their role and responsibility in comprehensive suicide prevention.

LIVES WORTH LIVING

If the goal of suicide prevention work is focused on strictly preventing deaths by suicide, the many factors that lead to a suicide crisis are overlooked and lost. The complex and complicated work of suicide prevention often overlooks the key components of living. Psychologist, researcher, and author Dr. Marsha Linehan created a treatment model that was successful in managing suicide risk in patients whose situations she found the most challenging and who had previously resisted treatment. The treatment's success was a combination of ancient mindfulness techniques and modern evidence-based therapies, with a continued focus not just on treating individuals but on empowering them to *lead lives worth living.*

When presented with a student in crisis, our schools often lose focus on their ability to be opportunity engines, building systems of connectedness, awareness, growth, and more. Our students come to us with potential, experience, and skills that they can cultivate in their own leadership journey and recovery. We can create the environments that best support these many journeys or that stifle them during points of crisis or vulnerability. Most importantly, just as Linehan captures the timeless aspects of healing to help her most vulnerable patients in their recovery, we can view our students in the continuum of their lives and not just at a moment of crisis.

ZERO SUICIDE IN SCHOOLS FRAMEWORK

Suicide is a significant public health concern, and schools have a powerful role to play. To make it to zero, we have to move our efforts further upstream. Upstream prevention involves the supports and strategies that get ahead of the problem and prevent suicidal thoughts and behaviors from ever occurring. This is the everyday work of schools. We've already installed walls, doors, floors, and exit signs. However, we must see our existing systems in a new lens in order to better utilize them. We must highlight the core elements within our system that not only prevent suicide but enhance the system as a whole. Almost everything we do in schools, from school climate improvement, to bullying prevention, to trauma-informed practices, to school safety initiatives, is helping to reduce a risk factor or build a protective factor for suicide. When we work upstream as we do in schools every day, we create environments that offer an improved quality of care. When we offer an improved quality of care, we create the conditions that support our students to lead lives worth living.

This book presents a guiding framework, adapted from the original Zero Suicide model for health and behavioral health care settings, which illustrates how to engage in comprehensive school-based suicide prevention. In describing the essential components of Zero Suicide in Schools and how these components align with other school efforts, the goal is to help schools structure their efforts and examine the impact of these efforts with intentionality (Figure 0.1). This model follows current

science, which highlights the need for expansion of youth suicide prevention efforts, upstream approaches, and a public health model of service delivery. Schools have the foundations to take on this work. By doing so, schools can build sustainable systems that more consistently support the development of resilient students.

FIGURE 0.1: ZERO SUICIDE IN SCHOOLS FRAMEWORK

ZERO SUICIDE FRAMEWORK		ZERO SUICIDE IN SCHOOLS FRAMEWORK	
LEAD	Lead systems-wide culture change committed to reducing suicide.	LEAD	Lead systemic change to reduce risk factors and build protective factors for lives worth living.
TRAIN	Train a competent, confident, and caring workforce.	EDUCATE	Educate a competent, confident, and caring community to create a safe and supportive environment.
IDENTIFY	Identify individuals with suicide risk via comprehensive screening and assessment.	IDENTIFY	Identify students' risk and protective factors and potential suicidality through comprehensive screening and assessment.
ENGAGE	Engage all individuals at risk of suicide using a suicide care management plan.	ENGAGE	Engage youth and families in a collaborative and safe environment.
TREAT	Treat suicidal thoughts and behaviors using evidence-based treatments.	CARE	Deliver care to prevent and address suicidal thoughts and behaviors using evidence-based practices.
TRANSITION	Transition individuals through care with warm hand-offs and supportive contacts.	CONNECT	Support students with care transitions through proactive cross-systems connections.
IMPROVE	Improve policies and procedures through continuous quality improvement.	IMPROVE	Improve policies, procedures, and care through continuous quality improvement.

CHAPTER 1

Lead

Lead systemic change to reduce risk factors and build protective factors for lives worth living.

The very first component of the Zero Suicide framework is LEAD, and for good reason. Leadership is the foundation of comprehensive school-based suicide efforts. The essential components under leadership are all-encompassing, meaning they incorporate all other aspects of the Zero Suicide framework. These components include policies and procedures for suicide prevention, dedicated teams that view suicide prevention as their role (or part of their role), data that help drive decisions around implementation of efforts, and authentic partnerships with youth and families to ensure that the voices of lived experience inform the work. When these components are missing, or when there is no *leadership* for suicide prevention efforts in school, then overall efforts are not viewed as cohesive. In other words, a school might implement staff training or have a screening tool that they utilize to identify students at risk, or they might host a suicide prevention awareness event or develop reentry plans for students when they return to school from a hospitalization. These are all important pieces of a comprehensive approach to suicide prevention. Yet, how are these strategies selected? How are they structured and implemented with intentionality? How are they integrated and aligned with the other work of schools? How do they reflect the culture, values, and needs of those they are designed to serve? How do we know if they are effective? These are just some of the questions that school leaders and teams, including students and families, must address.

LEADING SUICIDE PREVENTION IN SCHOOLS

Leadership, within the Zero Suicide framework, is about "system-wide culture change committed to reducing suicides" (Education Development Center, n.d.-a). There are many reasons that a school may decide to make this commitment, and the drive to do so may initially start off with one person, whether a school administrator, a school mental health professional, a student, a family member, or a community member. For many schools that have worked to expand their suicide prevention efforts, the push to effect change has come about in the aftermath of a tragic loss, though for some, it is a more proactive vision. From a suicide prevention standpoint,

school systems are the primary context for prevention and upstream work. Our efforts to lead systems change in schools must therefore be broadened to reduce risk factors and build protective factors, not only to reduce suicide among those with potential or known risk but to empower all students to lead lives worth living.

School leaders have plates that are overflowing, and priorities are often based on the many mandates that schools are required to fulfill. For suicide prevention to become a priority within a school, someone has to see it as such. In other words, it is essential for those in leadership positions to genuinely believe in the critical nature of this work. The goal is to transfer this belief into action and facilitate a true "system of care" in which every person in that system ascribes to this belief, as well as the notion that they have a direct role in preventing suicide. To do so, leadership must be able to articulate the importance of this work so that it is not seen by the school community as "just another initiative." With this foundation in place, the system can then develop and evolve over time, establishing and strengthening the other foundations that serve as anchors for implementation. These include the following:

- Efforts to create a safe and supportive environment for both students and adults
- Establishment of effective and efficient teams
- Engaging individuals (i.e., students and families) with suicide-centered lived experience
- Ongoing collaboration with community partners
- Intentional use of data to drive decisions and continuously improve upon efforts
- Development of suicide policies and procedures that are culturally relevant, equitable, and trauma-informed

COMPREHENSIVE SUICIDE PREVENTION

There are many models that exist to help guide and inform suicide prevention efforts, but across all of them is the notion that these efforts, regardless of population, setting, system, or sector, must be comprehensive. In other words, suicide prevention requires a combination of approaches that address different aspects of the problem, which makes sense when we recognize suicide as a complex behavior, or a complex outcome. One of the most widely represented national models for **comprehensive suicide prevention** was developed and adapted from the U.S. Air Force Suicide Prevention Program by The Jed Foundation and the Suicide Prevention Resource Center (SPRC) in 2020. The nine components of this framework address the **continuum of suicide prevention** and are visually represented as puzzle pieces that fit together to create the whole.

COMPREHENSIVE SUICIDE PREVENTION

- Identify and assist persons at risk.
- Increase help-seeking.
- Ensure access to effective mental health and suicide care and treatment.
- Support safe care transitions and create organizational linkages.
- Respond effectively to individuals in crisis.
- Provide for immediate and long-term postvention.
- Reduce access to means of suicide.
- Enhance life skills and resilience.
- Promote social connectedness and support.

SOURCE: Suicide Prevention Resource Center (SPRC; 2020b).

A Brief History of Suicide Prevention Care

Historically, suicide prevention was considered the role and responsibility of the behavioral health care system, with most efforts focused on identifying and treating individuals considered to be at high risk of suicide (Martinez-Ales et al., 2021). Common approaches have involved various therapies, medications, or both, which patients could receive while in the hospital full-time (i.e., inpatient psychiatric hospitalization), part-time (i.e., partial hospitalization program), or at regularly scheduled times while remaining primarily at home or in the community (i.e., intensive outpatient therapy, outpatient therapy).

