Alignment of Multi-Tiered Support Systems Following a School-Based Suicide Risk Assessment: Exploring the Lived Experiences of School-Based Mental Health Professionals

by

Lorraine May

A Dissertation Proposal Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education School of Behavioral Sciences

Liberty University

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Abstract

The purpose of this study was to explore the experiences of school-based mental health professionals (SBMHP) alignment of multi-tiered systems of support (MTSS) with completed suicide risk assessments (SRA). This qualitative, phenomenological study investigated the experiences of SBMHP with school-based SRA and MTSS. The experiences of SBMHP regarding aligning MTSS with completed SRA prior to this study were unknown. The social ecological model (SEM) provided the framework as it outlines the multiple systems that SBMHP should consider when aligning interventions within a MTSS when working with students, while Joiner's interpersonal theory of suicide (ITS) provided the grounding for suicidal behavior. Using these theoretical guidelines and the over-arching question, "What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA ," the research sought to answer: (1) What are the experiences of SBMHP with students' risk factors when selecting tiered interventions, and (2) What are the experiences of SBMHP with protective factors when conducting SRA? SBMHP who had delivered SRA within five years and informed of multi-tiered interventions were the target population. A purposive sample of SBMHP was interviewed using semi-structured open-ended questions, focus groups, and a reflective journal entry. Transcriptions were coded and analyzed for patterns and recurrent themes. Three themes were evident from the analysis: (1) SRA within an MTSS, (2) Risk and Protective Factors, and (3) Belongingness and the Importance of Connections. This study provided a viewpoint on how to effectively support students with suicidal behavior and recommendations for graduate training. The findings address the lack of research with SRA and MTSS and insights into SBMHP, which can enhance the alignment and implementation of interventions within an MTSS.

Keywords: youth, suicide risk assessment, school-based mental health, tiered intervention

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Dedication

I can do all things through Christ who strengthens me. Philippians 4:13 NKJV. I dedicate this dissertation to my Lord and Savior, Jesus Christ, who sustained me and provided all I needed throughout my dissertation journey.

This dissertation is dedicated to the many people who have guided, supported, encouraged, and invested in me.

Ancestral love and honor to Aunt Willie, my Godmother, Aunt Rebie, and Ma'Dear, whose shoulders I stand proudly upon.

To my mother and father, Mary and the late Theophalis May, who believed in and prayed for unborn generations, your unwavering faith and love have been my guiding light.

To CJ. God is not finished with us yet.

To Theophilus, Theophany, Theone, and Adrionna. Do big things, my beloved. May you always remember that your potential is limitless.

To Lorenzo, Lumon, Lemuel, LaRuby, and LaDonna. Keep trusting and believing.

To Stormiyah, may your brief journey in life inspire all SBMHP to be better.

To my nieces, nephews, and cousins, I hope you are inspired to trust God and live out your purpose in spite of any circumstance you may face.

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Table of Contents

Abstract 3

Copyright Page 4

Dedication 5

Acknowledgments 6

List of Tables 13

List of Abbreviations 14

CHAPTER ONE: INTRODUCTION 15

Overview 15

Background 15

- Historical Context 16
- Social Context 18
- Theoretical Context 21

Situation to Self 23

- Philosophical Assumption 23
- *Ontological Assumption* 23
- *Epistemological Assumption* 25
- *Axiological Assumption* 25

Problem Statement 27

Purpose Statement 29

Significance of the Study 30

Theoretical Significance 30

Empirical Significance 31

Practical Significance 31
Research Questions 32
Operational Definitions 34
Summary 35
CHAPTER TWO: LITERATURE REVIEW 37
Overview 37
Theoretical Framework 38
Ideation-to-Action Theory 38
Public Health Approach 40
Social Ecological Model (SEM) 40
Related Literature 42
Suicide 42
Developmental 45
Gender and Cultural Considerations 47
Suicide Risk Assessment 48
School-Based Suicide Risk Assessments 50
Goals of Suicide Risk Assessment 51
Challenges with Suicide Risk Assessment 53
Competency in Suicide Risk Assessment 55
Maintaining a Collaborative, Nonjudgmental Stance 56
Knowing and Eliciting Evidence-Based Factors Associated with Suicide 56
Determining Client's Level of Risk 58
Thorough Documentation 58

The Laws Concerning Suicide 59

Suicide Risk Assessment Training 60

School-Based Mental Health Professionals 61

Procedures in SRA 64

Risk Factors, Protective Factors, and Warning Signs 68

Risk Factors 68

Protective Factors 70

Warning Signs 72

Postvention 73

Risk Severity of Suicide Risk Assessment 73

Multi-Tiered Interventions 74

Tier One: Primary Classification 77

Tier Two: Secondary or Moderate Classification 77

Tier Three: Severe Classification 78

Summary 79

CHAPTER THREE: METHODS 81

Overview 81

Research Design 81

Research Questions 83

Setting and Participants 83

Procedures 85

Permissions 85

Recruitment Plan 85

Data Collection Plan 89

Individual Interviews Data Collection Approach 89

Focus Groups Data Collection Approach 93

Reflective Questionnaire Data Analysis Plan 97

Data Synthesis 98

Summary 101

CHAPTER FOUR: FINDINGS 103

Participants 103

Table 1 105

Participant One 105

Participant Two 106

Participant Three 107

Participant Four 108

Participant Five 109

Participant Six 109

Participant Seven 110

Participant Eight 111

Participant Nine 112

Participant Ten 113

Participant Eleven 113

Participant Twelve 114

Results 114

Theme Development 115

Research Question Responses 128
Summary 138
CHAPTER FIVE: CONCLUSION 139
Overview 139
Summary of Findings 140
Research Question 1 141
Research Question 2 142
Research Question 3 143
Discussion 144
Relationship of Findings to Theoretical Literature 144
Relationship of Findings to Empirical Literature 147
Implications 150
Theoretical Implications 150
Empirical Implications 152
Implications for Practice and Training 153
Christian Worldview Implications 154
Delimitations and Limitations 156
Delimitations 156
Limitations 156
Recommendations for Future Research 157
Summary 158
References 160
Appendix A: IRB Approval Form 191

Appendix B: Consent Form 192

Appendix C: Participant Recruitment Email 195

Appendix D: Pre-Interview/ Interest Google Form 196

Appendix E: Interview Questions 197

Appendix F: Focus Group Questions 198

Appendix G: Reflective Questionnaire Prompt 199

Appendix H: Participants' Recommendations for Student Tiered Supports and Strategies 200

List of Tables

Table 1. Participants' Overall Demographic Characteristics 105

Table 2. Research Questions and Identified Themes and Subthemes 115

Table 3. Keywords/Phrases/Subthemes/Major Themes 116

List of Abbreviations

Adverse Childhood Experiences (ACEs)
American Academy of Child and Adolescent Psychiatry (AACAP)
American Foundation for Suicide Prevention (AFSP)
American Academy of Pediatrics (AAP)
American School Counseling Association (ASCA)
Attention Deficit Disorder/ Attention-Deficit/Hyperactivity Disorder (ADD/ADHD)
Centers for Disease Control and Prevention (CDC)
Center for Surveillance, Epidemiology, and Laboratory Services (CSELS)
Children and Young People-Mental Health Safety Assessment Tool (CYP-MH SAT)
Every Student Succeeds Act (ESSA)
Family Educational Rights and Privacy Act (FERPA)
Health Insurance Portability and Accountability Act (HIPAA)
Helping Students at Risk for Suicide (HSAR)
Institutional Review Board (IRB)
Interpersonal-Psychological Theory of Suicide (IPTS)
Interpersonal Theory of Suicide (ITS)
Local Education Agency (LEA)
Mood and Feelings Questionnaire (MFQ)
Multi-Tiered Support System (MTSS)
National Alliance on Mental Illness (NAMI)
National Association of School Psychologist (NASP)
National Center for Health Statistics (NCHS)
National Center for Injury Prevention and Control (NCIPC)
National Vital Statistics System (NVSS)
No Child Left Behind Act (NCLB)
Non-Suicidal Self-Injury (NSSI)
Positive Behavioral Intervention and Supports (PBIS)
Response to Intervention (RTI)
School-Based Mental Health Professionals (SBMHP)
School-Wide Positive Behavior Supports (SWPBS)
Social Ecological Model (SEM)
Student Interview for Suicide Risk Screening (SISRS)
Student SRA Protocol (SSRAP)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Suicidal Behavior (SB)
Suicidal Ideation (SI)
Suicidal Thoughts and Behaviors (STB)
Suicide Risk Assessment (SRA)
Treatment Emergent Activation and Suicidality Assessment Profile (TEASAP)
Web-based Injury Statistics Query and Reporting System (WISQARS)
Youth Ratings Behavior Surveillance System (YRBSS)
Youth Risk Behavior Survey (YRBS)

CHAPTER ONE: INTRODUCTION

Overview

The phenomenon of suicide among children and teenagers is a significant public health crisis that affects all aspects of American society and poses a unique challenge for schools. In 2020, the overall rates of suicide dropped in the United States; however, the rates for teens increased (Curtin et al., 2020). In 2020, death by suicide was the third leading cause of death for youth 5-18 years of age. Schools have a crucial role in identifying and addressing the dangers of youth suicide. This study was designed to explore school-based mental health professionals (SBMHP) use of school-based Suicide Risk Assessment (SRA) alignment with a Multi-Tiered Support System (MTSS) or tiered interventions. MTSS, multi-tiered systems, multi-tiered interventions, and tiered interventions are used interchangeably throughout this study. Only a few studies have attempted to conceptualize and empirically investigate SRA alignment and MTSS, and even fewer have used a multi-disciplinary team to explore this phenomenon. Additional research is warranted on the utilization of SRA and their integration within a MTSS framework. The origins of the issue are first discussed in this chapter, along with some relevant historical, theoretical, and societal backdrop. The problem will then be stated, followed by the current study's goals. After explaining the study's significance, the chapter includes the study's objectives, research questions, and a glossary of terms used throughout the study. The chapter ends with a concise summary of its content.

Background

According to Rudd et al. (2006), assessing the risk of suicide was crucial for both student safety and selecting the most effective interventions for manageable or fluctuating risk factors. In recent decades, suicidology has expanded substantially (Berman, 2009). Schools provide an

optimal setting for the identification and intervention of youth suicide risks. Students spend more time in school than anywhere else. This section examines the importance of aligning MTSS with SRA by considering historical, societal, and theoretical perspectives.

Historical Context

In most societies, suicide has been taboo for centuries. Educational institutions have faced difficulty in providing appropriate services for all students. The Elementary and Secondary Education Act (ESEA) was passed to ensure that all students had access to a quality education at the federal level. With the enactment of the No Child Left Behind Act (NCLB) in 2002, the nation made significant progress in addressing areas in which kids required more support in schools. President Obama signed the Every Student Succeeds Act (ESSA) into law in 2015 to enhance elementary and secondary education. Under this legislation, the ESEA was extended for an additional 50 years.

In the 1990s, the isolationist culture of K-12 professionals began to change (Brown-Chidsey & Bickford, 2015). The U.S. Elementary and Secondary Education Act (ESEA), also known as the No Child Left Behind Act (NCLB), was updated, which reflected the revisions embracing a team approach to education. This legislation purposefully combined assessments and government financing for schools with efforts to improve interprofessional communication and collaboration and student results. The Every Student Succeeds Act (ESSA), passed in 2015, is the most recent amendment to the Elementary and Secondary Education Act (ESEA). The ESSA maintained its support for adopting multi-tiered prevention and intervention measures in schools, similar to earlier laws, which NASP (2017b) claims make for a well-designed MTSS. Prevention and intervention, the two essential elements of an effective MTSS, can be incorporated into MTSS while satisfying ESSA requirements (Brown-Chidsey & Bickford,

2015). Integrating the two models benefits school-based administrators and mental health specialists in addressing youth suicidal behavior.

ESEA/ESSA law has many standards, including evidence-based interventions, to ensure the success of all children and schools, particularly evidence-based interventions. The original early intervention service delivery models included Response to Intervention (RTI) and School-Wide Positive Behavior Supports (SWPBS). ESSA catalyzed schools to integrate comprehensive psychological services into multitiered systems of support (MTSS). The MTSS is a research-based paradigm for efficiently integrating several systems and services to address differentiated student needs, such as suicide risk (National Association of School Psychologists, 2016). Sandoval and Brock (1996) discussed the importance of tiered intervention delivered through primary, secondary, and tertiary prevention as well as postvention, but only from the perspective of a School Psychologist as the sole provider. The current method for identifying and responding to suicide risk in the school setting is prevention education and multitiered response to elevated warning signs or risk factors through a subsequent SRA (Breux & Boccio, 2019).

For the last 15 years, over half of the states have passed laws recommending or regulating school districts to establish and implement comprehensive suicide prevention policies and procedures (Lieberman & Poland, 2017). The law requires professionals to be aware of their moral and legal obligations and to fulfill these obligations to reduce the chances of poor outcomes. Therefore, when it comes to suicide law, it is an integral part of the comprehensive SRA process. Professionals, including mental health professionals working in schools, have a moral, ethical, and legal obligation to prevent suicide where conceivable (Nickerson et al., 2021). Professionals must carefully consider the ethical requirements of professional credentialing

boards, as well as the Family Educational Rights and Privacy Act (FERPA; 1974) and the Health Insurance Portability and Accountability Act (HIPAA; 1996) (U.S. Department of Labor, 2004).

Joiner and his colleagues developed a framework for SRA throughout the second part of the 20th century, highlighting the importance of two key areas. Interviews with a partially structured format were employed to facilitate school-based evaluations of suicide risk in students. Data spanning nearly 25 years have demonstrated the importance of risk and protective factors in relation to youth suicidal behavior (King et al., 2013). Some of the earlier measures that identified these factors included the Student Interview for Suicide Risk Screening (Brock & Sandoval, 1997), the Brief Suicide Risk Assessment Questionnaire (Miller, 2011), and the Columbia-Suicide Severity Rating Scale (Posner et al., 2006). However, they did not intend to integrate data from multiple sources or assist with selecting interventions (Boccio, 2015).

Social Context

In 1999, a framework for reducing suicide was introduced in the Surgeon General's Call to Action (U. S. Public Health Service, 1999). Social scientists have been plagued by youth suicide for over a century. Early in the twenty-first century, distinguished suicidologist Alan Berman advocated for SRA in schools. Nevertheless, schools frequently lack standardized methods and training for assessing and intervening with students who experience suicidal behavior (Nickerson et al., 2021). Despite the risk of suicide and evidence that suicide prevention programs save lives, mental health professionals and school managers face complex challenges in dealing with the risk of suicide at school (Manning et al., 2018). These challenges include school, limited time, and limited research (Lindh et al., 2020). Most studies on the identification and intervention of juvenile suicide have been conducted primarily in the clinical

environment (i.e., primary care, emergency departments, and hospital inpatients) or community mental health more than in a school environment (Erbacher & Singer, 2018).

One intervention for schools to use when students demonstrate a need for a more thorough investigation of suicide risk is a school-based SRA (Brock & Louvar Reeves, 2018). There is evidence that the use of SRA enhances prevention efforts, reduces suicidal ideation, and reduces suicide attempts, despite the paucity of studies on its utilization in educational settings (Beautrais, 2005; Bryan et al., 2017; Davenport & Crepeau-Hobson, 2021). SRA involves understanding warning signs, risk factors, protective factors, risk levels (Sisler et al., 2020), theoretical underpinnings of suicide, and legal and ethical obligations. According to earlier research, SRA is a technique, not an incident, which leads to identifying a risk level (Silverman & Berman, 2014).

One of the essential responsibilities of mental health professionals is to accurately and effectively identify individuals at high risk of suicide. School-based mental health professionals need to be knowledgeable of methods of completing suicide, collection methods from multiple sources, and understanding parental roles in providing an emotionally and physically safe environment (Boccio, 2015). Additionally, school staff members are required by law and ethics to take reasonable precautions to prevent juvenile suicide, including implementing appropriate policies, procedures, and interventions (Miller & Eckert, 2009). Accurate SRA is not an easy task. Many factors affect a person's suicide level and willingness to disclose this information (Crepeau-Hobson, 2013).

Therefore, clinicians need to take a systematic approach when conducting an assessment and document the predictability of a student's engagement in suicidal risk behavior. Research and clinical practice have provided many valuable tools and methods that enable a more

confident assessment of students utilizing standardized procedures. The majority of suicide screening and prevention strategies have been specifically designed for implementation in hospitals or community mental health facilities. These non-school protocols are not always appropriate for a complete evaluation of suicidal behavior risk (National Vital Statistics System, 2014). SRA designed for non-school settings often include suicide-critical information (e.g., family, medical records, more extended hours than usual for school mental health professionals) but may lack information such as school-specific suicide-critical information (e.g., standardized testing, social activities) (Cramer et al., 2013).

Many studies on suicide screenings have shown that it is a safe and effective way to identify adolescents at risk of suicide (Joshi et al., 2015). As suicide is one of the significant causes of death among American adolescents, it is critical for school counselors, school psychologists, and other school-based mental health practitioners to establish evidence-based procedures in SRA and multi-tiered interventions in response to SRA. The Helping Students at Risk for Suicide (HSAR) survey of school psychologists revealed comparable findings among school-based mental health professionals in that less than half had received training on the administration of SRA. However, most believed they would need to administer an SRA throughout their career (Nickerson et al., 2021).

Numerous research studies have been conducted to date on the tiered continuum of support for mental health services in schools. Using this tiered approach, students can get various services, from early to intensive intervention (Stephan et al., 2015). Tier-one and tier-three services provided in schools could be integrated into a comprehensive mental health assessment and treatment plan, enhancing the potential to strengthen SRA by establishing a therapeutic relationship (Wortzel et al., 2017) and professional collaboration with community resources.

These relationships would enable the identification of relevant intervention targets and potentially prevent an act of suicide (Wortzel et al., 2017).

Theoretical Context

A theoretical framework that contextualizes the current study within the broader context of previous research is presented. This study will be guided by Joiner's interpersonal theory of suicide (ITS) and the social ecological model (SEM). A discussion of how ITS and SEM are related to investigating the lived experience of SBMHP use of multi-tiered interventions with SRA. Joiner's (2005) ITS provides a framework for examining how SRA aligns with offering risk-level-appropriate interventions.

Joiner et al. (1999) supported the application of SRA in a clinical environment. Two domains were employed to develop a reasonably objective categorization system: the type of the current suicidal symptoms, the history of earlier suicide attempts, and any other relevant risk factors. It was discovered that SRA is useful for risk categorization and preventing clinicians from being overburdened in high-stress situations. The outcomes of their investigation led to guidelines for evaluating the risk of suicide based on objective standards (Joiner et al., 1999). Joiner’s (2005) ITS posits that thwarted belongingness and perceived burdensomeness increase suicidal ideation. The SRA processes correlate with the interpersonal theory of suicide (ITS) components of thwarted belongingness, perceived burdensomeness, and acquired capacity by identifying risk factors. ITS provides an understanding of the risk factors (Wolford-Clevenger, 2019) that SBMHP may observe in the school environment. SRA uncovers risk and protective factors to assist in subsequent steps (Ryan & Ouendo, 2020). When conducting an evaluation, Joiner et al. (1999) emphasized the importance of assessing other domains. These supplementary

domains provide context for interpreting the two primary domains, history, and adverse indications.

The social ecological model was used to understand the influence of all domains on the utilization of SRA and the selection of multi-tiered interventions among a collaborative team of school-based mental health professionals. From a social-ecological framework, it posits that consideration is given to the complex interplay between personal and environmental factors. The factors are dynamic, and individuals encounter different personal and environmental situations that vary their behavior throughout their lifespan. SBMHP are influenced by their knowledge, attitudes, and beliefs. They are also impacted by their interpersonal, community, and societal factors, such as school district mandates and state and federal regulations. An ecological approach was used to understand the determinants of suicidal risk factors and the supportive role of a multi-disciplinary team. Arora et al., (2019) study of MTSS delivery of depression interventions found a relative lack of available intervention options at the Tier 3 level.

MTSS is built on an ecological prevention model of delivery. Ecological approaches look at risk factors within each level and how multi-tiered interventions provide insight into selecting interventions. A social ecological model (SEM) guided my understanding of complicated relationships between multiple factors that shape the lived experience of SBMHP. Utilizing an SEM lens, a collaboration between teachers, students, parents, policymakers, and mental health professionals, both in the school building and community, is incorporated into the MTSS. In the context of suicidal risk behavior, increasing and accessing evidence-based mental health support within the school building is beneficial to students, and adequate training for SBMHP increases perceived confidence.

Public health models are effective because they build a structure that enables organizations to employ individuals with the knowledge to address risk factors even at the most intensive resource level. These specialists facilitate access to the required resources and enhance protection and recovery (Ewell Foster et al., 2017; Gould & Kramer, 2001). Youth suicide prevention programs and interventions can be conceptualized as responding to one of three levels of support using a public health model (Granello & Granello, 2007; Miller et al., 2009). MTSS service delivery aligns with the public health model of increasing the level of interventions and support based on the response in support of remediating or halting deficits early on (Schaffer, 2022). By exploring the lived experience of SBMHP implementing an ecological model of preventive and tiered support, this study incorporated three levels of the SEM Model, individual, relationship, and community, within an MTSS framework.

Situation to Self

Philosophical Assumption

Creswell and Poth (2018) have identified four philosophical assumptions: ontological, epistemological, axiological, and methodological. Creswell and Creswell (2018) state that philosophical beliefs ground the research problem and serve as a foundation for the research question. An individual's philosophical ideas are inextricably linked to their academic training and the academic setting in which they work (Creswell & Creswell, 2018). First, one must grasp the researcher's underlying beliefs to understand the research's development fully. This section discusses the ontological, epistemological, and axiological presuppositions of philosophy.

