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Los Angeles

Suicide Prevention Risk Strategies Addressing the Needs of Youth

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Education

by

Burgandie Montoya

2022

ABSTRACT OF THE DISSERTATION

Suicide Prevention Risk Strategies Addressing the Needs of Youth

by

Burgandie Montoya

Doctor of Education

University of California, Los Angeles 2022

Professor Pedro Antonio Noguera, Co-Chair

Professor Tyrone Howard, Co-Chair

The purpose of my research was to understand LAUSD counselors' perceptions related to professional development around crisis response before and during COVID. The goal of this project was to learn how we can best support prevention efforts for students. I learned about counselors' understanding of the suicide preventative measures the district endorses, if they felt comfortable implementing those strategies, and if they perceived those strategies to impact the student needs we see in schools. I was particularly interested in suicide prevention from an academic counselor's perspective. While there are supplemental counselors, I was particularly interested in the role of the norm-generated counselor. Thus, I learned learn what supports counselors' need to implement suicide prevention appropriately and with confidence in their skills to do so. This information informs next steps for the district in suicide prevention.

The dissertation of Burgandie Montoya is approved.

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Tyrone Howard, Committee Co-Chair

University of California, Los Angeles

2022

DEDICATION

I would not be where I am today if it were not for the unwavering support of my family, especially my mom. She has been my champion and critical support my entire life. Prior to applying, I shared the time commitment and the fact that I would need help with my daughter Alana. Without hesitation, my mom was excited for this opportunity to spend more time with Alana and encouraged me to pursue this dream…for a second time. She is the foundation for my success, and I share this with her.

I would also like to thank the large village that supports and empowers me and Alana. I am forever grateful to those people in my life who are constant cheerleaders and my ride or die familia: Arlett, Kristal, Felicia, Daniella, Javier, Ricky, my Nina and Nino, Chris, Dominic, Auntie Peggy, Toni, Mindy, Suzy, Juana Luna, Anikka, Nico, and Gina. There were hours upon hours when I was in class or writing, and I was able to focus because I knew my favorite human was happy and loved with one of you.

To the many loved ones not specifically named, your love and endless support was felt and understood. There were many days when I doubted myself, and your love and fierce belief in me kept me going.

My work is dedicated to the educators who show up every day and love so hard it hurts. My work is dedicated to my students, past and present, who make me want to be better and who keep me showing up even through the darkest days.

My work is dedicated to Alana Elaine Montoya, my favorite human. May you never doubt your strength or your power. I hope you know that everything you need is right inside your heart. Love deep, and never forget to save some of that love for yourself. You are the light you need. Do not be afraid to shine. I love you to pieces.

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VITA

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CHAPTER 1: THE PROBLEM

Statement of the Problem

According to the American Foundation for Suicide Prevention (AFSP), suicide is the 10th leading cause of death in the United States. In 2017, 47,173 Americans died by suicide, and there were an estimated 1,400,000 suicide attempts. Suicide rates have steadily increased in recent years. In 2001, there were 10.7 deaths by suicide per 100,000 people. By 2008, that number rose to 11.6 per 100,000, and by 2017 deaths by suicide were documented as 14 per 100,000 (see Appendix A, Figure A1).

Statistics consistently indicate that death by suicide is one of the primary causes of death for adults and youth (Anderson & Smith, 2003; Centers for Disease Control [CDC], 2017; Lindsey et al., 2019). The continual rise of death by suicide warrants additional exploration in order to appropriately address what continues to be a public health concern that devastates families and communities (Steele et al., 2018). What is known is that suicide is preventable and is highly correlated with mental health conditions (AFSP, 2019). We also know that there is a negative stigma attached to mental health issues, and this often impedes or delays one from seeking help (Forbes et al., 2017). Thus, we must learn more about suicide in order to develop appropriate prevention strategies.

Current research focuses on suicide trends and the identification of risk factors (Banks & Diambra, 2019; Cheref et al., 2019; Forbes et al., 2017; Lindsey et al., 2019; Steele et al., 2018). Prevention is mentioned within discussions about suicide, but there is little information available

on whether or not current prevention strategies utilized in schools target the needs defined by suicide trends (Forbes et al., 2017; Lindsey et al., 2019; Steele et al., 2018).

This study explored national, regional, and local suicide trends in order to understand suicide from a macro level. I then focused on the trends for students within Los Angeles Unified School District (LAUSD) in Grades 6-12. Finally, this study explored LAUSD counselors' perceptions related to suicide prevention. It is my hope that the findings will inform next steps for the district in suicide prevention.

Background of the Problem

National Suicide Trends

In order to understand how suicide impacts our society, it is important to explore longitudinal trends. Statistical data confirms the significant health issue suicide poses. In 2017, there were 4,400 more recoded suicides than in 2014 according to the Center for Disease Control's (CDC) National Center for Health Statistics (NCHS). Furthermore, the suicide rate has increased 24% between 1999 and 2014. In addition, CDC data shows that the suicide rate increased in every state within the United States, with the exception of Nevada, since 1999.

According to a study by Anderson and Smith in 2003, suicide is the third leading cause of death for young people 15-24 years old. Suicide jumped to the second leading cause of death for people between the ages of 15-34 by 2015, and it was the third leading cause of death for those between the ages of 10 and 14 (CDC, 2019).

In addition to being one of the leading causes of death for both adults and youth, suicide trends show a marked difference between suicide rates for males and females. In 2015, suicide was the seventh leading cause of death for males and the 14th leading cause for females (CDC, 2015). Males consistently have higher rates of suicide in comparison to females. In 1981, death

by suicide for females was six per 100,000 people in comparison to males at 18 per 100,000. By 2016, deaths by suicide for females remained about six per 100,000 people, yet the numbers for men rose to 22 per 100,000. The rates for females actually dropped in 1986 through 2011 and then rose back to match the statistics we saw in 1981. This trend is not the same for males whose numbers rose until 1996, then dropped below 18 per 100,000 briefly until 2001. This trend changed again in 2001, and the statistics for death by suicide for males increased steadily from 2001 to 2016 (see Appendix A, Figures A2 and A3).

Youth Trends

Suicide was the third leading cause of death for adolescents from 1987-1997. In 2017, the Centers for Disease Control and Prevention reported that suicide was the second leading cause of death for ages 10-24. In addition, suicide is the second leading cause of death for college-age youth and ages 12-18 (CDC, 2017). The shift from third to second leading cause of death amongst youth disproportionately impacts youth of marginalized populations (Pumariega & Sharma, 2018).

In the United States, there is an average of 3,041 attempts every day amongst students in Grades 9-12. According to the American Foundation for Suicide Prevention, the highest rate of suicide is 20.2% and is amongst adults aged 45-54. The second highest rate, 20.1%, was amongst adults aged 85 or older. In adult populations, white males accounted for 69.97% of suicide deaths. While not the highest rate, 7.4% of youth in Grades 9-12 reported that they made at least one suicide attempt in the past 12 months. Interestingly, the trends amongst high school age youth do not align with those we see in adults. In high school age students, females attempt suicide twice as often as males (9.3% vs. 5.1%).

Furthermore, according to Pumariega and Sharma (2018), suicide increased for non-Hispanic whites between 1999-2014. The rates increased by 59% for males between 14 and 24 years of age and by 17% in females. However, for Hispanics, the increase was 89% for females and 16% for males. The suicide rates also increased by 35% for Asian males between 15 and 24 years of age. They also found that the most at risk are American Indian/Alaskan Native adolescent males and the lowest risk group is African American females. However, in a later study conducted in 2019, Lindsey, et al. found that in school age youth, black students reported the highest rate of suicide attempts. The drastic change in adolescent trends and the fact that it is markedly different from adult trends highlights the importance of focusing in on youth.

For the purpose of this study, I wanted to understand national suicide trends in order to gain a clearer picture of how the demographics for suicide has changed. In addition, I explored data trends within Los Angeles County and Los Angeles Unified School District as I intended to narrow my focus to adolescents and students in Grades 6-12. According to the Center for Disease Control and Prevention, four out of five teens who attempt suicide have given clear warning signs. If we can better understand the suicide trends for adolescent youth and how to identify warning signs, we can create powerful prevention strategies.

Example of the Problem: Los Angeles Unified School District Data

LAUSD is the second largest school district in the country. The trends that exist within Los Angeles schools will provide relevant information, for other large, urban school districts. While the demographics of Los Angeles vary from many other areas in the country, the trends seen within Los Angeles Unified School District can help inform others. The more we understand about factors that impact suicidal ideation, the more we can respond and build programs to prevent those factors from resulting in suicidal ideation.

Within LAUSD, all employees are required to fill out a Risk Assessment Referral Data (RARD) report if a child is assessed for suicidal behavior that includes: 5150/5585 Hospitalization, Suicidal Behavior/Ideation (injury), self-injury/cutting, or suicidal behavior/ideation (non-injury). The RARD information is collected as a piece of the incident report required to be filed through Los Angeles Unified School District's Incident System Tracking Accountability Report (iSTAR). The iSTAR system has been used since the 2010-2011 school year.

The iSTAR system is used to document all incidents or emergencies that occur at a school site. In order to understand the information collected in iSTAR, the district conducts an annual evaluation of iSTAR data that results in an annual report. Each year, the report identifies the top issues reported. Types of issues reported through iSTAR include: injury, suicidal behavior, fighting/physical aggression, accident, inappropriate conduct, medical, threat, sex crime/sexual behavior, illegal/controlled substance, weapons, damaged school property, heating system problems, fire alarm issues, environmental hazards, etc. This report helps LAUSD zero in on the primary reported concerns they have faced each year.

It is significant to note that each year since the 2010-2011 school year, suicidal behavior has been one of the top 15 reported issues. In the 2010-2011 school year, there were 255 RARD reports for suicidal behavior which ranked as the 14th issue reported. However, that number changed drastically between 2010 and 2018. In fact, the number of suicidal behaviors documented in the 2017-2018 school year was 10,633 and suicidal behavior ranked as the number one issue reported (see Appendix A, Figure A4). Thus, there is a clear and defined need for suicidal behaviors within LAUSD to be evaluated within LAUSD.

Relevance of RARD Data

The RARD data is very useful in understanding the macro numbers being reported under suicidal behaviors. However, the way the RARD data is reported in the annual iSTAR report changed over time. The RARD data was most clearly defined in the 2015-2016 iSTAR annual report and separated the total number of suicidal behaviors (5,264) into the four defined categories.

In the 2015-2016 school year, non-injurious suicidal behavior occurred more than three times the rate of any other category (see Appendix A, Figure A5). Unfortunately, the iSTAR reports for 2016-2017 school year and the 2017-2018 school year no longer include a categorized report of suicidal behaviors. The information is still collected, but the iSTAR reports do not delineate the information. I believe a more in depth evaluation of this data would provide context for the statistics.

It is also interesting to note that the 2015-2016 iSTAR report did not have any instances of suicidal behaviors reported in elementary schools. In addition, there were 2,153 incidents reported at the middle school level. This number is significantly lower at the high school level with 1,539 incidents (see Appendix, Figure A6 and A7). The total number of suicidal behaviors reported in the 2015-2016 school year was 5,624. While that number almost doubled by 2017-2018, we cannot delineate the numbers into categories. Ultimately, I would like to gain a more in-depth break down of the data for subsequent school years. Through comparison of similar data, trends will emerge that may help determine where we should focus our attention as we attempt to understand the trends that currently exist. In addition, this will powerfully inform our efforts to evaluate prevention strategies.

Once we are able to identify the types of problems students are facing and the type of suicidal activities that are more predominant, we can work to implement supports that would target those behaviors and age range of students. Understanding the trends will provide a foundation that prevention strategies may be informed by.

Existing Interventions and Gaps in the Research

The research on suicide and mental health is very robust for adults. However, the research on youth is not as well understood specifically because the trends amongst youth are drastically different than those of adults. Many of the studies on suicidal behaviors focus upon risk assessment and identifying risk factors in order to use those as risk predictors (Banks & Diambra, 2019; Cheref et al., 2019; Forbes et al., 2017; Lindsey et al., 2019; Steele et al., 2018). However, there is a gap on how to effectively use the understanding of risk factors and suicide trends to inform targeted prevention strategies. My research compiled what is known about suicide amongst adolescents and evaluated current prevention strategies while gaining insight from the experiences of counselors who provide direct services to students.

Research Questions

I investigated LAUSD counselors' perceptions related to suicide prevention. The goal of my research was to inform next steps for the district in suicide prevention. The following over-arching question guided my study: *According to counselors' perceptions, how do current prevention strategies address the needs of youth who are at risk for suicide?* To answer this question, I focused on four specific research questions:

1. What are the preventative strategies used in the school district?
2. To what extent do counselors feel prepared, if at all, to implement preventative strategies?

3. How important are race, ethnicity, gender, and sexual orientation in professional development about suicide prevention?
4. What additional support or training, if any, do counselors perceive as necessary in order to feel prepared to implement preventative strategies?

Research Design

This research study will utilize a quantitative, descriptive research design. The goal was to collect counselor input across the entire district. I intend to survey counselors within a large organization (school district) to gather information about their understanding of prevention, determine if the strategies implemented address the needs they see with their students, and identify support they may need to implement strategies more effectively.

Significance of the Study

As suicidal behaviors continue to rise, schools, districts, and educators are faced with the reality that death by suicide and self-harm are more common than ever before. Within Los Angeles Unified, the number of reported suicidal behaviors increased from 255 to over 10,000 in under 10 years. Thus, we evaluated current prevention strategies to assure that we are addressing the needs we are seeing through suicidal behaviors.

This study helps educators understand the trends of suicide and suicidal attempts amongst students in grades 6-12. This understanding illuminates areas of need that we can address in order to properly implement prevention strategies. This study also highlights which students are most at-risk and identifies the preventative measures that are deemed most appropriate for students resorting to suicidal behaviors as coping strategies. Once we understand that phenomena, we may develop and provide support to our most at-risk populations. In addition, we are able to create more supportive educational spaces that nurture the mental well-being of all

students. Although certain populations may be more at-risk than others, suicide negatively impacts the entire community, thus the devastation caused by suicide is not isolated to the youth impacted. Therefore, it is important to ensure that we build school communities that promote healthy coping strategies for all students by implementing effective prevention strategies.

CHAPTER 2: LITERATURE REVIEW

Suicide is the 10th leading cause of death in the United States (AFSP, 2017). This fact alone is alarming. It is even more alarming that suicide rates have increased steadily in the past few years. These facts have garnered national attention and there is an understanding that suicide prevention is possible and critically necessary (AFSP, 2019). However, prevention strategies are inherently complicated to implement (Miller, 2014). Furthermore, the suicide trends for adults and youth are vastly different which would indicate that prevention strategies should also be different (Forbes et al., 2017; Lindsey et al., 2019; Steele et al., 2018). The goal of this study was to understand LAUSD counselors' perceptions related to suicide prevention.

This literature review explores the history of suicide on a national and local level and provides current suicide rates and risk factors for adults and youth. Understanding the national trends of suicide provides context of the problem. Then, the focus narrows to explore local suicide rates for youth. Understanding local suicide rates for youth informs which students are most in need of prevention. The current suicide rates for youth provide critical pieces of information such as which student populations have been impacted the most by suicidal behaviors. Next, the chapter includes an overview of prevention strategies and the approaches utilized by schools in addition to an exploration of stakeholders' perceptions of their roles in suicide prevention. Finally, I review social ecological theory as a theoretical framework for my research.

National Trends Suicide Trends and Risk Factors

The U.S. Department of Health and Human Services Center for Disease Control and Prevention (CDC) publish a yearly report through the Division of Vital Statistics titled "Deaths: Leading Causes for (year of report)." In the year 2000, suicide was not one of the top ten causes

of death. Unfortunately, recent reports tell a different story. Suicide remains the second leading cause of death for people between the ages of 10 and 24 for the years 2015-2017. For people between the ages of 25 and 44, suicide was the fifth leading cause of death in 2015, the fourth leading cause of death in 2016, and the third leading cause of death in 2017. Adults between the ages of 45 and 64 have relatively lower incidents of death by suicide and it is defined as the ninth leading cause. The gravity of these numbers indicates the severity of the problem and suicide is a major health concern in the United States which warrants close review in order to identify risk factors that will help identify what preventative strategies are needed (Steele, et al., 2018).

As evidenced by the CDC statistics, suicide impacts people differently across the lifespan. Thus, it is important to understand the risk factors that impact each age group. Steele et al. (2018) conducted a literature review to evaluate risk factors. They reviewed research studies that looked at suicide and risk factors. Limiting their review to the United States and research within the past twenty years, they found that risk factors fell into two categories: static risk or dynamic risk. Static risk included attributes that were stable such as sex, race, age, sexual orientation, and family history. Dynamic risk included attributes that were fluid and could change over time such as substance use, symptoms of mental illness, firearm possession, and access to health care. In addition, they found significant differences in risk for adults and youth.

The static risk factors that Steele et al.(2018) found to be similar for youth between the ages of 5 and 19 and adults between the ages of 20 and 64 included male gender, family history of suicide, and personal history of suicide attempts, any non-suicidal self-injury (NSSI), or abuse. The static risk factors that were different for youth between the ages of 5 and 19 included LGBTQIA sexual orientation, witness to violence, witness to suicidal behavior, witness to suicide, family history of psychiatric illness, or NSSI with severe medical complications or NSSI

methods other than cutting or drug overdose on first attempt. Static risk factors that were different for adults between the ages of 20 and 64 years included those identifying as white; less than a high school education; serving in the military; personal history of more NSSI methods used or a higher frequency and amount of NSSI; personal history of suicide attempt(s); any diagnosed psychiatric disorder; serving in the military; or being arrested (more arrests increased risk).