For individuals experiencing a mental health or suicide-related crisis, **acute care settings** that provide immediate, short-term treatment include emergency departments and inpatient psychiatric hospitals (Johnson et al., 2022). While sometimes necessary, these settings have often served as a default option for care, in part because of their accessibility in operating 24 hours a day. Sometimes, they are the only option for safety in the midst of a crisis. However, those who have experienced these settings in their most vulnerable moments report that they have often felt the opposite of safe (Schmidt & Uman, 2020).

Significant progress has been made within the behavioral health care system in terms of the capacity to effectively identify and treat those at risk of suicide (Education Development Center, n.d.-b). There is a broader continuum of services and a wider array of evidence-based therapies and treatment approaches. This

progress is due to not only advances in research but also stories and insights shared by those who have lost a loved one to suicide, survived a suicide attempt, or had some other personal lived experience in navigating the system. Beyond just providing treatment, there has been national emphasis on implementing comprehensive suicide prevention such as Zero Suicide within these settings.

With downstream efforts as the primary focus, we have seen youth suicide rates in the United States continue to steadily rise.

Moving Upstream

Downstream suicide prevention efforts that serve to intervene with and support those at risk of suicide are a necessary component of comprehensive suicide prevention. However, with downstream efforts as the primary focus, we have seen suicide rates in United States, including those for youth, continue to steadily rise.

EXAMPLES OF DOWNSTREAM SUICIDE PREVENTION

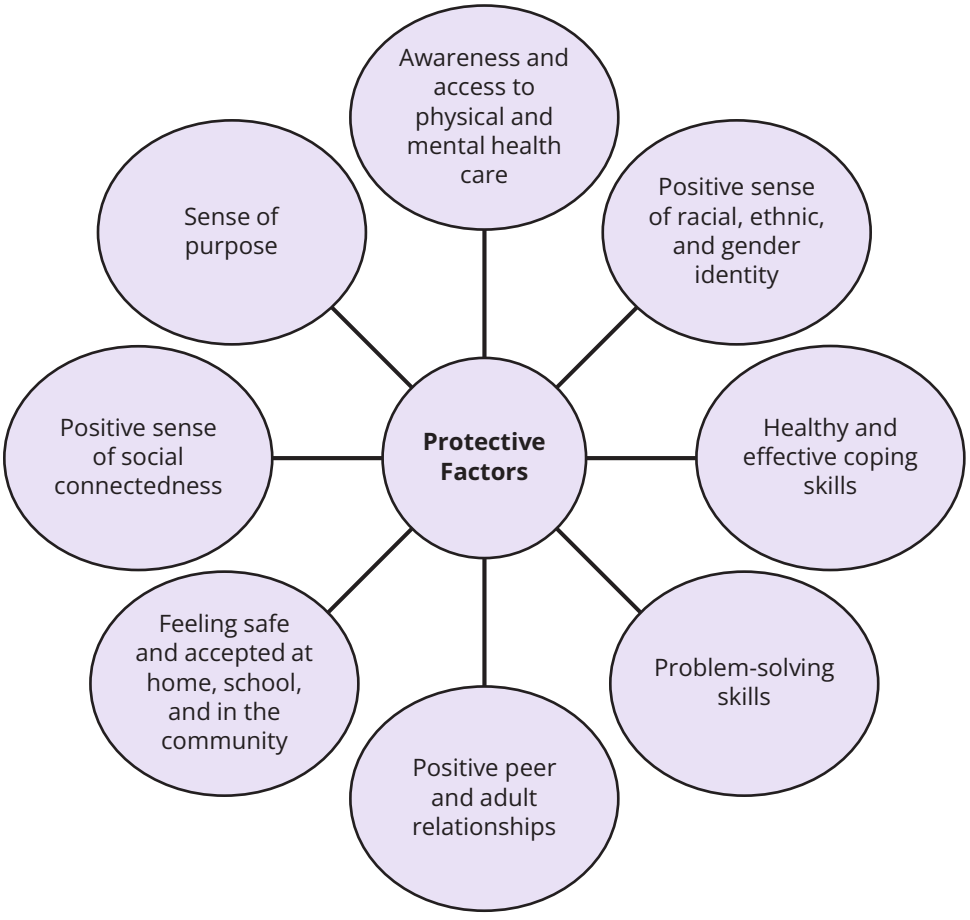
- Screening and assessment
- Safety planning
- Crisis response and intervention
- Therapy or other forms of mental health treatment
- Lethal means safety

SOURCE: U.S. Department of Health and Human Services (2024).

This has led to a growing focus on **upstream suicide prevention**, which refers to the population-wide efforts that aim to prevent not only suicide attempts or deaths but also the onset of suicidal thoughts. If *downstream* efforts occur once individuals are already struggling or in crisis (essentially, when they've already "fallen into the water"), *upstream* suicide prevention represents the universal, population-wide efforts that aim to reduce suicide risk factors and enhance protective factors that can help mitigate risk of suicide or prevent individuals from "falling into the water" in the first place.

Part of the complexity of suicide is the number of **risk factors**, which by definition do not *cause* suicide but do increase the possibility of suicide. Because of the sheer number of risk factors that exist at the individual, family, community, and systems levels, no person is immune to suicide. However, we now have awareness of what these risk factors are and a variety of research-backed tools to both prevent and reduce many of those risk factors, as well as develop and strengthen **protective factors** that can counteract that risk.

FIGURE 1.1: PROTECTIVE FACTORS



SOURCE: Adapted from SAMHSA, 2020, 2024.

Like risk factors, protective factors exist across multiple systems levels. They serve as a buffer against risk factors, mitigating their potential impact and helping to reduce the likelihood that a person will die by suicide. Beyond reducing risk, protective factors build resilience. They are the essential ingredients of leading lives worth living. While protective factors have not received as much attention in research as risk factors, they are arguably more important when considering the many opportunities we have to support our youth at school. Through a system-wide effort to create safe and supportive learning environments, cultivate connectedness, and teach life skills, schools can begin to protect youth from the moment they walk through our doors.

In April 2012, Dr. Peter Wyman led a panel of suicide prevention experts and advocates in discussing current limitations in the field and expanding the "youth suicide prevention paradigm" (p. 3) to include upstream approaches to youth suicide

prevention. Their rationale highlighted the following points (Wyman & Upstream Suicide Prevention Workgroup, 2012):

- Relying solely on the behavioral health care system to meet the needs of youth at risk of suicide is not sufficient because many youth in need of treatment—including those with diagnosable mental health conditions—do not receive it.
- Addressing more common concerns in early childhood and elementary school (e.g., social-emotional skill needs) can "set the stage" for lower suicide rates later.
- It is more efficient to address risk factors that can lead to multiple adverse outcomes (e.g., substance use, mental health conditions, school drop-out, etc.) that subsequently increase suicide risk.
- Universal approaches that are designed for large groups of youth and/or adults have the potential to reduce risk for suicide among more individuals.

If we only focus on downstream efforts, we will continually be in crisis response, or "putting out fires." We will miss key opportunities, especially in those childhood and adolescent years during which time we have our youth with us in schools, and during which time we have the resources to intervene early with risk factors and cultivate those protective factors that can build resilience and set up our students for success over the course of their lifetime. By acknowledging the need for upstream approaches in suicide prevention, we are moving closer to a public health approach to this public health problem, in other words, an approach that is comprehensive both in terms of what it is designed to do and whom it is designed to serve.

Expanding School-Based Suicide Prevention

School-specific models for comprehensive suicide prevention have existed for more than a decade, having evolved over this time period. Earlier models, such as the one presented in SAMHSA's (2012) *Preventing Suicide: A Toolkit for High Schools*, acknowledged suicide prevention as a continuum, with dedicated prevention efforts focused on education and training, methods for identification (e.g., screening), and policies and procedures that span prevention, intervention, and response efforts. These essential components to school-based suicide prevention were depicted as connected but not necessarily integrated in any particular way, either with each other or with the other efforts of schools that are closely related to suicide prevention, such as upstream approaches. Over the past several years, national emphasis on multi-tiered frameworks and comprehensive school mental health efforts has grown, and these efforts have helped to create a system-wide structure for addressing the needs of *all* students, as well as *all* student needs, beyond just academics or behavior.