Ontological Assumption

The ontological assumption states that realities are co-constructed. From an ontological perspective, I sought to understand the world in which I work. I searched for the realities of

SBMHP alignment of SRA with MTSS. I searched for the participant's truth, not the *truth*. I considered all participants' realities *correct.* Truths are highly relative, fluid, and dependent on context.

Constructivism is founded on the philosophy of relativism, which maintains that reality cannot be understood apart from context. Perception is not analogous to reality. However, perception significantly impacts how we interpret reality and can become a person's reality. Romans 12:2 provides instruction on aligning perceptions with biblical principles' realities. The Bible teaches, "Do not conform yourselves to this world, but be transformed by renewing your mind so that by testing you may discern the will of God, what is good and acceptable and perfect." A person's perceptions are formed in their mind. This vantage point is the lens through which knowledge is established.

According to the Bible, the lens or compass used to interpret reality should be corrected to align with God's will. Outside of this valuation, a life compass may misdirect its user. This causes confusion between reality, how things exist, and perception, which is how a person comprehends or interprets them. Multiple mental constructions of reality are possible, according to relativists. Individuals may have distinct mental representations of reality influenced by context and perception. From a relativist perspective, individual truth is derived from a situationally subjective framework.

As a Christian, I believe in universal truth and that there are absolute rights and wrongs. However, as a member of an ethnic minority living in the United States, I have experienced and witnessed a culture shaping the perceptions of the majority into *truths* about an entire race of people based on *truths*. Knowledge is, therefore, contextual. I investigated participants' perceptions by evaluating the significance they attribute to the phenomenon under investigation.

The experiences and interactions that individuals have with one another shape these realities (Guba & Lincoln, 1994). Perception and reality are distinct. Ecclesiastes 2:14 illustrates how individuals can experience the same situation but perceive it differently.

Realizing that my perceptions influenced the study motivated me to expand my comprehension through qualitative means, with constructivism as a minor source of inspiration. This study used a constructivist worldview heavily influenced by Christianity to investigate the lived experiences of SBMHP and the significance that can be derived from these experiences. The truths of the research participants significantly influenced the findings. My personal, cultural, and historical experiences shaped my interpretations. Therefore, the findings represented a collective perspective on SBMHP experiences, infused with a vast multitude of individual, cultural, and contextual experiences.

Epistemological Assumption

Epistemology pertains to our knowledge of SRA and MTSS, whereas ontology involves our perception or the actual implementation of these interventions to help students address suicidal risk factors, behavior, and other mental health concerns. This reality validates the ontological mindfulness of school-based multi-tiered mental health supports. The findings were summarized from a constructionist viewpoint using the interactions and interview experiences with the participants. Exploring the SBMHP experience helped build relationships and categories while processing the findings.

Axiological Assumption

The situation in which researchers reveal their own biases and values within the context of a study is referred to as the axiological philosophical assumption (Creswell & Poth, 2018). Many knowledgeable mental health professionals with various experience levels shared their

experience conducting SRA. This study was approached mindful of the phenomenon of SRA and MTSS, considering both ontological philosophy and constructivist beliefs. There are many distinct perspectives on the nature of the world and various ways to experience it. The practical knowledge and insight gained by professionals who are a system's primary service provider and user is extremely valuable. Context and reality are inseparable concepts because the significance that we ascribe to the events that occur in our lives determines whether or not something is "truth" (Killam, 2013, p. 21).

The research emphasized the need to recognize and address the diverse needs and rights of vulnerable children who may lack the ability to advocate for different levels of mental health support in their school environment. It did so by considering numerous perspectives and giving students a crucial voice. My bias regarding SRA and MTSS may be present since I engage in conducting SRA in the school setting, and I am part of a community that experienced the loss of a youth due to a poorly executed SRA. SRA and MTSS are important topics of interest to me.

This study gave me a detailed understanding of SBMHP's experiences and situations. The meaning derived from these experiences is where the value lies. I investigated the phenomenon of SRA and the multi-tiered system as I explored the lived experience as SBMHP presented it. It is important to recognize the probability that my experience impacted the interpretation and description of the participant's experience, reflecting a singular viewpoint versus multiple viewpoints. Measures were implemented to ensure that the interpretation of participant experiences was trustworthy and could be easily followed by others. I sought to raise awareness of the importance of all SBMHP understanding of an array of interventions based on a student's risk level.

As a lifelong educator and school-based mental health provider, I have a personal and professional investment in the well-being and mental health of the students served. I believe this research impacts practices to better serve the entire school body and community by valuing interpretivism over description and explanation. I provided improvements in my profession by conducting sound and solid research that ultimately benefits my fellow SBMHP, students, families, and communities.

Problem Statement

The problem is two-fold, both for American school systems and public health. Suicidal behavior prevails among youth as a public health concern. A tool to assist schools in responding to suicidal behavior is conducting an SRA to assess the student's risk levels. A tool for the school to meet the needs of all students is implementing an MTSS system. Additionally, MTSS models are mandated to be a part of schools; the existing literature does not support integrating the two. While research supports tiered-level support and laws expect schools to implement these models, only some studies address the integration of these supports.

Schools are likely settings to address these issues (Singer et al., 2018; Marraccini & Brier, 2017; Borowsky et al., 2001). Crepeau-Hobson (2013) discovered scant empirical support for using SRA procedures and no published research on risk assessment practices in the school setting. Only some studies elucidate how to integrate tiered prevention and intervention with risk levels. A review of the current literature on SRA in the school setting revealed that it is comparable to previous research findings.

SBMHP are asked to assess and implement interventions for students' suicidal risk levels. While an SRA is conducted to screen whether students are in an emergent or urgent need of mental health care (Boudreaux & Horowitz, 2014), few to no extant studies explain evidence-

based tiered responses aligned to prevention, intervention, and risk levels. Nevertheless, educators and public health professionals must consider moral and legal mandates (American Foundation for Suicide Prevention, 2022a; Van Meter et al., 2018).

Most SRA procedures were created for clinical settings, not educational institutions (Erbacher & Singer, 2018). Minimal research has been undertaken to understand how SBMHP functions collaboratively in addressing mental health issues. Serka and Mainwaring's (2022) study of educators and mental health professionals found a preference for implementing interdisciplinary interventions. The research focused on discipline-specific interventions versus working collaboratively as an interdisciplinary team. Although the roles and responsibilities of the professionals in the study varied, there was a mutual understanding of the mental health issues affecting youth. There is widespread agreement that it is crucial to address youth mental health issues (Serka & Mainwaring, 2022).

There is also a lack of theoretical understanding of suicidal risk behavior among students by school-based mental health professionals. According to studies, suicide training provided in graduate programs for school psychologists is either insufficient or nonexistent. Nonetheless, the likelihood of providing help to students engaging in suicidal behavior was high (Monahan & Karver, 2021). Detection and intervention at an early stage are critical components of school-based prevention programs. These efforts are aided significantly by including strategies for identifying and responding to students contemplating suicide (Davenport & Crepeau-Hobson, 2021). Wasserman et al. (2015) found that universal suicide preventive intervention is effective in schools in reducing suicide attempts and severe suicidal ideation in middle school and high school students. School-based mental health professionals must be trained to assess suicide risk and intervene using evidence-based risk assessment and prevention practices to guide their

practice when working with students with suicidal behavior (Crepeau-Hobson, 2013). Evidence-based assessments employ well-validated instruments and quantitative methods (Van Meter et al., 2018; Youngstrom, 2018; Youngstrom & Frazier, 2013).

A phenomenological study of SBMHP's experiences with SRA alignment with MTSS for K-12 students was necessary to further the existing body of knowledge. The existing literature on school-based suicide prevention programs lacks studies that specifically examine the beliefs of mental health providers in schools regarding their understanding, competence, and capacity in dealing with student suicidal behavior (Davenport & Crepeau-Hobson, 2021). Even less research is available regarding school-based mental professionals providing tier-two and tier-three intervention services to students, in addition to how school-based mental health SRA processes correlate with the interpersonal theory of suicide (ITS) components of thwarted belongingness, perceived burdensomeness, and acquired capacity. The social ecology model (SEM) provides a broad theoretical lens for conceptualizing the role of SBMHP and how MTSS can address all aspects of a school-based suicide prevention program. MTSS initiatives are currently in place in many schools to address school-based efforts to improve students' overall academic and mental health functioning (Singer et al., 2019). This study was designed to bridge the gap in the current literature between school-based SRA research and school-wide evidence-based mental interventions with a focus on MTSS.

Purpose Statement

The purpose of this qualitative, phenomenological study explored SBMHP experiences aligning multi-tiered interventions or MTSS following the SRA process when working in a K-12 school setting across the United States. Multi-tiered systemic interventions are generally defined as MTSS, the intentional efforts of a school to provide suicide prevention efforts to support

various levels of suicide risk. The theory that guided this study is Joiner's (2005) interpersonal theory of suicide (ITS), as this theory sets forth the idea that specific domains and risk factors can be targeted to reduce suicidal behavior. The second theory that guided this study is Bronfenbrenner's (1979) social-ecological model (SEM), as this theory focuses on multiple systems, including the student development and understanding of suicidal risk behaviors and the context in which they occur.

Significance of the Study

Theoretical Significance

This study is essential to the existing literature because of its focus on the experiences of SBMHP with SRA and MTSS for K-12 students. The current study added to the body of knowledge on school-based SRA facilitation of the delivery of assessments and interventions. Initiatives for incorporating tiered suicide prevention efforts into the school setting, such as screenings, observations, referrals, and interventions, are maximized when intentionally integrated into a school's systemic mental health response (Singer et al., 2019). Efforts to increase teachers' knowledge of suicide-related interventions improve the effectiveness of a multi-disciplinary team in supporting students' success (Nickerson et al., 2021; Shannonhouse et al., 2017). The presence of mental health services in schools is associated with a lower likelihood of suicide ideation and attempts (Paschall & Bersamin, 2018).

Additionally, targeted efforts help improve students' feelings of safety and connectivity, which improves vital protective factors against suicide (Singer et al., 2019). The review of the literature shows that most studies related to youth suicide in the school setting are centered around gatekeeper programs or Tier 1 interventions. In contrast, only a few studies cover the topic of SRA alignment with tiered interventions. A novel contribution to the sparse body of

knowledge resulted from addressing the elements of ITS congruence with SRA techniques and tiered interventions. This study was designed to begin examining how SBMHP experienced the alignment of SRA within an MTSS

Empirical Significance

The importance of SRA cannot be underestimated (Gould et al., 2009). Data indicating SRA need for tiered intervention responses may inform SBMHP decision about aligning tiered interventions with SRA. Research on the benefits of tiered interventions alignment with SRA may motivate teachers and SBMHP to utilize school-based multi-disciplinary mental health supports. Motivations are key in prompting individuals to engage in the SRA process (Monahan & Karver, 2021). In either scenario, however, the opportunity to understand SRA role in SBMHP delivering tiered intervention may go largely overlooked. Neither of these entities can function individually to provide optimal programming for students.

Examining SBMHP experiences with SRA and MTSS for K-12 students was a starting point for research design. The research focused primarily on understanding the how and why of tiered interventions. Additionally, it focused on the SRA process in addressing accessibility issues, impediments to care, usage, and follow-up, suicidal behavior, feelings of shame, hopelessness, and generally holistic wellness for students could begin with an analysis of SBMHP's experiences with SRA and MTSS for K-12 students (Suldo et al., 2014; Knopf et al., 2016) as well as data that could result in more opportunities for cross-training among experts in the school context.

Practical Significance

To address the issue of youth suicide, SBMHP must work collaboratively, holistically, in a comprehensive and integrated manner (Breux & Boccio, 2019). School-based mental health

professionals are uniquely positioned in the school setting (Boccio, 2015; Nickerson et al., 2021). The current study provided a view of the current epidemiology of youth suicide in the United States. These data are pertinent to professionals working with youth in the United States (Sisler et al., 2020).

To appropriately respond to the rise in youth suicide behavior, it is essential to comprehend SBMHP life experiences as well as how they integrate human development of suicidal desire and capability effects and decision-making in responding to SRA using an MTSS paradigm. Singer et al. (2019) have called for a more comprehensive suicide prevention program that is integrated into existing systemic programming such as MTSS. This study has the potential to influence SBMHP perspectives on the significance of MTSS as a fundamental component of school-based suicide prevention. This study enhances the understanding of supporting all students, regardless of their level of risk, in the context of suicidal behavior and mental health. It underscores the significance of experts possessing a thorough comprehension of suicide behavior assessment and interventions, and emphasizes the function of SBMHP in this procedure.

Research Questions

The study's primary aim explored the lived experience of SBMHP utilization of school-based SRA results alignment with MTSS/tiered interventions among K-12 students across the USA. This study shed light on the paucity of research on using MTSS in the SRA process. While answering three research questions, this study will aim to answer the following research questions:

RQ1: What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?

A team approach is necessary for tiered interventions and improves the chances of sustaining development, implementation, and long-term success (Brown-Chidsey & Bickford, 2015). According to MTSS, it is essential to correlate interventions to students' specific needs in terms of risk level and intensity of the behavior (Bohnenkamp et al., 2021; Hoover et al., 2015). The Every Student Succeeds Act (ESSA) urges schools to leverage MTSS as an evidence-based tool to reduce obstacles to students obtaining comprehensive school psychological services (National Association of School Psychologists, 2016). SBMHP are essential resources for increasing access and executing MTSS successfully. In the past, there was a lack of cohesiveness and range in the continuum of care for school mental health services (Stephan et al., 2015).

RQ2: What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?

Zhu et al. (2019) study of the trajectory of suicidal behavior found evidence to support specific risk factors as well as protective factors should be included in comprehensive screenings. The study highlights critical periods for screening and intervening in youth development that led to the prevention of the escalation of suicide risk (Zhu et al., 2019). Understanding these critical opportunities allows the SBMHP to tailor interventions that are sensitive to developmental needs as well as understand the trajectory of when suicidal behavior is identified.

RQ3: What are the experiences of SBMHP with protective factors when conducting SRA?

The evidence for a single protective factor preventing an outcome like suicide is limited. Protective variables, on the other hand, have been shown to mitigate various outcomes in youth mental health and wellness, suggesting that they may potentially work as a preventive factor in

youth suicidal behavior (King et al., 2013). Thwarted belongingness and perceived burdensomeness are proposed to be common pathways to engagement in suicidal behaviors.

Operational Definitions

1. *Completed suicide* – Intentional, self-harm is fatal (Miller, 2011).
2. *Multi-tiered systems of support (MTSS).* The MTSS is a research-based paradigm for efficiently integrating several systems and services to address differentiated student needs, such as suicide risk (National Association of School Psychologist, 2016).
3. *Non-suicidal self-injury (NSSI)* - The purpose of self-harm without trying to kill oneself (Sadek, 2019). It may be an attempt to control miserable emotions, control their lives, punish themselves, and influence others. Common forms of non self-harm that feel comfortable include self-harm, self-immolation, starvation, relationship damage, and haircutting.
4. *Postvention* - A planned response to a suicide that is intended to mitigate its impact on the community or environment (O'Neill et al., 2021).
5. *Protective factor* - Personal or environmental features that help protect people from suicide and respond more effectively to stressful events (King et al., 2013; Substance Abuse and Mental Health Services Administration, 2019).
6. *Risk factor* - A suicide feature or condition that increases the likelihood that a person will attempt suicide; attributes that make it more probable that someone will consider, attempt, or die by suicide. A suicide attempt cannot be predicted or caused by them. (Substance Abuse and Mental Health Services Administration, n.d.; Miller, 2011). These may include environmental factors such as stressful life events, health factors such as mental health status, and historical factors such as family history of suicide. It is important to note that risk factors are not necessarily the cause of suicide. However, the person is more likely to have suicidal ideation.

7. *School-based Mental Health Professionals*- Various professionals, including school counselors, school psychologists, school social workers, school nurses, and special education teachers whom, deliver school-based mental health services (Mellin et al., 2011).

8. *Suicide attempt* – It is a non-lethal, self-inducing, potentially dangerous behavior intended to die as a result (Gold & Frierson, 2020; King et al., 2013).

9. *Suicidal behavior* - Behaviors related to suicide, including ideation, attempts, suicide-related communication, and suicide (Miller & Reynolds, 2021).

10. *Suicidal ideation* – The reference to the thinking or planning suicide (Miller, 2011).

11. *Suicide risk assessment (SRA):* Techniques for eliciting information about an individual's needs, stressors, strengths, and resources, as well as for estimating an individual's suicide risk (Patterson, 2016).

12. *Suicide threat* - Verbal or nonverbal; an interpersonal action that may indicate a serious intention of suicide (Sadek, 2019). Direct speech includes "kill yourself" and "want to die." Indirect speech includes "pay for friends and family" and "don't wake up." Come up and come again".

13. *Warning signs* - Signs of being at risk of suicide (Miller, 2011), such as talking about suicide and finding a way to end life, severe changes in mood and behavior.

Summary

SRA is a potentially effective tool for suicide prevention, but little is known about SRA practices in schools. Suicide prevention necessitates early detection and intervention (Davenport & Crepeau-Hobson, 2021). SRA can be used in school-based suicide prevention programs to identify and intervene when students are exhibiting suicidal risk behaviors. ITS and SEM offer a framework for comprehending suicidal risk behavior among students. Evidence suggests that

more than half of youth identified as being at risk of suicide are identified in school, most likely due to the substantial amount of time youth spend in schools with school-based mental health practitioners (Erbacher & Singer, 2018). Many school-based mental health practitioners report having some but insufficient training in administering and tiered intervention after conducting SRA (Miller & Reynolds, 2021). There is a scarcity of current literature on the use of SRA protocols or procedures in the school setting (Exner-Cortens et al., 2021), as well as the use of MTSS in addressing suicidal risk behavior in the school setting.

School-based mental health services have been shown to be utilized by students in distress. Understanding the process and perceptions of school-based mental health professionals while implementing SRA can contribute to the emergence of standardized practices within the school-based response when intervening with students engaging in suicidal risk behavior. A greater understanding by a school-based mental health professional of the vast spectrum of intervention services available to students experiencing suicidal risk behavior, whether at the minimal or tier-one level or the intensive, tier-three level, would enable school-based mental health professionals to deliver services with greater competence and a higher likelihood that services both in and out of the school are appropriate and informed by evidence-based practices. The purpose of this planned qualitative study was to learn about SBMHP experiences with MTSS and SRA.

CHAPTER TWO: LITERATURE REVIEW

Overview

MTSS and youth suicidal behavior have both been brought to the forefront of American culture. Lawmakers and public health experts have taken measures to advise those who serve youth in any capacity, justifying a coordinated effort and necessitating thoughtful consideration of how to address pupils' mental health needs. Suicide among children and teenagers is a severe public health crisis that affects all aspects of American society and poses a unique challenge for schools.

Suicidal behavior includes both suicidal ideation and attempts. However, there are distinctions between the two (Miller & Eckert, 2009). The phrase *suicidal ideation* describes when a person experiences thoughts related to the deliberate termination of life. The term *suicide plan with attempt* refers to thinking about ways to end one's life. A suicide attempt occurs when a person follows through with a plan (Pumariega & Sharma, 2018). Suicide is the willful taking of one's life (Gold & Frierson, 2020). For this research study, all of these phrases collectively referred to suicidal behavior.

Notably, the conceptualization of suicide risk as cumulative and intervention-responsive within the development of suicidal behavior implies that there are opportunities to provide appropriate interventions that can alter the trajectory of suicidal behavior. At the same time, neglected opportunities to intervene at earlier stages of risk development and inadequate responses to elevated risk can result in irreversible consequences. Identifying a student's level of need and then providing them with appropriate interventions and, to the utmost extent possible, assistance in navigating the school environment is the essence of school-based SRA. Similar,

multi-tiered supports are designed to provide prevention and intervention. The MTSS framework is built upon a public health prevention model (Loftus-Rattan et al., 2023).

In a review of what is currently known about evidence-based school suicide prevention, a greater emphasis on "upstream" approaches in the integration of suicide prevention programming with multi-tiered interventions is recommended (Singer et al., 2019, p.56). According to the Youth Risk Behavior Survey (YRBS), more than 18.8% of high school students in the United States reported having severe suicidal thoughts within the preceding 12 months (Ivey-Stephenson et al., 2020). This alarming increase in adolescent suicidal thinking and behavior is a disturbing trend that calls for intervention and prevention (Cha et al., 2018). Data from 2014 and 2015 reported suicide as the third leading cause of death among 10- to 14-year-olds and the second leading cause among 15- to 19-year-olds (National Vital Statistics System, 2014; 2015).

Between 2007 and 2017, the suicide rate among 10-14-year-olds more than doubled (Lieberman & Poland, 2017). Suicide has been the second highest cause of death for youth ages 10-17 in the United States since 2010, and it is the 11th leading cause of death in children ages 5-11 (National Center for Injury Prevention and Control, 2021).

Theoretical Framework

Ideation-to-Action Theory

The ideation-to-action theory also framed this study. Using an ideation-to-action framework, multi-tiered interventions are thought to help the school-based mental health team respond more effectively and cause enough disruption in suicidal ideas that the capabilities to complete suicide are eliminated. According to the ideation-to-action theory, suicides are completed because, through the accumulation and evolution of suicidal ideas, individuals gain

the propensity and capacity to progress from suicidal ideation to suicide attempts or completed suicides. Interventions that impede the development of these abilities can introduce adequate prevention that disrupts the progression from suicidal ideation to suicidal action.