The dynamic risk factors that Steele et al.(2018) found to be similar for youth between the ages of 5 and 19 and adults between the ages of 20 and 64 included insomnia and impulsivity. The dynamic risk factors that were different for youth between the ages of 5 and 19 include psychological symptoms of burdensomeness or active suicidal ideation; access to lethal means such as firearms or means for suffocation; interpersonal conflicts with parents (children ages 5-11) or romantic partners (adolescents ages 12-19); legal trouble/incarceration (adolescents); social isolation; victim of bullying; perpetrator of bullying; or perpetrator and victim of bullying. The dynamic risk factors that were different for adults between the ages of 20 and 64 included recent arrests or incarceration, recent loss of job, financial distress, and current conflicts with romantic relationships. Additional differences included access to lethal means, psychiatric symptoms of agitation or hopelessness, marital status, being a member of active military (army or lower rank of any branch), current psychiatric illness, history of traumatic brain injury, or substance use. Finally, risk factors for adults also include psychiatric hospitalization course recently discharged, suicide attempt/self-harm during stay, unplanned discharge/short length of stay, or attempted elopement.

Risk factors allow insight into the age level issues people face. Based on the differences in the static and dynamic risk factors, we are able to see the unique needs for adults and youth

(Steele et al., 2018). For this reason, preventative measures in schools should be tailored to the needs displayed by youth. Understanding the risk factors allows us to determine appropriate preventative measures (Nock et al., 2013). For the purpose of this study, I focused specifically on high school students because the statistics show that the number of deaths by suicide is incrementally increasing amongst this age group and prevention is possible. Thus, we must understand the needs of this targeted group in order to implement appropriate prevention strategies.

Suicide Trends for Adolescents

The CDC conducts a yearly survey to help support adolescent and school health efforts titled "Youth Risk Behavior Survey." This survey collects national data with the goal of providing educational institutions with information that will support development of appropriate school programs and practices. Lindsey et al. (2019) used this data to evaluate suicidal behavior trends for youth by racial, ethnic, and gender groups. Using data from 1991 – 2017 they found that nationally, almost one in five adolescents are thinking about suicide and greater than one in 10 has a suicide plan. In addition, they discovered significant racial, ethnic, and gender disparities in suicidal deaths.

The Youth Risk Behavior Surveys indicate linear decreases in suicide attempts for specific groups: adolescents (male and female) who identified as white, Hispanic, Asian American, or Pacific Islander, and American Indian or Alaskan Natives. This decline held true for girls who self-reported suicide attempts and classified as white, Hispanic, and Asian American or Pacific Islander (Lindsey et al., 2019).

Despite that, research has shown that girls are more likely than boys to attempt suicide and have suicidal ideation although boys are more likely to die by suicide (Borges, 2010). The

Youth Risk Behavior Surveys from 1991-2017 indicate that there has been a significant decline of suicide attempts amongst adolescent girls although recent studies show that the suicide rate in young girls between the age of 5 and 11 is increasing (Glenn & Nock, 2014; O'Carroll et al., date; Silverman et al., 2007). Additionally, research has found there has been an increase in the rate of suicide deaths for black children between the ages of 5 and 12 years old is two times higher compared to their white counterparts (Bridge, Asti & Horowitz, 2015; Bridge, Horowitz & Fontanella, 2018; Sheftall, 2016). Thus, this new increase for younger children potentially indicates that that age group is experiencing risk factors that may impact future trends for adolescents.

However, despite a decrease in suicide attempts for adolescents for specific groups, there has been an alarming increase in the rate of suicide deaths for black boys between the ages of 5 and 11 years old (Bridge, Asti & Horowitz, 2015; Bridge, Horowitz & Fontanella, 2018; Sheftall, 2016). The Youth Risk Behavior Surveys from 1991-2017 also shows that there was a significant increase in suicide attempts for male and female black adolescents. The rates show an acceleration in the increasing rate of self-reported suicide attempts for black adolescent youth (Lindsey et al., 2019).

Although there has been a decline in recent years of suicide attempts by adolescents with the exception of black youth, suicide, as reported by the CDC, has steadily remained one of the top ten leading causes of death youth between the ages of 10 and 24 and within recent years (2015-2017) it has become the second leading cause of death.

The Role of Schools in Suicide Prevention Strategies: United States

Schools provide an ideal platform for suicide prevention and intervention. Since students spend so much of their day in school, there are ample opportunities to educate youth regarding

suicide and/or provide monitoring, care, and appropriate follow-up including mental health counseling for at-risk youth (Hart, 2012; O'Neil et al., 2020; Swanson & Colman, 2013). Schools are also social systems through which students learn and understand the culture of the school, events, and news and may obtain knowledge about individuals and peers that have engaged in suicidal behavior (O'Neil, 2019). This is a concern as a known risk factor for suicidal behaviors is the knowledge or awareness of peers engaging in suicidal behavior (O'Neil, 2010).

Due to the magnitude of death by suicide, many states require that schools include guidelines for suicide prevention (Capuzzi, 2009). The American Foundation for Suicide Prevention (AFSP) publishes a team brief titled "State Laws: Suicide Prevention in Schools (K-12)." This briefing defines state action regarding suicide prevention strategies in the following categories: states that mandate annual training, states that mandate training but not annually, states that encourage training, states that have school policies and programs on suicide prevention, intervention, and postvention, and states that have other unique school suicide prevention statutes.

The data from the 2016 briefing and the 2020 briefing highlight the change in the application of suicide prevention strategies within the United States (see Appendix B). In the 2016 briefing, 10 states had laws mandating annual training, but that number increased to 13 states as reported in January of 2020. In 2016, 18 states had laws that required non-annual training and the number of states requiring that increased by one. In 2016, 15 states encouraged suicide prevention training and that number remained constant in the most recent briefing. In 2016, eight states encouraged school policies and programs on suicide prevention, intervention, and postvention and in 2020 that number increased by one state. The largest growth seen in this

briefing is the number of schools that require school policies and program on suicide prevention, intervention, and postvention from 13 states in the 2016 briefing to 23 states in the most recent publication.

The increase in the number of states that have laws or encourage suicide prevention training indicate that through actionable policy states are acknowledging that suicide is a serious, yet preventable public health problem that requires attention (AFSP, 2020). According to the American Foundation for Suicide Prevention, schools have two key tasks in preventing youth suicide, including identifying students that are at risk and working with the families to ensure students are assessed properly (AFSP, 2016, 2020).

The Role of Schools in Suicide Prevention Strategies: California

Understanding national data trends provide context for the extent of the problem, but part of the focus of this study was to understand local trends. Thus, California's shifts in policy are relevant. The American Foundation for Suicide Prevention's State Law 2016 briefing reported that California encouraged suicide prevention training and encouraged schools to implement school programs on suicide prevention, intervention, and postvention. Soon after that briefing published, California passed Assembly Bill 2246 chaptered as California Education Code (EC) 215; it stated that before the beginning of the 2017-2018 school year, the governing board of a local educational agency that serves pupils in Grades 7 to 12 must adopt a policy on pupil suicide prevention that specifically addresses the needs of high-risk groups. Assembly Bill 2639 was signed into law on September 17, 2018 and extended the fidelity of that law by requiring that every educational agency that serves pupils in Grades 7 to 12, to review, at minimum every fifth year, its policy on pupil suicide prevention and, if necessary update its policy. Since this imposed additional duties on local educational agencies, the bill imposed a state-mandated local

program that included reimbursement for any costs incurred due to the mandate by the state. Therefore, all schools in California are required to have a prevention program and should regularly review and modify in order to meet the needs of students.

Counselor's Role in Prevention Strategy Implementation

According to the 2012 National Strategy for Suicide Prevention, a gatekeeper is anyone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers may be anyone including teachers, counselors, administrators, coaches, office staff, school personnel, parents/guardians, family members, friends/peers, neighbors, and others who may be strategically positioned to recognize and refer someone at risk of suicide. The National Strategy for Suicide Prevention identifies gatekeepers as ideal candidates to help implement prevention strategies due to their face-to-face contact with at-risk individuals. Objective 7.1 of the National Strategy for Suicide Prevention specifically indicates school counselors as persons "on the frontlines of suicide prevention" that should receive training.

Counselors also adhere to a set of professional ethics and standards. Several counselor associations such as the Association for Counselor Education and Supervision (ACES) and the American Counseling Association (ACA) weigh in on what those ethics and standards are by publishing ethical guidelines (Banks & Diambra, 2019). Both sets of ethical guidelines discuss the need for competence and the use of evidence-based practice in guiding students through crisis situations. Thus, the counselor as a key responder to crisis is expected. According to the American Foundation for Suicide Prevention, students at-risk of suicide are in crisis and require immediate intervention. Thus, counselors working with suicidal youth is an anticipated experience they may have in their career (Dass-Brailsford, 2007).

Prevention Strategies in Schools

There is a great deal of research indicating the need for prevention strategies in schools (Banks & Diambra, 2019; Lindsey et al., 2019; Stein et al., 2010). This understanding has led to research about the types of prevention strategies that are used most frequently by schools. Stein et al. (2010) focused on the implementation of a school-based suicide prevention program. In order to do so, they first reviewed the differences between curricular suicide prevention which refers to programs that present information to students to increase their knowledge about suicide and risk factors, screening-based suicide prevention programs which aim to identify youth suffering from a mental illness and/or contemplating suicide in order to refer them to appropriate care, and gatekeeper suicide prevention programs that train teachers and school staff to improve their abilities to detect students who may be at risk for suicide and be able to intervene with appropriate services. They chose to study to a school-based program because it was rated as most favored by school personnel. They were able to identify factors that supported successful implementation such as clear school protocols and procedures, supportive administration, practical information that staff members may access when needed, centralized data systems, and appropriate training. Their work did not look at differentiation of preventative strategies based upon individual student needs. Rather, all preventative strategies were the same for all students.

Prevention strategies often incorporate staff that may not have the appropriate training to identify and adequately manage suicide risk (Banks & Diambra, 2019). A study conducted in 2019 by Banks and Diambra evaluated if counselors in training were receiving adequate training to prepare them to perform gatekeeper duties once at a school site. They wanted to understand to what extent counseling students' knowledge and attitudes about suicide and suicide response

relate to and predict simulated suicide response behavior. They discovered that nearly one third of their participants received no training in suicide response and that all programs needed to increase their focus on incorporating suicide-specific training as it is an issue counselors will face. In addition, counselors are responsible for implementing preventative strategies and may not be adequately prepared to do so.

According to Gould et al. (2003) suicide prevention has focused primarily on individual-level psychiatric risk factors and on prevention associated with treating high risk youth and has been implemented within three domains: school, community, or through the health care system. Gould et al. (2003) reviewed 10 years of suicide risk and preventative intervention and found that school-based suicide prevention programs include: suicide awareness curriculum, skills training, screening, gate-keeper training, peer helpers, and postvention/crisis intervention. Though these programs have promising practices, more evaluation is needed in order to evaluate the effectiveness.

State Mandates

Many states are now mandating training on prevention strategies for school personnel (AFPS, 2016, 2020) and school personnel are expected to take on a greater role in suicide prevention (Ward & Odegard, 2011). However, the types of prevention vary by school and state laws. Some of the strategies that are widely utilized include school training for school personnel on suicide risk assessment and appropriate responses based on the outcome of the assessment (Lindsey et al., 2019; Miller, 2014; Stein et al., 2010; Ward & Odegard, 2011). Prevention also includes appropriate parent/guardian notification and follow up and some states have written this into their governing laws (AFPS, 2016, 2020). While the need for suicide prevention is well documented and widely accepted, defined best practices for those prevention strategies are not

universal (Lindsey et al., 2019; Steele et al., 2018; Ward & Odegard, 2011). Suicide prevention protocols vary by school district, school, and state. Some school districts call for several layers of response: prevention, intervention, and postvention (Miller, 2011; O'Neil et al., 2020) while others simply encourage some level of prevention strategies (AFPS, 2016, 2020).

The need for prevention strategies is clearly defined and the personnel who should be able to respond has been narrowed (Capuzzi, 2009; Miller, 2014). Despite this, counselor perspective on the effectiveness of the school's chosen strategies has not explored. In addition, suicide trends provide detailed information about the populations most impacted. Despite this information, prevention strategies are universally implemented (Capuzzi, 2009; Joe, 2006; Lindsey et al., 2019).

Conceptual Framework: Ecological Systems Theory

The Ecological Systems theory was developed by American psychologist Urie Bronfenbrenner. The theory maintains that child development is a complex system of relationships that are affected by multiple layers of the environment (Guy-Evans, 2020). This theory is relevant to education because it includes the many layers that impact students experience. Bronfenbrenner divided a person's environment into five different systems: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem. The microsystem is the most influential to child development and include things that directly impact a child including the immediate environment, parents, siblings, teachers, and school peers. This level includes relationships that are bi-directional. The child influences others as well as is influenced by others in this level. The mesosystem is the next layer and includes the interactions that occur between those that encompass the microsystem. An example is where and how the interactions between teachers and parents of the microsystem then impact the child. The next

layer in this theory is the exosystem. The exosystem includes formal and informal structures that do not contain the child, but directly influence them as they impact one of the child's microsystems. These structures include the neighborhood, parent's workplace, mass media, parent friendships, etc. The macrosystem is the next layer and includes cultural elements that impact a child such as socioeconomic status, wealth, poverty, ethnicity, race, geographic location, and ideologies of the culture. Finally, the fifth layer is the chronosystem and includes environmental changes that occur throughout a lifetime which influence development including major life transitions, historical events. The chronosystem also includes all transitions ranging from starting school to divorce or moving.

Though this theory was developed in the 1970's, and though much has changed in the world, it can easily incorporate technological advancements such as social media and technology. This theory supports prevention strategies as it incorporates the multiple tiers within prevention models: Universal, Targeted, and Tertiary although they are named differently by Brofenbrenner. In fact, there are many studies that have investigated the effects of the school environment to students and find the Brofenbrenner's theory aligns well.

In 2019, Kelly and Coughlan used grounded theory analysis to develop a theoretical framework for youth mental health recovery and found that there were many links to Brofenbrenner's ecological systems theory. Kelly and Coughlan's theory suggested that the components of mental health recovery are embedded in the "ecological context of influential relationships' and that aligns with Brofenbrenner's theory that ecological systems including family and peers help mental health development.

In 2017, Lippard, LA Paro, Rouse, and Crosby conducted a student to test Bronfenbrenner's theory and investigated teacher-child relationships through teacher reports and

classroom observation. They concluded that these relationships are critical to child development. These findings were supported in Wilson et al.'s 2002 study that concluded that creating a positive school environment through a school ethos valuing diversity had a positive effect on a student's relationship with school. Furthermore, Langford et al. (2014), found that whole-school approaches to health curriculum can positively improve educational achievement and student well-being, thus the development of the students are being affected by the microsystems.

Ecological Systems theory aligns with prevention because it addresses each layer in a student's world. In order to effectively implement prevention strategies, it is important to understand each level of intervention. At every level, there is a need to educate with the goal of impacting behavior. Thus, it is appropriate to also approach the discussion of suicide prevention from an ecological systems lens.

Ultimately, this study will approach the discussion of suicide prevention from an ecological systems perspective as it addresses the multiple layers within a student's world, that prevention should address to ensure that it is a comprehensive approach.

The Current Study

Previous studies have addressed the dire need for suicide prevention in schools but have not provided clear guidance on which strategies are most effective (Gould et al., 2003; Stein et al., 2010). The statistics for death by suicide clearly indicate the magnitude of the problem and legitimizes the statement that suicide is a national public health priority (Pearlman et al., 2018; Stein et al., 2011). We also know that many states are responding to the need to address suicide as it is preventable (AFPS, 2016, 2020). However, the studies that have been conducted fail to examine the effectiveness of the chosen suicide prevention strategies. Furthermore, they fail to

utilize counselor perspective in determining if these strategies are appropriate or if they meet the needs of targeted student populations.

My study adds to the body of knowledge in the field by exploring counselor perspective at a large school district. By obtaining counselor insight, I aimed to clarify how counselors perceive the current training opportunities. In addition, I hoped to gain insight into counselor perception on current suicide prevention strategies and whether or not they believe the strategies implemented effectively address the needs of their students, specifically in comparing targeted student populations. The results of this study will be used to inform and guide schools towards implementing effective suicide prevention strategies.

CHAPTER 3: METHODOLOGY

The purpose of my study was to understand LAUSD counselors' perceptions related to suicide prevention. Specifically, I examined whether counselors understand the preventative measures the district endorses, if they werer prepared to implement those strategies, and whether they perceived those strategies to be effectively meeting student needs. Finally, I investigated what supports and training counselors need to appropriately and confidently implement suicide prevention strategies. The findings yielded important information for the district to consider when evaluating their suicide prevention services.

Research Questions

The following over-arching question guided my study: *According to counselors' perceptions, how do current prevention strategies address the needs of youth who are at risk for suicide?* As I gathered and analyzed the quantitative data, I focused on four specific research questions:

1. What are the preventative strategies used in the school district?
2. To what extent do counselors feel prepared, if at all, to implement preventative strategies?
3. How important are race, ethnicity, gender, and sexual orientation in professional development about suicide prevention?
4. What additional support or training, if any, do counselors perceive as necessary in order to feel prepared to implement preventative strategies?

Research Design and Rationale

With the goal to collect counselor input across the entire district, my study utilized a quantitative, descriptive research design. I surveyed counselors within a large organization to

gather information about their understanding of prevention, determine if the strategies implemented address the needs they see in their students, and identify supports counselors may need to implement strategies more effectively. I decided to implement a quantitative, descriptive model as it was the most effective way of gathering input from such a large sample within such a short amount of time. Qualitative research would not allow me to efficiently draw a representative understanding of all 650 counselors in the district. Though I am asking questions about counselors' perceptions of prevention strategies, which could be used in a qualitative study, the need to gather a broad sample of responses lended itself to a quantitative study and the creation of a survey that allowed for statistical analysis of counselors' perceptions (Fowler, 2014).