For instance, various models for school-based suicide prevention efforts have been aligned with or situated within a multi-tiered framework (Education Development Center, n.d.-a; Erbacher et al., 2023; The Jed Foundation, 2023; Miller, 2021; Singer

et al., 2018). As part of their Multi-Tiered Suicide Prevention (MTSP) for Schools model, the Education Development Center has integrated elements of the *Toolkit for High Schools* with the SPRC's framework for comprehensive suicide prevention into six key components that can be aligned with existing social, emotional, and behavioral initiatives that schools may have in place or are also working to implement, such as social-emotional learning. The suicide prevention components are embedded across three tiers, with underlying "drivers of effectiveness," such as leadership and data-driven decision-making (Education Development Center, n.d.-a), that are consistent with Zero Suicide. The Jed Foundation's (2023) Comprehensive Approach to Mental Health Promotion and Suicide Prevention for Districts aligns with multi-tiered systems of support (MTSS) as well as the Whole School, Whole Community, Whole Child (WSCC) framework (Centers for Disease Control and Prevention, 2024) and also includes elements of the SPRC's comprehensive framework laid out as seven thematic core domains and two foundational domains: Strategic Planning and Equitable Implementation.

TABLE 1.1: COMPREHENSIVE MODELS OF SCHOOL-BASED SUICIDE PREVENTION

MULTI-TIERED SCHOOL SUICIDE PREVENTION (EDUCATION DEVELOPMENT CENTER)	THE COMPREHENSIVE APPROACH TO MENTAL HEALTH PROMOTION AND SUICIDE PREVENTION FOR DISTRICTS (THE JED FOUNDATION)
• Written protocols for helping students at risk for suicide • Written protocols for response after a suicide • Identification of youth who are at risk for suicide • Promoting protective factors • Engaging key school stakeholders • Developing community partnerships	• Develop life skills • Promote social connectedness and a positive school climate and culture • Encourage help-seeking behaviors • Improve recognition and response to signs of distress and risk • Ensure student access to effective mental health treatment • Establish and follow crisis-management procedures • Promote means safety

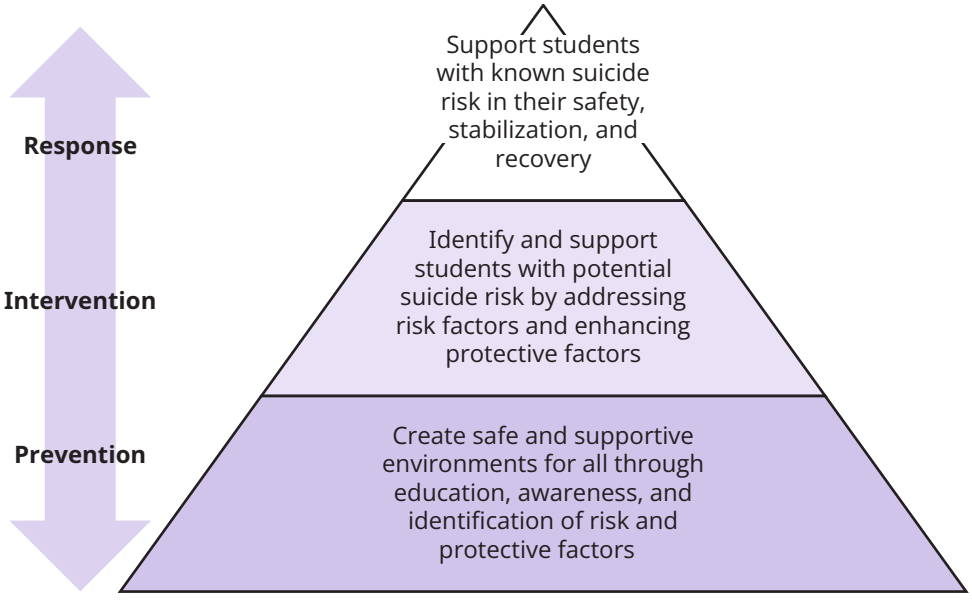
Utilizing a Multi-Tiered Framework

Taken together, the emphasis within the field of suicide prevention on a comprehensive and public health approach, the expansion of multi-tiered frameworks in schools, and the various existing models for school-based suicide prevention provide strong rationale for schools to situate their suicide prevention efforts within a **multi-tiered system of supports (MTSS)**. The Center on Multi-Tiered System of Supports at the American Institutes for Research defines MTSS as "a proactive and preventative framework that integrates data and instruction to maximize student achievement and support students' social, emotional, and behavioral needs from a strengths-based perspective" (p. 1). Through the use of data-based decision-making, MTSS attends to

the strengths and needs of both the system and the individuals within the school community to promote a range of positive outcomes. As a systemic approach, the framework seeks to proactively address inequities within the educational system through culturally sustaining policies, procedures, and practices (Jackson, 2021).

Within the MTSS framework, there are three tiers of support designed to meet the needs of all students through the provision of interventions that increase in intensity and individualization (Harlacher & Bailey, 2025). In considering how school-based suicide prevention efforts may be embedded across these tiers, efforts span the full continuum from prevention, to intervention, to response. This framework enables the simultaneous care for students at low and high risk of suicide through the provision of universal, upstream strategies that support all students (Tier 1), targeted strategies to support students who may be at risk of suicide based on identified risk and protective factors (Tier 2), and indicated strategies to support students with known risk of suicide in their safety, stabilization, healing, and recovery (Tier 3).

FIGURE 1.2: ZERO SUICIDE IN SCHOOLS TIERED FRAMEWORK: LEAD

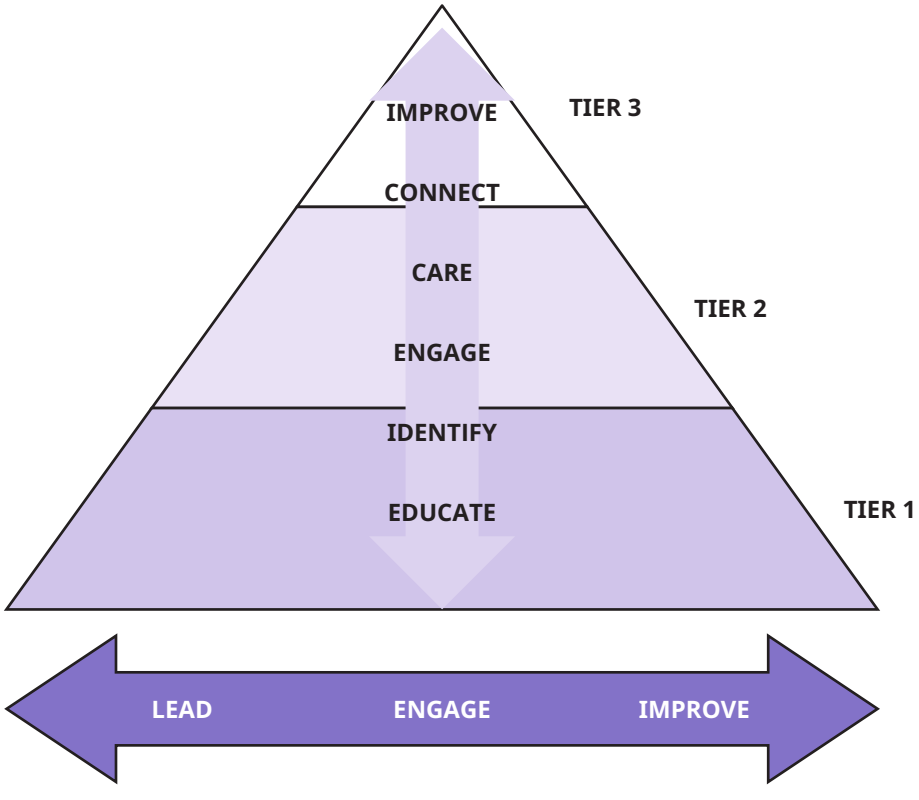


The key components of an MTSS framework that are essential to implementation align with the overarching components of the Zero Suicide framework. For instance, the process to install MTSS begins with *leadership* through the creation of a team that establishes an overarching vision, assesses school capacity for implementation, and conducts resource mapping. An initial goal is to *engage* staff, students, and families at the onset of this work through proactive communication and partnership strategies. *Identification* practices, such as universal screening, are an essential data

collection tool to identify students that may be at risk, as is the provision of high-quality, evidence-based instructional strategies, through which student progress is closely monitored. Implementation efforts should be continuously *improved* upon to support sustainability at a system-wide level (Harlacher & Bailey, 2025).