One of the most prominent Ideation-to Action theories is the Interpersonal-Psychological Theory of Suicide (IPTS) or Joiner's ITS. The Interpersonal Psychological Theory of Suicidal Behavior (Joiner, 2005) makes a conceptual connection that accounts for suicidal behavior. According to the theory, those who are capable of suicide have become so accustomed to suffering, harm, and death that they no longer fear them. They develop this condition as a result of repeated painful or unpleasant experiences, such as self-harm, recurring accidents, multiple physical confrontations, and occupations in which pain and injury are frequently encountered, either directly or indirectly. The development of the desire to die, according to Joiner's IPTS, may occur when the mental states of feeling like a burden and not belonging or being socially isolated persist for a prolonged period. According to IPTS, people commit suicide because they are able to and desire to. The theory clearly distinguishes between the ability to engage in suicidal behavior and the desire to engage in suicidal behavior (Van Order et al., 2010).

Using the IPTS or ITS framework for addressing suicidal risk behaviors in the school, the preventive efforts would include understanding and addressing students' feelings of thwarted belongingness, perceived burdensomeness, and acquired capability. ITS aligns relationships and belongingness to youth suicide risk. For comprehending teenage suicide risk, the ITS model has empirical validity (Davenport & Crepeau-Hobson, 2021). Not only does ITS provide a framework for understanding teenage suicide risk, but it also has empirical evidence as a tool for recognizing suicide risk (Davenport & Crepeau-Hobson, 2021).

ITS identifies common aspects of suicidal behavior as the relational frameworks of perceived burdensomeness, thwarted belongingness, and acquired capability (Smith et al., 2016). ITS proposition is that when feelings of perceived burdensomeness and disconnection persist, they result in a desire and capacity for suicidal behavior (Chu et al., 2017). Based on this theory, the interaction of loneliness and hopelessness increases suicidal ideation significantly.

Perceived burdensomeness refers to a person's perception that they are such a burden to others that dying would benefit them more than living. Another component of perceived burdensomeness is an element of self-hatred (Zullo et al., 2021). Joiner et al. (2002) analyzed suicide notes of successful and unsuccessful suicides. Perceived burdensomeness was the sole predictive factor of a completed suicide. Marraccini and Brier (2017) discovered that students who expressed a connection to their school were less likely to have suicidal thoughts or attempt suicide. According to ITS theory, connecting with others is critical to building a sense of belonging. This need to connect is called thwarted belongingness (Zullo et al., 2021). A multinational study of adolescents by Barzilay et al. (2019) offered evidence that students who perceived less teacher support reported higher incidents of suicidal ideation. This study supports teachers' and school-based professionals' significant role in suicide prevention. Isolation and a lack of interpersonal trust are two signs of stifled belongingness.

Public Health Approach

Social Ecological Model (SEM)

Lev Vygotsky and Kurt Lewin were major influencers on Bronfenbrenner's development of the Social-Ecological Approach to public health interventions. In the 1970s, Urie Bronfenbrenner first proposed the social ecological model (SEM), which he later developed into a theory in the 1980s. Bronfenbrenner's SEM offered a framework for comprehending the

significance of the dynamic relationship between a person and their environment and the context in which they exist (Stokols, 1996). According to Bronfenbrenner, students who grow up in negative social structures require support beyond their family and including members of their local community.

According to Bronfenbrenner's (1979) Social-Ecological Model, a student's social environment significantly impacts that student's development. Bronfenbrenner's Ecological Systems divides the student's ecological community into five systems. Students' lives are immediately affected by these five interconnected levels: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. Human development occurs within the interconnected, recursive social networks of culture, tradition, community, and policies (Trach et al., 2018). According to Bronfenbrenner, a child's future is not defined by his or her DNA but by the environment in which he or she is raised.

The cornerstone for comprehending the determinants of suicide risk factors is an ecological perspective. The SEM model considers the complicated relationships between individual, familial, community, and societal issues. It makes it easy to appreciate the diversity of factors that either raise the risk of suicide among students or protect them from having suicidal thoughts or acting on them. The systems are interconnected and have unintended effects on one another. The relationship between the SBMHP, students, and families is important.

This study investigated how a focus on SBMHP processes and role (social dynamics) can help school-based initiatives address suicide risk behaviors through effective multi-tiered interventions. Using the four levels of the social-ecological model and ecological systems theory (Bronfenbrenner, 1979), this study examined the connections between SBMHP procedures, including SRA, and the selection of multi-tiered interventions. A SEM approach considers the

SRA procedures and their effect on selecting multi-tiered interventions that promote healthy development and mental well-being.

Prevention is the fundamental premise underlying all three levels. It is essential to ensure the availability of interventions, such as professional development, competent school-based mental health experts, and family-school-community collaborations to support students across the development continuum. These aspects of the school environment serve as the basis for Tier One, Tier Two, and Tier Three interventions. It is crucial to deploy interventions across a multi-tiered system in order to provide appropriate assistance for varying degrees of suicidal risk. The goal of the support, from a social-ecological standpoint, is to enable students to be more successful in the educational environment. A SEM Model has the ability to overcome gaps in teacher training regarding their role and involve parents and the community in an active role within the tiered supports. Using an MTSS enhances the possibility that students will have access to interventions tailored to their strengths and needs.

Related Literature

Suicide

A complex network of interdependent elements influences suicidal behavior (Huber & Illle, 2002). Suicidal behavior includes both suicidal ideation, risk, and attempt. However, there are distinctions between the terms (Miller & Eckert, 2009). The phrase *suicidal ideation and suicide risk* describes when a person experiences thoughts related to the deliberate termination of life. The term *suicide plan with attempt* refers to thinking about ways to end one's life. A suicide attempt occurs when a person follows through with a plan (Pumariega & Sharma, 2018). Suicide is the willful taking of one's own life (Gold & Frierson, 2020). For this research study, all of these phrases collectively referred to suicidal behavior.

Joint efforts by the National Institute of Mental Health, American Foundation for Suicide Prevention, National Alliance on Mental Illness & American Academy of Pediatrics (2020) found that three million young people had serious suicidal thoughts and a 51% rise in reported suicide attempts among 12- to 17-year-olds, with a greater rate among young people of color. According to the American Academy of Child and Adolescent Psychiatry (2019), eight percent of high school students in the United States reported an attempt on their own lives in 2018. The cause of death for about one thousand youth in this age group was suicide (Centers for Disease Control and Prevention, 2019). From 2009 to 2018, the United States' high suicide rate among young people was a significant problem for the nation's public health. In addition to the number of young people who take their own lives, there are also many more who attempt suicide and battle with suicidal thoughts (Centers for Disease Control and Prevention, 2019).

Suicide is more common among adolescents aged 12 to 17 (Glenn & Nock, 2014; Glenn et al., 2015). Nevertheless, preliminary evidence suggests that even younger youth are exhibiting suicidal tendencies and behaviors. These youth were previously thought to be too young to contemplate or comprehend suicide. In a small study, researchers discovered that youth aged two to five attempted suicide on numerous occasions (Whalen et al., 2015).

The Web Based Injury Statistics Query and Reporting System (WISQARS) reported that the second leading cause of death for ages 10 to 14 years old (n=581) in 2020 was suicide, and the third leading cause for ages fifteen to twenty-four (n=6,062) and the tenth leading cause for ages five to nine (n=20). In 2019, almost 20% of youth had seriously considered attempting suicide, 16% had made a suicide plan, close to 10% had tried, and nearly three percent had made a suicide attempt requiring medical treatment (Ivey-Stephenson et al., 2020; National Center for Injury Prevention and Control, 2021). The prevalence of youth engaging in suicidal behavior has

been a consistent public health concern for more than 15 years (Burnette et al., 2019). Over the course of the 10 years between 2006 and 2016, in youth ages 10-19, the suicide rate increased by 30% (Whalen et al., 2021). The 2019 Youth Risk Behavior Survey (Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention, 2020) suggested that approximately 18.8% of all American high school students reported having seriously thought about committing suicide in the past 12 months. From 1991 to 2009, the percentage of high school students who reported requiring medical assistance as a consequence of a suicide attempt remained constant. In 2017, however, the percentage rose to 2.4 (Child Trends Data, 2019).

As of 2019, suicide was the fifth-leading source of death for youth aged 5 to 12. The National Institute of Mental Health (NIMH, 2021), along with the help of top experts and stakeholders, two influential national organizations, held a workshop in May 2019 that was specifically focused on reducing the risk of child suicide. A considerable increase has occurred in the number of high school students who engage in suicidal behavior. Studies have found that youth who visited the hospital emergency room with mental health issues had a three times higher risk for death by suicide or indeterminate causes (Freedman & Newton, 2020). According to 2018 figures, suicide among school-age adolescents is the leading cause of death (Ivey-Stephenson, 2020). The national suicide rate among those aged 10 to 24 increased by 57.4% between 2007 and 2018 (Ivey-Stephenson, 2020). Almost 47,000 people aged 10 and up died by suicide in 2017 (Ryan & Oquendo, 2020).

Suicidal behavior is a challenging subject to study. One of the challenges associated with research related to this subject is that individuals with active or significant suicidal behavior are excluded from clinical studies for their safety (Van Orden et al., 2010). Students who are

engaged in suicidal risk behavior are generally frightened to seek help and, hence, are less likely to receive formal therapy. Many of these services are underutilized because students are unsure of where to look or lack time to seek official help (Breet et al., 2021)

As suicide is one of the significant causes of death among American adolescents, school counselors, school psychologists, and other school-based mental health practitioners must establish standards of care or best practices in SRA. Allen et al. (2002) survey of school psychologists revealed comparable findings among school-based mental health professionals in that less than half had received training on administering SRA. However, most believed they would need to administer an SRA sometime during their career (Nickerson et al., 2021). In their study of graduate students, Cramer et al. (2013) identified a lack of training in the graduate training program as a factor in poor SRA skills.

Developmental

School-based suicide prevention should be implemented in accordance with student's developmental characteristics (Lee et al., 2018). The ability to design and carry out a suicide plan can be influenced by differences in cognitive abilities between children and adolescents (Lee et al., 2020). The risk of suicide increases with age. Childhood-age students (i.e., 5-11 years old) do not appear to be at elevated risk, while adolescents (i.e., 12 to 19) have a higher risk of suicide (Steele et al., 2018). Nock et al. (2013) examined the lifetime prevalence of suicidal ideation, planning, and attempts. The study distinguished suicidal behavior based on ideation, plans, and attempts that began at various ages. Suicidal ideation is uncommon before age 10, progressively increasing until age 12, and fast-tracking between ages 12 and 17.

Elementary students may appear more extroverted and have fewer academic difficulties. These results are consistent with prior research implicating family issues as a factor affecting

elementary children (Lee et al., 2020). As students move from elementary to high school, they are given more freedom and independence from their parents, which may make detachment more likely and conceal the awareness of impending dangers (Bridge et al., 2006).

Adolescence is a period of development characterized by a complex interplay of physical, mental, social, and emotional functioning (Bertuccio et al., 2021; Glenn & Nock, 2014). Within the first year, more than half of adolescents move from ideation to plan or attempt, and just a year after developing a plan, more than 80% of adolescents move from plan to attempt (Nock et al., 2013). The desire to kill oneself appears and disappears. The intensity of the ideation can also vary. The prevalence of episodes among adolescents is higher than among adults (Erbacher et al., 2015). If we understand how and why youth suicide risk develops, we can offer opportunities to intervene at an earlier age (Cha et al., 2018).

Studies show that teens who commit suicide have a higher chance of mental illness than the overall population. In suicide victims, however, indicators of mental illness are less common among children than among teenagers (Labuhn et al., 2021). Across youth age groups, risk factors for mental health issues, substance abuse, and capacity to manage discomfort and anxiety in social circumstances are comparable (Steele et al., 2018). During the developmental period of adolescence, economic and health-related funds, such as school-based mental health clinics, can result in greater health and a more positive social and economic environment in adulthood (Soleimanpour et al., 2022). Zhu et al.'s (2019) study on Chinese elementary school students found that middle childhood is the best period to assess the suicide risk and act to prevent it from intensifying in adolescence.

Gender and Cultural Considerations

A range of racial and ethnic characteristics have been linked to youth suicidal behavior in studies along with socioeconomic status (Miller & Eckert, 2009). People of color are underrepresented in the majority of suicide and suicidal behavior studies and understandings (Lorenzo-Luaces & Phillips, 2014). Consequently, safeguards should be adhered to while establishing acceptable norms for assessing suicide risk within cultural, racial, and ethnic groups. Using WISQARS data, high school students identifying as sexual minorities' rate of attempted suicide was nearly four times higher than the rate reported among heterosexual students. For females aged 10-24, the rate of emergency department (ED) visits for self-harm doubled in 2019 from 2001 (National Center for Health Statistics, 2022). WISQARS data on children ages one to fourteen for the year 2020 for all races and both sexes reported 601 total deaths.

According to the Center for Surveillance, Epidemiology, and Laboratory Services (2020), Females (24.1%), white non-Hispanic students (19.1%), students who reported having intercourse with people of the same sex or both sexes (54.2%), and students who identified as lesbian, gay, or bisexual had the highest prevalence estimates of students seriously considering suicide (46.8%). Suicide patterns among females and blacks have increased since 1999. The rate among black boys and girls younger than 13 was approximately two times higher than white children from 2001-2015 (Cwik et al., 2020). Researchers studied the similarities of risk factors between elementary-aged and adolescent students and found that black males with recent relationship stressors were more likely to commit suicide (Troxell Klingenbjerg, 2017). In a study of American Indians, bullying and harassment were connected to increased suicidal ideation and lifelong suicide attempts. At the same time, it has been shown that suicidal ideation and suicidal behavior increase when students feel unsafe, threatened, or lack safety at school

(Gloppen et al., 2018). According to a review of the literature, school connectedness among Hispanic and Latinx students protects them from STB (suicidal thoughts and behaviors) (Marraccini et al., 2022; 2021). Asian American and Pacific Islander youth expressed a tension between their upbringing of communal values and Western individualistic thinking, which resulted in interpersonal problems that may trigger suicidal ideation (Wyatt et al., 2015).

According to Davenport and Crepeau-Hobson (2021), gender-minority students are another vulnerable group. Suicidal behavior has increased in minority race/ethnic groups, as well as lesbian, gay, bisexual, and transgender people, according to findings. Findings in research studies among adolescents suggested that white non-Hispanic adolescents may be more likely than other racial/ethnic groups to seek treatment for suicide behavior when the threat level is low (Nestor et al., 2016).

Nestor et al. (2016) compared the rate of mental health care usage for suicidal thoughts and behavior among a nationally representative sample of adolescents reporting suicidal ideation and behavior. The researchers discovered that suicidal behavior treatment prevalence was modest across all racial/ethnic groups. The study also found that the number of adolescents who had accessed mental health professionals was consistent with previous research. Half of the sample that had attempted suicide and slightly fewer adolescents who experienced suicidal ideation without an attempt had accessed mental health professionals (Nestor et al., 2016).

Suicide Risk Assessment

SRA has been defined broadly, encompassing any activity taken to prevent, intervene with, or defer suicide (Erps et al., 2020). The three prongs of suicide include suicide, suicide attempts, and suicidal ideation. Suicide prevention refers to the efforts to prevent all three aspects of suicide from occurring. SRA is a technique for identifying and intervening with suicidal

behavior (Davenport & Crepeau-Hobson, 2021). An SRA is more comprehensive and is generally conducted by professionals with formal mental health clinical training (Cwik et al., 2020). SRA is a critical clinical skill for mental health professionals in all settings (Gold & Frierson, 2020). Early recognition and reporting of suicidal behavior is a critical step in reducing suicide deaths (Bertuccio et al., 2021).

Shannonhouse et al. (2017) study of suicide intervention training found that when teachers increased their knowledge of suicide-related interventions, they could assist the school-based mental health professional in providing a more comprehensive evaluation. A SRA is typically undertaken by a professional who possesses the additional experience to corroborate a person's suspicion of suicide (Brock & Louvar Reeves, 2018). Cramer et al. (2013) reviewed the literature and identified numerous competencies. The authors discovered agreement among numerous sources and consolidated the competencies into 10 domains. These topics are classified into clusters, including a clinician's views and approach to suicidal patients, data collecting for evaluation, treatment, and service plans, and legal and ethical considerations (Cramer et al., 2013).

There is little research on the use of SRA with students. The literature on school-based mental health professionals' standardized application of SRA procedures in the school is even more limited (Davenport & Crepeau-Hobson, 2021). Researchers have found that using a structured or semi-structured instrument to conduct a complete evaluation reduces the danger of the mental health professional overlooking essential factors that escalate or lessen the risk of suicide (Gold & Frierson, 2020).

School-Based Suicide Risk Assessments

Suicide risk assessment (SRA) was defined broadly to include any effort made to stop, intervene with, or prevent suicide (Erps et al., 2020). O'Connell et al. (2009) reported that very few school safety initiatives addressed both the prevention and management of mental health and behavioral crises. Regrettably, this is still the case almost 15 years later. After a comprehensive review of suicide prevention approaches, Van Der Feltz-Cornelis et al. (2011) concluded that tiered intervention is the most effective strategy for preventing suicide. School-based SRA differs from SRA conducted in other settings such as emergency departments, community settings, clinical offices, and other settings. The majority of school-based suicide prevention activities fall into the screening group rather than the evaluation category. Screening assists in weeding out people who are at low risk.

In contrast, an evaluation lens focuses exclusively on quantifying the seriousness of risk (Gray & Dihigo, 2015). A study of suicide intervention training found that when teachers increased their knowledge of suicide-related interventions, they could assist the school-based mental health professional in providing a more comprehensive evaluation (Nickerson et al., 2021; Shannonhouse et al., 2017). Individuals who work in schools perform a critical and vital duty known as *gatekeeper*. Because they interact with students regularly, gatekeepers often have a wealth of knowledge about their health and well-being (Youth Suicide Warning Signs, n.d.). However, the goal of SRA moves beyond gatekeeping expectations.

The goal of a school-based risk assessment is to make a referral to the appropriate resources. According to the American Foundation for Suicide Prevention, schools have two essential responsibilities in addressing suicidal behavior: identification and referral to appropriate mental health providers (American Foundation for Suicide Prevention, 2016). The appropriate

resources can confirm and develop a treatment plan (Brock & Louvar Reeves, 2018). Exner-Cortens et al. (2021) gave a checklist of themes to consider while addressing student suicide behavior at a school, including youth participation, professional limits, authorization processes, meeting practicalities, and care planning.

Schools are uniquely positioned to act as a protective factor by assessing suicidal risk behavior quickly and effectively. Schools have a crucial role in preventing suicide (Exner-Cortens et al., 2021). Additionally, accessing school-based mental health professionals is easier in the school setting than finding a clinician in the community or private setting (Nickerson et al., 2021). Bilsen (2018) reported that youth must have access to supplemental resources to manage the problems posed by risk factors. School-based mental health professional staff are considered supplemental resources.

Specific tools synthesize best practices to assist school-based workers in identifying suicide risk factors and warning signs, responding appropriately with referrals, and actively participating in the treatment plan (Brock & Louvar Reeves, 2018). To my knowledge, school-based clinicians have very few tools available to assist in synthesizing best practices in undertaking an entire SRA that includes the intervention and postvention stages. Cramer et al. (2013) reviewed the literature and identified numerous competencies associated with administering SRA. The authors discovered agreement among numerous sources and consolidated the competencies into 10 domains.

Goals of Suicide Risk Assessment

Young people are increasingly displaying suicidal tendencies, which underscores the need for schools to organize and implement comprehensive suicide prevention programs (Brock & Louvar Reeves, 2018). SRA has two objectives: to measure actual suicidality and the

likelihood of future suicidal activity (Harris et al., 2015; Joshi et al., 2015). SRA provides information on the actual risk of young people and provides information on the level of risk (Bardick & Bernes, 2007). SRA are not meant to forecast future events; instead, they are meant to combine what is known about a student with what can be learned about the student, as well as what is known about youth suicidal behaviors, such as risk factors, protective factors, and warning signs, to ensure safety, mitigate the risk of suicidal behavior, and improve wellness (Ryan & Oquendo, 2020).

SRA should help determine if a student is engaging in suicidal behavior (Brock & Louvar Reeves, 2018). A comprehensive SRA is required when suicidal behavior is indicated through prevention programs, referrals, or identification of students displaying warning signs (Crepeau-Hobson, 2013). Comprehensive screening involves asking about the risk of suicide; for example, a brief assessment of the Columbia Suicide Severity Scale asks about the reason and intent. However, most schools do not employ established screening protocols like the Columbia School Suicide Severity Brief Assessment Scale (Crepeau-Hobson, 2013).

SRA best practices for deciding whether to keep students in school or send them to hospitals include evaluation of thoughts, intentions, and suicide plans (Erbacher & Singer, 2018). Identifying risk factors, warning signs, and protective factors is essential to assess the risk level of suicidal behavior (Ryan & Oquendo, 2020). Suicidal thoughts, plans, behaviors, mental health reviews, psychological symptoms, historical suicidal conduct, current stressors, strengths, protective factors, precipitating events, and the child’s notion of death should all be documented. The responses of the student’s support system should all be assessed as part of a school-based SRA (Crepeau-Hobson, 2013).

Challenges with Suicide Risk Assessment

One risk associated with conducting SRA is the lack of appreciation for the severity of the risk (Ryan & Oquendo, 2020). A benefit of conducting SRA is the opportunity for engagement between the student and the school-based professional (Ryan & Oquendo, 2020).

When conducting assessments, it is essential to ask the right question. Adolescents tend to limit the information they provide to adults conducting the assessment. Screening tools can ensure that specific questions are asked to reach accurate results (Gray & Dihigo, 2015; Nickerson et al., 2021). Students may not voluntarily report suicidal thoughts in the absence of explicit inquiry, especially in the company of their parents (Steele et al., 2018). It is crucial to analyze the student's apprehension of death or their exposure to experiences that could make them less sensitive to death. Additionally, it is critical to check the student's physiological health, as hyperarousal from exhaustion, agitation, and other factors elevate the likelihood of suicide ideation (Steele et al., 2018). Once suicidal risk behaviors have been identified in students, it is imperative to focus on further evaluation (Gray & Dihigo, 2015).