Site of Study

The study was conducted within Los Angeles Unified School District (LAUSD). LAUSD is currently the second largest school district in the country serving 130,431 high school students (LAUSD, n.d.). In the past four years, LAUSD has seen a dramatic increase in suicidal behaviors. In the 2016-2017 school year, there were 6,228 reported incidents of suicidal behaviors. In 2017-2018, the number of suicidal behaviors increased to 8,586, and in 2018-2019 the number of reported incidents increased again to 9,019. Finally, in the last school year (2019-2020), there have been 4, 286 reported incidents as of January 29, 2020. Thus, there is a critical need for effective prevention methods. Conducting this research within LAUSD was important because of the number of impacted students. Also, LAUSD was the ideal site for widespread understanding with the hope of informing preventative strategies to positively impact current prevention programs.

Population

Counselors within LAUSD were the focus of this study. According to the 2012 National Strategy for Suicide Prevention, a gatekeeper is anyone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers may be anyone including teachers, counselors, administrators, coaches, office staff, school personnel, parents/guardians, family members, friends/peers, neighbors, and others who may be strategically positioned to recognize and refer someone at risk of suicide. The National Strategy for Suicide Prevention identifies gatekeepers as ideal candidates to help implement prevention strategies due to their face-to-face contact with at-risk individuals. Objective 7.1 of the National Strategy for Suicide Prevention specifically indicates school counselors as persons "on the frontlines of suicide prevention" that should receive training.

Los Angeles Unified School District's Policy Guide titled BUL 2637.3, *Suicide Prevention, Intervention, and Postvention Policy*, dated October 15, 2019 is applicable to all schools, district and school-related activities, and in all areas within the District's jurisdiction. Therefore, teachers, administrators, and all personnel are bound by this policy guide. However, due to the structure of schools, teachers are often unable to respond to an immediate need as they are teaching. Therefore, when a teacher or staff member has a concern, they often connect with the out-of-classroom personnel (counselors) who are better able to respond due to the nature of their role and the fact that their schedule is more flexible.

Counselors within LAUSD are expected to respond to student need. There are several types of counselors in the district: school counselors, A-G Counselors, and Student Support Program (SSP) counselors. Every student is assigned a school counselor that is responsible for the overarching counseling program for that student. If a student is three or more courses

behind, they are assigned an A-G counselor to help monitor progress. In addition, SSP counselors are assigned to students in specialized populations such as a student in foster care or a student experiencing homelessness. However, the primary counselor is the school counselor. The A-G and SSP counselors are assigned based on student need and expected to work closely with the school counselor and the student. However, due to the structure of schools and the number of students, all three types of counselors may respond to a crisis. Despite this, the counselor that I focused on is the school counselor. Since every secondary student is assigned a school counselor within LAUSD, they were the ideal candidates to survey in order to gain useful insight into the implementation of preventative strategies across the district.

Currently, there are 650 school counselors, 134 A-G counselors, and 150 SSP counselors within LAUSD. I distributed the survey during school counselor professional development meetings.

Access to Site Participants

LAUSD Research Proposal

Los Angeles Unified School District requires that all research proposals are approved through their research proposal process. The process has two windows for submission, one in October and one in April. I submitted my proposal during the April 2020 window per approval of my Dissertation Chair. Upon approval of my research proposal, I defined the details related to the distribution of the survey and gathering results.

Access to Counselors Within LAUSD

I was a Counseling Coordinator for Los Angeles Unified School District from July 2017 to June 2020. As such, I built close relationships with the Academic and Counseling Team and worked closely supporting all counselors within LAUSD.

LAUSD is divided into six local districts. There are 10 Counseling Coordinators in total, and they meet regularly to ensure consistency across the entire district. Each local district has one or two Counseling Coordinators that are responsible overseeing the counseling program for that local district, and they create and deliver all of the professional development for school counselors in each district. In addition, Local District Counseling Coordinators are the first level of support to all school counselors within the district. The professional development is very comprehensive, and in order to ensure consistency of practice, they often invite A-G counselors to their professional development sessions. When I worked for LAUSD, I developed a positive relationship with counselors as they understood that my role was to assist them in various capacities. My experience in the district afforded me unique access to counselors since I worked so closely with the district leadership that oversees all school counseling groups.

As a thank you for counselor time, I raffled off two $25 gift cards per local district to all counselors in attendance. Participation in the raffle was not contingent upon completion of the survey. In order to be entered in the raffle, counselors filled out a google form that was separate from the Qualtrics survey. The google form was linked to *Wheel of Names* for the raffle. *Wheel of Names* is an online program that allows you to raffle off items to a list of participants. The purpose of the gift card was simply to show coordinators and counselors that they are valued regardless of their completion of the survey.

Survey Recruitment

There are several types of counselor categories within Los Angeles Unified School District (LAUSD). For the purpose of my study, I decided to survey counselors that fall under the title of School Counselor. School Counselors are often the primary responders to crises, and every student is assigned a school counselor. Currently, there are 650 secondary school

counselors that serve the six local districts within LAUSD. My intention was to survey all secondary school counselors within LAUSD.

Each of the six Local Districts hosts monthly or bi-monthly professional development meetings for their respective school counselors. To ensure I reached all school counselors, I worked with each Local District Counseling Coordinator to schedule a date to attend their meeting and present the opportunity to participate in my study. Between the February and April 2021, I visited one professional development meeting per local district.

At each meeting, I explained my role and the purpose of the survey. I then gave counselors 15 minutes to complete the survey, and after the fifteen minutes passed, I raffled off thank you gift cards to four meeting attendees.

I asked counselors to fill out an attendance google form that asked for their name, email, and local district. In order to ensure anonymity, this form was not connected to the survey and was solely used for the raffle. Prior to my presentation, I shared the attendance google form link. Once I finished presenting my study, I asked counselors to participate in the Qualtrics survey and shared the link to the survey. I explained that the survey was completely anonymous and not connected to the attendance google form. After counselors were given time to complete the attendance form, I used a website called *Wheel of Names* to raffle off thank you gift cards to those that filled out the attendance google form. I gave out four gift cards of $25 per local district.

The survey was open for all districts from February 2 through April 30, although each LD received the survey at a different time. I presented to Local District 1 on February 2, 2021, Local District 2 on February 1, 2021, Local District 6 on February 9, 2021, Local District 3 on February 18, 2021, Local District 4 on February 24, 2021, and Local District 5 on April 6, 2021.

After I presented to each local district, I asked the Local District counseling coordinator to send a follow-up email to all counselors who may have missed the counselor professional development meeting informing them of my study and asking for their participation.

In five of the six local districts, I was able to share out my survey as planned. However, there were time constraints at the Local District 6 meeting, and I was not able to stay with the counselors while they filled out the survey; thus, we asked the counselors to fill out the survey on their own time.

Data Collection

To address the research questions in this study, participants completed a survey adapted from the King Instrument (King, 1999). I created the survey on Qualtrics, and it was administered through this digital platform. The survey consisted of 25 questions, took participants 10-15 minutes to complete, and was anonymous. Counselors were asked to complete the survey at the end of their mandatory counseling meeting. While the survey was distributed, I encouraged counselors to volunteer by sharing how their participation might inform future practice. I hoped this possibility incentivized their participation as it allowed their voice to be heard.

The survey primarily utilized close-ended questions with one to two open-ended questions. More precisely, a majority of the survey questions used a Likert scale or another closed answer format. The Likert scale questions allowed for a clear understanding regarding the strength of how counselors felt about certain items such as their ability to identify risk. Other "yes" or "no" close-ended questions were used to gather an understanding of basic information about counselors' preparedness and perceptions. The final questions were open ended in order to

gather more specific information related to counselor perception. The survey instrument may be found in Appendix E.

Prior to district-wide distribution of the survey, I piloted the survey with a small group of district leaders to gather feedback and ensure that questions were clearly stated and that the items effectively addressed my research questions. I used the results of the pilot to revise the survey instrument and procedures as necessary.

Each Local District hosts monthly or bi-monthly professional development meetings for counselors. School, A-G, and SSP counselors are required to attend different meetings. I presented to each school counselor group at one of the regularly scheduled local district meetings. I scheduled my time in conjunction with the Local District Counseling Coordinator to ensure that I reached all school counselors. I attended 10 meetings total across all 6 districts. The Coordinator who hosted the counseling meetings collected attendance, and I emailed missing counselors to invite them to participate.

At each meeting and in the follow up email, I explained my role and the survey. I also explained that the survey will be given through Qualtrics survey software which will not collect email addresses or save IP address information. In addition, I added that Qualtrics survey software is not attached to Los Angeles Unified District platforms.

Description of the Participants

As a result of my recruitment efforts, I was able to gather a significant amount of data to address my research questions. Of the 650 school counselors within LAUSD, 645 counselors provided consent, 630 responded to the first question, 604 answered through question four, 596 answered through question six, and 572 answered more than eight questions. For the purpose of this study, I am including data for the 572 who completed at least eight questions. As indicated

in Table 1, the number of counselors per district varies by size. The response I received was aligned to the size of the district. The only district that was limited in response was Local District 6 and that may have been due to the fact that counselors were not provided time to complete in their professional development meeting.

Table 1

Description of Sample by District (n=549)

Local District	n	%
1	121	22.0
2	115	20.9
3	99	18.0
4	73	13.3
5	99	18.0
6	26	4.7
Prefer not to say	16	2.9

Note: Responses were received from 549 counselors, 23 counselors did not respond.

Table 2 describes the experience level of the counselors in the sample. Experience as a counselor varies within the district. Across all local districts, almost 30% of all counselors have five years of experience or less. There is a slightly higher number of new counselors within in Local District 2 at 34.8%. Despite that, the counselor make up is similar for new counselors across LAUSD. The level of experience beyond five years varies, but it is similar amongst the next three tiers of experience. The next three five-year intervals (6-10, 11-15, and 16-20 years) have 17 to 21 percent of all counselors in each tier. Thus, a majority of LAUSD counselors have been a counselor for 6-20 years. The numbers decrease after the 20 year milestone and markedly declines for those with 26 or more years of experience.

Table 2

Years of Experience as a Counselor (n=549)

Years of Experience	LD1		LD2		LD3		LD4		LD5		LD6		Unknown		All	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
0-5	32	26.4	40	34.8	26	26.3	11	15.1	27	27.3	10	38.5	4	25.0	150	27.3
6-10	19	15.7	28	24.3	21	21.2	11	15.1	16	16.2	3	11.5	3	18.8	101	18.4
11-15	19	24.0	24	20.9	25	25.3	10	13.7	23	23.2	2	7.7	3	18.8	116	21.1
16-20	23	19.0	10	8.7	12	12.1	22	30.1	19	19.2	6	23.1	2	12.5	94	17.1
21-25	14	11.6	7	6.1	12	12.1	17	23.3	13	13.1	2	7.7	2	12.5	67	12.2
26-30	2	1.7	2	1.7	2	2.0	1	1.4	0	0.0	1	3.8	2	12.5	10	1.8
31-35	2	1.7	4	3.5	1	1.0	1	1.4	1	1.0	2	7.7	0	0.0	11	2.0

Note: This table includes the 549 individuals who answered years of experience and local district, 23 did not provide both answers.

The education level of counselors in this sample was similar across all Local Districts. In this sample, 3.3% of counselors have a bachelor's degree, 2.2% have doctoral degrees and 94.5% of LAUSD counselors have a master's degree. In addition to education level, the counselors provided information about their credentials.

Table 3 summarizes the professional credentials of the survey respondents within each district and across LAUSD as a whole. All LAUSD counselors are required to have a Pupil Personnel Services (PPS) credential. The PPS authorizes specialization in school counseling, school social work, school psychology, and child welfare and attendance. Since my focus was school counselors, the most common PPS is school counseling or child, welfare, and attendance. Of the LAUSD counselors that participated in this study, 88% held the PPS (school counseling) and 27.5% have the child, welfare, and attendance. The Child Welfare and Attendance credential is often referred to as a CWA rather than PPS (although it is a PPS with a specialization in Child Welfare and Attendance). This may account for the reason some counselors stated they did not have a PPS. Often, counselors hold multiple credentials, and some may have the PPS (school counseling) and child, welfare, and attendance. In my sample, 12% of the 27.5% of counselors with the child, welfare, and attendance credential also had the PPS

(school counseling credential). I also asked about teaching credentials as requirements, for counselors has changed over the years and a teaching credential was required in the past although that is not currently required for counselors. Across LAUSD, there are 650 school counselors. Thus, Table 3 represents 88% of the counselors within the district.

Table 3

Respondents' Professional Credentials (n=549)

Credential	LD1		LD2		LD3		LD4		LD5		LD6		Unknown		All	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Single Subject Teaching	28	23.1	32	27.8	20	20.2	18	24.7	30	30.3	7	26.9	2	12.5	137	25.0
Multiple Subject Teaching	23	19.0	11	9.6	15	15.2	12	16.4	15	15.2	4	15.4	1	6.3	81	14.8
Pupil Personnel Services	100	82.6	106	92.2	90	90.9	69	94.5	82	82.8	23	88.5	13	8.1	483	88.0
Child Welfare & Attendance	44	35.4	35	30.4	24	24.2	12	16.4	25	25.3	9	34.6	2	12.5	151	27.5
Administrative	33	27.3	28	24.3	14	14.1	15	20.5	33	33.3	11	42.3	1	6.3	135	24.6
Other	8	6.6	6	5.2	5	5.1	3	4.1	4	4.0	4	15.4	4	25.0	34	6.2

Note: This table includes the 549 individuals who provided their professional credentials and local district. 23 did not provide both pieces of information

As noted above, of the 650 counselors within LAUSD, 645 counselors provided consent, 630 responded to the first question, 604 who answered through question four, 596 who answered through question six, and 572 who answered more than eight questions. For the purpose of this study, I am including data for the 572 who completed at least eight questions. Therefore, I am including 572 out of 650 potential responses, yielding a response rate of 88% and ensuring that my sample is very representative of the school counselor population of LAUSD.

Data Analysis

The survey data was analyzed to address the four major areas indicated by my research questions:

- Counselors' ability to identify preventative strategies,
- Counselors' feelings about their abilities to implement preventative strategies,

- Appropriate impact of current prevention strategies on student needs, and
- Counselors' perceptions about their preparedness to implement preventative strategies.

The data was downloaded and cleaned before the analysis. For example, I checked for incomplete survey items (i.e., missing data), and I reviewed skip patterns to ensure respondents did not answer questions that were not intended for them. Once data was reviewed and cleaned, I created various charts, graphs, and analysis may be utilized to evaluate responses. I also utilized descriptive statistics to explain my findings. For instance, many of the questions were geared towards capturing counselor perspective; thus for some items, the largest percentage provided the clearest understanding of what a majority of counselors perceive to be true.

The two open-ended questions were coded to gain a clearer understanding of counselor perception about how prevention strategies supported students positively or negatively (if at all) and what additional supports and training counselors perceived to be necessary (if any).

Other Considerations

Role Management/Positionality

My role as the counseling coordinator assigned to all six local districts was to serve as a secondary level of support for school counselors. In addition, as my role is central to the district, I worked closely with the A-G and SSP units of counselors, which are technically separate divisions apart from academic counseling. I oversaw policy revision and served as the district liaison for The University of California Office of the President (UCOP) and the National Collegiate Athletic Association (NCAA). Part of this role included delivering professional development to school counselors, A-G counselors, and SSP counselors regarding policy, UCOP, or NCAA.

In order to gain buy-in for my research, I set up meetings with the Division of Academic and Counseling Services. I discussed the opportunity my research may provide to the district as a whole. By assessing counselor perception related to prevention strategies and counselor perception related to their ability to implement prevention, we may better inform our practices and professional development implementation.

Ethical Issues

Originally, I was concerned about conducting my survey while working for the district. However, an opportunity arose, and I was no longer working for the district when I collected my data. Despite that, I regularly self-evaluated the research and the writing in order to avoid making connections based on my prior experience within the district. Rather, I wanted to ensure that the counselors who took the survey were appropriately voiced and represented. My previous role in the district provided a unique "in" to the district, but I took appropriate measures to remain unbiased in that space and not overstep because of my previous role. Constant self-checking and receiving input from colleagues helped ensure as objective a study as possible. Another area of focus for me was to ensure that all parties who contributed to this research, either in planning or survey participation, understood that participation was optional, the survey was anonymous, and their participation or abstention would not result in any repercussion.

Reliability

The survey I created utilized the King Instrument (King, 1999) as a framework, and I included additional questions specific to my research project. Two-thirds of the survey used questions from the King instrument. Those items have been tested for face and content validity by utilizing input gathered from six national experts on adolescent suicide and three national experts on self-efficacy. Factor analysis was used to assess the construct validity for the King

Instrument. In addition, the reliability of the instrument was established by distributing the survey on two separate occasions to a convenience sample and then analyzed.

In order to validate the new survey questions, I gathered input from experts on suicide and prevention. Joan Asarnow, a Professor of Psychiatry and Biobehavioral Sciences who specializes on suicide prevention, served as a member of my committee and worked with me to validate the new survey questions. In addition, I employed a test-retest method with my pilot group.

In order to ensure the reliability of my research, I incorporated a systematic protocol starting with finalizing the survey through delivery and collection of survey responses. Prior to finalizing the survey, I gathered feedback from various divisions within Los Angeles Unified School District to ensure that the questions gathered the information needed. I also used a small group to pilot the survey and test the clarity of the questions, the functionality of the survey, and the data collection process of the surveys. Using this systematic protocol increased the validity of my results.