Given this alignment, the key components of Zero Suicide can be embedded within the MTSS framework, which is how schools are already working to meet the academic, behavioral, and social-emotional needs of students, and how other comprehensive, system-wide efforts, including mental health (Hoover et al., 2019), have been integrated in schools. As described earlier, several components of Zero Suicide are foundational to implementation, meaning that they should be considered or in place at the onset of the process. These foundational components include LEAD, ENGAGE, and IMPROVE. As schools move into implementation, they must consider multiple components of the Zero Suicide framework that span the three tiers of intervention, including EDUCATE, IDENTIFY, CARE, and CONNECT. Specific strategies within each of these components may be implemented *across* all tiers, with varying degrees of intensity and individualization, as noted previously. While ENGAGE and IMPROVE are foundational components in that efforts to identify partners through resource mapping and gathering data are essential to preparing the system, both of these components also span the tiers and support ongoing implementation of the framework.

FIGURE 1.3: ZERO SUICIDE COMPONENTS WITHIN A MULTI-TIERED SCHOOL FRAMEWORK



CREATING SAFE AND SUPPORTIVE ENVIRONMENTS IN SCHOOLS

In health and behavioral health care settings, for which the Zero Suicide framework was originally developed, the concept of a "**just culture**" is presented as an alternative to the traditional culture of blame and the retrospective analysis that has tended to occur following a death by suicide (Turner et al., 2020). Instead of seeking to determine "what went wrong" and investigating errors in judgment or violations in policies and protocols (an approach that is overly focused on human error), a just culture recognizes both the complexity of the system and the bidirectional relationship between the system and the individuals within (Clinical Excellence Commission, 2024). It is focused on proactive efforts that seek to identify and build upon successes to empower the system, those who work within the system, and those served by the system.

This concept has been expanded by the Clinical Excellence Commission and the State of New South Wales in Australia (2024) as a "restorative just and learning culture" that is embedded within a broader *safety* culture. It is considered the "paradigm shift" that is necessary for the successful implementation of Zero Suicide. While there are a range of practices that contribute to the establishment of a safety culture, the overarching goal and outcome is that *everyone is safe and feels safe* (Clinical Excellence Commission, 2024, p. 9). To move toward this goal and outcome, everyone must understand their role in creating and maintaining a safe environment with a culture and climate characterized by care.

In schools, the impact of a safe and supportive learning environment on positive student outcomes has been well established (National School Climate Center, 2021). When it comes to supporting student mental health and wellness (i.e., upstream suicide prevention) through the lens of school safety, there are existing comprehensive frameworks that have served as resources for schools for more than a decade (Cowan et al., 2013). In *A Framework for Safe and Successful Schools* (Cowan et al., 2013) six national associations—the American School Counselors Association, National Association of School Psychologists, School Social Work Association of America, National Association of School Resource Officers, National Association of Elementary School Principals, and National Association of Secondary School Principals—outlined key policy recommendations and essential best practices for school safety efforts and supporting student mental health. The framework recognizes a comprehensive approach that underscores the integration and alignment of school safety with school climate efforts and mental health supports and services. Safety within this framework refers to the balance between both physical and psychological safety.

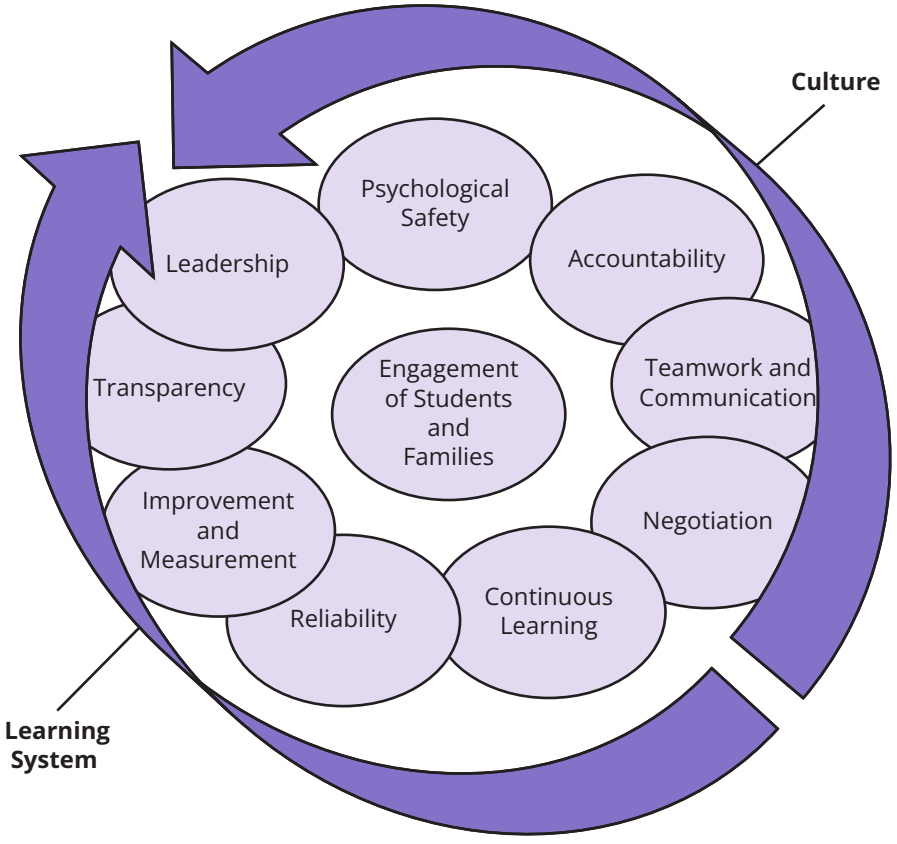
More recent guidance by the U.S. Department of Education (2023) takes a broadened view of school safety that explicitly articulates the importance of inclusion, support, and fairness in promoting both equity and belonging for everyone in the school community. The document highlights and condemns certain long-standing

educational practices, including exclusionary disciplinary practices that undermine a school's efforts to establish a culture of belonging and safety. Given the disproportionate impact of these practices on certain populations of students, including those who are Black and Brown, have disabilities, and/or identify as LGBTQ+, it is essential to highlight that these same groups of students are disproportionately impacted by mental health challenges and suicide. When these harmful practices are in place, they not only adversely impact individual students and groups of students already at increased risk of suicide but also negatively impact school climate for all. The use of punitive practices interferes with the establishment of positive, caring, and trusting relationships between staff and students, which is one of the most significant protective factors for suicide. It also reinforces "codes of silence" among students, interfering with help-seeking and opportunities for early identification and intervention. Such approaches also adversely impact family engagement when interactions with the school are centered on blame, negativity, and punishment.

When school leaders actively work to create a culture of safety, it lays the groundwork for a high sense of trust, facilitating effective teaming and collaboration and promoting staff and student well-being. While students are our primary population of focus with regard to eliminating adverse outcomes, staff well-being is a core driver of safety culture and an authentic system of care. When staff feel supported in their roles and when their own self-care efforts are reinforced, they can be fully present in their roles as team members or in supporting individual students. Within such a culture and climate, there is greater capacity to support the whole child as opposed to focusing on academics alone. It is an environment in which both students and staff feel valued and respected, setting a foundation for this work.

A framework that helps to tie together these concepts of a safe and supportive school environment with that of a "restorative just and learning culture" is the framework for Safe, Reliable, and Effective Care (Frankel et al., 2017). Though originally developed for health care organizations, the framework can be adapted to a range of other types of organizations, including schools. The framework consists of nine components that are all interrelated and embedded within two underlying domains: *culture* and the *learning system* (p. 4). In this framework, culture is described as the foundation upon which a learning system can be built and is product of both individual and group "values, attitudes, competencies, and behaviors" (p. 7). In schools, we can think of this as both the more tangible feel of the school environment, as well as the values and norms of the school community that help create that environment. The learning system represents the system-wide commitment to continuous reflection on performance, which is highly consistent with concepts discussed further in the IMPROVE chapter. It is not expected that schools will inherently have these components in place. Rather, schools must continuously work toward these components to support the ultimate outcome of becoming safe, reliable, and effective systems that effectively engage and care for students and families, which are at the center of the model.