There is no way to identify with complete certainty individuals contemplating suicide (Ryan & Oquendo, 2020). Screenings and assessments are not flawless. Screenings and assessments often lack specificity in the screening process, leading to over-identification of students. However, studies found support for the ability of screenings to identify students at the most elevated level of need (Scott et al., 2009). Cwik et al. (2020) noted that adolescents with suicidal ideation typically do not seek help. This lack of assistance-seeking highlights the critical role of school-based workers in being attentive and knowledgeable on risk factors and appropriately reacting to risk assessments.

Safety plans have been used as interventions for students not in imminent danger. While safety plans are considered the standard of care in most outpatient and emergency settings, they are less prevalent in schools (O'Neil et al., 2021). A safety plan will include six main elements. It is noted that a safety plan is different from a no-suicide contract (Gray & Dihigo, 2015). An important feature of safety plans includes students' transition or return to school and a partnership with parents or a support system outside the school. A safety plan can include coping strategies, identifying support and emergency contacts, increasing awareness of fatal means and keeping them out of reach, and strengthening parental monitoring and supervisory presence (O'Neil et al., 2021). An examination of the current body of literature uncovered limited data regarding the execution of school safety plans. The National Association of School Psychologists (NASP, 2015) endorses using safety plans when intervening with students at risk of suicide in the school setting. Safety planning includes an often vital piece of intervening with suicidal behavior that is parents.

Parents' perceptions of the problem are another area that can present hurdles to the SRA follow-up process. Frequently, parents minimize the problem and dismiss the concerns as not significant. The key to mitigating those barriers is educating the parent and student regarding the seriousness of the risk factors (Gould et al., 2009). Follow-up care after identification of a student at high risk is an area where most SRA are deficient. This step is critical as students are most likely returning to a vulnerable state (Nickerson et al., 2021). Literature supports that schools and suicide prevention programs and interventions lack a systematic assessment of whether at-risk students have accessed services after their identification by the school-based intervention (Gould et al., 2009).

Competency in Suicide Risk Assessment

The phrase "standard of care" describes SRA procedures that are regarded as the gold standard in the field since they are founded on a clinician's education, expertise, and involvement in empirically supported SRA research. The terms "standard of care" and "gold standard" are interchangeable in the context of interventions (Simon, 2011). Researchers and practitioners have extensively recorded the need for competency-based training and the shift towards this type of training in various psychology domains, including clinical practice (Szlyk, 2021). However, there is not yet a list of specific actions and skills needed in assessing the risk of suicide. To close this gap, key researchers and organizations in the field have created a list of key capabilities for assessing the risk of suicide (Erbacher & Singer, 2018). Through the list of core competencies, they can get the theoretical realm to reach the foundation of SRA-specific practice, maintaining a collaborative and unjudgmental stance, obtaining warning signs, risks, and evidence-based protective factors, complete documentation, and knowledge of suicide law (Freedman & Newton, 2020). It is critical for school-based professionals to be competent in the warning signs associated with suicidal behavior, especially since students may not always approach adults to talk about suicidal thoughts they may be experiencing (Bertuccio et al., 2021). Manning et al. (2018) found evidence suggesting that risk assessments may not provide any additional insights compared to the clinical judgment of experienced mental health professionals. This data emphasizes the significance of competent school-based professionals. Similar to previous research, Alonzo et al. (2022) provided evidence that teaching professionals' empirically based skills can improve knowledge and comprehension of SRA utilization, including preparedness and response (Kubota et al., 2016; McNiel et al., 2008).

Maintaining a Collaborative, Nonjudgmental Stance

The first core competency area deals with the professional establishing and fostering a compassionate attitude. Utilizing a collaborative and nonjudgmental stance is essential for healing relationships, but that becomes even more pronounced when mental health professionals encounter a suicidal client. Mental health professionals working with clients with suicidal ideation have been noted to show strong reactions (e.g., anxiety, fear, anger, resentment, shock, insufficiency, anxiety) (Cramer et al., 2017). These thoughts and emotions can have an adverse effect when dealing with students exhibiting suicidal conduct (Substance Abuse and Mental Health Services Administration, 2020). All of these, among other things, negatively impact clients' relationships and outcomes. Therefore, school-based mental health professionals need to be aware of the situation and respond in a compassionate, unjudgmental way so that they can make improvements that allow them to control their response to students with suicidal behavior. Researchers and organizations studying suicide have emphasized the significance of cultivating a cooperative and understanding therapeutic connection when working with clients who are at risk of suicide (Cramer et al., 2017).

Knowing and Eliciting Evidence-Based Factors Associated with Suicide

The second area of SRA competency is possessing the knowledge and capacity to comprehend the intricate elements that form the foundation of SRA. These elements are supported by evidence indications, factors associated with risk, and preventative factors (Substance Abuse and Mental Health Services Administrations, 2020). Failure to inquire about the client's suicidal ideation and the contributing reasons may impede the client's ability to reveal such information. The sharing of this information may be contingent upon the student's request of school-based mental health providers. It is crucial for specialists working with individuals at

risk of suicide to comprehend the components that lead to their susceptibility to suicide, as this has significant ramifications. They have the ability to gather these factors from the students they serve. Some of the risk variables that have been substantiated by suicide research, as well as theories, include but are not restricted to, prior attempts at suicide (Nolta, 2014).

Comprehending the elements that can safeguard individuals against suicide, such as social support, active engagement in therapy, and healthy familial connections, is of utmost importance. Although multiple elements contribute to the complexity of various interrelated aspects, including family history, psychological functioning, and social circumstances, it is crucial to have knowledge and awareness of these risk factors for effective prevention (Bilsen, 2018; Van Heeringen, 2001).

Understanding these aspects is crucial. However, specialists in this field concur that only being aware of the warning signs, hazards, and preventative factors of suicide is insufficient. The National Center for Injury Prevention and Control (NCIPC, 2015) states that SBMHPs should be knowledgeable about the methods of acquiring these factors from a client who is at risk of suicide. One way to summarize these elements is by using precise terminology, such as "suicide attempt" and "self-harm," to make certain individuals have a clear understanding and agreement. Focus on examining the client's suicidal thoughts rather than the conflict. Provide clients precise feedback and improvements (Brock & Louvar Reeves, 2018). Be aware of honest, candid, nonverbal signals that normalize client sentiment (e.g., client presence, stressful speeches, hesitation), maintain a non-aggressive, unjudgmental attitude, and show patience and comfort (Brock et al., 2021).

Determining Client's Level of Risk

Another important competency area is the ability to determine the level of suicide risk of the client (Calati et al., 2020). Such decisions can immediately impact clinical decisions about what SBMHP can or should do to keep clients safe. Risk levels frequently fluctuate abruptly and surprisingly (Gold & Frierson, 2020). Determining the level of immediate risk is an important step in SRA, but determining the level of immediate and chronic suicide risk in a person represents a paradigm shift in the field of suicide (Casiano et al., 2019). Opinions of newly developed theoretical experts' preliminary research show significant differences between acute and chronic risks. These theories use aspects from the three-step theory, the fluid vulnerability theory, the suicide motivation model, and the suicide personality theory to distinguish suicides from suicide attempts and/or death (Calati et al., 2020). Together with protective factors and various warning signs to help combine risk factors, it is an easy-to-understand differentiation of risk.

Another advantage of a standardized risk assessment, in addition to the simple approach, is to use empirical studies to identify which risk factors are more important in the client's current risk situation, including a history of suicide attempts. Self-harm is one of the strongest predictors of future suicide attempts and mortality (Van Meter et al., 2018). As a result, standardized risk assessments often emphasize the presence of risk factors.

Thorough Documentation

Another competency is the complete documentation of the risk assessment, including clients' responses. These conversations and discussions need to be recorded in detail. This ability serves three important functions, and perhaps most important is client safety and documentation (Wortzel et al., 2017). The complete document should be able to draw a clear picture of the

factors contributing to the client's suicide risk. By documenting the ascertained information, SBMHP can obtain the information later (Van Meter et al., 2018). Cafferty et al. (2022) reported that roughly 54% of the 220 charts analyzed in their investigation of the reporting of youth suicide risk factors lacked documentation of suicide risk factors. The findings supported using a standardized method, such as an SRA, for identifying suicide risk.

Ultimately, this will improve student performance (Wortzel et al., 2017). Mental health professionals can be accused of negligence if a client attempts suicide or dies from care, so documentation is critical. However, many sources say that all documentation of risk assessments and clinical decisions is the best defense against accusations. It is very difficult to prove in court without documentation to confirm these actions. Complete documentation protects the best interests of the student (Singer, 2017).

The Laws Concerning Suicide

Another area of competency in SRA is understanding the law regarding suicide. Standards and cases of potential confidentiality breaches vary from state to state (Szlyk, 2021). In addition to individual state law, SBMHP are expected to recognize and comply with the American Psychological Association's standard care and ethical obligations when working with suicidal clients, such as recognition of warning signs (risk factors and protective factors) and effective treatment guidelines (Turecki et al., 2019).

Although school-based mental health specialists are unlikely to make independent decisions about students' suicidal behavior intervention, the school has an ethical and legal role in safeguarding students' safety and welfare. The school must consider the following factors: (a) evaluating the risk of suicide once it is suspected, (b) alerting parents, (c) intervening as part of a valid response to prevent harm, (d) linking students and families to relevant services, (e)

education for school personnel, and (f) planning and implementing policies and protocols on suicide prevention, intervention, and postvention (American Foundation for Suicide Prevention, 2022a). Understanding the legal and ethical issues associated with suicide is an important ability for suicide agents. Mental health professionals need to understand state laws regarding suicide and legal challenges that are difficult to protect as a result of nonexistent or incomplete documents (Van Meter et al., 2018).

Suicide Risk Assessment Training

A component of all comprehensive suicide prevention initiatives is ensuring that professionals' skills are properly developed (Gold & Frierson, 2020). Current evidence of the effectiveness of SRA training is limited to medical education programs (mainly psychiatry) that deal with outcomes such as learner abilities and subjective confidence in psychiatry. Ryan & Oquendo (2020) conducted a study of mental-health professionals training. The types of training used in that study included intensive three-hour workshops, one- to two-day workshops, or six to eight hours of training; some overtime was split into sessions (Ryan & Oquendo, 2020). Subjective data suggest that training increases mental health professionals' confidence in accuracy in risk estimation and management planning. However, other available data suggest that these effects may be temporary. In the most comprehensive review of workshop-based SRA training, Poland and Ferguson (2022) concluded that these workshops generally showed desirable results for suicide. Work is needed to improve suicide care and prevention (Singer, 2017). Other assessment mechanisms, such as training in SRA and intervention planning, have been shown to improve the quality of interviews and documentation.

However, due to some limitations, it is difficult to assess the effectiveness of a SRA training program. The most obvious drawback is the lack of another dependent means of

preventing suicide (Singer, 2017). Therefore, it can be difficult to assuage this issue due to low base rates and other methodological concerns. Clinical/counseling psychologists and medical professionals face many of the same issues when assessing risk. However, certain specialized issues need to be included in the training of psychology trainees [e.g., evidence-based psychological evaluation, psychotherapy of suicide tendency] (Sisler et al., 2020). However, only one study supported that conclusion. Evidence-based SRA training improves competence and self-confidence among clinical psychology students. However, this training program was only available in a military environment.

There are additional methodological issues. For example, many software ratings have no comparison group or relatively small comparisons, although long-term information has been gathered about the effectiveness of such programs (Shannonhouse et al., 2017). The lack of comparison groups limits the ability of researchers to conclude that their ability to perform effective SRA derives from a particular training experience rather than other learning opportunities, inconsistent content, and training methods. Little emphasis is placed on evidence-based core competencies for risk assessment. Their abilities vary greatly when competency-based training is conducted (Sisler et al., 2020). They need to define a brief list of core competencies for a short but comprehensive training. An additional disparity is that some programs use psychology workshops and role-playing. Some programs use more complex, illustrated or illustrated interview strategies.

School-Based Mental Health Professionals

School mental health services are delivered by a variety of professionals, including school counselors, school psychologists, school social workers, school nurses, and special education teachers (Mellin et al., 2011). Although many SBMHP engage as individuals within the school

building, MTSS cannot operate independently. The effectiveness and longevity of MTSS are directly related to collaboration. The success of MTSS requires that SBMHP understand both teamwork and the function of MTSS (Brown-Chidsey & Bickford, 2015).

School-based mental health professionals' knowledge of suicidal behavior and utilization of standardized procedures for undertaking suicide risk assessment and tiered interventions are crucial to addressing the suicidal behavior crisis. When procedural standards are based on best practices and correlate with standard evaluation procedures, the process of providing interventions to students exhibiting suicidal behavior can be improved (Boccio, 2015). In the school environment, individuals with specialized mental health knowledge are best suited to conduct suicide risk assessments (King et al., 2013). However, teachers and parents have a vital role in providing support for students at every tier of suicide prevention.

School psychologists and other school professionals play a critical role in addressing suicidal behaviors (Brown et al., 2018; Nickerson et al., 2021). However, many school-based mental health providers lack the skills to address crisis responses such as SRA (Erps et al., 2020). A study of school-based counselors and nurses notes that minimal research has examined suicide awareness among these school-based professionals (Decou et al., 2019). SBMHP play a critical role in addressing suicidal behaviors (Brown et al., 2018; Nickerson et al., 2021) including depressive symptoms (Arora et al., 2019; Lyon et al., 2014). The presence of mental health services in schools is associated with a lower likelihood of suicide ideation and attempts (Paschall & Bersamin, 2018). Furthermore, a decrease was observed between schools that expanded mental health service availability and schools that did not improve mental health service availability (Paschall & Bersamin, 2018).

Minimal resources are available to assist SBMHP in identifying the most appropriate evidence-based intervention to implement within a school-based MTSS framework. However, almost half of the young people identified with an elevated risk level of suicide attend school (Marina et al., 2019). School staff and school-based mental professionals can be trained to identify and respond to adolescents' suicide risks (Martinengo et al., 2019). Decou et al., (2019) study of school-based counselors and nurses found that comfort levels in providing suicide prevention interventions were increased with training. While various measures exist to assess children's suicide risk, standardization among school-based experts is unclear and varies by specialist. SBMHP have much fewer resources and knowledge in the application of multi-tiered interventions.

Effective assessment requires an understanding of the problem. While various measures exist to assess children's suicide risk, standardization among school-based experts is unclear and varies by specialist. Another obstacle to implementing treatment and best practices standards is the absence of competencies among many school-based mental health providers to address crisis responses such as SRA (Erps et al., 2020). Davenport and Crepeau-Hobson (2021) investigated school-based mental health professionals in Colorado and discovered inconsistency in the use of standardized SRA methods in the school setting. Schmidt (2016) discovered that mental health practitioners who did formal suicide assessments with students, as opposed to unstructured, nonstructural interviews, felt better equipped to do so.

SRA should use a multidisciplinary team to deal with a difficult situation that includes elevated anxiety levels. Cornell's (2020) study of threat assessments found several advantages to a multidisciplinary team, including multiple perspectives, a wider range of information, and multiple resources for interventions. School psychologists and other school professionals play a

critical role in addressing and reversing high suicide rates by implementing best practices and creating standards of care. Standardization of risk assessment best practices can be thought of as the profession's gold standard. These standardizations should define what most counselors consider best practices and incorporate them into their daily practice (Granello & Witner, 2011). There is currently no empirical consensus regarding the best parameters or specific methods necessary for suicide risk prediction (Wortzel et al., 2017).

Cwik et al. (2020) noted that adolescents with suicidal ideation typically do not seek help. This lack of assistance-seeking highlights the critical role of school-based workers in being attentive and knowledgeable of risk factors and appropriately reacting to risk assessments. Given the critical role, school-based professionals can have in intervening and providing postvention support for students presenting with suicidal behavior through implementing therapeutic standards of care and established protocols (Cwik et al., 2020). Studies found that students were 21 times more likely to visit school-based versus community-based centers for mental health issues (Nickerson et al., 2021). Gould et al. (2009) study of at-risk students' utilization of services found that two-thirds of students reporting severe suicidal behaviors, mental health issues, and substance usage were not receiving services. These students were identified in a school-based screening.

Procedures in SRA

Certain features of suicidal risk behaviors are difficult to assess, even more so when the procedures within the SRA are flawed due to insufficient data gathered through poor procedural methods or clinician incompetence (Gould et al., 2009). Additional consequences of poor SRA preparation include no-suicide contract, unnecessary hospitalization, and other ineffective and potentially dangerous behaviors (Monahan & Karver, 2021; Ryan & Oquendo, 2020). According

to Davenport and Crepeau-Hobson (2021), school districts can substantially affect the development and implementation of standardized practices for conducting SRA among school-based mental health providers.

Assessment tools are recommended in the screening and follow-up treatment process of SRA (Van Meter et al., 2018). Scientific evidence supports that assessment should use well-validated assessment tools with methods that measure and manage risk and uncertainty associated with suicidal behavior (Boccio, 2015; Van Meter et al., 2018). To evaluate the imminent danger threatening students, screenings should use standardized and established procedures (Freedman & Newton, 2020). Validated assessment instruments can be helpful in recognizing and mitigating suicide risk among young people (Horowitz et al., 2009). Scott et al. (2009) found that using school-based suicide screening tools could identify students at high risk for suicide. Scott et al.'s (2009) findings suggested that the absence of using the screening tool would have missed a large portion of students.

A study of the practical training component to increase suicidal behavior knowledge among school-based mental health professionals found that standardized procedures and documentation templates were beneficial (Nickerson et al., 2021). In a clinical setting with youth participants, Ngai et al. (2021) demonstrated that a tool used expressly to identify suicide risk increased the predictability of the measurement instrument used to identify a positive suicide risk. Ryan and Oquendo (2020) noted that the benefits of using a structured tool along with clinical skills such as interviewing and diagnostic competencies are the optimal ways to establish guidance following an SRA, along with following a consistent and process-orient procedure that integrates risk and protective factors into the referral and follow-up services (Gould et al., 2009).

A decision tree to assist in assessing suicidal behavior was developed by the Western

Interstate Commission for Higher Education and the Suicide Prevention Resource Center. The decision tree outlined that the first step was identification and assessing the risk severity (Gray & Dihigo, 2015). The Columbia Suicide Screen (CSS) is designed to assess suicide risk. It is a self-report questionnaire comprised of 11 questions embedded in a health survey (Scott et al., 2009). The CSS is designed to assess suicide risk. It is a self-report questionnaire comprised of 11 questions embedded in a health survey (Scott et al., 2009). The Columbia Suicide Severity Rating Scale (C-SSRS) is used to differentiate between suicidal thoughts and suicidal attempts.

Other semi-structured interview tools appropriate for the school setting include the Student Interview for Suicide Risk Screening and the Brief SRA (Boccio, 2015). The Mood and Feelings Questionnaire (MFQ) and the Treatment Emergent Activation and Suicidality Assessment Profile (TEASAP), both of which are suited for students aged 7 to 17, are additional suicide screening instruments (Heise et al., 2016). The Children and Young People-Mental Health Safety Assessment Tool (CYP-MH SAT) is a measurement tool used to identify the immediate risk of self-harm and suicide in children and young people (10-19 years) in acute pediatric hospital settings (Manning et al., 2018). The Student SRA Protocol (SSRAP) uses a collaborative approach and integrates major risk factors and warning signs identified in research to identify suicidal behavior in young people (Boccio, 2015). Another essential step in the SRA process is documentation.

Documentation reduces liability (Boccio, 2015) and records evidence of parental concerns and involvement. Van Meter et al. (2018) discovered that using only two questions to identify suicidal risk behavior was sufficient. Adolescents may be more likely to disclose suicidal behavior through a self-report method versus disclosing it to an adult (Van Meter et al., 2018). Schools, families, and community mental health agencies can benefit from the collaborative

efforts gained from SRA screening (Scott et al., 2009). In contrast, a recent study by Gratch et al. (2022) provided evidence in favor of using multi-item assessments for SI. They discovered that a single-item test failed to detect two-thirds of teenagers who presented with static SI. These findings are consistent with other studies that underscore the need for a comprehensive SRA technique.

SRA techniques often contain a question to ascertain risk variables and prior suicidal conduct (Joshi et al., 2015). SRA are more comprehensive and generally conducted by professionals with some level of formal mental health training (Cwik et al., 2020). SRA are typically undertaken by a professional who possesses the additional experience to corroborate a person's suspicion of suicide (Brock & Louvar Reeves, 2018). Techniques for risk assessment should not be used in isolation but in conjunction with structured instruments (Wortzel et al., 2017). Due to a lack of preparedness in SRA skills, inappropriate and highly risky procedures may be utilized (Monahan & Karver, 2021).

A study by Heise et al. (2016) highlighted the importance of supplementary measures in conjunction with screening instruments. They emphasized that individual screening tools are insufficient since they provide limited information. However, the screening tools assist in identifying issues and determining when a referral to a local or specialist mental health practitioner is necessary (Heise et al., 2016). Tier-two and tier-three services provided in schools could be integrated into a comprehensive mental health assessment and treatment plan, enhancing the potential to strengthen SRA by establishing a therapeutic relationship (Wortzel et al., 2017) and professional collaboration with community resources. This relationship and collaboration would enable the identification of relevant intervention targets and potentially prevent an act of suicide (Wortzel et

al., 2017). The use of collaboration across a multidisciplinary team is highlighted.