In order to address reactivity, I included directions that explained the purpose of the survey was to inform future practices in order to meet student need. Thus, the survey did not evaluate the current practices, but rather informed planning for future improvements. Counselors were more likely to be transparent if they understood it was not a reflection of evaluation of current practice. In addition, the survey was anonymous, and data was collected through a non-LAUSD platform. I also explained that these results would be shared after being summarized and would not be available in raw data form to LAUSD. Thus, these actions supported the anonymity of survey data and ensured that counselors' feedback could not be connected back to them as individuals. Therefore, reactivity will be lessened.

Study Limitations

Given the closed answer format, these results did not provide an in-depth or layered understanding of counselor perceptions. Rather, the data collected provided a broad understanding of counselor perceptions. In order to avoid bias, I collected a broad range of responses to eliminate insufficient evidence that was not representative of counselors as a whole. Ensuring a large response rate increased the internal validity of my results.

Though this study will gather information from a large subset of counselors within the second largest school district in the country, the information may not be generalizable to all other schools or districts. However, it may benefit other large districts with similar demographics in urban areas. This information is gathered from counselors that serve specific student populations within a range of conditions from urban to suburban settings and across a large variance of socio-economic status. Thus, the experiences of our students and our counselors may be limited to Los Angeles Unified School District. However, the information gathered may inform thinking and planning of other organizations even if their context is similar.

Summary

The information gained by this study was intended to inform district practices and provide insight into counselor perception related to suicide prevention. Ultimately, the goal of this study was to prioritize the improvement of suicide prevention strategies. The results from the survey are presented in Chapter Four.

CHAPTER 4: FINDINGS

This study used a descriptive quantitative research design to examine how current prevention strategies address the needs of youth at risk of suicide through the lens of counselors who are often first responders to crisis. Additionally, the study was designed to understand LAUSD counselors' perceptions related to suicide prevention and their preparedness. I wanted to know if they understood the preventative measures the district endorses, if they felt comfortable implementing those strategies, if they perceived those strategies to impact the student needs we see in schools, and how their preparedness differed before and during COVID, if at all. Finally, I wanted to gather data on what skills they believed they needed to appropriately and effectively implement suicide prevention strategies. I am hopeful that the findings will inform next steps for the district in suicide prevention. In this chapter, I present the findings organized by my research questions.

Findings Related to Research Question 1

The primary purpose of this study was to determine whether counselors believed that the district's suicide preventative strategies addressed the needs of their students. To understand what counselors believed, it was important to identify what strategies are utilized. Therefore, I asked counselors several questions related to prevention strategies. First, I asked respondents if their district has Universal Strategies, Targeted Strategies, and/or Tertiary Strategies. I then asked what preventative strategies were used in the school district.

Tiers of Support: Universal, Targeted and Tertiary Strategies

There are three tiers of support. Tier I includes universal strategies that impact all students and are implemented school-wide. Tier II includes targeted strategies that are focused on identifying students who may be at risk for suicide or suicidal behaviors. Tier III includes

tertiary strategies that intervene with students who are suicidal or practice suicidal behaviors. When asked about universal preventative strategies, almost two-thirds of counselors (64.3%) stated that their schools provided these strategies, 12.4% of the counselors stated they did not have universal strategies, and 23.3% of the counselors were not sure. In regard to targeted strategies, 62.8% identified that the district did have targeted strategies. The number of those that were unsure remained the same, while 13.8% of counselors stated that the district did not have targeted strategies. When asking about tertiary strategies, the number of people who said not sure is almost equal to the number of counselors who said yes at 43.5% and 45.2% respectively. Thus, I saw a significant increase in the number of counselors who could not readily name tertiary strategies. Despite that, fewer counselors stated that the district did not have tertiary strategies at 11.1%.

Counselor Response Based on Years of Experience

After gathering overall data about the counselors' awareness of their district's prevention strategies, I disaggregated their responses based on years of experience. Table 4 shows how counselors' awareness of prevention strategies varieed according to their experience.

Table 4

Respondents' Awareness of Prevention Strategies, by Years of Experience (n=549)

	Experience															
	0-5		6-10		11-15		16-20		21-25		26-30		31-35		All	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Universal Prevention Strategies																
Yes	95	17.3	64	11.7	75	13.7	59	10.7	47	8.6	6	1.1	7	1.3	353	64.3
No	18	3.3	9	1.6	15	2.7	14	2.6	8	1.5	2	0.4	2	0.4	68	12.4
Not Sure	37	6.7	28	5.1	26	4.7	21	3.8	12	2.2	2	0.4	2	0.4	128	23.3
No + Not Sure	55	10.0	37	6.7	41	7.5	35	6.4	20	3.6	4	0.7	4	0.7	196	35.7
Targeted Prevention Strategies																
Yes	103	18.7	56	10.2	73	13.3	56	10.2	43	7.8	5	0.9	9	1.6	353	62.8
No	15	2.7	14	2.6	16	2.9	16	2.9	11	2.0	3	0.5	1	0.2	68	13.8
Not Sure	32	5.8	31	5.6	27	4.9	22	4.0	13	2.4	2	0.4	1	0.2	128	23.3
No + Not Sure	47	8.5	45	8.2	43	7.8	38	6.9	24	4.4	5	0.9	2	0.4	196	37.2
Tertiary Prevention Strategies																
Yes	69	12.6	41	7.5	60	10.9	35	6.4	35	6.4	6	1.1	3	0.5	249	45.4
No	10	1.8	13	2.4	14	2.6	13	2.4	7	1.3	1	0.2	3	0.5	61	11.1
Not Sure	71	12.9	47	8.6	42	7.7	46	8.4	25	4.6	3	0.5	5	0.9	239	43.5
No + Not Sure	81	14.8	60	10.9	56	10.2	59	10.7	32	5.8	4	0.7	8	1.5	300	54.6

Note: This table includes the 549 individuals who answered awareness of Universal, Targeted, and Tertiary Strategies and years of experience and local district.

Initially, I noticed that the number of people who did not know about universal, targeted, or tertiary strategies was similar to the number of newer counselors, so I wanted to look at the data by years of experience. Once I analyzed the data by years of experience, it was interesting to find that the number of counselors who did not know if the district had universal, targeted, or tertiary strategies did not correlate with the number of years of experience for counselors.

A majority of the counselors who answered no or not sure fall between 6 and 20 years of experience. When you get beyond 21 years of experience, that number who answered no or not sure dropped significantly. This indicated that those counselors with the most experience are aware of the strategies the district utilizes.

Counselor Identification of Strategies

In addition to knowing if counselors were aware of the levels of strategies used, I wanted to know if counselors could identify which strategies were used in the three main tiers of support (universal, targeted, and tertiary). Counselors who responded yes or not sure were then asked to identify strategies from a list. I also provided the option “other” so counselors could include an item that was not listed (see Table 5 below).

Table 5

Universal Strategies Utilized (n=549)

Strategy	n	%
Positive Behavioral Intervention Strategies (Encourage Connectedness)	403	73.4
Awareness drives: Bullying, Kindness, Mental Health, Suicide, etc.	360	65.6
Curriculum: Lessons taught to inform students about bullying, kindness, mental health, suicide, etc.	294	53.6
Students are taught strategies to manage emotions	278	50.6
Parent Education is offered	303	55.2
Other	34	6.2

Note: Responses were received from 549 counselors, 23 counselors did not respond.

The strategies utilized by counselors in the universal category are listed above. The most widely used universal strategy was Positive Behavior Intervention, as reported by 73.4% of counselors. The next strategy that was widely represented by 65.7% of counselors was awareness drives. Three other strategies were identified by at least 50% of the respondents, with parent education indicated by 55.2%, curriculum and targeted lessons by 53.6%, and students explicitly taught emotional management by 50.6%. It is significant to note that all five major universal strategies were utilized by more than 50% of respondents. Thirty-four counselors chose the “other” category, yet responses fell under categories already noted.

Table 6 summarizes the most common targeted strategies utilized by counselors. The most widely utilized strategy by counselors was restorative practices, as identified by 55.9% of respondents. The next most utilized strategy was screening at 52.3%. Gatekeeper training was identified by 22.4% of counselors and reducing access to means was noted by 9.3%. The other category was reviewed, and the responses fell under other categories already noted. While universal strategies were utilized more often by counselors, only two out of four targeted strategies were utilized by more than 50% of respondents.

Table 6

Targeted Strategies Utilized (n=549)

Strategy	n	%
Gatekeeper Training	123	22.4
Screening	287	52.3
Reduce Access to Means	85	15.5
Restorative Practices (repair harm in communities)	307	55.9
Other	51	9.3

Note: Responses were received from 549 counselors, 23 counselors did not respond.

Interestingly, as shown in Table 4, the strategies listed in the tertiary category were ones that many counselors stated they were unsure of or explicitly stated they did not utilize. Despite that, the responses in this category showed that a majority of counselors were aware of the strategies and have them in their schools, as shown in Table 7 below. Re-entry plans, connections to counseling, and ongoing social emotional support were identified by 82.5%, 81.8%, and 80% of all counselors. The less widely used strategies included family counseling and postvention plans, respectively identified by 39.5% and 37.5% of counselors. Again, the "other" category included descriptions of behaviors that fell within the identified categories above.

Table 7

Tertiary Strategies Utilized (n=549)

Strategy	n	%
Re-Entry Plan (1)	453	82.5
Ongoing social emotional support (2)	439	80.0
Family counseling (3)	217	39.5
Connections to additional support and counseling (4)	449	81.8
Postvention Plans (5)	206	37.5
Other	20	3.6

Note: Responses were received from 549 counselors, 23 counselors did not respond.

Finally, while three tertiary strategies were utilized by a high percentage of counselors, two strategies were utilized by just over one-third of counselors. If we use 60% as a low benchmark for utilization of strategies, then only five out of 14 strategies from all three tiers are widely utilized. This should be of concern for districts as they seek to better prepare counselors, and the implications are discussed in Chapter Five.

Findings Related to Research Question 2

The primary purpose of this study was to determine if, according to counselors' perceptions, the utilized suicide preventative strategies addressed the needs of their students. The second question asked to what extent do counselors feel prepared, if at all, to implement preventative strategies pre- and during COVID. In order to explore that research question, I asked four specific survey questions.

First, I asked counselors about their confidence related to preparation, and the results are shown in Table 8. Pre-COVID, the majority of counselors felt moderately to extremely confident in all categories of preparation. When asked if they believed they could recognize a student at risk of attempting suicide, 63.3% felt moderately confident and 22.2% felt extremely confident. When asked about training, 53.8% of counselors reported that they felt moderately confident,

while 26% reported that they felt extremely confident that their training prepared them to talk to teachers to help determine if a student is at risk. When asked about their ability to speak with parents to help determine if a child is at risk, 53% of counselors felt moderately confident and 26% felt extremely confident in their ability to do so. When asked about speaking directly with a student who may be at risk, 40.4% of counselors felt moderately confident and 49.3% of counselors felt extremely confident in their ability to do so. Counselors also reported that they felt moderately confident (51% of counselors) to extremely confident (33.9% of counselors) in offering support to a student at risk of attempting suicide. Finally, 30.9% felt moderately confident and 64% felt extremely confident in their ability to refer a student at risk to a therapist. These responses show that counselors felt prepared to identify risk, talk to teachers and parents, and support students that were in crisis pre-COVID.

Table 8

Counselors' Confidence Levels Pre-COVID (n=572)

How confident are you that…	Not at All Confident (1)		Slightly Confident (2)		Moderately Confident (3)		Extremely Confident (4)		Mean	SD
	n	%	n	%	n	%	n	%		
you can recognize a student at risk of attempting suicide?	9	1.6	74	12.9	362	63.3	127	22.2	3.06	0.64
your training prepared you to talk with teachers and counselors at your school to help determine whether or not a student is at risk of attempting suicide?	20	3.5	95	16.6	308	53.8	149	26.0	3.02	0.75
you can talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide?	18	3.1	97	17.0	303	53.0	154	26.9	3.04	0.75
you can ask a student at risk of attempting suicide if he/she/they is suicidal?	10	1.7	49	8.6	231	40.4	282	49.3	3.37	0.71
you can effectively offer support to a student at risk of attempting suicide?	14	2.4	72	12.6	292	51.0	194	33.9	3.16	0.73
you can refer a student at risk of attempting suicide to a school counselor (therapist)?	6	1.0	23	4.0	177	30.9	366	64.0	3.58	0.62

As shown in Table 9, fewer counselors felt moderately to extremely confident in all categories of preparation while performing their duties during the pandemic. When asked if they

believed they could recognize a student at risk of attempting suicide, 25.9% of counselors felt moderately confident and only 2.8% felt extremely confident. When asked about training, 39.9% of counselors reported that they felt moderately confident that their training prepared them to talk to teachers to help determine if a student is at risk during the pandemic, while 10.1% reported that they felt extremely confident. When asked about their ability to speak with parents to help determine if a child is at risk, 36.7% of counselors felt moderately confident and 12.6% of counselors felt extremely confident in their ability to do so. When asked about speaking directly with a student who may be at risk, 37.1% of counselors felt moderately confident and 29% extremely confident in their ability to do so. Counselors who reported that they felt moderately confident in offering support to a student at risk of attempting suicide was 33.2% and 11.9% reported feeling extremely confident. When asked about confidence in referring a student to a therapist, 31.1% reported feeling moderately confident while 47% reported that they felt extremely confident. These responses show that during the pandemic fewer counselors felt less confident in their ability to identify risk, talk to teachers and parents, and to support students at risk of suicide than they did pre-COVID.

Table 9

Counselors' Confidence Levels During COVID (n=572)

How confident are you that…	Not at All Confident (1)		Slightly Confident (2)		Moderately Confident (3)		Extremely Confident (4)		Mean	SD
	n	%	n	%	n	%	n	%		
you can recognize a student at risk of attempting suicide?	148	25.9	260	45.5	148	25.9	16	2.8	2.06	0.79
your training prepared you to talk with teachers and counselors at your school to help determine whether or not a student is at risk of attempting suicide?	76	13.3	210	36.7	228	39.9	58	10.1	2.47	0.85
you can talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide?	73	12.8	217	37.9	210	36.7	72	12.6	2.49	0.87
you can ask a student at risk of attempting suicide if he/she/they is suicidal?	36	6.3	158	27.6	212	37.1	166	29.0	2.89	0.90
you can effectively offer support to a student at risk of attempting suicide?	80	14.0	234	40.9	190	33.2	68	11.9	2.43	0.87
you can refer a student at risk of attempting suicide to a school counselor (therapist)?	22	3.8	103	18.0	178	31.1	269	47.0	3.21	0.87

I compared the changes in counselor perception before and during COVID to determine the difference and impact. The results of this test are in Table 10. When exploring counselor feelings of being prepared to support students at risk of suicide before and during COVID, there was a significant difference. Pre-COVID, 75.5% of counselors had a higher confidence in their ability to recognize a student at risk of suicide. Similarly, 46.9% reported more confidence Pre-COVID in their training to speak with teachers or other counselors to determine if a student is at risk of suicide. 47% were more confident to speak with parents to help determine if a child was at risk of suicide Pre-COVID. At the student level, 38.8% of counselors were more confident Pre-COVID to ask a student if they were suicidal, and 57.2% were more confident at effectively offering support to a student who was at-risk of attempting suicide. Finally, 29.4% of counselors were more confident Pre-COVID to refer a student at risk of suicide to therapy.

Table 10

Counselors' Confidence Levels Pre-COVID Versus During COVID (n=572)

How confident are you that…	Pre-COVID vs. During COVID			Level Change	
	Lower	No Change	Higher	Mean	SD
you can recognize a student at risk of attempting suicide?	1.7	22.7	75.5	1.01	0.78
your training prepared you to talk with teachers and counselors at your school to help determine whether or not a student is at risk of attempting suicide?	1.6	51.6	46.9	0.56	0.71
you can talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide?	1.7	51.2	47.0	0.55	0.73
you can ask a student at risk of attempting suicide if he/she/they is suicidal?	1.0	60.1	38.8	0.48	0.72
you can effectively offer support to a student at risk of attempting suicide?	1.2	41.6	57.2	0.73	0.78
you can refer a student at risk of attempting suicide to a school counselor (therapist)?	1.9	68.7	29.4	0.37	0.71

As you can see from the responses to these questions, on the whole counselors felt less confident in their preparation to deliver preventative services during the COVID pandemic. This was especially evident in questions about the ability to recognize a student at risk of attempting suicide and if their training prepared them to talk with teachers and counselors to help determine if a student is at risk.

To gain a deeper understanding of this finding, counselors were asked to answer an open-ended question to explain why they chose not at all confident or slightly confident pre- and during COVID. Pre-COVID, counselors reported that their confidence levels were hindered by being new to the profession, the difference between training and actual interaction with students, and feeling a lack of support so they did not miss any signs. However, the answers were very different for counselors during COVID. Counselors focused mainly on access to students as the primary hindrance to their confidence. Many reported that it was extremely difficult to assess a student through limited Zoom meetings. Others reported that many students refused to turn on their cameras, so they missed many non-verbal cues that are usually present when meeting in person with students. Many counselors elaborated on the change to virtual learning and how

deeply that limited their ability to get in contact with students and parents if phone numbers were incorrect and emails were not returned. Confidence pre-COVID was much more related to experience, where confidence during COVID was focused solely on the ability to access students in a meaningful way.