FIGURE 1.4: FRAMEWORK FOR SAFE, RELIABLE, AND EFFECTIVE CARE IN SCHOOLS



SOURCE: Adapted from Frankel et al., 2017.

Of the nine components that compose these two higher-level domains, leadership is the only one that spans both. While there may be designated leadership roles, this model promotes leadership at all levels, including among students and family members. Leaders set the stage for the learning system, meaning that they establish the culture of continuous reflection on the system and practices, develop a psychologically safe environment in which all voices are heard, and prioritize the values of the system to make sure they are reflected in action.

The following additional components of the framework can be described as follows (Frankel et al., 2017):

- Psychological Safety: establishing an environment in which all members of the school community are empowered to share feedback, ideas, and suggest change, as well as seek out and offer help and support
- Accountability: establishing and maintaining expectations for both physical and psychological safety, as well as respect, while providing the training, coaching, and support to do so

- Teamwork and Communication: establishing norms and procedures for internal and external collaboration, including problem-solving and conflict resolution
- Negotiation: establishing methods to arrive at consensus when integrating diverse perspectives reflecting the needs of the school community (e.g., staff, students, families)
- Continuous Learning: gathering various forms of data in ongoing ways to learn from and improve upon strengths and challenges
- Improvement and Measurement: emphasis on monitoring and improving both processes and outcomes using standardized measures
- Reliability: promoting standardization and fidelity to evidence informed protocols and practices to promote equitable outcomes for students
- Transparency: openly sharing data and seeking feedback on processes and outcomes with the school community

TEAMING

In Zero Suicide, leadership is characterized by organizational commitment to preventing suicide that "goes beyond one person, one leader, one department" (Education Development Center, n.d.-a). In other words, leadership within this framework is a team approach. It has to be, because it is impossible for any one person to hold the responsibility for suicide prevention efforts and carry out those efforts in an effective or comprehensive manner. While this work ultimately seeks the engagement of all individuals within the system, school leaders and leadership teams must work together to lay the groundwork for a safe and just culture through "compassionate leadership" (p. 9, Clinical Excellence Commission, 2024), which consists of four leadership behaviors:

- Attending: being present and actively listening, particularly when presented with challenges or frustrations
- Understanding: practicing inquiry and asking powerful questions to understand
- Empathizing: providing emotional support and the ability to connect with what others may be feeling
- Helping: taking action that is thoughtful, considerate, and informed

This style of leadership can facilitate ongoing bidirectional communication between school administrators and staff, between and among teams, and between school staff, students, and families, in addition to creating pathways to partner with and engage those with lived experience. It promotes cohesion and transparency, which in turn helps build trust in addition to reducing stigma around the topics of mental health and suicide. Ultimately, this is foundational in advancing a proactive, preventive system of care that focuses on wellness and recovery to promote lives worth living.

It is not uncommon for schools to designate one staff member as responsible for the whole of "suicide prevention" within a school building or sometimes within an entire district. However, this not only overburdens one person and can lead to burnout, but it also opens up opportunities for gaps and inconsistencies that can potentially create liabilities for schools. For instance, when one person is the "keeper" of all of the information about a school's policies and protocols, it does not always get transferred effectively or efficiently to all of the individuals that need that information and are responsible for aspects of suicide prevention (e.g., screening) as part of their day-to-day responsibilities. If that person decides to leave the district, sometimes that information leaves with them, and school staff still in the district are left putting pieces together or having to start over.

While it is logical to designate one or more leaders of this work (e.g., a suicide prevention "coordinator" for the district), the Zero Suicide framework posits that there should be an implementation team established early on in the process of moving toward this comprehensive approach (Education Development Center, n.d.-a). The team should be multidisciplinary, meaning that it includes staff with diverse roles and expertise, as well as other internal and external members of the school community. In schools, this may include youth, families, and various organizational partners within the broader community. It also refers to those individuals with suicide-centered lived experience, discussed further in the next section.

The roles and responsibilities of the team include gathering, reviewing, and synthesizing data to inform efforts; setting goals and objectives, as well as timelines for desired action steps; and gathering data and feedback to monitor progress toward goals and objectives, making adjustments to plans as needed. Members of the team may be responsible for drafting or revising suicide prevention policies and protocols or gathering feedback from the school community to support this process. They may be tasked with gathering feedback from the school community on training needs or creating tools to evaluate the impact of training. The specifics of the team's responsibilities will vary based on gathered data and established goals.

Establishing this type of implementation team early on in the process is consistent with how other comprehensive approaches like MTSS are installed and scaled up in schools. However, the thought of having to create yet another team may feel daunting for schools, and understandably so. Schools typically have a multitude of teams, often with overlapping members and responsibilities. There is nothing more frustrating for the members of these different teams to realize they are spending time talking about similar concerns for the same students at different team meetings. Therefore, it may be especially useful for schools looking to engage in this work to start by conducting a **teaming inventory** to assess the alignment of teams that may serve a similar function.

One existing tool to help schools in this process is the School Mental Health Team Alignment Tool developed by the University of Maryland School of Medicine (National Center for School Mental Health, n.d.). This tool provides a structure for

schools to reflect on all existing teams specifically related to student mental health and well-being by documenting the following:

- Team name (e.g., school crisis team)
- Team composition, including member names and roles
- Tier of intervention at which the team operates (e.g., Tier 1, Tier 2, and/or Tier 3)
- Purpose of the team, including primary activities and goals
- Meeting frequency
- Whether the team overlaps with any other teams

Once this information has been gathered, schools can reflect on their options to make an informed decision. They may choose to develop a Zero Suicide implementation team that is dedicated solely to this effort. If this option is feasible, then a secondary consideration may be whether this team will be established for the long run or with short-term goals of initial installation of comprehensive school-based suicide prevention efforts and then become embedded in another team for long-term implementation, scale-up, and monitoring. If it is not practical for the district to establish another team despite wanting to prioritize comprehensive suicide prevention, another option would be to utilize an existing team with a related focus (e.g., school mental health team, school safety team, etc.) and to embed their Zero Suicide efforts within that team.

Regardless of what options works best, the team should consider how their efforts will align existing suicide prevention efforts with other related efforts in the school to ensure a comprehensive approach. As previously discussed, comprehensive suicide prevention requires explicit focus on preventing, intervening, and responding to suicidal thoughts, attempts, and deaths, as well as the integration of broader, upstream efforts within the school. These efforts may include bullying prevention, substance use prevention, trauma-informed approaches, school climate initiatives, school safety initiatives, and school mental health efforts, to name a few. Teams can and should consider these efforts as part of their suicide prevention strategies, and the impact of these efforts as part of their suicide prevention outcomes.

SUICIDE-CENTER LIVED AND LIVING EXERIENCE

While suicide rates alone are a powerful justification for this work, it's what those numbers represent and what's behind those numbers that has brought the field of suicide prevention to where it is today. **Suicide-centered lived or living experience** refers to anyone who has had or currently is having thoughts of suicide, survived one or more suicide attempts, lost a loved one to suicide, or has provided significant support to someone with experience of suicide (Roses in the Ocean, 2025). It represents the full continuum of experiences both past and present. Within the Zero Suicide framework, it is expected that lived experience is reflected in all aspects of suicide prevention.

Those with lived experience have been the true champions of suicide prevention in this country, elevating this topic as one that now has a national focus in legislation, policy, research, and practice. Expanding upon early efforts by clinicians that had begun in the 1950s, the efforts of those bereaved by suicide grew starting in the 1980s, leading to the development of national suicide prevention organizations such as the American Foundation for Suicide Prevention (AFSP) in 1987, as well as the prioritization of suicide prevention at a national level through the establishment of Senate Resolution 84 and House Resolution 212 (American Foundation for Suicide Prevention, 2025; *Recognizing Suicide as a National Health Problem*, 1997; U.S. Department of Health and Human Services, 2012). Ongoing advocacy was also critical to the development of the first National Strategy for Suicide Prevention in 2001 (U.S. Department of Health and Human Services, 2012). Within the current National Strategy for Suicide Prevention, recently released in 2024, there is now explicit focus on including the voices of those with suicide-centered lived experience "in all suicide prevention planning, practice, and partnerships in the public and private sectors" (U.S. Department of Health and Human Services, 2024, p. 85).