Risk Factors, Protective Factors, and Warning Signs

There is room to improve school-based responsiveness by broadening the filter through which we examine what fits the criteria for suicidal risk factors. If all suicide prevention efforts are directed toward preventing suicide, students who exhibit suicidal thinking and behavior will be underserved and, in some cases, overlooked. Shifting the focus from risk factors to the different mechanisms related to suicide behaviors is needed (Zullo et al., 2021). Risk factors are important but only in the context of the student's life.

Although no risk factors are directly linked to a decisive certainty about suicide, knowing the risk and protective factors is crucial to deciding the risk severity (Van Meter et al., 2018). Understanding and identifying these risk factors is essential for prevention, although many factors contribute to and illustrate the complexity of interwoven genetic, biological, psychological, and social aspects (Bilsen, 2018; Van Heeringen, 2001).

In research comparing the use of a screening measurement tool to observations by school-based professionals, the professional's identification of high-risk students was equivalent to the screening measurement tool's identification of high-risk students (Scott et al., 2009). School-based professionals can be *mindful* and hyper-vigilant when observing cues from students. These risk factors include verbal and nonverbal gestures.

Risk Factors

Few studies have been conducted to discriminate between the factors that affect high-risk and low-risk students. Understanding how risk factors such as social influences, recent trauma, and affective reactions influence adolescents' vulnerability to suicide is critical for school-based mental health practitioners (Steele et al., 2018). The American Academy of Child and

Adolescent Psychiatry noted that adolescents' most significant risk factor is unidentified or untreated mental illness (AACAP, 2019). Risk factors are biological, psychological, familial, community, or cultural variables that underlie and are associated with an increased risk of adverse outcomes (Substance Abuse and Mental Health Services Administration, 2019). Wishing to live no longer, despair about the future, perceived burdensomeness to others, diminishing pleasure or enjoyment in activities, and pervasive misery are all less explicit risk factors for suicide (Picard & Rosenfeld, 2021). Suicide risk factors are often persistent and can keep an open door for an individual to act suicidally (Joiner, 2009). The literature on risk factors has highlighted two categories: static and dynamic. Static risk variables are qualities that remain unchanged or stable over time, whereas dynamic risk factors change over time (Steele et al., 2018).

Sleep deprivation is a risk factor that was not mentioned in the past and is well-recognized in the scientific literature as a factor in suicidal behavior. Goldstein and Franzen (2022) discovered a tiny but statistically significant cyclical connection between sleep disruption and suicide fatalities in teenagers. A combined investigation revealed that sleep-deprived teenagers were more likely to have suicidal thoughts, intents, and attempts (Liu et al., 2019). Sleep risk factors include reduced sleep, insomnia, and nightmares (Turecki et al., 2019). Social conflict is regarded as a risk factor, particularly strained peer relationships produced by incongruent cultural standards and prejudiced teacher expectations, which can lead to academic and relationship problems (Marraccini et al., 2022;2021).

Students in high school are more likely to engage in suicidal behavior as a result of the stressors associated with this stage of development, such as an inability to adapt to increased work, bullying, a lack of interpersonal skills, and the stigma associated with seeking help for

mental health issues (Breet et al., 2021). There is a strong correlation between depression and youth suicide attempts, according to research on adolescent suicide attempters and youth experiencing suicidal ideations; only insofar as stress and depression and other mental health indicators were interconnected was a relationship established between attempts and ideations (Stewart et al., 2019).

The majority of what is known about suicide risk factors was derived from empirical studies examining a history of psychiatric disorders as a risk factor for adolescent suicide. In a study of elementary and adolescent students, ADD/ADHD was more prevalent among younger children (Troxell Klingenbjerg, 2017). In recent years, bullying has emerged as a significant risk factor. Students who have been bullied or cyberbullied are more likely to engage in suicidal behavior, according to researchers (Crepeau-Hobson & Leech, 2016; Davenport & Crepeau-Hobson, 2021; Hinduja & Patchin, 2010). Goldston et al. (2016) investigated the developmental trajectory of suicidal thoughts and behaviors from youth to adulthood. The researchers found that sexual abuse was a major predictor of a very high risk for suicidal ideation and conduct. These findings highlight the significance of recognizing warning signs, risk factors, and protective factors that may be associated with sexual abuse when working with students.

Protective Factors

Protective factors can considerably lower the prevalence of suicide behavior and boost the capacity of students to interact safely in the educational environment (Steele et al., 2018). Suicide prevention efforts are concentrated on reducing risk factors and strengthening protective factors that are most closely associated with suicidal behavior. Just as risk factors derived from biological, psychological, familial, community, or cultural variables elevate the likelihood of poor results, protective factors decrease the likelihood of poor outcomes.

Protective elements should mitigate the likelihood of negative consequences. Although there is less research on protective variables, they are equally important in reducing the likelihood of a tragic outcome (Gold & Frierson, 2020). Risk and protective variables are likely to fluctuate throughout time (Substance Abuse and Mental Health Services Administration, 2019). Maintaining awareness of these changes is critical for students as peer groups and adverse childhood experiences (ACEs) are two factors that may lead to an increased or decreased risk of suicidal behavior, respectively, and both of these factors have a high likelihood of change.

Moving beyond recognizing the risk factors, the school professional can identify and discuss protective factors through open discussion of suicidal behavior (Boccio, 2015). The emphasis is shifted from risk factors to protective factors, which highlights the importance of school-based professionals as critical components in school-based suicide prevention. Other protective factors include uncovering the student's motivation for engaging in suicidal behavior or, more importantly, their reason for living (Boccio, 2015).

The school environment, excellent teacher-student interactions, strong family support, and school connectedness through socioemotional/socialization groups and activities with similar peers have all been identified as protective variables in the school setting that can help prevent or temper the expression of suicidal behavior (Benbenishty et al., 2018; Davenport & Crepeau-Hobson, 2021; Joiner, 2009; Madjar et al., 2018; Sulkowski & Simmons, 2018). Access to family and social support are considered protective factors. Participation in treatment, family obligations, child-related concerns, strong religious convictions, and cultural perspectives against suicide are also protective factors (Gold & Frierson, 2020). Athletic activity, positive friendships, and general enthusiasm for school (Steele et al., 2018) are among the protective factors that school-based mental health clinicians can examine while conducting an SRA.

Warning Signs

When a risk is forwarded, the position of behavior is no longer regarded as a factor but rather as a warning sign (Davenport & Crepeau-Hobson, 2021). Warning signs differ from risk and protective factors in that warning signs indicate that the behavior is happening. Warning signs are more likely to indicate probable engagement in risky suicidal behavior (Bertuccio et al., 2021). Warning signs include sudden behavior changes, changes in school functioning, social isolation, and preoccupation with themes of death and dying (Davenport & Crepeau-Hobson, 2021; King, 2006). Staff at schools must be equipped to identify warning signals of suicidal behavior. Staff should watch for specific suicidal indications, such as student communication and behavior (Brock et al., 2021).

Another warning sign is Non-Suicidal Self-Injury (NSSI), which is linked to a person's acquired capability for suicidal behavior. The presence of NSSI among youth is the distinguishing factor between youth who attempt suicide, youth who have suicidal ideation, and youth who do not engage in any type of suicidal behavior (Davenport & Crepeau-Hobson, 2021). A collection of researchers and specialists from throughout the country have compiled a list of warning indications for healthcare professionals and gatekeepers to observe. This list includes cases in which students contemplate or attempt suicide, express pessimism about the future, exhibit overwhelming and substantial emotional pain and distress, and exhibit problematic behavioral signs along with the student experiencing substantial changes in social relationships/situations, such as withdrawing from others, sleep patterns, out-of-character aggression and hostility, and a noticeable shift in agitation or anger (Youth Suicide Warning Signs, n.d.).

Postvention

Postvention is the coordinated intentional response after a suicide that helps individuals recover and grieve from the impact of suicide loss, reduce additional suicide-related harm, or reduce further suicide-related harm to those considered high risk (Survivors of Suicide Loss Task Force, 2015). More than half of the respondents to O'Neill et al. (2020) study on school psychologists' suicide postvention practices reported having little awareness about, readiness for, or competence in suicide postvention. Protocols for postvention are an essential aspect of suicide prevention (Diefendorf et al., 2022).

Cox et al. (2016) identified 20 core specific actions for school suicide postvention. The actions included the establishment of emergency response plans and teams. Procedures for activating the team, managing suspected school suicides, and notifying relatives, students, and the community are among the actions aiding those at high risk, as well as anyone who has been impacted. Monitoring, documentation, prevention, critical incident procedures, and protocols for communication, such as the Internet and social media, are considered components of the procedure (Cox et al., 2016). "Suicide in Schools" (Erbacher et al., 2015) and "After a Suicide: A Toolkit for Schools" (American Foundation for Suicide Prevention, 2018) provide guidance on best practices. After a student commits suicide, it is critical for schools to respond promptly and appropriately, avoiding the dissemination of misinformation and providing information about the types of reactions students may experience and can anticipate when dealing with grief and loss, as well as where to seek support (Diefendorf et al., 2022).

Risk Severity of Suicide Risk Assessment

Suppose a student has an elevated rating for suicidal behavior during an initial preventive screening. In that case, it is crucial to follow up and document the degree of seriousness,

including the severity, frequency, and actual intent of the behavior (American Academy of Child and Adolescent Psychiatry, 2019). It is vital that the management of suicide risk be carried out in the least prohibitive manner possible while still ensuring students' safety (Steele et al., 2018). After initiating the risk assessment, the next step is determining the risk level and considering interventions, including a safety plan. Risk levels are categorized as low, moderate, and high or mild, moderate, and high (Brock et al., 2021; Gray & Dihigo, 2015). A literature review noted that others categorize these levels as primary, secondary, and tertiary prevention (Crepeau-Hobson, 2013). The capacity of schools to accurately assess and intervene in suicide risk is a strong predictor of whether schools utilize systems to select responsive interventions or referrals to prevent suicide (Marracini & Brier, 2017).

Based on a public health model, categorizing the level of the risk into primary, secondary, and tertiary prevention allows for appropriate next steps (Brock & Louvar Reeves, 2018). Some schools place risk levels within their socioemotional multi-tiered support system and stratify the classification tier one, tier two, and tier three (Arora et al., 2019). Tiers integrate incremental procedures, which govern the methods while delivering services to pupils and are based on a prevention framework (Torres-Pagán et al., 2022). Tiers assist school-based mental health professionals communicate students' risk to administrators, community mental health professionals, hospitals, and parents (Erbacher et al., 2015).

Multi-Tiered Interventions

The Every Student Succeeds Act (ESSA) served as a catalyst for schools to integrate comprehensive psychological services into a MTSS. The MTSS is a research-based paradigm for efficiently integrating several systems and services to address differentiated student needs, such as suicide risk (National Association of School Psychologists, 2016). One of MTSS goals is to

increase students' chances of succeeding socially, emotionally, behaviorally, and academically by utilizing a triangular three-tiered framework to provide evidence-based interventions, programs, and support to students in general education (Schaffer, 2022). MTSS provides services on tiers centered on presenting concerns and intervention degrees. Intervention intensity frequently determines resource allocation (Arora et al., 2019). Behavioral and mental health services are a part of the tiered learning models that school psychology and the field of education have incorporated, such as response to intervention, school-wide positive behavior support, and interconnected systems framework (Splett et al., 2013). According to the American Foundation for Suicide Prevention (American Foundation for Suicide Prevention, 2022b), suicide interventions can generate a considerable interruption during a suicidal crisis, increasing a person's chances of preventing suicide.

Suicide prevention programs should include four health components: prevention, education, intervention, and postvention (Joshi et al., 2015). Suicide risk screenings are a critical element of preventive activities (Gould et al., 2009). Suicide screenings prove a quick and effective identification of students requiring a more in-depth assessment. Screenings should employ standardized and validated tools to determine immediate risk (Freedman & Newton, 2020). SRA differs from the universal suicide prevention interventions that are typically part of a school-based tier-one strategy. Suicide risk screenings are sensitive to recognizing students at risk (Gould et al., 2009). Screenings are different from gatekeeper educational and informational efforts that are often part of tier-one, school-based universal suicide prevention interventions. Screening moves beyond providing information and education by asking students directly via self-report (Gould et al., 2009).

Heise et al. (2016) findings supported a number of suicide risk screening instruments, including clinician-guided interviewing, parent response instruments, and child self-reporting instruments. According to the researcher, conducting clinically guided discussions requires time and specific expertise (Heise et al., 2016). Suicide risk monitoring provides a procedure to monitor students who have been assessed and determined to have a low, moderate, or high suicide risk (Erbacher et al., 2015). According to Erbacher et al. (2015), suicide risk monitoring should only be applied to students who have had a comprehensive SRA.

Evidence supports that students who require interventions beyond universal or tier-one preventative interventions and meet the criteria for more comprehensive actions in the SRA process are best evaluated using a combination of trained specialists and risk assessments (Manning et al., 2018). There is currently no empirical consensus regarding the best parameters or specific methods necessary for suicide risk prediction (Wortzel et al., 2017). Given the critical role, school-based professionals can have in intervening and providing postvention support for students presenting with suicidal behavior through implementing therapeutic standards of care and established protocols. In a study of multi-tiered interventions, risk factors such as depression, anxiety, at-risk (not clinical) emotional and behavioral issues, and broad mental health issues showed a discrepancy between Tier 1 and 2 interventions and Tier 3. The limited research available supported several Tier 1 and Tier 2 interventions for symptoms of depression, anxiety, at-risk emotional and behavioral factors, and broad mental health issues (Arora et al., 2019).

However, interventions specifically for suicidal behaviors, such as hopelessness and perceived burdensomeness, were absent. Students' experiences can vary greatly. Therefore, the experience of risk and protective factors that occur in actual practice as it relates to suicidal

behavior is paramount to developing an appropriate response in addition to elucidating any gaps between actual practice and research in suicidal behavior prevention.

Tier One: Primary Classification

Tier-one strategies encompass the general student population and are considered universal preventive measures. These students may have fleeting thoughts that are not impactful to their everyday routines, no concrete plans or intentions, minimal risk factors, and apparent protective factors (Erbacher et al., 2015). Tier-one strategies correlate with students screened at the mild or low-risk level. Tier-one interventions are primary in nature and include psychoeducation and increasing awareness of suicide. Other strategies included in tier-one interventions are teaching appropriate responses and how to access resources when encountering someone engaging in suicidal behavior, whether it is the student or someone they know (Crepeau-Hobson, 2013). Erbacher et al. (2015) identified the tier-one school-based key actions as contacting parents, developing a safety plan, establishing school-based support, and coordinating community support with parents.

Suicide prevention effectiveness is highly dependent on early detection and intervention (American Foundation for Suicide Prevention, 2022b). School-based suicide prevention programs should include procedures for identifying and responding to students contemplating lethal self-harm (Davenport & Crepeau-Hobson, 2021). Schools should not implement universal screeners unless they have staff who are able to analyze and respond quickly to positive suicide risk warning signs (Bertuccio et al., 2021; Horowitz et al., 2010).

Tier Two: Secondary or Moderate Classification

Tier-two interventions are geared toward students whose results from the initial screening in the SRA are moderate or in need of secondary interventions. The characteristics of students in

the tier-two or moderate-risk category are comparable to those of students in tier one; however, the intensity and duration of their behaviors increase but remain relatively limited. There is a plan but no stated intent. Generally, students exhibit sufficient willpower, a few additional risk factors, and the ability to identify both reasons for living and protective factors (Erbacher et al., 2015).

Tier-two techniques are associated with students who struggle with mental health issues. These techniques cover students exhibiting varying degrees of suicidal ideation (Crepeau-Hobson, 2013). Tier-two students are considered "at-risk" and experience severe suicidal ideation (Gould et al., 2009). SRA are most strongly related to suicidal conduct when it comes to suicidal ideation, which is largely concerned with suicidal thinking. Suicidal ideation can range from a questionable wish or intention to end one's life to a conscious hope to end one's life (Substance Abuse and Mental Health Services Administration, 2019). A student may have suicidal thoughts at a secondary or moderate severity level but does not intend to commit suicide or engage in suicidal behavior. A student may have suicidal ideation but no actual plans at the secondary level. These students have not attempted suicide in the past. Examples of school-based interventions include increased frequency and length of visits to school-based support adults, reassessment of risk level at each meeting, monitoring the progression from low risk to high risk, and frequent interaction with students' parents and community mental health providers (Erbacher et al., 2015).

Tier Three: Severe Classification

Students with prior experience acting on suicidal thoughts are classified and necessitate tier-three interventions. Tier-three interventions are intended to reduce the risk of continued or future suicidality (Crepeau-Hobson, 2013). Tier-three interventions involve students with a high

level of engaging in suicidal behavior. A student who needs interventions at the tier-three or high-risk level exhibits severe, persistent, and frequent suicidal ideation. They have well-thought-out plans, which cover accessibility, availability, and the choice of a suicide method. They exhibit a significant number of risk factors, but few, if any, protective factors are identified (Erbacher et al., 2015). The preventive efforts are tertiary and indicate the need to involve other professionals outside of the school setting. According to Nickerson et al. (2021), interventions at this level involve long-term planning and provide an opportunity for collaboration between the school, hospital, community mental health providers, and the student's family. Students classed as high risk are those with a high-risk factor for suicide and a detailed and prepared suicide plan (Gray & Dihigo, 2015). When students have made a suicide plan, they are considered at a more immediate risk than students expressing other ideations of suicide (Davenport & Crepeau-Hobson, 2021). School-based interventions just after an SRA should include notifying parents immediately, coordinating with core members to transport the student to a hospital or outpatient facility, and discussing the entire process with the parents. These follow-up interventions should include the hospital process of evaluating the student and reintegrating them into the school (Erbacher et al., 2015).

Summary

School-based mental health professionals can increase their confidence and competency in handling suicidal behaviors through education and training (Nickerson et al., 2021). The literature available on identifying who will or will not complete suicide makes preventive efforts paramount in addressing the rising public health issues. Universal suicide prevention strategies and SRA remain the mainstays of suicide prevention (Ryan & Oquendo, 2020). SRA are essential to the broader response to how school-based mental health professionals address suicide

prevention. Research must increase available data on the complete SRA process and standardized tools. Current research has only provided limited data regarding SRA beyond preventive interventions. While school-based mental health professionals may be limited in the level of service they can provide for students exhibiting level-three moderate to severe suicidal behavior, increased competency in standardized standards of care procedures can facilitate the adequate assessment of risk level, level of school-based support and continuity of care for students. It can also serve as a measure of accountability to ensure that professionals are continually following up with students, as they have several daily access opportunities to verify that students are receiving the assistance they require (Heise et al., 2016).

CHAPTER THREE: METHODS

Overview

This chapter's primary focus is to outline the methods employed. This qualitative phenomenological research study explored SBMHP experiences aligning multi-tiered systemic interventions following the SRA process when working in a K-12 school setting across the United States using an open-ended approach to data collection with a follow-up probing question followed by a focus group. Qualitative research is concerned with the "what" and "why" of human thought. The methodology of the study is described in this section. After a brief explanation of the study's context and methods, a list of research questions is presented. The researcher's responsibilities are laid out in detail. All of the ethical considerations that need to be taken during the course of the study are outlined, as well as the data collection methods that will be used and how the data will be processed. At the chapter's conclusion, there is a summary of this information.

Research Design

I employed a phenomenological research design. The research design was selected based on the problem, objective, and purpose of the study. Suicide attempts and mental health concerns among students have been on the rise, exacerbated by the COVID-19 pandemic and ongoing racial injustices (U.S. Department of Education, 2021; American Academy of Pediatrics, 2020; National Alliance of Mental Health, 2020). Schools are ideally situated to prioritize suicide prevention and mental health initiatives using a tiered systems approach. According to Basias and Pollalis (2018), research design refers to the research plan and structure used to obtain clues to answer research questions. According to Vasileiou et al. (2018), the study design describes the

types of evidence collected throughout the study, where the evidence is collected, and how the evidence is interpreted to provide appropriate answers to a given study question.

Qualitative methods seek to comprehend human behavior in the context of the social systems in which it occurs, such as schools (Austin & Sutton, 2014). This study related to the lived experience of school-based mental health professionals' utilization of SRA results and the interventions they used at varying levels to support students within the SRA process. Qualitative studies focus on the lived experiences of the participants of interest. Therefore, this study took an interpretive phenomenological approach (Neubauer et al., 2019). A qualitative approach was useful for understanding how professionals viewed SRA interventions (Dent, 2011). An examination of SBMHP from a phenomenological standpoint provided a distinct viewpoint on this issue due to their close association with youth suicide attempts, which is trending upward, as well as increased occurrences of other mental health difficulties among youth. According to Moustakas (1994), understanding discovered through intuition and significance is more valuable than empirical knowledge. Unlike natural science studies, qualitative studies seek to apprehend or decipher on an individual level what stimulates and informs actions and thoughts (Taylor et al., 2016).

This study benefitted from an interpretive phenomenology due to the nature and concentration on bringing clarity to the lived experiences of SBMHP use of SRA and MTSS. The initial step in phenomenology involves identifying a phenomenon, such as an increase in suicide rates, which catalyzes researchers to investigate the detailed experiences described in the study's objective (Bynum & Varpio, 2018). In order to fully understand the importance of suicide prevention, it was essential to consider the firsthand experiences of those in the field of school-based mental health professionals who work directly with K-12 students. The personal

experiences of SBMHP, who have close interactions with K-12 children, were included. The study employed qualitative methods, as I did not conduct a quantitative survey of the study participants.

Research Questions

This study was designed around three research questions surrounding SBMHP experiences with SRA and MTSS.

RQ1: "What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?"

RQ2: "What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?"

RQ3: "What are the experiences of SBMHP with protective factors when conducting SRA?"