Findings Related to Research Question 3

Research question 3 asked "How important are race, ethnicity, gender, and sexual orientation in professional development about suicide prevention?" In order to identify how counselors felt the strategies impacted students, I asked a series of questions that gathered data about what information related to youth suicide trends was shared in professional development. We know that youth suicide trends show differences based on gender, race, ethnicity, and sexual orientation (Bridge, Asti & Horowitz, 2015; Bridge, Horowitz, & Fontanella, 2018; Sheftall, 2016). Thus, I wanted to understand if the professional development offered by the district provided information about the demographic trends for suicidal behaviors in youth. Next, I wanted to explore how important understanding the identifiers of race, ethnicity, gender, and sexual orientation were in the professional development training they received. Finally, I wanted to understand if the training counselors received explicitly addressed race, ethnicity, gender, and sexual orientation in suicide prevention training pre- and during the COVID pandemic.

Professional Development Related to Demographic Trends

According to counselors, 74% (n=406) believed that their district professional development provided information about the demographic trends for suicidal behavior in youth. Just over one-fourth of counselors, or 26% (n=143), felt that the district did not provide information on demographic trends. In exploring this data, I found that the numbers fell into two groups. Local districts 1, 2, 3 and 4 shared similar statistics, and local district 5 and 6 shared

similar statistics. The percentage of counselors that stated demographics were shared was 78.5% for LD 1, 79.1% for LD 2, 72.7% for LD 3 and 72.6% for LD 4. These numbers dropped to 67.7% for LD 5 and 65.4% for LD 6. Those that preferred not to state a district reported at 68.8%.

Counselor Ratings of Importance of Understanding Key Identifiers in Professional Development Training (Pre-COVID and During COVID)

As seen in Table 11 below, more than 50% of counselors identified that understanding the impact of race, ethnicity, gender, and sexual orientation was extremely important in professional development training related to suicide prevention pre-COVID. Sexual orientation was identified as extremely important by 66.4% of counselors, gender was identified by 58%, and ethnicity and race were both identified as extremely important by 54% of counselors. When I added in the responses of those that feel like race, ethnicity, gender, and sexual orientation are moderately important, the numbers jumped to over 75% for all four identifiers. More specifically, 82.5% of counselors identified the importance of sexual orientation, 80.3% identified gender, 78.9% identified ethnicity, and 76.6% identified race as moderately to extremely important. In fact, the number of counselors who reported that race, ethnicity, gender, and sexual orientation were not important factors in a professional development training was under 2% in each category.

Table 11

Counselors' Ratings of Importance Pre-COVID (n=557)

How important are understanding the following factors in a professional development training about suicide prevention?	Not at All Important (1)		Slightly Important (2)		Moderately Important (3)		Extremely Important (4)		Mean	SD
	n	%	n	%	n	%	n	%		
Race	9	1.4	41	6.4	145	22.5	362	56.1	3.54	0.70
Ethnicity	8	1.2	40	6.2	145	22.5	364	56.4	3.55	0.69
Gender	11	1.7	28	4.3	144	22.3	374	58.0	3.58	0.68
Sexual Orientation	6	0.9	19	2.9	104	16.1	428	66.4	3.71	0.58

Note: Responses were received from 557 counselors, 15 counselors did not respond.

Table 12 shows how counselors answered the same questions when thinking about the importance of such training during COVID. More than 60% of counselors identified that race, ethnicity, gender, and sexual orientation are extremely important in professional development training related to suicide prevention. Sexual orientation was identified as extremely important by 67.3% of counselors; gender and ethnicity were identified by 60.5% of counselors; and race was identified by 60.2% of counselors. When you add in those that feel like race, ethnicity, gender, and sexual orientation are moderately important, the numbers rose to over 79% of all counselors. More specifically, 82.3% of counselors identified sexual orientation as moderately to extremely important, 80.5% identified gender, 79.3% identified ethnicity, and 79% identified race. In fact, the number of counselors who reported that race, ethnicity, gender, and sexual orientation were not important as factors in a professional development training about suicide was 2% or lower in each category.

Table 12

Counselors' Ratings of Importance During COVID (n=557)

How important are understanding the following factors in a professional development training about suicide prevention?	Not at All Important (1)		Slightly Important (2)		Moderately Important (3)		Extremely Important (4)		Mean	SD
	n	%	n	%	n	%	n	%		
Race	11	1.7	36	5.6	122	18.9	388	60.2	3.59	0.70
Ethnicity	11	1.7	35	5.4	121	18.8	390	60.5	3.6	0.70
Gender	13	2.0	25	3.9	129	20.0	390	60.5	3.61	0.69
Sexual Orientation	8	1.2	18	2.8	97	15.0	434	67.3	3.72	0.60

Note: Responses were received from 557 counselors, 15 counselors did not respond.

Table 12 clearly indicates that counselors believe that all four factors are moderately to extremely important to understand in a professional development training for suicide prevention. Notably, the counselors indicated the importance increased during the COVID pandemic, and although all four factors were important, counselors selected sexual orientation as the most important factor.

Race, Ethnicity, Gender, and Sexual Orientation in Professional Development

Table 13 shares counselors' response to the question that race, ethnicity, gender, and sexual orientation were explicitly discussed in professional development related to suicide prevention pre-COVID. Counselor response to this question is split. The largest percentage of counselors either somewhat or strongly agreed that race, ethnicity, gender, and sexual orientation was addressed, but the percentage was less than 50% for race and ethnicity, at 42.1% and 39.2% respectively. A very small majority of counselors somewhat or strongly agreed that gender was addressed at 51.3% and that sexual orientation was addressed at 55.9%. In Chapter Five, I discuss the reasons for these low percentages.

Table 13

Counselors' Agreement that Key Identifiers were Addressed in Professional Development Pre-COVID (n=572)

The professional development I received related to suicide has explicitly discussed	Strongly Disagree		Somewhat Disagree		Neither disagree nor Agree (3)		Somewhat Agree (4)		Strongly Agree (5)		Mean	SD
	n	%	n	%	n	%	n	%	n	%		
Race	49	7.6	89	13.8	147	22.8	204	31.6	68	10.5	3.27	1.13
Ethnicity	55	8.5	95	14.7	154	23.9	188	29.1	65	10.1	3.2	1.15
Gender	33	5.1	60	9.3	133	20.6	216	33.5	115	17.8	3.57	1.10
Sexual Orientation	30	4.7	55	8.5	111	17.2	217	33.6	144	22.3	3.7	1.11

Table 14 shares counselors' responses to the question that race, ethnicity, gender, and sexual orientation were explicitly discussed in professional development related to suicide prevention during COVID. Counselor response was very similar to that of pre-COVID responses. During COVID, the largest percentage of counselors either somewhat or strongly agreed that race, ethnicity, gender, and sexual orientation was addressed, but the percentage was less than 50% for race, ethnicity, and gender at 42.3%, 39.7%, and 46.7% respectively. In this category, only 50.1% of counselors somewhat or strongly agreed that sexual orientation was addressed. In Chapter Five, I discuss the reasons for this split response.

Table 14

Counselors' Agreement that Key Identifiers were Addressed in Professional Development During-COVID (n=557)

The professional development I received related to suicide has explicitly discussed	Strongly Disagree		Somewhat Disagree		Neither disagree nor Agree (3)		Somewhat Agree (4)		Strongly Agree (5)		Mean	SD
	n	%	n	%	n	%	n	%	n	%		
Race	62	9.6	62	9.6	160	24.8	189	29.3	84	13.0	3.31	1.18
Ethnicity	63	9.8	79	12.2	159	24.7	179	27.8	77	11.9	3.23	1.19
Gender	49	7.6	61	9.5	146	22.6	190	29.5	111	17.2	3.45	1.18
Sexual Orientation	30	7.3	57	8.8	130	20.2	187	29.0	136	21.1	3.55	1.20

Note: Responses were received from 557 counselors, 15 counselors did not respond.

I compared the changes in counselor preparation pre- and during COVID, and this is represented in Table 15. Counselors report that key identifiers are addressed in PD, but there is variance in response. Despite this, pre- and during COVID, a majority of counselors did not change their response to the questions related to whether or not race, ethnicity, gender, or sexual orientation were explicitly discussed in professional development related to suicide prevention. In Chapter Five, we will explore why counselors may have varied in their response to this question.

Table 15

Counselor agreement that key identifiers are addressed in Professional Development (PD) Pre-COVID Versus During COVID (n=557)

	Pre-COVID vs. During COVID						Level Change	
	Lower		No Change		Higher		Mean	SD
	n	%	n	%	n	%		
Race is explicitly discussed in PD	74	11.5	416	64.5	67	10.4	-0.03	0.74
Ethnicity is explicitly discussed in PD	69	10.7	426	66	62	9.6	-0.03	0.75
Gender is explicitly discussed in PD	38	5.9	435	67.4	84	13.0	0.12	0.76
Sexual Orientation is explicitly discussed in PD	41	6.4	428	66.4	88	13.6	0.14	0.80

Note: Responses were received from 557 counselors, 15 counselors did not respond.

Findings Related to Research Question 4

The fourth question was designed to gather insight from counselors to understand how frequently they supported a student at risk of suicide or suicidal behaviors and to understand what additional supports counselors perceived as necessary.

Counselors were asked to share how often the supported students at risk of suicide or suicidal behaviors. Table 16 summarizes the frequency of support. This table allows us to see that while 32.8% of counselors reported that they support a suicidal or self-harming student less than once every three months, 23% reported providing support at least once every three months. However, 44.3% of counselors reported that they supported a suicidal or self-harming student at

least once a month if not more frequently. In fact, 11% of counselors reported that they regularly support students at risk of suicide or suicidal behaviors once or more per week. These numbers are astounding when you think of the fact that suicide prevention is a secondary responsibility for LAUSD counselors, but it is not a primary focus of their work.

Table 16

Frequency of Support for Students at Risk of Suicide or Suicidal Behaviors

On average, how often do you support a suicidal or self-harming student?	LD 1 (121)		LD 2 (115)		LD 3(99)		LD 4 (73)		LD 5 (99)		LD 6 (26)		Prefer not to state (16)		All (549)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
More than once per week (1)	7	5.8	2	1.7	6	6.1	4	5.5	2	2.0	1	3.9	2	12.5	24	4.4
One time per week (2)	8	6.6	8	7.0	7	7.1	5	6.9	7	7.1	1	3.9	2	12.5	38	6.9
At least once per month, but not weekly (3)	35	28.9	36	31.3	40	40.4	25	34.3	36	36.4	7	26.9	2	12.5	181	33.0
At least once every three months. (4)	27	22.3	31	27.0	20	20.2	22	30.1	17	17.2	7	26.9	2	12.5	126	23.0
Less than once every three months (5)	44	36.4	38	33.0	26	26.3	17	23.3	37	37.4	10	38.5	8	50.0	180	32.8

Note: This table includes the 549 individuals who provided frequency of support and local district.

Open-Ended Responses

To understand what additional supports are needed by counselors, I asked an optional open-ended survey question. There were 293 counselors (53% of the 548 total study participants) who provided a response. The categories that emerged from counselors aligned with three main

areas: additional and/or specialized training, additional personnel support, and more resources for tiered support. Additional/specialized training was requested by 76.5% of the counselors who responded to this question, additional personnel support was identified by 11.9%, and more support and training on the three tiers was requested by 11.6% of counselors. Within each category, there were a vast array of insightful suggestions.

Additional and/or Specialized Training

The largest response was related to training. Counselors identified that they would appreciate additional training in several areas, including targeted training sessions, data driven sessions, best practices, problems of practice focus, and more training for all stake holder groups. Some of the comments counselors made was that "I would like to receive as much training as possible in regard to suicide." Additional comments included, "ongoing PD, specifically related to distance learning, and how race, ethnicity, gender, and sexual orientation impact the strategies we use."

Specialized Training and Data Driven Training

In regard to targeted training, counselors identified the need for more specialized sessions on everything from filing an *istar* report (a report that must be filed when a risk assessment is held, or an incident occurs) to leading conversations with parents on how to support students virtually. More training also meant more practical training that used updated data to drive discussions and decisions around student support. Given the trends in youth, counselors expressed a desire to have more information on how to support students while understanding that their race, ethnicity, gender, or sexual preference may impact the way they respond to support.

Best Practices

Counselors would like more frequent opportunities to focus on suicide prevention and to review best practices. Counselors identified that best practices should include refresher trainings and opportunities to sharpen skills.

Problem of Practice

Counselors would like more actual case studies so they may be better prepared for individual scenarios. The case review might also include role playing and group discussion. They specifically named the need for more training on tiered intervention strategies.

More Training for All Stakeholder Groups

Counselors identified that in addition for more training for themselves, they would like more training for themselves, as well as for parents, teachers, and staff members who should be aware of all levels of suicide prevention.

Additional Support

The category of additional support included three main areas of focus: administrative support and understanding, more resources and partnerships with outside agencies, and additional staffing. I will explain each category more in the sections below.

Administrative Support

Administrative support was identified as meaningful in several ways. Counselors shared concern over the many duties they are responsible for and the importance of having administrators who understood how that impacts the work. Given the plethora of duties that fall to counselors, supportive administration is critical because there will be times that crisis pushes a counselor's ability to fully support student needs. In addition, administrators may assist with reinforcing the importance of strong tier 1 supports for all students. Counselors reported that

having administrative support would be beneficial for setting a foundation at the school site and supporting counselors so they may best support students.

Resources and Partnerships with Outside Agencies

Counselors identified the gap in services provided by the school when students leave for breaks and over summer. They suggested stronger partnerships with outside organizations that operate year-round and would be able to provide a constant system of support for students not contingent on the school calendar. In addition, it is often difficult to provide appropriate services to students with counseling needs that extend beyond support we can offer during school and business hours. Students who may need intensive counseling support would benefit from a service provided that may be reached outside of school hours and who is licensed to provide more in depth care.

More Resources for Tiered Support

Counselors believed that they would benefit from additional resources that would support with the establishment and implementation of strong systems of tiered support. Within this category, many counselors acknowledged that LAUSD has a very strong suicide assessment plan but asked for more resources to support Tier I and II prevention and intervention, as well as strategies to monitor students that have re-entry plans. For Tier I supports, counselors identified the need for curriculum to support student education in matters related to mental health, wellbeing, and coping skills. They also mentioned curriculum to support with parent education. Finally, counselors identified the need for additional staffing. They identified positive collaboration with the school psychiatric social workers (PSWs) and how much they appreciated the partnership to provide comprehensive student support. They suggested that each school would benefit from a PSW as a normed position. In addition, they said that the size of their

caseload made it difficult to spend enough time with each student throughout the year and that more support would be beneficial.

Conclusions

Overall, my findings were that counselors felt much more confident implementing suicide prevention strategies pre- versus during the COVID pandemic. They highlighted the severity of the issue of suicide and how it increased during the pandemic. As counselors, they understood that their role is often the main point of contact for a student that may be at risk of death by suicide, and they did not take that responsibility lightly. They voiced a belief that race, ethnicity, gender, and sexual orientation were moderately to extremely important in regards to prevention strategies and asked for additional support in that area. They also highlighted the fact that LAUSD does have a very thorough assessment protocol. Despite that, counselors would like more Tier I and II supports. In Chapter Five, I discuss the implications of these findings and make recommendations.

CHAPTER 5: DISCUSSION

The aim of my study was to gather a district-wide sampling of counselor's awareness of current practices and perceptions of self-reporting on their own preparedness. Additionally, I gathered data on suggested improvements for professional development . Finally, my data analysis yielded suggested directions for district policies, practices, and professional development in the future. I organized this chapter around each research question, with suggestions for future research and implications for practice.

Review of Findings

Awareness of Preventative Strategies

Research Question #1 sought to understand if counselors were aware of preventative strategies and to identify which strategies were most widely used in their schools. Universal strategies were identified as Tier I preventative strategies that target all students. Targeted strategies were identified as Tier II strategies specifically for students identified as at risk of suicidal behaviors. Tertiary strategies were identified as Tier III strategies for students who have a known risk of behaviors. My data showed that 64.3% of counselors identified the use of universal strategies at their school site, 62.8% of counselors reported the use of targeted strategies at their school site, and 45.4% of counselors stated that their school site used tertiary strategies. In my analysis, I found that the numbers above may have more to do with semantics and less to do with counselor knowledge of strategies in each tier of support. For instance, only 45.4% of counselors identified that their school site had tertiary strategies. Despite this, over 80% of counselors were able to identify that their school site utilized re-entry plans and ongoing social emotional supports, which are Tier III tertiary strategies. Therefore, Research Question #1 explored counselor knowledge of the broad categories, but the numbers by category does not

accurately account for actual counselor knowledge of the strategies within each larger category. This may indicate a disconnect based on semantics. Counselors were more likely to identify specific strategies, but they were less likely to be able to name which Tier they fall into.

Counselor Confidence Before and During the Pandemic

Research Question #2 sought to understand if counselors felt confident in their ability to support students through preventative strategies before and during the COVID pandemic. What I found was that counselors felt moderately to extremely confident in all categories of preparation pre-COVID. However, during the COVID pandemic, fewer counselors reported feeling moderately to extremely confident in all categories of preparation. The comparison was quite stark. During the pandemic, 25.9% of counselors felt moderately confident and only 2.8% of counselors felt extremely confident in their ability to recognize a student at risk of suicide, as compared to 63.3% feeling moderately confident and 22.2% feeling extremely confident pre-COVID. Based on counselor elaboration in the open ended questions, it stemmed from the lack of contact with the student. In a virtual space, counselors lacked consistent access to students, and when they did connect with students through Zoom, they were often unable to see the student's face because they kept the camera off. Therefore, counselors were unable to gather multiple facets of input (verbal and non-verbal) to aid them in their evaluation. Furthermore, they did not have contact with students as frequently or easily. During in-person learning, counselors may see students a few times a week in passing or in the hallways, even if they did not see the student in a session. However, in a virtual space, they often did not have contact with students unless there was a pointed reason to reach out. In addition, the other adults that interact with students were also less likely to know how a student was doing because students kept their cameras off. Therefore, it may easily be missed that a student is struggling if they do not verbally

respond to something and are simply a blank screen in a zoom class. Counselors reported that the pandemic created challenges that were new to schools and created barriers that counselors felt decreased their ability to truly connect with students.