The advocacy efforts of those with suicide-centered lived experience have often focused explicitly on youth suicide, and there has been far-reaching impact when suicide prevention champions are in positions of leadership themselves. For instance, after the death of his son Garrett to suicide, Senator Gordon Smith proposed and helped Congress pass the Garrett Lee Smith Memorial Act in 2004. This legislation provides grants to states, college campuses, and tribal entities to implement suicide prevention efforts focused on youth and young adults up to age 24 (Garrett Lee Smith Memorial Act, 2004). Over a nearly 15-year period following the passage of this legislation, the Substance Abuse and Mental Health Services Administration (SAMHSA), awarded 230 state and tribal grants and 295 campus grants focused on a broad range of strategies, including education and training, screening, crisis hotlines, community partnership enhancements, and development of infrastructure to support continuity of care and linkage to services (Goldston & Walrath, 2023).

While Garrett Lee Smith (GLS) grant activities have varied to address the needs of the communities they are designed to serve, efforts have been made to evaluate their impact (Goldston & Walrath, 2023). In counties with suicide prevention activities (specifically, training) funded by these grants, there were significantly fewer youth suicide attempts and deaths in the year following implementation (Godoy Garraza et al., 2015; Walrath et al., 2015). Additionally, extrapolations from national data sets indicate that prevention efforts funded by GLS grants helped to avert nearly 80,000 suicide attempts that would have resulted in a visit to an emergency department or hospitalization (Godoy Garraza et al., 2018). This translates to medical cost savings of more than $200 million, or approximately $4.50 saved for every dollar invested through these grants, and an even greater emotional cost savings that can never be quantified. One especially critical finding of these studies was that decreases were not typically sustained beyond a year, underscoring the importance of continuous and ongoing efforts.

Individuals with suicide-centered lived experience have also been inspirational leaders of nonprofit movements and grassroots efforts that aim to create safe communities and offer hope and resources to those struggling with mental health challenges and suicide. For instance, more than 10 years ago, Amy Bleuel began a national movement that started with a simple request on social media in which she drew a semicolon on her wrist, took a photo, and posted it along with the words "Your story isn't over." She then challenged others who had struggled with their mental health to do the same. Project Semicolon has since become a worldwide movement, with the semicolon itself looked to by millions as a source of solidarity and hope for the future (Project Semicolon, 2023).

As experts in their own lived experience, youth have been among the most vocal suicide prevention advocates and leaders when given the support and mentorship to do so. Following the death of a classmate by suicide in 2003, a group of high school students approached their English teacher and expressed their drive to do something to prevent such a tragedy from ever happening again at their school. This was the beginning of the first Aevidum club, with the term *aevidum* being coined by students and meaning "I've got your back." This student-led initiative continued to grow, gaining national recognition and becoming a nonprofit organization in 2010, the same year that Aevidum club students became the first youth to present at a plenary at the national conference for the American Association of Suicidology. Today, Aevidum clubs, which seek not only to promote mental health and prevent suicide but also to create caring school environments in which all students feel a sense of belonging, are present on elementary school, middle school, high school, and college campuses. The organization facilitates youth leadership, advocacy, and education with the support of adult mentors and is continually developing youth-centered resources based on direct feedback from its student leaders (Aevidum, 2024).

WHAT STUDENTS SAY . . . About Student Leadership and School Suicide

"Student leadership is important because it communicates that we are here to support and uplift our peers and that kids are not alone in their struggles."

"It is important for students to be involved in leading suicide prevention efforts because of the similarities they possess with those that are struggling. Those struggling are more likely to listen and get help if their peers close in age and interests are promoting it."

"I think students can be involved in clubs and organizations like Aevidum or other suicide and mental health awareness groups to show support for people who might be going through a hard time and need someone. It shows them they are seen and are not alone, and that there are people who care about them and can help." ●

These examples demonstrate the widespread impact that one person's lived experience can have and the role that story-sharing plays in the field of suicide prevention. These are the voices we need at the table for all facets of suicide prevention work, including policies and procedures, selection and evaluation of implementation strategies, and evaluation of effectiveness. However, we must carefully consider how we engage these individuals and incorporate their stories and experiences into the work. Doing so is directly related to the extent to which we have established safety culture within our schools and are actively building a system that embraces the concepts of inclusion, belonging, equity, and cultural humility (Suicide Prevention Resource Center, 2020a).

The People With Lived Experience Workgroup and community champions from 100 Million Healthier Lives developed the *Engaging People With Lived Experience Toolkit* (Mann et al., 2020), which offers guidance for groups looking to authentically involve those with lived experience in their efforts. Two areas of emphasis within their toolkit are especially valuable for school systems and are applicable to working with both adults (e.g., staff, family, and community members) and students. First, schools need to find ways of *connecting* with those with lived experience who would like to contribute to comprehensive school-based suicide prevention efforts. While it may be easier for schools to identify these individuals since many of them are already part of the school community, not all individuals will feel comfortable or ready to share. Considering individual preference for the context and conditions in which to share (e.g., individually or in a group with other individuals with lived experience, one-on-one with a team member, or with the full team, verbally or in writing, etc.) is essential.

SAMPLE QUESTIONS TO ENGAGE INDIVIDUALS WITH LIVED EXPERIENCE

- What are their concerns and priorities?
- What challenges and barriers have they experienced?
- What resources and assets are available to them within their community?
- What strategies have been tried before, and what was the outcome? What went well and what could have gone better?
- Is there anyone else they think we should talk to or collaborate with to learn more? ●

SOURCE: Adapted from Mann et al. (2020).

Schools must also consider what it means to fully engage those with lived experience. This goes beyond just "inviting" or "involving," such as by seeking feedback on a particular goal or strategy. It starts with actively integrating students and families into a team or workgroup. The concept of co-design is defined as "the shared mapping of a problem, identifying shared priorities, and designing, implementing, and evaluating a potential solution together with those most affected by the issue" (Mann et al., 2020). For all individuals with lived experience, but especially in considering the participation of students, authentic engagement should be proactive in considering the potential for exploitation and retraumatization. This means identifying strategies and approaches that are trauma-informed and healing-centered and that promote equitable participation and outcomes (Skelton-Wilson et al., 2021). The Capacity Building Center for States offers considerations for school teams on engaging youth.

STRATEGIES AND APPROACHES FOR AUTHENTIC YOUTH ENGAGEMENT

- Plan proactively with a goal and expectation of equity, in which historically excluded populations can meaningfully participate.
- Recognize imbalances in power, and work collaboratively to promote meaningful participation.
- Clearly define the purpose, expectations, and parameters for engagement.
- Ensure a person-centered, healing-centered, trauma-informed approach.
- Meet in a space in which youth feel comfortable and safe.
- Build in enough time for meaningful engagement.
- Offer appropriate and equitable compensation for youth's time and expertise.
- Engage youth throughout the decision-making process to the fullest extent possible. ●

SOURCE: Skelton-Wilson et al., 2021.

As part of their involvement in the school's efforts to develop or expand their comprehensive suicide prevention efforts, some individuals may have the desire to share some or all of their personal story. While story-sharing is a powerful tool for advocacy and change, as highlighted in the examples shared earlier, some of the ways in which the topic of suicide may be discussed can be harmful and can increase risk among those who may already be struggling (National Action Alliance for Suicide Prevention, n.d.).