Setting and Participants

Qualitative research participants discuss life events, letting researchers see the world through someone else's eyes. Participants were recruited from online forums targeted at school-based mental health professionals, including social media pages. Researchers can reach more potential volunteers using social media than through other, more traditional recruitment methods (Ellington et al., 2022). This section describes the criteria for participant selection and the sampling techniques used to obtain study participants.

Setting

The setting of this study was K-12 schools across the United States. New studies confirm alarming rates of youth suicide, making the school environment a crucial one for suicide prevention efforts. (Poland & Ferguson, 2022). This research investigated the SBMHP

experiences with SRA alignment with tiered interventions. As a result, K–12 institutions from around the country were selected as the research setting.

Participants

The criteria for the population studied included the following: (1) school-based mental health professional, (2) currently practicing or have practiced as an SBMHP within the past five years in the school setting, (3) have conducted an SRA, and (4) knowledge of multi-tiered interventions systems such as MTSS, RTI, PBIS, SWPBS.

For phenomenological research, Creswell and Poth (2018) recommend five to twenty-five participants. The sample consisted of 12 participants. The participants were selected using purposive sampling. Purposive sampling provides a wealth of data that can be gathered to comprehend the phenomenon being studied (Bloomberg & Volpe, 2008). Purposive sampling was utilized to select participants deemed representative of the specified population (Mills & Gay, 2019). Intensity sampling, a form of purposive sampling, enables qualitative researchers to pick a sufficient number of SBMHP in order to have participants who are representative of the environment (Mills & Gay, 2019).

A transcript is considered saturated when it has redundant concepts, minimal or no fresh information, or a lack of innovative ideas. Saturation was not evident after reviewing the tenth transcript. Therefore, I did not cease data collection because further interviews were warranted (Coates et al., 2021). If deemed necessary, either the participants or I would cancel the scheduled interviews. The interviews were conducted with a preselected sample of 12 people due to the fact that each transcript featured unique and varied perspectives that were helpful in the coding process. The act of reaching out to participants through the contact details provided by other participants is referred to as snowball sampling (Noy, 2008). Noy (2008) states that snowball

sampling relies on and includes the mechanisms of fundamental, spontaneously happening social interactions and linkages.

A homogenous group was important in this study. The participants shared the following criteria: (a) school-based mental health professional, (b) currently practicing or have practiced as an SBMHP within the past five years in the school setting, (c) have conducted an SRA, and (d) knowledge of multi-tiered interventions systems such as MTSS, RTI, PBIS, or SWPBS.

Procedures

This section of the study detailed information on the steps implemented to carry out the research plan. Site approval was the first step in the study procedures. The methods for obtaining site approval are outlined in the subsequent paragraphs along with the participant recruitment plan.

Permissions

Approval from the Liberty University Institutional Review Board (IRB) was obtained to conduct this study (see Appendix A). According to Grady (2015), the goals of the IRB are to protect human participants and assess research ethics, clinical investigator biases, and compliance with human subjects protection legislation. The risk of harm to the research participants was minimized or eliminated by gaining IRB approval.

Recruitment Plan

Social media pages for mental health professionals were used to publicize the study and its qualifying conditions (see Appendix C). When an applicant expressed interest in the study, I was contacted via the link provided on the flyer or electronic post. Once contacted, I emailed the applicant to gain consent and inform them of the research objectives (see Appendix C). The email explained the purpose and requirements to participate as well as a link to the consent form

(see Appendix B). Human research requires adherence to ethical guidelines (Moustakas, 1994). Signed participant consent forms were required before data was collected. Once consent forms were signed, a pre-interview electronic form (see Appendix D) was emailed to establish that the participation criteria were satisfied.

Criterion sampling was used in this study to purposefully include SBMHP, who has worked in a K-12 school-based setting over the past five years. The inclusion of this standard ensured that participants brought current school-based experience to the topic. Participants were SBMHP of grades K-12. The experiences of SBMHP are valued because these professionals experience the entire school day with students and share core *technical* functions regarding student mental health support. This criterion was included to capture mental health professionals who work with students enough time each day to share meaningful experiences with SRA. It was essential to recruit from the school-based mental health profession in order to investigate professional nuances and the possibility that SRA and MTSS are structured or comprehended differently, depending on the professional roles of the SBMHP.

Criterion sampling was selected for this study because of its utility in producing a sample of participants who have shared similar experiences (Creswell & Creswell, 2018). These criteria were posted on a virtual flyer advertised in professional mental health social media groups to gain participants for the study. In order to research a group of people who have all encountered this phenomenon, a sample size of 12-15 participants was sought (Creswell & Creswell, 2018). Given the small scale of this research study, it was essential to include a variety of SBMHP with varying levels of involvement and expertise with SRA and MTSS in order to gain a comprehensive understanding.

Researcher's Role

After receiving permission to conduct this study from Liberty's Institution Review Board (IRB), I was the study's chief investigator and analyst for the study. As a school psychologist, I have served in various school environments. I hold a Bachelor of Arts in Special Education-Emotional Disabilities, a Master of Science in Community/Health Education, and a Certificate of Advanced Graduate Studies in School Psychology. I undertook a sincere effort to identify themes that emerged from participant data collection and conveyed the key elements of the lived experience of SBMHP utilization of SRA and tiered interventions by reflecting on, sharing, and remaining vigilant to my subjectivity throughout data collection and analysis (Bynum, 2018).

The interview process utilized open-ended questions that allowed individuals to share their experiences with SRA and MTSS. I was responsible for selecting the topic, researching, creating the open-ended questionnaire, and conducting interviews. To ensure that the primary investigator's preexisting associations, understandings, facts, or biases do not affect or color the interview, he or she should complete the Epoche procedure beforehand (Moustakas, 1994). By examining each interview and transcription, I remained an active researcher.

My earliest encounters with adolescents exhibiting suicidal tendencies indicated the lack of available resources at the school level. I may be biased because I have personally encountered many of the difficulties and shortcomings of SRA in the school environment. I am aware of numerous areas that could be improved, as well as a lack of uniformity, implementation of interventions, and collaboration with professionals. I communicated clearly to the participants my own professional status as a mental health professional throughout the interview. I did not have preconceived notions about how participants might answer questions, reducing the chance that personal bias would be introduced. Follow-up questions were based on the participant's

responses. I remained aware of the possibility that a question could introduce persuasion or leading questions. Therefore, follow-up questions were dependent on the participant's response.

While working as a SBMHP on student support teams, I was responsible for providing academic support for struggling students in an attempt to align with the expectations of the 2004 reauthorization of the Individuals with Disabilities Act (IDEA). During this time, I uncovered a gap in the research available to support preventive efforts in school's response to universal screeners that identified students struggling with suicidal risk behaviors. I have completed numerous SRA where students needed a substantial amount of support.

While the primary goal of SRA is to identify the most efficient measures to guarantee the immediate safety and welfare of the student, it is crucial to also take into account the long-term implications in accordance with the recommendations of the National Association of School Psychologists (NASP, 2015). SRA do not predict but rather alert an individual to implement strategies aimed at decreasing or reducing the impact and potential risks associated with the forecast. The SRA cannot promise that a suicide will not occur. Suicides are always unfortunate circumstances. They are especially difficult for me as a school-based mental health professional when the school dismisses or fails to provide school-based support.

Several years ago, I received a call from a family member asking questions about the role of the school when dealing with a student reporting suicidal ideation. The call was related to a 12-year-old girl who committed suicide after expressing suicidal ideations with a plan and access to commit suicide. I had ties to her family, making this suicide particularly difficult. The school's suicide risk screening had determined that the student's suicide risk was low. The school did not implement additional interventions such as informing the parent, monitoring, a safety plan, or identifying community resources following the screening. The investigation discovered that the

school lacked clear protocols and processes surrounding suicidal student behavior. The experience of conducting more than 30 risk screenings in a school year and the suicide of the young girl drove me to advocate for improved training and the use of tiered interventions, as well as the establishment of best practices within schools for addressing suicidal risk behavior.

Data Collection Plan

This study employed three distinct data collection methods. The first method of data collection was a semi-structured, one-on-one interview. Interview transcripts were reviewed for recurring topics (Claxton & Michael, 2021). The second approach for receiving information was focus groups. This group interview had five participants. Questionnaires were the third type of data collection. During the interview, participant-specific quotations were utilized to develop broad themes, verified for accuracy by the participant.

Individual Interviews Data Collection Approach

Electronic interviews were conducted using Microsoft Teams to collect data, which were transcribed electronically. After each interview, I reviewed the content to evaluate the accuracy of the electronic transcription. In qualitative research, it is essential to accurately capture the opinions of participants (Mills & Gay, 2019; Moustakas, 1994). Interviews are one approach qualitative researchers use to comprehend the significance that people derive from their experiences (Merriam & Tisdell, 2016). Instead of leading and follow-up questions, interviews consisted of open-ended questions.

According to Patton (2015), with open-ended questions, researchers can elicit participants' opinions without being able to predict these perspectives through the prior selection of questionnaire categories. Each participant received a semi-structured interview with thirteen identical questions. The semi-structured interview was developed especially for this research. I

opted to utilize this approach since a semi-structured interview affords the interviewer with increased autonomy. Open-ended interview questions are essential for phenomenological research, such as this study, as they allow participants to describe a situation using their own words. This study specifically focused on the lived experiences of SBMHP (Claxton & Michael, 2021).

Interviews were scheduled five days after the initial contact and lasted 30-45 minutes. Participants were assigned a pseudonym and interview number before the interview, ensuring a consistent tracking mechanism. Before analyzing the data, I removed any personally identifiable information.

Individual Interview Questions

1. What prompted you to pursue a career in mental health in a K-12 setting?
2. Tell me about a typical SRA assessment and how you select follow-up interventions? (RQ1)
3. When you have been involved in SRA, what has your role? (RQ3)
4. What is your understanding about what best practices are in MTSS following a SRA? (RQ2)
5. Where do you find information regarding evidence-based tiered interventions to support suicidal students? (RQ3)
6. What is it like working in a multi-disciplinary team to select tiered interventions for students K-12 following a SRA? (RQ3)
7. How do you describe challenges concerning selecting multi-tiered interventions following a SRA? (RQ3)

8. What risk and protective factors do you describe as most pertinent to the SRA and MTSS process? (RQ1)
9. How are Joiner's perceived burdensomeness, thwarted belongingness, and acquired capability to prevent suicidal behavior incorporated into the participants' practice? (RQ2)
10. What are you likely to select as a tier one intervention(s) for SRA? (RQ1)
11. What are you likely to select as tier two and tier three intervention(s) for SRA? (RQ1)
12. Some would say that SRA and MTSS are not necessary. What would you tell them?
13. Is there anything that I have not asked that you feel is worth mentioning?

The initial question of the interview was intended to build rapport between the researcher and the participant. This kind of query, which Patton (2015) referred to as background or demographic, aims to discover how people view themselves. Court et al. (2018) advocate a gradual progression when attempting to establish rapport with the participant. Similarly, Moustakas (1994) proposed that relaxed dialogue aids in fostering a relaxed and open atmosphere prior to a phenomenological interview. The second question was similar to the first and was designed to orient the participant to the process by asking them to describe a typical SRA assessment and subsequent interventions. This question should reflect the researcher's expectations and appreciation for the participant's role in the research process (Roberts, 2020).

The third, fourth, and fifth questions are adapted from Moustakas' (1994) general interview guide. These questions, according to Moustakas (1994), were intended to add depth to the interview. The phrasing of the questions encouraged participants to provide full transparency. Participants elaborated on their experience and thoughts about the event in a generalized way when asked to describe their experience with the phenomenon. The interview questions were made to delve into the experience both emotionally and cognitively.

Questions six and seven were designed to determine how the experience influenced the SBMHP professional practice. One common theme in opinion questions is to find out what people think about a particular experience or issue (Patton, 2015). Inquiring about collaboration and challenges during the process allows participants to express their feelings.

Questions eight, nine, ten, and eleven were true opinion questions. These questions were designed to gain SBMHP's insight on the theories upon which the framework for this study has been built. Joiner (2005) theorized certain domains of risk and protective factors allowed for the cultivation of suicidal behavior. These questions asked the participant to indirectly speak to the theory that guides this research.

The intent of question 12 was to encourage the respondent to consider an alternate opinion or comment on the topic. This type of inquiry is known as "devil's advocate" and fits under one of the four categories of information-eliciting questions (Strauss et al., 1981). When a researcher is particularly interested in a participant's thoughts and feelings about a subject, these questions are very useful (Merriam & Tisdell, 2016;2015).

The purpose of question 13 was to ensure that the purpose of this phenomenological study was met, which is to give SBMHP a voice and help the public comprehend SBMHP experiences with intervening with youth suicidal behavior. When attempting to construct questions that would best facilitate an investigation of the research questions, I realized that the actual experiences of the participants might yield more insight than projected. Consistent with the reasons the semi-structured interviews were selected for data gathering, I chose these questions because they have the potential to reveal themes that would otherwise go missing. The interview questions were structured according to Patton's (2015) recommendation that ideas and feelings

can be stated in greater detail after the event has been explored. Before the interview began, experts in the field reviewed each question included in the interview.

Individual Interview Data Analysis Plan

Individual interview data were evaluated using a modified version of Moustakas's (1994) Van Kaam (1959) technique. In this seven-step approach, I compiled a list of words and phrases important to the experience using the interview transcripts of each participant. The process of horizontalization is known as *Listing and Preliminary Grouping*. In the second stage, *reduction and elimination*, I identified unchanging aspects by determining if each assertion was required or adequate to comprehend the experience. Expressions that were superfluous or insufficient were eliminated, and the remaining expressions were labeled and acknowledged as the Invariant Constituents. Step three of the data analysis plan was grouping the Invariant Constituents by themes. This grouping revealed the primary subjects of the conversation. In the fourth phase, *validation,* I checked each invariant component and topic to determine if they were compatible or clearly portrayed throughout the transcription. Non-explicitly specified or incompatible Invariant Constituents were deemed unnecessary and eliminated. In the fifth phase of the plan, Individual Textural Descriptions were developed for each participant individually. The sixth step was to generate Individual Structural Descriptions of the experience utilizing Individual Textural Descriptions and creative variation. At the final step of data analysis, a Textural-Structural description of the meanings and essences of the experience was created for each participant.

Focus Groups Data Collection Approach

Focus groups were utilized as an alternative form of data collection. There was one focus group with five participants. Even though focus groups are less personal than interviews, they

can be a more effective approach to collecting data (Claxton & Michael, 2021). A well-planned focus group can also assist in triangulating information acquired from interviews. The social environment of the focus group distinguishes this data collection strategy from conventional interviews. Participants can hear the comments of other participants and add to or refute those responses (Patton, 2015).

During a focus group, the interviewer will communicate with participants individually and with the group as a whole (Claxton & Michael, 2021). Participants' ability to converse with one another improves the data's quality, which is likely the most significant advantage of the focus group data collection method. Patton (2015) has found that in the context of a focus group, shared and diverse ideas emerge rapidly. This study utilized a focus group to broaden data collecting around the key research issue and to triangulate the data acquired with field specialists.

Focus Group Questions

1. Please share your role and experience as a school-based mental health provider, assignment or how many schools you service and grade levels you service.
2. What is your opinion of a school-based mental health collaborative multi-disciplinary team selecting multi-tiered interventions that align with SRA results? (RQ1, RQ3)
3. Do you feel you received adequate preparation in your training program or through district provided professional development to understand how to align MTSS with SRA? (RQ1, RQ3)
4. How are Joiner’s domains of thwarted belongingness, perceived burdensomeness and acquired capability prioritized in your district and school’s SRA procedures? (RQ2)

The focus group questions included in this study were designed to gain a deeper understanding of how SBMHP align MTSS with SRA results.

Question one served as an icebreaker for the participants in the focus group. Question two allowed the participant to expound on the functions of a multi-disciplinary team and illuminate themes that may have been covered in the semi-structured interview. Question three addressed the participants' perception of the training they received and whether it was provided. Graduate program directors reported that their courses include instruction on how to deal with students with suicidal tendencies in the school (Monahan & Karver, 2021).

However, graduate students have stated that this content is absent from their program. If the program addressed school suicide at all, it did so inadequately or gave students a cursory overview of the topic (Monahan & Karver, 2021). I found no empirical evidence that MTSS alignment with SRA training is available. Few studies have examined school-based mental health practitioners as a standalone profession or in collaboration with another, aligning MTSS with SRA.

Even more limiting was research with SBMHP operating as a multi-disciplinary team. Question four allowed for dialogue and perspectives regarding how the participants' domains of suicidal behavior are addressed at the district and school levels. This question required SBMHP to consider systemic policies and expectations that significantly influence their roles. Relevant information was collected concerning these related topics to help SBMHP advocate for areas of need, including empirical data and robust tiered interventions.

Focus Group Data Analysis Plan

The focus group met at an agreed-upon date and time and was recorded using Microsoft Teams, an online meeting platform. The meeting was electronically recorded and transcribed.

Prior to the commencement of data collection, each participant was instructed to maintain anonymity and confidentiality. As part of the focus group data analysis technique, I read all the data to have a general grasp of its significance (Creswell & Creswell, 2018). This was achieved by reading the data and making notes and comments on the portions I felt prompted to reexamine.

The next step involved coding and categorizing the data. According to Patton (2015), categorization is necessary to avoid disorganization. The data was coded using Tesch's (1990) eight steps of coding. Understanding the transcripts, taking notes on each document's topic, creating a list of topics, returning to the data to add codes for the topics where appropriate, selecting topic descriptions, deciding on categories, placing the data into the categories, and, if necessary, recoding are all steps in this procedure.

Patton (2015) compared theme development to creating an index of field notes. I reread the notes multiple times, highlighting the key themes with different colored pencils and tabs (Patton, 2015). The data was read multiple times. This procedure helped me discover instances in which the data's meaning changed (Merriam & Grenier, 2019). In the final step, themes and similarities were extracted from the data.

According to Claxton and Michael (2021), themes are common perspectives or patterns of information provided by respondents that address the goals of this research. Written accounts of these topics were used to highlight the phenomenon's underlying concepts (Creswell & Poth, 2018). In the final two steps, I wrote an explanation of the data and each theme. These steps are supported by Creswell and Creswell's (2018) idea that data analysis should begin with a foundational layer and advance to a more complex layer of analysis.

Reflective Questionnaire

As the third method of data collection, participants in this study were requested to complete a reflective questionnaire entry by responding to a question. This questionnaire entry was supplied following the initial interview in order to triangulate data. According to Billups (2021), reflective postings allow individuals complete freedom to examine and explain their experiences in whatever way they choose. It was appropriate for this study to use a reflective questionnaire because it allowed participants to reflect on and further explore a particular incident (Janesick, 1999). In addition, it permitted the central topic from the interview or focus group to be reflected on and elaborated upon, highlighting the participants' beliefs and confirming the responses acquired through those methods (Billups, 2021).

Individuals who feel uneasy discussing their opinions and experiences during the semi-structured interview and focus group may find it beneficial to do a journal entry in private (Chabon & Lee-Wilkerson, 2006). Depending on the respondent, comments can be handwritten (Chabon & Lee-Wilkerson, 2006), typed into a Google Form (Bennett & Pye, 2002; Hayman et al., 2012), or recorded using a cell phone (Matlala & Matlala, 2018). The questionnaire's single question will require a response from each participant.

Questionnaire Prompt

1. Joiner (2005) explains engagement in suicidal behavior as thwarted belongingness, acquired capability, and desire for suicide. How does knowledge of this term relate to your personal experience with aligning MTSS with SRA results?

Reflective Questionnaire Data Analysis Plan

I checked each transcription for accuracy by cross-checking the transcription with each entry and making corrections as necessary. The construction of a classification or coding system is the initial stage in data analysis (Patton, 2015). In order to identify patterns in the participants'

questionnaire responses, the journal prompts were reviewed twice. The data was categorized using data coding. These categories provided the basis for themes. The data was coded using Tesch's (1990) eight steps of coding.

Data Synthesis

Data synthesis is one of the phenomenological analysis processes that Moustakas (1994) suggests doing as part of the whole procedure. After finishing the data analysis plan, I used the participants' Individual Textural-Structural Descriptions to create a Composite Description that captured the experience's meanings and essence that represented the group as a whole (Moustakas, 1994). This description served to capture the meanings and essences of the participants' experience and accurately represented the entire group (Moustakas, 1994). According to Patton (2015), description is the most important factor in determining meaning. The creation of Individualized Textual-Structural Descriptions was accomplished through the analysis of interview transcripts. A Composite Description was formed by considering the full experience (Moustakas, 1994). In order to convey the experiences of the group, I analyzed the ways in which all of the members' opinions and perspectives are similar (Moustakas, 1994).

Trustworthiness

A researcher's trustworthiness refers to the true value, applicability, consistency, and neutrality of this qualitative study. Trustworthiness criteria outlined by Guba and Lincoln (1994) include credibility, dependability, confirmability, and transferability; they later added authenticity. Not all procedures are used in each study. Through prolonged engagement, triangulation, and persistent observation, I demonstrated trustworthiness. To protect the confidentiality of the research participants, all names and locations were pseudonyms. Each component of trustworthiness is addressed below. Several methods for demonstrating

trustworthiness, including expert review, research positionality, dense descriptions, and self-reflection, are described in this section (Merriam & Grenier, 2019).

Credibility

I independently analyzed all electronic recordings and transcripts in order to create prolonged engagement. By using clarifying questions, member-checking guaranteed that the researcher was truly interpreting accurately (Theron, 2015). Credibility was achieved in this study through triangulation. The individual interviews, focus groups, and questionnaire prompts used for data collection were purposely included in this study for the purpose of triangulation. Triangulation through the use of multiple data collection methods is recognized as one way to establish dependability (Merriam & Grenier, 2019).