Effectiveness of Strategies

Research Question #3 sought to understand if counselors felt that the strategies used supported students positively or negatively, if at all. I asked counselors if key identifiers such as race, ethnicity, gender, and sexual orientation were important to learn about in professional development focused on prevention strategies and if those demographics were currently included in professional development. I found that counselors believed that race, ethnicity, gender, and sexual orientation were moderately to extremely important to understand in a professional development training for suicide prevention. Notably, the counselors indicated the importance of being aware of the impact of these identifiers increased during the COVID pandemic. Although all four factors were important, counselors selected sexual orientation as the most important factor.

Additionally, over 30% of all counselors either somewhat or strongly agreed that race, ethnicity, gender, and sexual orientation were explicitly discussed in professional development. Interestingly, counselor response to this question was split with at least 20% of counselors somewhat or strongly disagreeing that there was explicit mention of race and ethnicity in professional development related to suicide prevention. In reference to gender, 14.4% of counselors somewhat or strongly disagreed that it was discussed in professional development. Similarly, 13.2% of counselors somewhat or strongly disagreed that sexual orientation was explicitly discussed in professional development. This discrepancy may be explained through the information gathered in Research Question #4 in which counselors asked for more detailed

professional development around race, ethnicity, gender, and sexual orientation. Some counselors indicated they wanted "more specific information on the differences/different risk factors in relation to ethnicity, race, gender, sexual orientation, etc. Should we be approaching supports or assessments differently? Are there better resources to refer students to depending on their identification, etc.?"

Supports Needed to Enhance Suicide Prevention Strategies

Research Question #4 sought to gather insight from counselors to understand the frequency of support needed for students at risk of suicide or suicidal behaviors and to gather more information on the additional supports counselors perceived as necessary. It was clear that though a supplemental duty, suicide prevention and response was a frequent practice for counselors in LAUSD. The reason I refer to suicide prevention as a supplemental duty is because school counselors' primary function is to support and provide holistic support to students: academic guidance, social emotional support, and ensuring overall wellbeing. However, counselors are not hired or trained to provide therapy. LAUSD does hire social workers to support with those types of duties, but social workers are not assigned as a primary student support to all secondary students in the district. The function of the school counselor is to provide every LAUSD student with an adult who may guide them through their secondary years with academic and social emotional support. However, suicidal ideation often requires the support of a trained therapist. Thus, the counselor role is critical as that gatekeeper who supports the student and family to ensure they receive the appropriate care. That responsibility should not be viewed lightly. Though this is a supplementary duty, it is profoundly important. The weight of this supplemental duty is significant. The dedicated work of counselors speaks to their professionalism and their ability to multi-task and utilize district trainings to support students in a

way that is not aligned perfectly with their primary purpose or the duties their credentials prepare them to implement, and their input in this study indicated how challenging it is to fulfill this supplementary duty.

Counselors shared that supporting students at risk of suicide or suicidal behavior was common. In fact, 11% of counselors reported that they supported students at risk of suicidal or suicidal behaviors at least one time or more per week; 33% supported students at least once per month, but not weekly; 23% provided support at least once every three months; and 33% reported that they provided support less than once every three months. Thus, supporting students at risk of suicide or suicidal behaviors is a practice that LAUSD counselors inevitably execute in the course of a school year and better capacity building is necessary.

When asked about supports they would benefit from, they provided three main areas of need: additional and/or specialized training (including more resources for tiered support), administrative support, and additional personnel support. Counselors were very explicit in why additional training was needed. They explained that "you can never get enough training" and "supports should be current in terms of dealing with the impact of the pandemic." Counselors asked for "as many possible trainings to further educate myself," and they would like "smaller chucks" and "more scenarios that walk us through the steps we should take backed by data." Counselors would like detailed "training on sexual orientation, gender, race, and ethnicity as it relates to suicide." They believe it would be beneficial to review and break down the tiers, and they stated they "definitely need more training on preventative strategies based on culture, ethnicity, gender and sexual orientation." The theme that emerged was that counselors felt that they would benefit from ongoing, specialized training on prevention strategies that relate to the intersectionality of the student population.

Two additional themes emerged. The first was that they believed additional personnel support was necessary. The second was that they identified administrative support as a critical factor in their success. Without strong administrative support, counselors felt that their role was often difficult to manage.

Connections to Prior Research

Counselors working with suicidal youth is an anticipated experience they may have in their career (Dass-Brailsford, 2007). In my study, I identified that 100% of LAUSD counselors who participated in this study reported that they have worked with a suicidal or self-harming student. My study supports prior research by Banks & Diambra, 2019 and Gould et al, 2003, that validates the need for professional development. Therefore, professional development is critical for counselors as suicide prevention is a support that all counselors will provide throughout the school year. In addition, there is a great deal of research that validates the need for multiple layers of prevention strategies in schools (Banks & Diambra, 2019; Lindsey et al., 2019; Stein et al., 2010). Therefore, the information I collected validates prior research that states that counselors may benefit from specialized training. Schools provide an ideal platform for suicide prevention and intervention. Since students spend so much of their day in school, there are ample opportunities to educate youth regarding suicide and/or provide monitoring, care, and appropriate follow-up, including mental health counseling for at-risk youth (Hart, 2012; O'Neil et al., 2020; Swanson & Colman, 2013).

Limitations of the Study

This study largely consisted of closed answer survey questions. Therefore, the results do not provide an in-depth or layered understanding of counselor perceptions. This data provides a broad understanding of counselor perception of their preparedness. The open-ended questions

provide additional insight, yet it is still limited. Additionally, this study gathered information from a large subset of counselors within the second largest school district in the country, and the information may not be generalizable to all other schools or districts. Los Angeles Unified School District does an excellent job of providing shared policy to all school sites. Thus, as my data has shown, there is a level of coherence of counselor practice across the district. Despite that, other districts may have policies that vary from LAUSD, and my findings may not be applicable. Despite that, the implication of my study may benefit other large districts with similar demographics in urban areas.

An additional limitation is that the data I collected was gathered from counselors that serve specific student populations within a range of conditions that vary from urban to suburban settings and across a large variance of socio-economic status. Thus, the experiences of our students and our counselors may be limited to LAUSD. However, the information gathered may inform thinking and planning of other similarly situated organizations even if the results are not generalizable.

Suggestions for Future Research

Suicide trends are not the same for youth and adults. Lindsey et al. (2019) evaluated data in the CDC yearly survey “Youth Risk Behavior Survey” to gather suicidal behavior trends for youth by racial, ethnic, and gender groups. Using national data from 1991–2017, they found almost one in five adolescents are thinking about suicide and greater than one in 10 has a suicide plan. In addition, they discovered significant racial, ethnic, and gender disparities in suicidal deaths, which means that youth within these subgroups are at a higher risk of suicide. This information, coupled with the fact that we know that suicide is preventable, should naturally lead to implementation of differentiated prevention strategies. Currently, we do not see differentiation

in prevention strategies based on race, ethnicity, gender, and sexual orientation. Future research should examine how these key identifiers may inform suicide prevention strategies. Some of the questions that may be addressed include: what do counselors need to know about race, ethnicity, gender, and sexual orientation to personalize their response to their students, and what does a personalized response based on race or ethnicity look like.

Future research should also examine how students respond to the tiered supports we provide. The research that exists largely lacks student voice. Therefore, future research should include student experience as their voices will provide important insight to inform the improvement of suicide prevention.

Recommendations for Practice

This study highlighted multiple ways the district may address professional development so that we may best support students. Additionally, it identified a need for additional personnel support as well as strong administrator support. These three findings led to my recommendations for practice, which focus on staffing and professional development. This study highlighted the fact that counselors believe that additional staff is critical to meet the emotional and academic needs of students at the secondary level. The number of students who need support outweighs the number of counselors available to provide such support. Counselors are also unable to support students through times when school is not in session. Often, those instances correlate with high stress time periods such as the holidays. Therefore, I recommend the following: purposeful staffing through all K-12 schools, specialized professional development, and professional development for administrators.

Purposeful Staffing Through All K-12 schools

Currently, LAUSD does not have school counselors in elementary schools. One of the most impactful actions LAUSD may do is hire counselors at each elementary school. It is important that the counselor role is clearly defined and designed to provide Tier I supports to all elementary students. These supports will include education on emotional regulation, school-wide positive behavioral instructional strategies, and personnel trained to identify the need for more intense emotional support. If LAUSD universally provided these Tier I supports, students in secondary schools will learn coping strategies prior to their secondary experience. The goal of increasing early prevention strategies would be to reduce the need for Tier II and Tier III strategies.

Additionally, increase the number of psychiatric social workers in each Local District. School counselors repeatedly reported positive outcomes when they partner with a social worker. School counselors value the partnership and the ability to confer with a counselor trained to provide mental health therapy. Realistically, one social worker per school may not be enough depending on the school size, but it would notably improve the support schools are able to provide students.

Finally, I recommend that each district spend time partnering with local mental health agencies to ensure that schools across the district are able to refer students to appropriate comprehensive care with mental health therapists that will be available during times when schools are closed. Currently, the district has meaningful partnerships, but there are not enough. Many times, these partnerships are created at the school level. It would be beneficial to create a streamlined process to solidify these partnerships at the district, while centralizing the

information so all schools in the area may access the information. Thus, support would increase and be available to all students in each district.

Specialized Professional Development

LAUSD does have a very robust suicide response policy. In addition, counselors reported that they do receive professional development on suicide prevention. However, there are several things that could be adjusted to provide more support for counselors. Those requests include: ongoing professional development that will be provided in small chunks throughout the year, a video library that provides instant support and examples of dealing with various scenarios, more in-depth training on how to support students who need mental health therapy, detailed training on tiered support (universal, targeted, and tertiary strategies), in-depth support on how race, ethnicity, gender, and sexual orientation inform the strategies they use with students, and training that will support some of the functional necessities of the job such as filing an *istar* incident report.

In preparing for professional development around tiered support, Tables 5, 6 and 7 highlight areas that may be addressed so that tiered supports are implemented with fidelity across the district. The two most-widely reported universal strategies (Tier I - Table 5) used are Positive Behavioral Intervention Strategies (73.4% of counselors) and Awareness Drives (65.6%). There is not one universal (Tier I) strategy reported to be present at 100% of LAUSD schools. Furthermore, the strategies of curriculum, explicit instruction to students regarding emotion management, and parent education is only reported by an average of 53% of counselors. These numbers, coupled with the open-ended responses provided by counselors confirm that more training on universal strategies is desired and needed. Universal strategies are preventative in

nature, and it would be very meaningful to ensure that all schools have strong prevention strategies that impact all students and are present in 100% of LAUSD schools.

In regard to targeted strategies (Tier II), all strategies were reported as being implemented by less than 56% of counselors. Targeted strategies are focused on identifying students who may be at risk for suicide or suicidal behaviors. Counselors reported the need for more support in this area. Professional development around gatekeeper training, screening, removing access to means, and restorative practices would be beneficial.

Finally, tertiary strategies (Tier III) were used by a majority of counselors. Tertiary strategies support students who are suicidal or practice suicidal behaviors. Three strategies stood out as the most widely used; those included re-entry plans (82.5% of counselors), ongoing social emotional support (80% of counselors), and providing connections to additional support and counseling (81.8% of counselors). The goal of professional development on tertiary strategies would be to increase implementation to 100% across the district while also supporting counselors to provide family counseling and postvention plans.

Professional Development for Administrators

This study highlighted the importance of counselors based on the many duties assigned to them. It also asked counselors what support they needed to be successful. Finally, it outlined very specific suicide prevention strategies. The connection that may not be overtly noted is that counselors need the strong support of their administrator to be successful. Thus, it would help if there was professional development available to help administrators understand suicide prevention because it begins at a school wide level. Universal strategies go far beyond the counseling office.

Furthermore, it would be beneficial to share in-depth training with administrators so it may inform the planning that must be done every year. When creating their budget and school calendar, administrators may be mindful of how important it is to have a strong supportive student environment and this may impact staffing choices, professional development, staff team assignments, and school-wide activities. In addition, administrators who understand the importance of suicide prevention will be able to understand that teachers must also have professional development.

When looking at the numbers reported by counselors as to how often they support at risk students, it is clear to see that they must have in depth knowledge on all three tiers of support. However, the most critical layer of support is Tier I universal strategies that focus on prevention and include all stakeholders.

Reflections

This study confirmed many of my beliefs about professional development for counselors within Los Angeles Unified School District. My passion has always been counseling, and it was clear that the counselors within LAUSD care deeply about their students. It was also clear that the district cares for the students and employees since they allowed me to gather insight from the counselors. Time is one of the biggest challenges that the district faces. Counselors are tasked with a huge role. It is a role that is difficult to define because there is no way to prioritize the many duties that they carry. They must do them all, and they must do them all well. When you are working in an environment that demands that level of perfection, the task of suicide prevention is daunting. Furthermore, as a society, we are terrified of this tragedy. We fear it so much that we avoid talking about it and dealing with it unless it forcefully and tragically impacts our lives. I was honored to read the many comments and insights shared by counselors. I felt

their stress and concern in their comments. I am grateful for their time and the incredible response rate I received. I hope that the data shared in my study is useful and helps to inform future practice within Los Angeles Unified School District. Ultimately, the goal is to support the adults that work in LAUSD so they may better support our students and their families. It is a team effort. This is especially imperative as the pandemic enters a new stage and we must learn to live with COVID. Currently, the world is polarized, and the ongoing social justice movement, which aims to create equitable learning spaces, faces many challenges. Supporting adults is the key to supporting kids.

Conclusion

This findings from this study provide important insight into the experience of LAUSD counselors who work closely with our students at risk of suicide or suicidal behaviors. Drawing upon the experiences of counselors in the field, my hope is that this information informs next steps for professional development and staffing in order to support students on a comprehensive level.

Appendix A

Figure A1

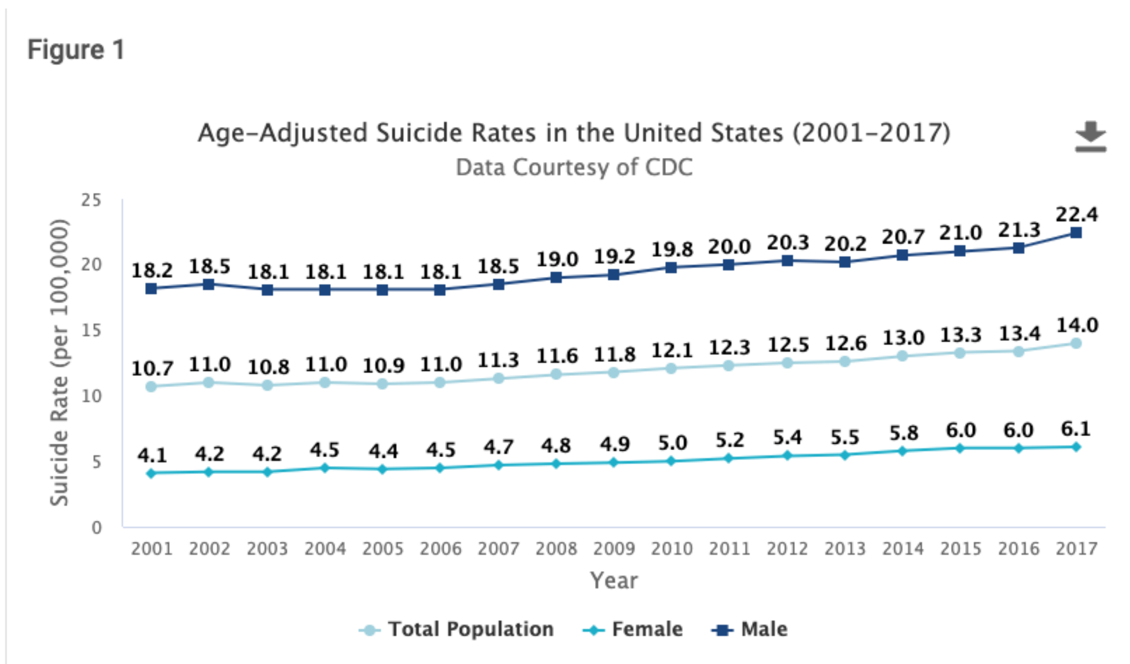
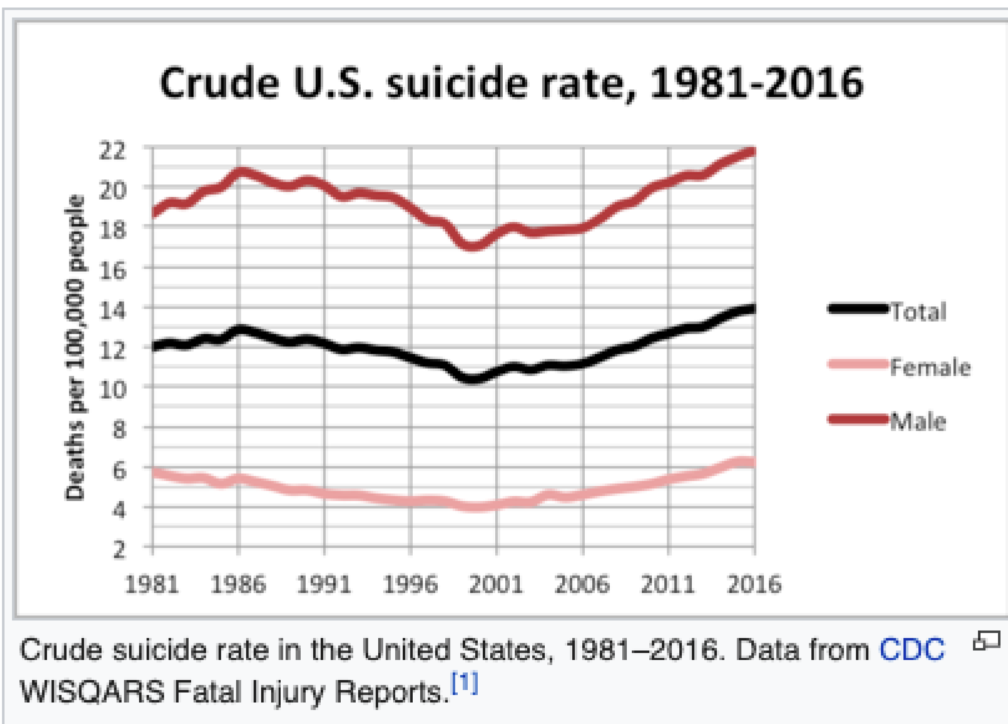
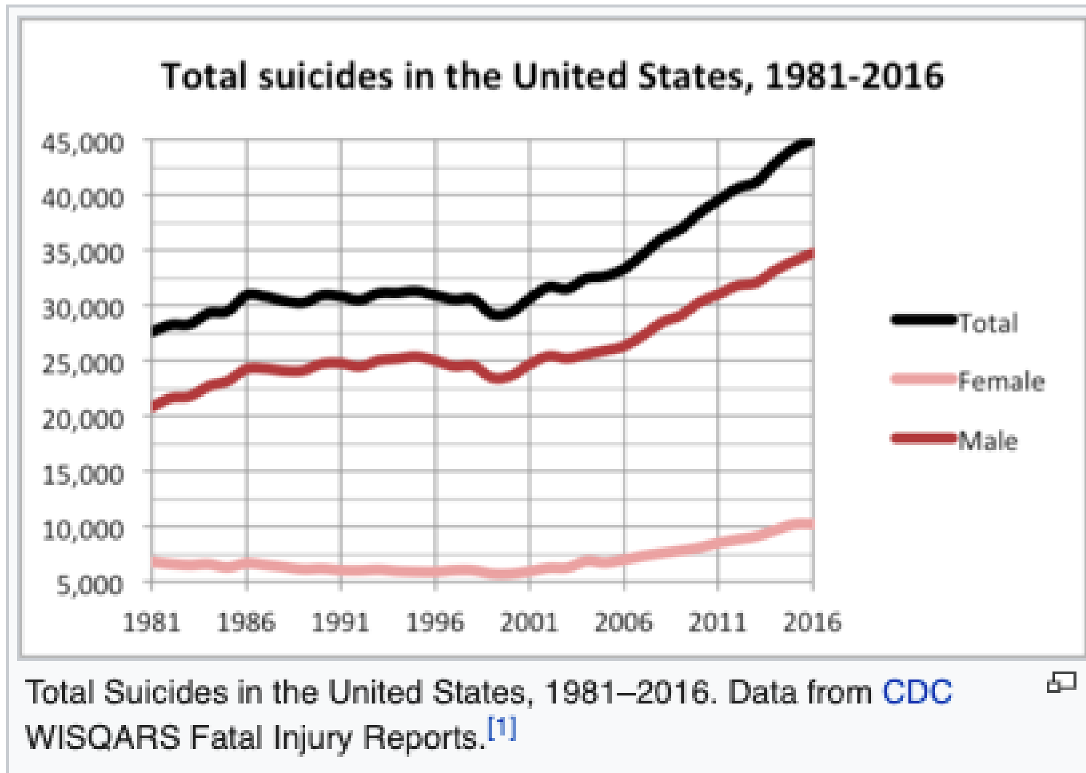