It is essential to work closely with those individuals seeking to share and participate meaningfully by first gauging where they are in their healing journey and the extent to which they can implement effective self-care strategies. Additionally, schools can help equip students and families with information on safely sharing their stories with a goal of supporting prevention efforts. Schools can do so by providing informational resources and support in the following areas, drawn from national safe and effective messaging guidelines (National Action Alliance for Suicide Prevention, n.d.):

- Language to use when talking about suicide, which includes avoiding stigmatizing language and language that sensationalizes or oversimplifies suicide
- Details to avoid when sharing one's story, such as specifics on a method or location
- Opportunities to highlight prevention, including positive actions, strategies, and resources that can help others at risk of suicide
- Opportunities to reinforce hope, healing, and recovery

COMMUNITY PARTNERSHIPS

Just as one individual cannot be solely responsible for suicide prevention for an entire school, schools as one system cannot implement comprehensive suicide prevention on their own, nor should they. Community partners can support school-based suicide prevention in various ways, whether they are offering direct services and supports to schools, implementing community-based suicide prevention efforts, or both. They can support not only the school's suicide-specific efforts but also much broader upstream approaches that can benefit both students and their families. A school's Zero Suicide efforts are stronger from the onset when school leaders and teams have already identified and engaged relevant community partners. These partners are best identified proactively through a resource mapping process, discussed more extensively in the ENGAGE chapter of this book. However, partnership work is constantly evolving and must be ongoing for schools as their efforts evolve.

There are different types of community partners that may be helpful to schools in addressing suicide prevention efforts at each tier of intervention. It is not unusual for schools to first consider community partners for suicide prevention that are from the behavioral health system, since schools have historically focused their suicide prevention efforts on supporting students with possible or known risk of suicide. Sometimes, possibly due to shortages of school mental health professionals, or other issues related to staffing that lead to higher-than-recommended ratios, schools may even rely on these partners to implement strategies that would typically be implemented by school staff. Ideally, these partners play a supportive role that helps to enhance the school's existing efforts rather than supplant them. For instance, local crisis providers who offer phone consultation, mobile services, or drop-in centers may support

schools in their identification and referral efforts at Tiers 2 and 3, serving as a resource for schools navigating follow-up steps for students who present with risk of suicide and helping to facilitate referrals to behavioral health resources in the community.

While behavioral health systems partners are an obvious choice in offering a variety of possible supports, schools should also consider the opportunities created by community partnerships in supporting universal suicide prevention efforts. Whether schools seek programming to offer to staff, students, or families, or whether they want to implement or participate in an awareness event, community-based groups such as local suicide prevention task forces or nonprofit/grassroots organizations that have mental health promotion and suicide prevention as their core mission frequently offer these types of resources as part of awareness and stigma reduction efforts. They may also have existing funding through grants or donors to provide suicide prevention awareness, education, and training at low or no cost, sometimes even with schools as their primary target setting. For instance, local chapters of the American Foundation for Suicide Prevention (AFSP) may offer Talk Saves Lives, a suicide prevention awareness program that can be tailored to different audiences, as well as More Than Sad, a suicide prevention education program designed for teachers and other school staff. Their offerings also include an adapted Talk Saves Lives for Hispanic and Latinx populations and L.E.T.S. (Listening, Empathy, Trust, Support) Save Lives, an introductory training on suicide prevention for Black communities (American Foundation for Suicide Prevention, n.d.).

From an upstream perspective, community partners offer boundless opportunities to address suicide risk factors and build protective factors. For instance, partnerships with local media outlets offer the opportunity to highlight positive school events or feature proactive stories about mental health and recovery. When this type of coverage of mental health occurs proactively, outside of a crisis situation or tragic event, it provides the opportunity to reduce stigma, reinforce hope, and share resources. Partnering with a county or local United Way chapter can provide pathways to supporting families that may face financial or economic challenges. While this is not the direct role of the school, having knowledge of these resources and related contacts to facilitate connections for families, or including such partners at school events like resource fairs, sporting events, or back-to-school nights, is protective for students in that financial instability is a risk factor for suicide and also for family conflict and discord, which itself is a risk factor for suicide.

Beyond those partners in the immediate community, schools can look to a range of other partners to support their efforts. State agencies may offer direct services (e.g., suicide prevention training, suicide prevention education/curricular materials) and indirect services (e.g., consultation on school district policies and procedures, dissemination of relevant resources such as tip sheets or guidance) to schools. They may even support schools by providing financial resources through grants or other funding mechanisms. Local colleges or universities might provide practicum students or interns from school psychology or school counseling training programs to

implement prevention programs, run small groups focused on developing emotion regulation or coping strategies, or provide other counseling or clinical support. University partnerships also afford the opportunity for a data and evaluation partner, if schools are looking to evaluate school-based suicide prevention efforts or are willing to participate in a research grant that can offer needed supports at no cost.

As an essential foundation of a school's comprehensive suicide prevention efforts, community partners and schools must work together around shared goals to enhance overall effectiveness and ensure a full continuum of supports. However, the parameters of these partnerships should be a consideration that is addressed proactively. This can ensure clarity in the differentiation of roles and responsibilities, as well as the specific supports and services that community partners are to provide, especially when they are delivering these services within the confines of the school (National Association of School Psychologists and National Center for School Mental Health, 2021).

Formalizing these partnerships, such as by establishing a **memorandum of understanding (MOU)**, offers partners a tool for documentation and accountability. It also provides a mechanism for schools and their partners to proactively communicate about expectations, within-organization policies and protocols, and ways to resolve issues or concerns that arise. For instance, schools may opt to establish MOUs with local behavioral health agencies to provide crisis response services or assist with crisis recovery efforts in the aftermath of a suicide or other tragic loss. Doing so can provide schools with greater opportunity for proactive planning so they can operate with intentionality as opposed to "on a whim" in the midst of a crisis.

USING DATA

In getting started with Zero Suicide, and in laying the groundwork for engaging the full school community in these efforts, school leaders will need to establish the "why." There are countless ways to justify this work, but the challenge for school leaders and implementation teams is to provide a rationale that is unique to their school, district, and surrounding community. This may be necessary to secure board approval, to obtain or allocate funding to support the work, and to address any barriers present in the school and community that may impede the work. To establish a relevant "why," school leaders and teams need to think about how they will tell their unique data story. This story should capture the existing assets and resources, as well as the needs, gaps, and challenges related to suicide prevention, to support the proposed action steps involved in moving forward.

A **needs assessment** is a "process used by a system, such as a school, district, or agency to identify strengths and gaps, clarify priorities, inform quality improvement, and advance action planning" (National Center for School Mental Health, 2023b, p. 3). To best inform a process for systems change and to establish a baseline of what

is presently in place with regard to comprehensive suicide prevention, a needs assessments should be one of the first actions taken. The Zero Suicide Institute's Organizational Self-Study (Education Development Center, 2021) was developed for this very purpose, with a recommendation to use data gathered through this tool to inform the development of an action plan for the organization (Education Development Center, n.d.-b). The measure is best completed by the implementation team rather than by a single individual within the organization. This approach is believed to provide a more valid and holistic representation of the organization's efforts, since it is not uncommon for different individuals to be aware of different aspects of the efforts presently in place.

There are several iterations of the organizational self-study available at no cost on the Zero Suicide website, including the original self-study designed for outpatient behavioral health organizations, an inpatient health and behavioral health version, and two community-based organization versions—one for organizations that employ health and behavioral health care workers and one for organizations that do not. The Education Development Center (2024a, 2024b), which created the Zero Suicide model and is home to the Zero Suicide Institute, also created the Multi-tiered Suicide Prevention (MTSP) for Schools Environmental Assessment, based in part on the Zero Suicide model, and an accompanying companion guide to support school teams in completing the measure.

To support school leaders and implementation teams in assessing their comprehensive efforts based on the **Zero Suicide in Schools** framework presented in this book, the authors developed the Zero Suicide Perceptions of Organizational Policies and Practices (POPP) Quiz for Schools, which can be found in Appendix A. Similar to the design of the original Zero Suicide Institute's Organizational Self-Study, the POPP Quiz includes items that reflect each of the seven components of the Zero Suicide in Schools framework. Most items are structured on a 5-point scale that describes the school's level of implementation ranging from "not in place" (rating of 1) to "comprehensive practices in place" (rating of 5). The scale describes practices in a concrete way at each level of implementation so that teams can determine whether initial steps have been taken (rating of 2), some actions have been taken (rating of 3), or multiple steps are in place that are approaching comprehensive best practice (rating of 4).