Transferability

Transferability refers to the extent to which qualitative research findings are transferable to various contexts or settings with different respondents (Korstjens, 2018). The purpose of this study provided detailed descriptions and findings to help readers trust that the results are plausible. The study's details should benefit readers in determining the applicability of its findings to their own experiences. Transferability will be established by providing a thick, rich description throughout the study (Creswell & Poth, 2018; Lincoln & Guba, 1985). This study can be transferred to various educational agencies and various professions to understand how their organizations utilize multi-tiered interventions in supporting suicidal behavior.

Dependability and Confirmability

A study is dependent on whether researchers can agree that the results of the study are supported by the data collected (Merriam & Grenier, 2019). In the chapter's section on the researcher's role, I discussed my perspective in relation to this study. I discussed the interpretive

framework used for this study, as well as my philosophical assumptions and role in the research. Readers can better understand the framework used to evaluate data when the researcher's perspective is fully described (Merriam & Grenier, 2019). Additionally, dependability and confirmability were addressed with rich, detailed descriptions of themes. This study provided a detailed, comprehensive description of SBMHP experiences with SRA and MTSS. Triangulation was used to satisfy confirmability, allowing for multiple data collection methods such as interviews, focus groups, and reflexive questionnaires to eliminate researcher bias (Patton, 2015).

Ethical Considerations

According to Dodds and Hess (2020), research ethics refers to an ethically acceptable research procedure. This research upheld the strictest ethical standards. During each phase of the procedure, the safety and wellbeing of all participants was stressed. All records were kept in password protected storage.

During data collection, I discussed the process of sharing information with participants and provided information about the proposed study; during data collection, I encountered private knowledge of the participants. Basias and Pollalis (2018) argued that researchers have an ethical obligation to participants regarding the information provided. Priority number one is the protection of participant confidentiality. All interviews were conducted with extreme discretion; participants were assured privacy and anonymity.

Discussions about suicide may cause individuals to approach the subject with trepidation and caution. Participants were given a detailed consent form that outlines the entire process. Participants were informed that they were able to discontinue at any time. A list of nationwide resources to support mental health providers and suicide prevention was provided. All interviews

were conducted with extreme discretion. No participant in the study had access to the raw data provided by the contributors, which are utilized solely for educational purposes. All Institutional Review Board (IRB) protocols were adopted, followed, and assessed to ensure the highest ethical standards.

Limitations

Phenomenological research encapsulates the core aspects shared by multiple participants in the phenomenon (Creswell & Poth, 2018). For this study, the recruitment process relied heavily on social media platforms and electronic technology. Due to the heavy use of these means, it may have limited participants who either do not utilize those services or do not access those modes of communication. This may have caused limitations in the selection pool of participants, thus limiting the context of the study.

Summary

The central research question, “What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?” guided the development of this study, leading to a qualitative research design. The interpretive phenomenological methodology was appropriate for this study because the researcher sought to understand the research topic by giving SBMHP a platform to voice their lived experiences (Moustakas, 1994). A qualitative phenomenological study was completed that examined the lived experience of school-based mental health professionals. Understanding the particular suicide-tiered interventions and protocol experiences of school-based mental health professionals/providers revealed gaps in available resources, training, identified targets, and improvement priorities.

The data collection methods included participant semi-structured interviews, focus groups, and participant reflexive questionnaire journaling. The study used a data analysis model

outlined by Moustakas (1994). The four pillars of trustworthiness were discussed: credibility, dependability, transferability, and confirmability were discussed (Lincoln & Guba, 1985). IRB permission was obtained, ensuring that consent forms and all other pertinent ethical considerations were met to the satisfaction of the Institutional Review Board.

CHAPTER FOUR: FINDINGS

The purpose of this qualitative phenomenological study was to set forth in detail the experiences of school-based mental health professionals (SBMHP) in coordinating multi-tiered interventions or MTSS in a K-12 school context following the SRA process. Data from individual interviews, focus groups, and reflective journaling of SBMHP sought to answer the following specific research questions:

1. What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?
2. What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?
3. What are the experiences of SBMHP with protective factors when conducting SRA?

This chapter begins with a description of each of the 12 participants as well as a brief narrative of their experiences as shared by each SBMHP in their semi-structured interviews. Through the analysis of participant data responses emerged revealing themes and subthemes that offered valuable insights into the perspectives of SBMHP regarding their employment of interventions that were aligned with a student's suicidal risk. Three themes and seven subthemes were identified using a modified version of Moustakas's (1994) Van Kaam's (1959) phenomenological data analysis. The chapter finishes with a comprehensive discussion of such themes and how they contribute to answering the research questions.

Participants

Twelve participants were selected for this study based on the selection criteria. All participants were K-12 school-based mental health professionals. There were six school

psychologists, four school counselors, one school nurse, and one Licensed Professional Counselor. I screened each participant using the following IRB-approved questions:

1. Are you a school-based mental health professional?
2. Are you currently practicing or have practiced as a SBMHP within the past five years in a school setting?
3. Have conducted/assisted with completing a Suicide Risk Assessment (SRA) of a student's behavior?
4. Do you have knowledge of multi-tiered interventions systems such as MTSS, RTI, PBIS, or SWPBS?

Criterion sampling was used to recruit school-based nurses, counselors, and psychologists based on their experience with K-12 kids throughout the school day, including time spent before, during, and after a school-administered suicide risk assessment. Twelve participants shared their experiences through individual interviews, five participants participated in the focus group, and 10 participants participated in the reflective questionnaire. A composite of the participants' data is included in Table 1 below. To protect participants' confidentiality, they were identified throughout by number only. Precisely identified information not relevant to the research was removed from the narratives to protect confidentiality. Some participants' comments, as quoted below, do not begin or end at the points that the original quotes began or ended to increase readability and decrease redundancy.

Table 1

Participants' Overall Demographic Characteristics

Table 1. Participants' Overall Demographic Characteristics

		N
Gender		
	Male	4
	Female	8
Specialty		
	School Nurse	1
	School Counselor	3
	School Psychologist	7
	Licensed Professional Counselor	1
Experience		
	less than 1 year	1
	1-4 years	1
	5-9 years	3
	10-15 years	3
	16-20 years	1
	25 + years	3
Highest Degree Earned		
	Master	5
	Specialist	1
	Doctorate	6
Grade Level		
	Elementary	8
	Middle	2
	High	2
# of campuses served		
	1	7
	2-3	3
	4 or more	2
Self-rated knowledge of multi-tiered systems		
	Limited	0
	Moderate	7
	Expert	5

Participant One

Participant One is a female school counselor with 1-4 years of experience and a master's in 2016. She indicates that she serves four or more campuses at the elementary school with a

moderate level of understanding of multi-tiered interventions. Participant One emphasizes that SRA is essential in the school building not just to detect individuals displaying suicide behavior, but more significantly, to uncover potential underlying issues even if it is not specific suicidal ideation. Participant One states:

> The SRA provides an opportunity to identify many more students who are experiencing other underlying behavioral concerns as well as mental health issues regardless of the level of tiered interventions needed.

Participant One articulated that her consideration of a profession in school counseling was prompted by her high school encounter with inadequate and restricted counseling services, which affected both herself and a significant number of her peers. Participant One acknowledges that her undergraduate studies shaped her desire to work with youth. She contemplated pursuing a degree in school counseling and school psychology during her undergraduate studies. Following the counsel of a mentor, she made the decision to pursue a career in school counseling.

Participant One defined her position as an SBMHP in aligning follow-up interventions as the professional tasked with monitoring the plan subsequent to its development. Participant One elaborated on the implementation of self-monitoring and check-in techniques. Participant One indicated that the American School Counseling Association (ASCA) framework for professional competencies and district-wide annual professional development have provided the majority of her SRA and MTSS-related training.

Participant Two

Participant Two is a female school psychologist with 5-9 years of experience. She completed a Certificate of Advance Graduate Studies in 2023. She indicates that she serves one campus with approximately 900 students in a middle school setting. She rated her knowledge

level of multi-tiered interventions as moderate. Participant Two attributes her background as a behavioral therapist to be a heavy influence on pursuing a career as a school psychologist. She notes that her passion for children and counseling provides an excellent opportunity for her to intervene in students' lives. Participant Two explains that multi-tiered systems give schools a systemic tool to apply targeted interventions. Participant Two elaborated:

> However, when we're not giving them (students) a chance to have those small groups, those targeted skills, we're not giving them a chance to succeed. We're pushing them to a level without any help and without any interventions, really, because when you don't have that MTSS process, a lot of students are missing key interventions. They're just going straight from general education to special education. They are at high risk, and they're not getting the help that they need. And that changes the trajectory of their lives.

Participant Two notes that her current district does not have a process for applying interventions. She states that her district is currently facing a crisis as it is approaching federal government limits for over-identification and qualifying students for special education. Many of these students are children of color or second language learners. Participant Two implied many students would benefit from the delivery of targeted interventions.

Participant Three

Participant Three is a female school nurse with 10-15 years of experience. She completed a master’s degree in 2021. She indicates she primarily serves a high school student with a population of approximately 540 students. She rated her knowledge level of multi-tiered interventions as moderate. Participant Three’s devotion to being an engaged mother led her to working in the school setting. Participant Three notes that she has seen an increase in mental

health needs post COVID. Participant Three explains that the follow-up interventions after completing a Suicide Risk Assessment is the most important part of the process. She states:

> It's not just check-in and answering the box and telling the risk, what's the number it's a lot more than that. It's not just a score. There is a person. This is an actual person going through something. We're talking about a person's mental health. Number one, they're a person. Number two, we have got to take care of the person in the best way we can and so those interventions are there for a reason.

Participant Four

Participant Four is a female school counselor with 25 plus year of experience. She completed a master's degree in 1983. She indicates that she primarily serves one elementary school with approximately 640 students. She rated her knowledge level of multi-tiered interventions as moderate. The participant started her professional career as a classroom teacher. She transitioned to school counseling after returning to school and gaining a degree in community counseling. The participant notes that it was natural fit of combining counseling and education.

Participant Four elaborated on the importance of the administration team and the school-based mental health professionals having connections with experts outside of the school building. She notes:

> Knowing how to maneuver and work with different professionals and articulate what they're seeing, what the school is experiencing, and helping others to understand the severity of what is needed as a school and opportunities for counselors to counsel. She notes that a protective factor and at times a risk factor is parent's resourcefulness.

When addressing how she approaches selecting tiered interventions following an SRA, she states "it depends on the severity of the threat to harm self, whether it was an expression of frustration or true suicide intentions." She acknowledges her role on the SBMHP team as "primarily to act as an interviewer and ask the interview questions."

Participant Five

Participant Five is a female school counselor with ten to fifteen years of experience. She completed a doctorate degree in 2015. She indicates she serves in a middle school setting with approximately 890 students. She rated her knowledge level of multi-tiered interventions as expert. She was drawn to the mental health field after working with children as a foster parent. Additionally, she worked for the criminal justice system there she witnessed the use of medication as an intervention to managing behaviors. Participant Five discussed an intervention in which they achieved favorable results, characterizing it as a "step away challenge lasting seven to twenty-one days." In the challenge, students are encouraged to replace negative behaviors with positive ones and record their emotions in a journal as part of this challenge.

Participant Six

Participant six is a male school psychologist and school counselor with 16-20 years of experience. Currently, he serves as a school psychologist in a kindergarten through twelfth grade unit school with approximately 1200 students. He rated his knowledge of multi-tiered interventions as expert. The participants note it was important for him to have a career in which he could work with a broad range of kids, both in the general education and special education setting with autonomy. When addressing the benefit of SRA, Participant Six explained:

> Suicide risk assessments are an unbounded necessity, not only because it gives us a framework for understanding how to categorize, evaluate and deal with risk of harm to

> self in schools, but it is also a necessity because as education providers, we need to be able to tell parents that while their children are in our care, the loco parentis, that we have a way to deal with and address threats to self and then they need to know that and we need to be competent at doing that.

When asked about his experience with MTSS, participant six states, "I would say the public health model, which is the undergirding theoretical model for MTSS is very much at play."

Participant Seven

Participant Seven is a female Licensed Professional Counselor with less than a year in her current position at an elementary school. She had worked as a counselor and teacher for the past decade. She rated her knowledge level of multi-tiered interventions as moderate. She pursued additional training in counseling after having to function as the *de facto* counselor as a teacher. In fact, she recalls having to administer a suicide risk assessment at the request of an administrator because the student seemed to find comfort with her presence and the lack of staff trained to administer a SRA. She described a situation that prompted her to pursue mental health training as such:

> I did a lot of unofficial counseling in those days. I would have several students come in and express suicidal ideations. On this one occasion, I can remember becoming extremely frustrated. There was this kid; he was crying. He was like, I just don't want to live anymore. I don't know what to do. As a teacher, you know, I'm talking to him. I'm trying to talk him off the edge, but I'm like I have to get you help. So I had my cell phone, and I called guidance and the guidance counselors, and then they said we don't deal with that. So you need to call the community counselor and the community counselor was like the contracted mental health counselor. And so I said, Well, can you get her on the phone

> like I'm in the room with this kid and he's suicidal, you know? So they called her and she said, Well, he's not on my caseload. So I can't see him. And I said, Somebody get me some help. Like, somebody get down to this room, right this second. The bell was about to ring and I can't just send him to his next class like nothing's going on. Like somebody get down here. This is serious. So, one of the assistant principals came down and he dealt with it. At that point, I stepped out I don't know what happened, but I was extremely frustrated. Because here we had a kid who was begging for help, and everybody was turning him away.

The participant explains that the need for counseling, especially in the area of suicidal behavior is an integral part of why she pursued an advance degree to address mental health concerns. The participant pointed out that while school systems have structured interventions for academic behaviors, they often lack adequate mental health interventions. She emphasizes that a student's emotional well-being is vital to their academic performance and behavior. She noted that while there have been substantial initiatives at the state level to provide help for adults at risk of suicide, interventions for youth appear to be lacking.

Participant Eight

Participant Eight is a male school psychologist with five to nine years of experience. He completed a doctorate degree in 2019 and he rates his knowledge of multi-tiered interventions as expert. He serves several elementary and middle school campuses as a district-based school psychologist, depending on the schools' needs. Participant Eight notes that a role he sees lacking in school are social workers. Often, he mentions that school psychologists are expected because of their unique training to function in a *"*one size fits all." Participant Eight explained:

> Which is unfortunate because depending on your training you may be suited to do some things that another psychologist may not have received training in that area. Psychologist do not know how to do everything, that's just not true.

Participant eight stressed the significance of identifying risk and protective factors and administering screenings, particularly for marginalized groups. Participant eight stated:

> If you're looking at the trans populations, if you're looking at individuals who are a part of the LGBTQ plus, or, you know, individuals who are in the military community, especially high school, middle school, kids at that level, to not screen for those risk factors would be ridiculous.

Participant Nine

Participant Nine is a female school psychologist with five to nine years of experience. She completed a specialist degree in 2019. She serves three schools, Kindergarten through twelfth grade, with an approximate population of 1,200. She rated her knowledge of multi-tiered interventions as expert. She supports her school's SRA and MTSS process as the lead. She was drawn to a mental health field as a way to be a "helper and safe person*."* Having grown up in an environment with several risk factors. Additionally, her experience with school counselors and psychologist in the school setting when she sought help for her child drew her to a school-based mental health profession. Participant nine described the alignment of MTSS and SRA as an ideal situation.

However, she remarks "school psychologists are spread too thin to provide much in the way of services." When asked about finding information regarding evidence-based tiered interventions to support suicidal students, Participant Nine answered "I'm not aware of any specific *evidenced-based* tiered practices post SRA." Nonetheless, she would look to NASP

(National Association of School Psychologists) and PBIS (Positive Behavioral Interventions and Supports) for supportive practices.

Participant Ten

Participant Ten is a female school psychologist with 25 plus years of experience. She completed a doctorate degree in 1991. She serves two school both elementary with an approximate population of 1,400. She rated her knowledge of multi-tiered interventions as moderate. She pursued advanced studies in school psychology after working closely with a school psychologist in a residential setting. She notes that she imagines MTSS is happening across the board even in places where there is not a formalized process. Although, she notes, "I think having some formalized process is probably wise for liability." She mentions that she would love to see a MTSS implemented with fidelity and authentically. She states:

> If administrators took a year and did what they have done for other (academic) initiatives. They might be able to pull it off. But if they don't do that staff wide, with real trainers, real people who have seen it work effectively and are able to model it. I don't think they're ever going to get it off the ground. I think they give it lip service.

Participant Eleven

Participant eleven is a female school psychologist with ten to fifteen years of experience. She completed a specialist degree in 2009. She serves a unit school with grades kindergarten to twelfth with approximately 1,100 students. She rated her knowledge of multi-tiered interventions as expert. She was heavily influenced to enter the mental health field by her positive connection with her high school counselor. Participant eleven declared that she lacked any prior exposure to the formalized processes of MTSS and SRA. She elaborated:

> Prior to reading over the study I had really never thought about suicide and risk assessment in a MTSS framework. Furthermore, I don't think we're there but I think it's worth a conversation or just entertaining that they should be there (interventions) and that we should have conversations and we should have some things that are absolutely available, especially moving beyond Tier 1.

Participant Twelve

Participant twelve is a male school psychologist with over 25 years of experience. He received a doctorate degree in 1999. He serves a high school with an approximate population of 739. He rated his knowledge of multi-tiered interventions as moderate. Participant twelve felt compelled to enter the mental health profession as a means to protect kids "even from their parents at times. I found myself wanting to help the most difficult kids." He remarks that implementing procedures and processes are often initiated with good intentions. He notes that unfortunately:

> The people that are running these programs don't go in the classrooms. I think it is important to give schools the tools they need. It's not money or other things. It's how do you help teachers to care. Where do they get the energy and time to care. It all comes back to caring. If a kid knows you care, they're going to do better. If they (students) know you care, they're going to feel settled.

Results

The following section presents the themes that emerged from the responses to the questions posed to the research study participants and developed according to the tenets of a modified version of Moustakas's (1994) Van Kaam's (1959) phenomenological data analysis. Transcripts are considered in both the individual and group contexts throughout the seven steps

that make up this approach. The major themes and subthemes of the research study are identified in the following sections (Table 2).

Table 2

Research Questions and Identified Themes and Subthemes

Table 2. Research Questions and Identified Themes and Subthemes

Research Question	Major Themes	Sub-themes
What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?	1. SRA within an MTSS Framework	1. Flawed: Interventions but not necessarily aligned with MTSS. 2. SBMHP team work 3. Student Safety
What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?	2. Risk and Protective Factors	4. Poor coping skills 5. Group/Club involvement
What are the experiences of SBMHP with protective factors when conducting SRA?	3. Belongingness and the Importance of Connections	6. Adult connections 7. Parent connections

Theme Development

By concentrating on *horizontalization,* I was able to conduct a thorough examination of each participant's expression in relationship to their experiences. Subsequently, the invariant constituents were clustered according to thematic groupings. In order to capture the essential elements of each participant's lived experience, the following step in the data analysis involved writing *textual descriptions* and then developing *structural descriptions* based on the participant's experiences. Lastly, a *combined textual-structural description* was drafted to capture the essence of each participant's experience (Table 3).

Table 3

Keywords/Phrases/Subthemes/Major Themes

Table 3. Keywords/Phrases/Subthemes/Major Themes

Keywords	Phrases	Subthemes
Major Theme 1: SRA within a MTSS Framework		
Interventions, multi-tiered, SRA, suicidal ideation, targeted interventions, assessment, over-identification of special education, under identification, social-emotional, behavioral, mental health, process, data gathering, interview process, holistic, public health preventative framework, referrals from teachers, staff, peers, typically low risk, moderate or high typically underlying issues	Asking the right question; allow us to determine level of risk; list of interventions to pull from; student made statement to peer, journaled that triggered peer or adult to refer; fragmented, disconnected items are risky; consider ideations, intent and plan; depends on three tier levels of support needed	n/a
Skill Deficits, small group, individual, curriculum, therapeutic, clinical, diagnosis, evidence-based, academic, fidelity, implementation, lack of literature, focused on safety; practical	Never seen literature; it gets tricky because we're schools based not clinicians; heard of but never seen modeled; limited training in graduate program, PDs are general not specific to follow-up, no standard protocol for tiered-interventions; never considered SRA and MTSS	Flawed: Interventions but not necessarily aligned with MTSS.
Stressful, Overwhelmed, Approach, assist, stakeholders, constraints, limited resources, staying in your lane, competence, non-existent, solo expert, reliance on one subject area expert, scheduling, unavailability of team, daily/weekly meetings, progress monitoring, non-data gathering, inadvertent triggering, positive and negative dependent on individuals, caring, paperwork, critical information system, multiple tasks/ expectations	School team knows what they're doing or can work together; being able to pull from a team; I've had different experiences; team knowing their roles and their responsibilities	SBMHP team work

Acknowledge, hospitalized, clinical, diagnosis, stressors, belonging, high risk, safety planning, emergency department, psychiatrist, professional counselor, re-entry meeting, underlying issues, know the student, rapport, bio-psychosocial factors, cofactors, rely on outside providers, bullying	Always look at good safety plan; construct some type of behavior plan; create a plan to include parents and basic follow-up including outside sources; tackles home and school issues	Student Safety
Keywords	**Phrases**	**Subthemes**
Major Theme 2: Risk and Protective Factors		
Warning Signs, classroom lessons, perception, small group, individual, suicidal behavior, check-ins, interventions, developmental stages, military status, family history of suicide, Joiner's ITS	Some type of counseling; some type of informal assessment; look for pertinent risk factors; if you don't catch those signs or see those signals	n/a
Feelings, Anger, Frustration, not a real threat, triggered, therapy, bullying, violence, stressors, limited vocabulary describing emotions, feeling, risk factors,	Anger and frustration rather self-danger; can depend on development level; determine if viable threat or misspoke emotion/statement; amazed can't name emotions and feelings	Poor Coping Skills
Effective, Increases attendance and graduation rate, support, favorite artists, relieve stressors, self-esteem, angles, drama free, high-risk, hobbies, accessibility, transitions, peer connections, partnerships, churches, local agencies, community engagement, progress monitoring	Social support or social group effective; they feel left out; let them know they matter; positive friend group is important; negative space can be tied to their connections	Group/Club Involvement

Keywords	Phrases	Subthemes
Major Theme 3: Belongingness and the Importance of Connections		
Counselor, School Psychologist, Teacher, Principal, Administration, LPC, school connectedness, guidance counselor, coaches, front-office, lunchroom staff, maintenance staff, partnerships, social workers, Joiner's ITS, significant amount of time with student, one connection better than none, may not be SBMHP	Make the students feel connected; very important to build that sense of community; some parents are more resourceful; checking in knowing the kids connections and being connected	Adult Connections
Parent, connected, relates, important, burden, capability, acceptance of issues, reluctance, resourcefulness, educational level, employment status,	How supportive are parents; examine student then call parent; talking with parents important even if not an intervention; education and knowledge of what it looks like	Parent Connections

Theme One: SRA Within an MTSS Framework

The participants had diverse experiences when working within an MTSS framework. The primary goal of MTSS, as agreed upon unanimously by all participants, is to address each student's particular needs in terms of curricular access and safety. Nonetheless, the majority of participants deliberately did not consider MTSS and SRA when developing follow-up interventions with students following an SRA. The majority of the work done in schools related to MTSS and SRA are focused on Tier One Interventions and Safety Planning. Some participants addressed the progression of safety planning as part of a Tier 3 re-entry meeting following an elevated risk assessment.