Figure A2



Crude suicide rate in the United States, 1981–2016. Data from CDC WISQARS Fatal Injury Reports.[1]

Figure A3



Total Suicides in the United States, 1981–2016. Data from CDC WISQARS Fatal Injury Reports.[1]

Figure A4

TOP TEN ISSUES

Suicidal Behavior	10,633	23%
Injury	8,133	17%
Fighting/Physical Aggression	3,461	7%
Accident	2,883	6%
Threat	2,479	5%
Medical	2,409	5%
Inappropriate Conduct (Employee as Suspect Only)	2,318	5%
Sex Crime/Sexual Behavior-Inappropriate	1,536	3%
Bullying	1,447	3%
Illegal/Controlled Substance	1,148	2%

Figure A5

Suicidal Behavior

(continued)

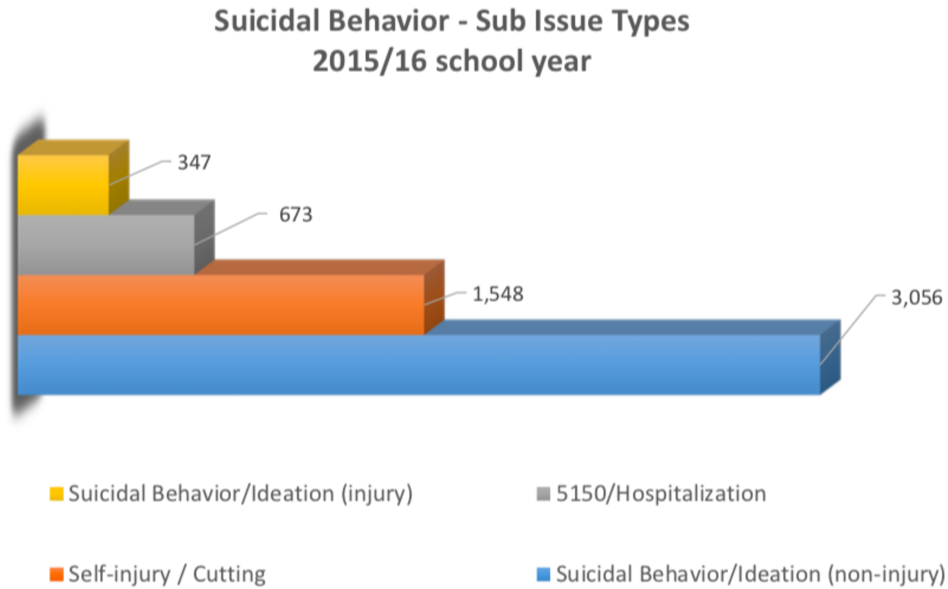
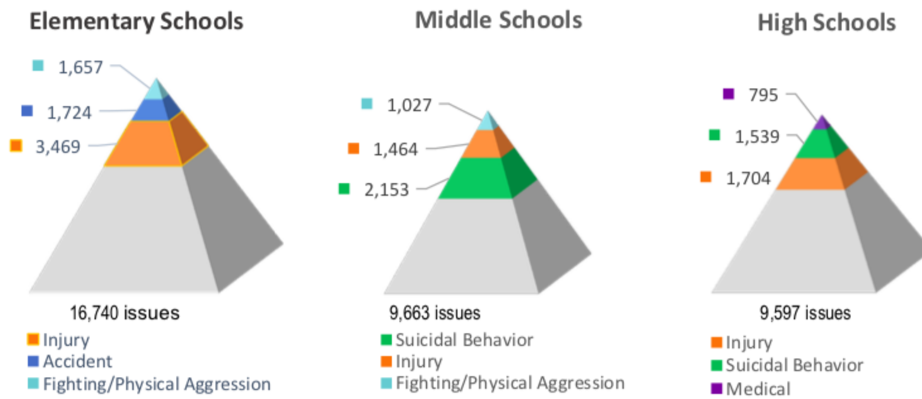


Figure A6

Top Issues by School Type



NOTE: Sizes of pyramid charts are relational to school types in demarcated group; gray denotes all other issue types

Figure A7

Span Schools | 1,588 issues

1. Injury / 296 or 19%
2. Suicidal Behavior / 292 or 18%
3. Fighting/Physical Aggression / 136 or 9%

Options Schools | 743 issues

1. Suicidal Behavior / 80 or 11%
2. Fighting/Physical Aggression / 78 or 11%
3. Illegal/Controlled Substance / 72 or 10%

Early Education | 612 issues

1. Injury / 189 or 31%
2. Inappropriate Conduct / 105 or 17%
3. Accident / 101 or 17%

Special Education | 504 issues

1. Injury / 161 or 32%
2. Accident / 76 or 15%
3. Medical / 54 or 11%

Adult Education | 241 issues

1. Injury / 60 or 25%
2. Accident / 43 or 18%
3. Medical / 32 or 13%

NOTE: Sizes of pyramid charts are relational to school types in

Number of LAUSD Schools and Centers

Primary School Centers	19
Elementary Schools	452
Middle Schools	83
Senior High Schools	98
Option Schools	54
Magnet Schools	42
Multi-level Schools	22
Special Education Schools	12
Centers for Advanced Transition Skills	1
Home/Hospital	1
Sub Total	784
K-12 Magnet Centers (on regular campuses)	
Elementary	46
Middle	55
Senior	55
Sub Total	156
Charter Schools	211
Other Schools and Centers	3
Community Adult Schools	10
Regional Occupational Centers/Program	1
Alternative Education Work Centers	23
Early Education Centers	86
Sub Total	334
Grand Total	**1,274**

Per LAUSD Fingertip Facts 2015-2016

Appendix B

Changes in the Application of Suicide Prevention Strategies Within the United States from 2016 to 2020

	State Mandated Annual Training		State Mandated Training, Not Annual		State Encourages Training		Require School Policies & Programs on Suicide Prevention, Intervention, & Postvention		Encourage School Policies & Programs on Suicide Prevention, Intervention, & Postvention	
State	**8/1/16**	**1/14/20**	**8/1/16**	**1/14/20**	**8/1/16**	**1/14/20**	**8/1/16**	**1/14/20**	**8/1/16**	**1/14/20**
Alabama					1	1	1	1		
Alaska	1	1								
Arizona				1	1					
Arkansas			1	1					1	1
California					1	1		1	1	
Colorado					1	1				
Connecticut			1	1			1	1		
Deleware	1	1					1	1		
Florida					1	1				
Georgia	1	1					1	1		
Hawaii		1						1		
Idaho		1						1		
Illinois			1	1			1	1		
Indiana			1	1				1		
Iowa		1						1		
Kansas	1	1					1	1		
Kentucky	1			1						
Louisiana	1	1							1	1
Maine			1	1			1	1		
Maryland		1	1						1	1
Massachusettes			1			1				
Michigan					1	1				
Minnesota					1	1				
Mississippi			1	1				1		
Missouri					1	1	1	1		
Montana					1	1		1		
Nebraska	1	1								
Nevada				1	1			1		
New Hampshire		1						1		
New Jersey			1	1					1	1
New Mexico										
New York					1	1				
North Carolina										
North Dakota	1					1				
Ohio			1	1						
Oklahoma					1	1			1	1
Oregon						1		1		
Pennsylvania			1	1			1	1		
Rhode Island					1	1				
South Carolina			1	1						
South Dakota			1	1						
Tennessee	1	1					1	1		
Texas	1	1							1	1
Utah			1	1			1	1		
Vermont										
Virginia				1	1				1	1
Washington			1	1			1	1		
Washington DC			1	1			1	1		
West Virginia			1							
Wisconsin					1	1				
Wyoming			1	1						
	10	**13**	**18**	**19**	**15**	**15**	**13**	**23**	**8**	**7**

Appendix C

Email Script: Recruitment Survey Tool

SUBJECT: How do current prevention strategies address the needs of youth people at risk of suicide?

To Counselor First Name / Last Name,

I hope you are well. I would like to invite you to participate in a web-based online survey as a part of a research project being conducted by me, Burgandie Montoya. Currently, I am a doctoral student researcher working with Dr. Pedro Noguera and Tyrone Howard, at UCLA Graduate School of Education and Information Studies. I was also a previous Counseling Coordinator for Los Angeles Unified School District.

The purpose of my survey is to understand LAUSD counselors' perceptions related to professional development around crisis response pre and during COVID. The goal of this project is to learn how we can best support counselors who provide prevention/intervention efforts for students. As a counselor and direct support to students, I believe your input is critical to this work. The survey should take approximately 20 minutes to complete.

I would greatly appreciate 20 minutes of your meeting time. I know time is precious and I really appreciate your consideration of this request.

Survey: http://uclaed.co1.qualtrics.com/jfe/form/SV_4PzdPinjOlW9wnY

Thank you,

Burgandie Montoya
Graduate Student Researcher
School of Education & Information Studies
University of California, Los Angeles
(310) 338-1807 or (310) 308-8489

Appendix D

Unit of Observation

<table>
<tr><td>Question</td><td>Observation</td><td>Data Collection Method</td></tr>
<tr><td colspan="3">According to counselors' perceptions, how do current prevention strategies address, <u>if at all,</u> the needs of local youth suicide trends?</td></tr>
<tr><td>What are the tiered preventative strategies used in the school district?</td><td>Universal Strategies:
Positive Behavioral Intervention Strategies (PBIS) such as:
• Activities to build a culture of acceptance (i.e. Restorative Justice Circles)
• Utilizing Language to encourage acceptance (Restorative Justice Language)
• Incentives for kindness (kindness campaign)

Counselors are able to report (Y/N):
• If the school includes specific lessons about suicide prevention in the curriculum.
• If the school has a crisis intervention team to respond to concerns.

Targeted Strategies:
Counselors are able to report (Y/N):
• If the school has a PSW.
• If referrals are made for additional mental health assessment and support.

Specific/ Tertiary Prevention:
Intense intervention for students that display additional needs.

Possibly referral to treatment center.
Referral to individual therapy.
Referral to family therapy.</td><td>Survey</td></tr>
<tr><td>To what extent do counselors feel prepared , if at all, to</td><td>Counselors are able to report (Y/N):</td><td>Survey</td></tr>
</table>

implement preventative strategies?	• If they have been trained to identify and assess risk for suicide. • If they feel confident in their ability to assess for suicide. • If they feel confident in their ability to respond to a student that may be in crisis. Counselors are/are not able to identify various strategies for prevention. Counselors are/are not able to articulate steps to follow in a crisis. Counselors are/are not able to identify and verbalize the steps they should follow if an assessment is needed.	
In what ways do counselors feel the strategies impact student need either positively or negatively if at all?	Counselors state that the prevention strategies fulfill/do not fulfill the needs displayed by their students by: • Targeting/not targeting immediate need for intervention • Targeting/not targeting long term treatment (ongoing counseling) Counselors utilize (Y/N) to answer: • Do universal strategies incorporate various approaches to target students with different interests? • Do universal strategies address students of all gender identities? • Do universal strategies target students of all races? • Do universal strategies address students of all ethnicities? • Do universal strategies address students of all grade levels within the school setting? • Do targeted strategies incorporate various approaches to target students with different interests? • Do targeted strategies address students of all gender identities?	Survey

	• Do targeted strategies address students of all races? • Do targeted strategies address students of all ethnicities? • Do targeted strategies address students of all grade levels within the school setting? • Do tertiary strategies incorporate various approaches to target students with different interests? • Do tertiary strategies address students of all gender identities? • Do tertiary strategies address students of all races? • Do tertiary strategies address students of all ethnicities? • Do tertiary strategies address students of all grade levels within the school setting?	
What additional support or training, if any, **do counselors perceive as necessary in order to** feel prepared to implement preventative strategies?	Counselors articulate additional needs such as: • Training to understand the risk factors and trends of youth suicide. • Training on how to identify students that may be at risk for suicide. • Training on how to implement universal prevention strategies. • Training on how to identify a student that may be at risk for suicidal ideation/behaviors. • Training on how to assess for suicide • Training to teach counselors how to respond to a student that may be at risk for suicide or suicidal behaviors. • Training on strategies that are effective with students in crisis • Strategies to reach students from a variety demographics.	Survey

Appendix E

Survey Consent and Questions

Counselor Survey: Counselors' perceptions related to suicide prevention strategies.

Q1 **PARTICIPATION:** Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. You are free to decline to answer any particular question you do not wish to answer for any reason.

BENEFITS: You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about counselor needs in order to inform future professional development so we may best support students.

RISKS The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering sensitive survey questions.

CONFIDENTIALITY: Your survey answers will be collected by Qualtrics where data will be stored in a password-protected electronic format. Qualtrics does not collect identifying information such as your name, email address, or IP address. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. The researchers will do their best to make sure that your private information is kept confidential. Information about you will be handled as confidentially as possible, but participating in research may involve a loss of privacy and the potential for a breach in confidentiality. Study data will be physically and electronically secured. As with any use of electronic means to store data, there is a risk of breach of data security. Your data, including de-identified data may be kept for use in future research.

CONTACT: If you have any questions, comments or concerns about the research, contact Burgandie Montoya, the principal investigator, at (626) 625-4915. If you have questions about your rights as a research subject, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the UCLA OHRPP by phone: (310) 206-

2040; by email: participants@research.ucla.edu or by mail: Box 951406, Los Angeles, CA 90095-1406.

ELECTRONIC CONSENT: Please select your choice below. You may print a copy of this consent form for your records.
Clicking on the "YES" button indicates that: you have read the above information, you voluntarily agree to participate, and you are 18 years of age or older

- Yes (1)
- No (2)

Q2 Does your school have universal preventative strategies that target all students at the school site?

- Yes (1)
- No (2)
- Not Sure (3)

Display This Question:

If Does your school have universal preventative strategies that target all students at the school si... != No

Q3 Please check off the Universal strategies used:

- Positive Behavioral Intervention Strategies (Encourage Connectedness) (1)
- Awareness drives: Bullying, Kindness, Mental Health, Suicide, etc (2)
- Curriculum: Lessons are provided to inform students about topics such as: Bullying, Kindness, Mental Health, Suicide, etc (3)
- Students are taught strategies to manage emotions (4)
- Parent Education is offered (5)
- Other (6) ____

Q4 Does your school have targeted preventative strategies that target students identified at being at risk of suicidal behaviors?