Completion of this measure can help orient teams to what best practice looks like and set a vision for their efforts. While individual practices are rated to indicate current level of implementation, the overall POPP Quiz has no grading system or score. This removes the expectation that schools should actively prepare to take the measure and reduces judgment of schools' starting point. Instead, the goal is to support schools in expanding their efforts, and schools can use the measure as a reflection tool regarding system-wide strengths and needs. Consistent with the Zero Suicide Institute's follow-up recommendations for the original self-study, teams should translate results of this measure into action through the development of a work plan, discussed further in the IMPROVE chapter.

For schools looking to align their suicide prevention specific efforts with related efforts, teams may opt to complete or integrate additional measures into early data collection to obtain information on the broader infrastructure. One tool that may be especially helpful for school teams to consider is the School Mental Health Quality Assessment, which is available at the school or district level within the School Health Assessment and Performance Evaluation (SHAPE) System, developed by the National Center for School Mental Health (2023a). This tool assesses components of comprehensive school mental health efforts, providing data on the system, as well as mental health related services and supports across the tiers of intervention.

While a structured assessment on the status of the system is an essential first step to establish a baseline, it is unlikely that one measure alone will adequately capture and reflect the voices of the diverse partners that the system is aiming to serve. It is essential for teams to seek out input that reflects the voices of staff, students, and families (including those with lived experience) to examine how their feedback may align with or diverge from that of the leadership team. Additionally, there is other data that school teams can integrate into their initial data story, including suicide-specific data on local or national trends, as well as suicide-related data on risk and protective factors. Additional best practice considerations for school teams developed by the National Center for School Mental Health (2023b) are described in their *School Mental Health Quality Guide: Needs Assessment & Resource Mapping*.

STRENGTHS AND NEEDS ASSESSMENT BEST PRACTICES

- Convene a diverse team with representation from different partners with diverse demographic characteristics.
- Review existing data to identify strengths and needs.
- Gather additional data on strengths and needs (e.g., school safety data, school climate data, review of recent community-level events, etc.).
- Use tools that are psychometrically sound and allow for disaggregation by demographic characteristics.
- Pilot test measures before implementing on a larger scale.
- Ensure measures are accessible to all partners (e.g., availability in multiple languages, multiple modalities, etc.).
- Analyze data for both strengths and needs, and disaggregate data to identify inequities and disparities.

SOURCE: Adapted from National Center for School Mental Health (2023b).

Another practice that frequently accompanies the needs assessment process is **resource mapping**. Conducting a needs assessment in the absence of engaging in resource (or asset) mapping is like planning a road trip without GPS. School teams may know where they need to end up, but they do not know the available routes, obstacles, or resources to get there efficiently. Without an understanding of the suicide prevention and related resources available within and outside of the district, schools may find themselves "reinventing the wheel" or duplicating efforts. For instance, they may opt to use funds to invest in a training or educational program that may be available for free from a community partner. Resource mapping is more than just listing available resources. It is an iterative process. Once resources are identified, the team should engage in a review process to better understand the extent to which those resources are accessible and utilized, as well as available data and outcomes related to implementation of those resources. The ENGAGE chapter of this book offers further details on this process.

Synthesizing available data takes time, and some schools may not have data readily available at the onset of these efforts. The IMPROVE chapter of this book offers more information about how data can be used to inform the work and considerations for identifying suicide-related data that can be integrated in these early phases if available. If not, then there is opportunity to strengthen data collection and data use for decision-making over time, and it may even become a specific goal of the implementation team in establishing priorities for advancing comprehensive suicide prevention efforts.

SCHOOL POLICIES AND PROCEDURES

A school entity's suicide prevention policies and procedures establish the breadth and depth of work to be done along the continuum of prevention, intervention, and response efforts. The **policy** typically outlines high-level guidance, including district- and school-level requirements and broad action steps for these components, while the **procedures** are meant to document detailed, step-by-step approaches. These documents are an essential part of leadership under the Zero Suicide in Schools framework because they anchor and guide the school's implementation efforts and are the tangible reflection of the school's continuous quality improvement efforts. Because of this, policies and procedures will be discussed in all subsequent chapters, in relation to each domain of focus.

Presently, 25 states and the District of Columbia have legislative mandates for schools to have policies and/or programming, while six additional states encourage but do not require this of schools (American Foundation for Suicide Prevention, 2024). Many of these mandates also stipulate requirements for the state department of education to offer guidance to schools, such as through development of a model policy posted publicly, typically through state education departments. Several national organizations, including the American Foundation for Suicide Prevention

(AFSP), American School Counselor Association (ASCA), National Association of School Psychologists (NASP), and The Trevor Project (2019), collaborated to develop a Model School District Policy on Suicide Prevention that includes sample language, commentary, and resources to support schools in their policy development efforts. Beyond some of the necessary introductory components of a school's policy, such a description of the purpose, scope, and key definitions, the model outlines the core components of prevention, intervention, and response.

While it is common for school entities to have a suicide prevention policy, it is far less common for them to have detailed protocols or procedures. While essential at all levels of the continuum, this tends to be especially critical for aspects of intervention and response, when school staff are expected to make decisions regarding suicide risk for individual students or to navigate sensitive and often intense situations in which there is the potential for actions taken to have far-reaching impact not only on individual students and their families but on the entire school community.

Fortunately, there are highly effective tools and practices to support the identification and follow-up support for students at risk of suicide, which will be discussed in depth in the IDENTIFY chapter. However, even when schools have policies and step-by-step procedures in place, there are further considerations in thinking about best practice. For instance, schools must keep track of when their policies and procedures were developed and last updated. They should review or update their policies and procedures on a regular timeline not only to ensure they are consistent with current best practice and specific to the school's unique context, but also to ensure that they are trauma-informed, culturally sustaining, and aligned with other related school policies and procedures, such as for parent/guardian consent, record-keeping, behavioral threat assessment, or school safety. Schools should ensure that they are training staff on their policies and procedures, and setting time points for updates or refreshers. Finally, schools should be gathering ongoing data to continuously improve upon their policies and procedures, which will be discussed further in the IMPROVE chapter.

The core components of a school's higher-level policy are consistent with the multi-tiered approach, including prevention, intervention, and response efforts described earlier in this chapter. While the policy itself is considered a foundation under the LEAD element of Zero Suicide, as mentioned earlier, the elements of the policy that span the three tiers of intervention should reflect the other six components of the Zero Suicide framework in schools: EDUCATE, IDENTIFY, ENGAGE, CARE, CONNECT, and IMPROVE, consistent with the image presented at the beginning of this chapter. The essential elements of school policy fit along the prevention continuum. While a school's policy should be tailored to the unique context, resources, and populations served, it should incorporate each of these elements, all of which will be described in detail in the remaining chapters of this book.

FIGURE 1.5: SCHOOL SUICIDE PREVENTION POLICY COMPONENTS

Prevention	Intervention	Response
• Designated team and/or suicide prevention coordinator • Staff professional development • Student awareness and educational programming • Family awareness and education • Early identification and referral • Accessibility and dissemination of policy	• Identification of youth that may be at risk of suicide (e.g., screening, assessment) • Appropriate supervision of students at risk • Parent/guardian communication • Referral and follow-up supports (e.g., safety planning, means safety) • Communication with relevant parties • Documentation	• Reentry supports following a suicide-related crisis • Response after a suicide attempt • Postvention response after a suicide death • Collaboration with community partners • Memorial plans

SOURCE: Adapted from AFSP, ASCA, NASP, and The Trevor Project (2019).

Reflection Questions

- Describe the rationale for the Zero Suicide in Schools framework and why LEAD is considered foundational to this framework.
- As a systemic framework, Zero Suicide in Schools is an ongoing commitment. What component(s) of LEAD should be prioritized in getting started with Zero Suicide in schools, and why?
- How can schools establish their capacity and readiness to lead comprehensive suicide prevention efforts? Describe the most significant barriers to starting this process and the ways in which these barriers can be overcome.
- Establishing a "just culture" is one of the most critical components of leading Zero Suicide in Schools. What policies, strategies, and actions should school leaders and implementation teams take to do so?
- The field of suicide prevention has evolved from the contributions of individuals with lived and living experience. Describe strategies schools can use to engage students and families, as well as other members of the school community (e.g., staff, community partners) from the onset of Zero Suicide efforts in order to facilitate successful implementation and sustainability.