- Yes (1)
- No (2)
- Not Sure (3)

Display This Question:

If Does your school have targeted preventative strategies that target students identified at being a... != No

Q5 Please check off the Targeted strategies used:

- Gatekeeper Training (1)
- Screening (2)
- Reduce Access to Means (3)
- Restorative Practices (repair harm in communities) (4)
- Other (5) ____

Q6 Does your school have tertiary strategies that target students who have a known risk of suicidal behaviors?

- Yes (1)
- No (2)
- Not Sure (3)

Display This Question:

If Does your school have tertiary strategies that target students who have a known risk of suicidal... != No

Q7 Please check off the Tertiary strategies used:

- Re-Entry Plan (1)
- Ongoing social-emotional support (2)
- Family counseling (3)
- Connections to additional support and counseling (4)
- Postvention Plans (5)
- Other (6) ____

Q8 Please answer the following question based upon **PRE-COVID** conditions ***(prior to March 13, 2020)*** and **DURING COVID** conditions (***March 14, 2020-present***):

	PRE-COVID Prior to March 13, 2020				**DURING** COVID March 14, 2020 - Present			
	Not at all Confident (1)	Slightly Confident (2)	Moderately Confident (3)	Extremely Confident (4)	Not at all Confident (1)	Slightly Confident (2)	Moderately Confident (3)	Extremely Confident (4)

How confident are you that you can recognize a student at risk of attempting suicide? (Q8_1)	○	○	○	○	○	○	○	○
How confident are you that: your training prepared you to talk with teachers and counselors at your school to help determine whether or not a student is at risk of attempting suicide? (Q8_2)	○	○	○	○	○	○	○	○

How confident are you that you can talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide? (Q8_3)	○	○	○	○	○	○	○	○
How confident are you that you can ask a student at risk of attempting suicide if he/she/they is suicidal? (Q8_4)	○	○	○	○	○	○	○	○

How confident are you that you can effectively offer support to a student at risk of attempting suicide? (Q8_5)	○	○	○	○	○	○	○	○
How confident are you that you can refer a student at risk of attempting suicide to a school counselor (therapist)? (Q8_6)	○	○	○	○	○	○	○	○

Q9 If you selected *Not At All Confident* or *Slightly Confident* **PRE-**COVID, please explain why….

Q10 If you selected *Not At All Confident* or *Slightly Confident* **DURING** COVID, please explain why….

Q11 Does the professional development provided by the district provide information about the demographic trends for suicidal behaviors in youth?

- Yes (1)
- No (2)

Q12 How important are understanding the following factors a professional development training about suicide prevention?

	PRE-COVID Prior to March 13, 2020				**DURING-COVID** March 14, 2020 - present			
	Not at all Important (1)	Slightly Important (2)	Moderately Important (3)	Extremely Important (4)	Not at all Important (1)	Slightly Important (2)	Moderately Important (3)	Extremely Important (4)
Race (1)	o	o	o	o	o	o	o	o
Ethnicity (2)	o	o	o	o	o	o	o	o
Gender (3)	o	o	o	o	o	o	o	o
Sexually Orientation (4)	o	o	o	o	o	o	o	o

Q13 Please answer the following question based upon PRE-COVID conditions (prior to March 13, 2020) and DURING COVID conditions (March 14, 2020-present):

	PRE-COVID Prior to March 13, 2020					**DURING-COVID** March 14, 2020 - Present				
	Strongly Disagree (1)	Somewhat Disagree (2)	Neither Disagree nor Agree (3)	Somewhat Agree (4)	Strongly Agree (5)	Strongly Disagree (1)	Somewhat Disagree (2)	Neither Disagree nor Agree (3)	Somewhat Agree (4)	Strongly Agree (5)

The professional development I received related to suicide prevention has explicitly discussed race? (1)	○	○	○	○	○	○	○	○	○	○
The professional development I received related to suicide prevention has explicitly discussed ethnicity? (2)	○	○	○	○	○	○	○	○	○	○

The professional development I received related to suicide prevention has explicitly discussed gender? (3)	○	○	○	○	○	○	○	○	○	○
The professional development I received related to suicide prevention has explicitly discussed sexual orientation? (4)	○	○	○	○	○	○	○	○	○	○

Q14 What additional training or support, if any, would you like to ensure you feel prepared to implement preventative strategies?

Q15 Please select your Race/Ethnicity:

- African American/Black (1)
- American Indian or Alaska Native (2)
- Asian (3)
- Hawaiian or Other Pacific Islander (4)
- Latinx (Latino/a) (5)
- White (not Hispanic/Latinx) (6)
- 2 or more (please state) (7) ____
- Other (please state) (8) ____
- Prefer not to say (9)

Q16 Pronouns:

- he/his (1)
- she/her (2)
- they/their (3)
- Prefer not to say (4)

Q17 Sexual Orientation:

- Heterosexual or straight (1)
- Gay or lesbian (2)
- Bisexual (3)
- Prefer to self describe (4) ____
- Prefer not to say (5)

Q18 Years as a Counselor:

- 0-5 (1)
- 6-10 (2)
- 11-15 (3)
- 16-20 (4)
- 21-25 (5)
- 26-30 (6)
- 31-35 (7)

Q19 Years at present school:

- 0-5 (1)
- 6-10 (2)
- 11-15 (3)
- 16-20 (4)
- 21-25 (5)

Q20 Local District

- East (1)
- Central (2)
- Northeast **(NE)** (3)
- Northwest **(NW)** (4)
- South (5)
- West (6)
- Prefer not to say (7)

Q21 Highest level of education:

- Bachelor's degree (1)
- Master's degree (2)
- Doctoral degree (3)
- Other ____________________ (4)

Q22 Professional Credentials held:

- Single Subject Teaching Credential (1)
- Multiple Subject Teaching Credential (2)
- Pupil Personnel Services Credential (3)
- Child Welfare and Attendance (4)
- Administrative Credential (5)
- Other (6) ____________________

Q23 Job Title:

- Academic/Guidance Counselor (1)
- College Counselor (2)
- Other (3) ____________________

Q24 On average, how often do you support a suicidal or self-harming student:

- More than once per week (1)
- One time per week (2)
- At least once per month, but not weekly. (3)
- At least once every three months (4)
- Less than once every three months (5)

Q25 I work with grades:

- 6-8 (1)
- 9-12 (2)
- Other (3) ____________________

References

American Foundation for Suicide Prevention. (2016). *State laws: Suicide prevention in schools (K-12).* http://afsp.org/wp-content/uploads/2016/04/Suicide-Prevention-in-Schools-Issue-Brief.pdf

American Foundation for Suicide Prevention. (2017). *Suicide facts at a glance*. https://afsp.org/about-suicide/suicide-statistics/

American Foundation for Suicide Prevention. (2019). *Suicide facts & figures: United States 2020*. https://chapterland.org/wp-content/uploads/sites/13/2017/11/US_FactsFigures_Flyer.pdf

American Foundation for Suicide Prevention. (2020, January 14). *State laws: Suicide prevention in schools (K-12)*. http://afspq.org/wp-content/uploads/sites/4/2018/09/AFSP_K-12-Schools-Issue-Brief-8-30-18.pdf

Anderson, R. N., & Smith, B. L. (2003). Deaths: Leading causes for 2001 (No. Vol. 52, No. 9). Hyattsville, Maryland: National Center for Health Statistics.

Association for Counselor Education and Supervision. (n.d.). *ACES online*. Retrieved April 1, 2020, from https://acesonline.net/

Australian Institute of Family Studies. (n.d.). *CFCA resource sheet*. Child Family Community Australia. https://aifs.gov.au/cfca/publications/cfca-resource-sheet

Banks, B. P., & Diambra, J. F. (2019). Suicide Response Preparedness in Counseling Students: A Study of Knowledge, Attitudes, and Simulated Behavior. The Journal of Counselor Preparation and Supervision, 12(1). Retrieved from https://repository.wcsu.edu/jcps/vol12/iss1/3

Bridge, J. A., Asti, L., & Horowitz, L. M., (2015). Suicide trends among elementary school-aged children in the United States from 1993 to 2012. *JAMA Pediatrics*, *169*(7), 673–677.

Bridge, J. A., Horowitz, L. M., Fontanella, C. A.(2018). Age-related racial disparity in suicide rates among US youths from 2001 through 2015. *JAMA Pediatrics*, *172*(7), 697–699.

Bronfenbrenner, U. (1974). Developmental research, public policy, and the ecology of childhood. *Child development, 45*(1), 1-5.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist, 32*(7), 513.

Borges, G., Nock, M. K., Haro Abad, J. M.. (2010). Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys. *Journal of Clinical Psychiatry*, *71*(12), 1617–1628.

Los Angeles Unified School District. BUL 2637.3, *Suicide Prevention, Intervention, and Postvention policy*, October 15, 2019

Capuzzi, D. (2009). *Suicide prevention in the schools: Guidelines for middle and high school settings* (2nd ed.). American Counseling Association.

Centers for Disease Control and Prevention. (2015). *Suicide facts at a glance*. https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

Centers for Disease Control and Prevention. (2017). *Youth risk behavior survey: Data summary and trends report 2007-2017.* https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf

Cheref, S., & Benoit, J. S. (2019). Refining psychological, substance use, and sociodemographic predictors of suicide ideation and attempts in a national multiethnic sample of adults, 2008-2013. *The Journal of Nervous and Mental Disease*, *207*(8), 675-682.

Cole, P. M., Martin, S. E., & Dennis, T. A. (2004). Emotion regulation as a scientific construct: Methodological challenges and directions for child development research. *Child Development*, *75*(2), 317-333. doi:10.1111/j.1467-8624.2004.00673.x

Daniolos, P. T., Boyum, E. N., & Telingator, C. J. (2018). Suicide and self-harm among sexual and gender minority youth: Resilience, coping, and despair. . In A. J. Pumariega & N. Sharma (Eds.), *Suicide Among Diverse Youth A Case-Based Guidebook* (pp. 199–219).

Evans, R., & Hurrell, C. (2016). The role of schools in children and young people's self-harm and suicide: Systematic review and meta-ethnography of qualitative research. *BMC Public Health,16*(1), 401-417. doi:10.1186/s12889-016-3065-2

Forbes, M. K., Crome, E., Sunderland, M., & Wuthrich, V. M. (2018). Perceived needs for mental health care and barriers to treatment across age groups. *Aging & Mental Health*, *21*(10), 1072–1078. https://doi.org/10.1080/13607863.2016.1193121

Fowler, F. J. (2014). *Survey research methods*. Sage Publication.

Glenn, C. R., & Nock, M. K. (2014). Improving the short-term prediction of suicidal behavior. *American Journal of Preventative Medicine*, *47*(3), S176–S180.

Godor, B. P. (2016). Academic fatalism: Applying Durkheim's Fatalistic Suicide Typology to student drop-out and the climate of higher education. *Interchange*, *48*(3), 257-269. doi:10.1007/s10780-016-9292-8

Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and preventative interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(4), 386–405.

Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *JAMA*, *293*, 1635–1643.

Hart, S. R. (2012). Student suicide: Suicide postvention. In S. E. Brock & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (2nd ed., pp. 525–548). National Association of School Psychologists.

The Jason Foundation. (n.d.) *Youth Suicide Statistics*. The Parent Resource Program. **Retrieved on 9/16/19**, from http://prp.jasonfoundation.com/facts/youth-suicide-statistics/

Joe, S. (2006). Implications of national suicide trends for social work practice with black youth. *Child and Adolescent Social Work Journal*, *23*(4), 458-471. DOI: 10.1007/s10560-006-0064-7)

Kelly, M., & Coughlan, B. (2019). A theory of youth mental health recovery from a parental perspective. *Child and Adolescent Mental Health, 24*(2), 161-169.

Kalodner, C. R. (2011). Cognitive-behavioral theories. In D. Capuzzi & D. R. Gross (Eds.), *Counseling and psychotherapy* (pp. 193–213). American Counseling Association.

King, K. A., Price, J. H., Telljohann, S. K., & Wahl, J. (1999). How confident do high school counselors feel in recognizing students at risk for suicide? *American Journal of Health Behavior*, *23*(6), 457. https://doi.org/10.5993/AJHB.23.6.5

Langford, R., Bonell, C. P., Jones, H. E., Pouliou, T., Murphy, S. M., Waters, E., Komro, A. A., Gibbs, L. F., Magnus, D. & Campbell, R. (2014). The WHO Health Promoting School framework for improving the health and well-beig of students and their academic achievement. *Cochrane database of systematic reviews, (4).*

Lindsey, M. A., Sheftall, A. H., Xiao, Y., & Joe, S. (2019). Trends of suicidal behaviors among high school students in the United States: 1991-2017. *Pediatrics*, *144*(5), 1-10. DOI: 10.1542/peds.2019-1187

Los Angeles Unified School District. (2011). *iSTAR Annual report 2010-2011*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=52109&FileName=iSTAR%202010-2011%20Annual%20Report%207.pdf

Los Angeles Unified School District. (2012). *iSTAR Annual report 2011-2012*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=52110&FileName=iSTAR%202011-2012%20Annual%20Report.pdf.

Los Angeles Unified School District. (2013). *iSTAR Annual report 2012-2013*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=52111&FileName=iSTAR%202012-2013%20Annual%20Report.pdf

Los Angeles Unified School District. (2014). *iSTAR Annual report 2013-2014*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=52112&FileName=iSTAR%202013-2014%20Annual%20Report.pdf

Los Angeles Unified School District. (2015). *iSTAR Annual report 2014-2015*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=52113&FileName=iSTAR_annual_Final_20150727.pdf

Los Angeles Unified School District. (2016). *iSTAR Annual report 2015-2016*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=52114&FileName=iSTAR%20Annual%20Report_15.16_FINAL_20160830.pdf

Los Angeles Unified School District. (2017). *iSTAR Annual report 2016-2017*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=70552&FileName=iSTAR%20Annual_2016-2017.pdf

Los Angeles Unified School District. (2018). *iSTAR Annual report 2017-2018*. https://achieve.lausd.net/site/handlers/filedownload.ashx?moduleinstanceid=38665&dataid=70939&FileName=iStar%20Annual%20Report%202017-2018.pdf

Los Angeles Unified School District. (2015). *iSTAR Annual report 2018-2019*. https://achieve.lausd.net/site/default.aspx?PageType=3&ModuleInstanceID=38665&ViewID=C9E0416E-F0E7-4626-AA7B-C14D59F72F85&RenderLoc=0&FlexDataID=84067&PageID=13197&Comments=true

Los Angeles Unified School District (LAUSD Public Records Request (PRA)

Nock, M. K., Green, J. G., Hwang, I., McLaughlin, K. A., Sampson, N. A., Zaslavsky, A. M., **et. al.**, (2013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: Results from the National Comorbidity Survey Replication adolescent Supplement. *JAMA Psychiatry*, *70*(3), 300-10.

O'Carroll, P. W., Berman, A. L., Maris, R. W., et al. (1996). Beyond the Tower of Babel: A nomenclature for suicidology. *Suicide Life Threat Behaviors*, *26*(3), 237–252.

O'Neil, C., Marraccini, M. E., Bledsoe, S. E., Knotek, S. E., & Tabori, A. E. (2020). Suicide postvention practices in schools: School psychologists' experiences, training, and knowledge. *American Psychological Association*, *34*(1), 61–71.

Pumariega, A. J., & Sharma, N. (2018). *Suicide among diverse youth: A case-based guidebook*. Springer International Publishing.

Pearlman, D. H., Vendetti, T., & Hill, J. (2018). Linking public schools and community mental health services: A model for youth suicide prevention. *Rhode Island Medical Journal*,

Pisani, A. R., Wyman, P. A., Petrova, M., Schmeelk-Cone, K., Goldston, D. B., Xia, Y., & Gould, M. S. (2012). Emotion regulation difficulties, youth–adult relationships, and suicide attempts among high school students in underserved communities. *Journal of Youth and Adolescence*, *42*(6), 807-820. doi:10.1007/s10964-012-9884-2

Sheftall, A. H., Asti, L., Horowitz, L. M., et al. (2016). Suicide in elementary school-aged children and early adolescents. *Pediatrics*, *138*(4), e20160436

Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., Joiner, T. E. Rebuilding the tower of Babel: A revised nomenclature for the study of suicide and suicidal behaviors. Part 1: background, rationale, and methodology. *Suicide Life Threat Behaviors*, *37*(3), 248–263.

Steele, I. H., Thrower, N., Noroian, P., & Saleh, F. M. (2018). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, assessment & management. *Journal of Forensic Sciences*, *63*(1), 162–171. https://doi.org/10.1111 /1556-4029.13519

Stein, B. D., Kataoka, S. H., Hamilton, A. B., Schultz, D., Ryan, G., Vona, P., & Wong, M. (2009). School personnel perspectives on their school's implementation of a school-based suicide prevention program. *The Journal of Behavioral Health Services & Research*, *37*(3), 338–349. doi: 10.1007/s11414-009-9174-2

United States Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *National Strategy for Suicide Prevention: Goals and Objectives for Action*. https://www.ncbi.nlm.nih.gov/books/NBK109917/

Ward, J. E., & Odegard, M. E. (2011). A proposal for increasing student safety through suicide prevention in schools. *Clearing House*,*84*,(4), 144–49.

Wilson, P., Atkinson, M., Hornby, G., Thompson, M., Cooper, M., Hooper, C. M., & Southall, A. (2002). *Young minds in our schools-a guide for teachers and others working in schools*. Year: YoungMinds (Jan 2004).

Wyatt, T. J., Oswalt, S. B., & Ochoa, Y. (2017). Mental health and academic performance of first-year college students. *International Journal of Higher Education*, *6*(3), 178. doi:10.5430/ijhe.v6n3p178