Participant Six and Eleven stated they had never read or heard of specific literature on the topic of SRA and MTSS together. MTSS is a holistic approach involving identifying and implementing interventions that address the specific needs of students, whether they are related

to social-emotional issues, suicidal risk, or any other needs. However, without intentional thought towards aligning SRA and MTSS, SBMHP felt that the pragmatism and organic nature of interventions connected well with the public health initiative of MTSS as a preventative framework. Participant Six stated, “the definitional force of multi-tiered systems of support and RTI is a holistic view of problems.” SBMHP emphasized that student service delivery focuses on accessing the curriculum and student safety in the school setting. Subthemes generated from this theme include Flawed: Interventions, which are not necessarily aligned with MTSS, SBMHP Teamwork, and Student Safety.

Sub-theme One: Flawed: Interventions but not Necessarily Aligned with MTSS. Throughout the interviews with participants, there was a consistent reference to systemic challenges in implementing Tier One interventions due to a lack of fundamental support for successful implementation. Furthermore, the participants demonstrated a lack of knowledge regarding MTSS and SRA, as the majority could only provide a conceptual description of the alignment of these terms. All participants stated they were unfamiliar with or had not yet perused information regarding the tiered interventions implemented in response to SRA findings.

Participants expressed a lack of literature addressing the specific topic of supporting students with suicidal ideation from an MTSS framework. Participant Eleven notes: “I've never thought about SRA in terms of like, multi-tiered systems of support.” Participant Twelve states, in response to his experience with MTSS and SRA, that he never received specific information, and outside of referrals to mental health, he had not implemented follow-up services. The participants expressed that most tiered interventions were primarily for academic problem and tiered interventions for suicide, mental health and social-emotional concerns lacked the robust efforts as academic interventions.

Participant Two described the holistic or universal function of MTSS as a Tier One Intervention when implemented. By implementing Tier One preventive measures, students are prevented from being inadvertently placed in special education and are instead specifically identified and supported within general education programs. Furthermore, Participant Two elaborated on the distinctions that existed between MTSS and traditional tutoring. MTSS interventions are targeted and are accompanied by forms of data collection and progress monitoring. When addressing the difference, Participant Two explained:

MTSS gives us the guidance that these (interventions) are going to be targeted interventions. The interventions are evidence-based to remediate and bring students back where they need to be.

MTSS often involves the engagement of teachers and staff in implementing universal as well as individual interventions. Participant Two spoke about her district's extensive efforts to work with teachers and schools on Tier One. Some participants noted that MTSS alignment was impacted by whether the student received other services, such as Special Education Services. In this case, the SBMHP would default as the lead facilitator of the school's response and relegate that role to the Special Education Case Manager.

Participant Three described the challenges she faces when striving to fulfill students' individual needs based on tiered levels as an SBMHP team. Participant Three highlights the difficulties she faces while addressing the growing social-emotional and mental health needs of students. She acknowledges that her primary focus as a school nurse is not specifically on mental health. A troublesome issue for her was the scarcity of other mental health professionals. Participant Three states:

I'm seeing a lot of anxiousness and social anxiety, and students are coming to see me crying or not wanting to be in the classroom. I'm a safe place for students.

Participants discussed the lack of human resources in the building. Executing an MTSS necessitates the involvement of several specialists in the educational environment. Participants cited that often, the SBMHP are shared among multiple buildings. Additionally, SBMHP are often tasked with multiple roles, leaving minimum time to implement, manage, or support interventions with staff or students. Participant Eight described their dilemma as such, “I am not a stable person in a building .”Participant Six summarized his position and the challenges he encountered in relation to ethical considerations and time constraints. He acknowledges the demands to sustain a rapid tempo of task completion.

Participant Four commented on two difficulties that present difficulty in the classroom environment. Participant Four found it challenging to accept that some of these difficulties are beyond the SBMHP control, as the solutions seem obvious in concept. Participant Four explained that instructor's and administration's expectations for SBMHP time allocation to support students might be more practical. Participant Four highlights a substantial need for clarification on the time required to assist students. Moreover, there needs to be more understanding of the time constraints related to the procedural aspects involved in SRAs and the implementation of tiered interventions.

The idea of aligning interventions with SRA results is great. Aligning MTSS with SRA in the classroom is challenging due to time restrictions and limited resources. Some participants linked these challenges to training, restricted resources, and time limitations.

Sub-theme Two: SBMHP Team Work. Many participants noted their experience as members of suicidal behavior response teams, including the CARES Team, Triage Team, Crisis

Team, and Student Support Team. A significant proportion of respondents assuming the role of school psychologists indicated a less cohesive team dynamic, attributing this to the role and expectations of school psychologists in the school building to be the subject matter experts. However, individuals in positions such as school counselors and nurses observed significant variation in their experiences partnering with SBMHP due to factors such as school placement, administrative structure, and temperaments of team members.

One concern regarding teamwork and SBMHP is its dependence on one individual to serve as subject matter expert. While this expectation is reasonable and warranted, it raises the question of how an individual can effectively fulfill the multiple responsibilities while also managing to align SRA within an MTSS. Participant Eight elaborated on several drawbacks associated with teamwork, including the reliance on one team member as the expert. This strategy does not encourage a collaborative culture or leverage the experience of a teammate. Participant One remarked that the difficulties in collaborating might often stem from a shortage of personnel to offer the necessary expertise and support.

Participant Four stated that the most difficult aspects of teamwork are the misunderstanding of roles and expectations. Participant Ten discussed the advantages of fostering a construction and cooperative team environment. Participant Seven shared that for the most part they work with very dedicated and empathetic team members. They shared an example of working with an administrator who lacked basic mental health training. Participant Seven states, “I had one principal that was just like, I don't get it, like tell them Don't do it. Like, just don't be sad”.

Ten of the 12 participants described instances of engaging additional team members, primarily community-based counselors and psychiatrists, as subject matter experts responsible

for the student's overall treatment plan. The participants expressed concern about engaging competent individuals and "staying in your lane." The participants unanimously consented to the limitations of school-based mental health services. They stressed the importance of including outside resources to address clinical concerns that are often associated with an SRA. The participants shared their understanding of tiered interventions that would assist different clinical diagnoses. However, they emphasized that the objective in the school setting is not to deliver services at a therapeutic level. Participant Four discussed factors and barriers to providing therapeutic care in the school setting. As discussed in the interviews, the school environment is not a therapeutic setting, and it is rare to have opportunities to have consecutive sessions with a student. Participant Eight noted the challenges of delivering school-based services as such:

> We're school-based and we're not clinicians, so we're looking at different goals. We're not looking to provide clinical treatment or, person centered therapy or behavioral therapy. We are looking to provide them with strategies to address, how to identify what those feelings and emotions are and then providing the appropriate coping skill that will help manage those things in school.

Sub-theme Three: Student Safety. Most research participants reported implementing measures to increase safety among students once a suicidal risk was identified with a student, including communication with parents and safety planning. Participants addressed Safety Planning as an intervention used when managing suicidal behavior. Participant Four emphasized the significance of incorporating the knowledge and expertise of all stakeholders in the safety planning decision-making process.

Participant Seven shared their perspective on the role of SBMHP in addressing the total needs of students, including social-emotional and mental deficits. Participant One described the

procedures utilized to convey safety plans established by medical professionals prior to the student's reintegration. Participant Twelve cited that contact with parents was paramount whenever there was engagement with a student, regardless of the level or intensity of the contact.

Participant Seven discussed the integration of teachers into the MTSS process. Highlighting how effective communication was used to convey crucial information in a need-to-know manner about students' suicidal risk and safety plans while the students are under the teacher's supervision, as well as strategies for the teachers to provide support to these students. Participant Ten emphasized the value of executing a well-developed safety plan. Participant Six discussed variables that are taken into account during the formulation of a safety plan.

Participant Six discussed how students' safety is put at risk when SBMHP initiates therapeutic and interventional procedures prematurely. Participant Twelve added further potentially unsafe practices SBMHP engages in and the importance of collaborating with an appropriate expert.

Theme Two: Risk and Protective Factors

Throughout the interviews, participants reiterated the importance of assessment and data gathering, which is inherent in this process. Participant Six noted the value of a high-quality bio-psychosocial assessment. The deliberate data gathering process during assessment can yield pertinent information on risk and protective factors and the entire Multi-Tiered System of Supports (MTSS) process. Many participants noted that the intentional inclusion of risk and protective factors is often ignored because of the pressing demands of their job duties.

When questioned about their experience with SRA, multiple participants spoke of inadequacies in students' coping abilities, which frequently led to a referral for an SRA or served

as the root cause of a student's frustration rather than their involvement or contemplation of suicidal behavior. Participation in group or club activities was mentioned as a risk and protective factor.

Sub-theme Four: Poor Coping Skills. Participant Two expressed how coping skills present differently depending on the developmental age of the student. Participant Two shared, “the initial referral may be a threat or self-danger to self, many times in elementary school, it's more anger and frustration and things like that”. It was noted that sometimes, the risk is an overreaction or poor coping skills and not necessarily suicidal ideation. Participants discussed methods to address inadequate coping skills, which differed from interventions chosen for an elevated risk level.

Sub-theme Five: Group/Club Involvement. Participant Five observes that when students find themselves in a negative space, it is frequently due to issues with their social connections. Participant Nine characterized the dynamics of these interactions as a negative space. Participant Seven elaborated on how their school addressed engaging students in group/club activities. She noted one of the reliable steps was finding out the students’ interest and pairing the interest with an extracurricular activity. Several SBMHP took initiatives to decrease hurdles preventing students from engaging in clubs/activities, such as transportation and financial issues. Participant Five shared how their school and a local church have formed a partnership. In the partnership, the church developed a club with a focus on creating a space for students who felt left out. As a way for students “to know that they matter and have opportunities to experience success.”

Theme Three: Belongingness and the Importance of Connections

School connectedness is considered a protective factor. The spirit of school connectedness was a theme reverberating throughout most participants. The consensus of the group conveys how critical the connections between adults and parents are. They also recounted several incidents of students sharing their desire to have a parent or guardian type to connect with at home. From working with students, the participants agreed that the student needed to feel the connection that comes from someone genuinely caring. Many of the participants pointed out that this participant did not have to be them as the SBMHP. As Participant Nine summed it up, "an aware and caring teacher, with boundaries/expectations especially in the elementary grades." Participant One expressed the vital role of establishing connections during the process of data gathering for the SRA, emphasizing the critical function it plays in the intervention phase.

Sub-theme Six: Adult Connections. Participant Four remarks that students are seeking opportunities to make contact to make connections with adults in the building. Stating that "is what they really want and need---real connections can someone genuinely support their needs." Participant Nine notes that connections to specific adults in the school setting can serve as a protective factor. Participant Three remarks, "I think rapport with a student is very important." Participant Eleven states, "It is important to build relationships and connections as well as identifying student needs and listening to them and then trying to meet those needs."

When sharing about connections and their importance upon serving the needs of students, Participant Five expressed the importance of relationship building, connections, identifying student needs and listening with the intent of trying to meet the student needs. As Participant Four shared, outstanding counseling skills are not necessary but rather genuine concern and dedication to providing the best care for students.

Some participants spoke of the connection of teachers and, at times, the reluctance of teachers to make the connections that any level of suicidal behavior carries a risk. Some participants spoke of teachers receiving notes from suicidal students or peers concerned about potential risk. Participants also spoke of teachers and staff taking proactive roles in reaching out to the SBMHP without making assumptions. Participant Two addressed the significance of gaining the support and commitment of teachers, highlighting how their training equips them to effectively implement interventions that target students' social-emotional and academic deficiencies concurrently.

Participant Seven expressed their viewpoint regarding the influence of SBMHP in establishing connections with adults in the building, as well as the inadequacy of schools solely adhering to the minimum requirements. Many participants expressed similar sentiments that their schools were focusing on bare essentials and not implementing genuine efforts when addressing the increased youth suicide crisis.

Sub-theme Seven: Parent Connections. When Participant Nine considers risk factors, she considers the lack of emotional connections with family members. Therefore, acknowledging the critical role of parents as both a protective and risk factor. Several participants mentioned the disconnect between parents and the follow-up care, particularly in the reentry phase of an elevated risk. Participant Three notes that often, parents will show up in the morning with paperwork (from an outside source, i.e., emergency department), expecting the student to simply return to school. Participant Seven pointed out that their school attempts to establish links between stakeholders, with a specific focus on ensuring the safety of students at home, when discussing risks and protective factors. Additionally, Participant Seven highlighted certain challenges the school encountered due to uncooperative parents. Participants identified various

aspects that influence whether parents act as a protective or risk factor, including resourcefulness, awareness of issues, educational background, employment status, and having dual military parents.

Research Question Responses

There were three research questions for this study. The questions sought to understand the lived experience of SBMHP regarding aligning tiered-interventions subsequent to an SRA. By employing the research inquiries as benchmarks, SBMHP were able to elaborate on their experiences developing, implementing, documenting, and monitoring the process surrounding student suicidal behavior within an MTSS framework. The first research question was *What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?* The second research question was *What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?* The third research question was *What are the experiences of SBMHP with protective factors when conducting SRA?*

Research Question 1

The first research question, *What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA,* was answered throughout all the themes. This question was the over-arching one to get a feel of the participants' thoughts about their work in general, and it supported the development of Theme One. In Theme One: SRA within an MTSS Framework, Sub-theme one: Not necessarily aligned with MTSS, Sub-theme two: SBMHP teamwork and Sub-theme three: Student Safety.

Several participants mentioned that although they had limited experience in aligning SRA results with tiered interventions, it does "make sense." However, due perhaps to time constraints, paperwork, lack of training, and the school's overall failure to function on evidence-

based pedagogy, mental health in schools, particularly in terms of suicidal behavior, lags behind in SBMHP training and delivery of services to students. The first research question was also answered and addressed in Theme Two: Risk and Protective Factors and Theme Three: Belongingness and the Importance of Connections.

Most participants stated that a typical SRA assessment was a teacher or concerned peer referral, with most SRA results yielding a low risk. High school providers administered the highest number of SRAs among individual SBMHPs, and this seemed to be correlated with grade level. Participants who served at the high school level said that they routinely administer SRAs on a daily basis. Participants who served at the elementary level expressed that results were typically low, with minimal expression of suicidal ideation but more of poor coping skills, frustration, or insufficient emotional regulation. Participant One acknowledges that recent laws implemented in light of previous school violence have led to increased awareness and instruction from her district regarding protocols for addressing homicide or suicide risk. The guidance instructs SBMHP to treat all threats as significant unless evidence from data shows that the risk of harming oneself or others has been resolved or disproven.

SBMHP across grade levels reported that often multiple SRAs are conducted on the same student, or as Participant Ten characterized "high fliers." Some participants expressed frustration with securing appropriate interventions for these students, who frequently triggered the need for an SRA. The frustration was exacerbated by a lack of resources to support these students, who often had underlying behavioral, social-emotional, or mental health issues, with the antecedent being outside of the school setting. With a typical SRA time commitment being reported as a minimum of two to three hours, and safety planning requiring an additional three to ten hours the amount of time spent on these students is substantial and often yields minimal

progress. Participant Seven expressed, “there has got to be a better way.” Similar sentiments were expressed by other participants of a more effective resolution to providing tiered level support to these students.

Although none of the participants implemented a formal MTSS at their schools, they all prioritized safety and implemented a safety plan as an intervention for completed SRA involving suicidal behavior, regardless of the risk level. Several participants utilized a standardized safety plan template provided by their district/school. Some participants mentioned using a self-made safety plan template, while others reported using safety plans provided by the student's parents or external sources such emergency departments, psychiatrists, pediatricians, or therapists/ counselors. A comprehensive safety plan was seen to encompass multiple factors, including past history, previous attempts, and stressors. Participant Six stated that when creating a safety plan, he conducted a comprehensive examination of the student's background, which encompassed factors such as exposure to suicide, mental health diagnosis, history of bullying, and social interactions at school.

It was reported that the work demands of SBMHP can be stressful, and many participants reported feelings of being overwhelmed on a daily basis. The demands varied per grade level and service provider. For most participants, time constraints and clinical concerns were the two most enormous demands on their time that impeded service delivery to students. Time constraints contributed by several contributors vary slightly by the type of service provider. School counselors expressed duties such as classroom lessons, scheduling, Section 504 and special education meetings, testing coordination, small groups, social skills, emotional regulation, and constraining their time. Most school psychologists reported concerns about being expected to address student's clinical issues.

Moreover, the ethical issue for service providers was reported of addressing clinical issues in a non-therapeutic school environment while often outside the scope of their training and performance expectations. Additionally, school psychologists reported that their limited service time in buildings or more so that they service multiple buildings restricted their ability to deliver interventions. Participants Two and Twelve shared that they were okay with being perceived as the expert expected to develop interventions. However, they expressed concern with the implementation and fidelity of the interventions they developed for others to implement. Failure of others to implement the plan would lead to students being inadequately serviced for such severe matters as suicidal behavior. The Licensed Professional Counselor (LPC) notes that she is often "putting out fires" with such a high caseload that developing tiered interventions is an "after thought." She shared that she typically pulls from her "toolbox" of strategies, techniques, and interventions. The school nurse explained that caring for students' health issues was demanding. She felt overwhelmed in her building as the school psychologist was unavailable on certain days, and the school counselors only dealt with academics.

While participants noted collaborative efforts when conducting an SRA, only three participants expressed any collaborative efforts in developing interventions or a safety plan. While most participants thought it was a good idea, they expressed the need for more teamwork or collaboration among SBMHP. When asked about collaborative work in developing interventions as an SBMHP, Participant Eight responded, “it doesn’t exist.”

Participants explained and gave examples of implementing Tier 1, Tier 2, and Tier 3 interventions. Tier 1 techniques utilized or considered appropriate include finding the function of the behavior, communication, connections, psychoeducation, and universal supports. Participants’ recommendations for tiered supports and strategies for students are listed in

Appendix H. Tier 2 interventions involve continuing Tier 1 counseling strategies, as well as creating a behavior plan with the student, maintaining deliberate communication, establishing and monitoring connections, and engaging a school-based mental health team. Tier 3 interventions involve increased services and intensity of support to include more outside community resources, daily engagement of school-based mental health team, and intensified communication, in addition to Tier 1 and Tier 2 counseling supports.

When addressing specific interventions within tiers, Participant Eleven notes that when she can administer a universal Tier 1 intervention, such as Signs of Suicide, to an entire grade level, she tends to see an influx of false positives. She expressed challenges when implementing Tier 3 interventions, such as a residential facility recommendation. Participants primarily utilized psychoeducation, counseling, and connection activities as their preferred intervention options. Several participants highlighted the distinctions between the common Check-in/Check-out (CICO) technique used frequently in schools and check-ins. Participant Four clarified that the distinction between the two techniques lies in the fact that Check-Ins involve a brief observation of the student, which may occur anywhere in the school environment, such as the hallway or lunchroom. With CICO, students have a certain level of awareness.

Like many other participants in the study, Participant Eleven expressed reluctance from parents in accepting recommendations. In addition, she expressed she experienced reluctance from the administration when making certain recommendations. She expressed that, at times, she has felt pressure from the administration to engage in situations that she perceived as illegal and unethical. Participants' experiences conveyed an understanding of the continuum of services offered in a tiered support system.

Research Question 2

The second research question, *What are the experiences of SBMHP with students' risk factors when selecting tiered interventions,* was evident throughout the interviews. These risk factors appeared in all three themes but particularly in Theme Two: Risk and Protective Factors; Sub-Theme Four, Poor Coping Skills; and Sub-Theme Five, Group/Club Involvement. Typically, identifying risk factors involves interviewing the student or the referring individual using a standardized risk assessment protocol. Participants noted that most standardized risk assessment protocols provided a compilation of risk factors to select from as applicable to the student's needs. The more risk factors selected increased the rating of suicide risk. Participant One shared that she felt the interview process was a critical risk and protective factor when assessing students and that it is important to go beyond the standard questions and individualize the process.

All participants acknowledged the importance of communicating with parents. Parental involvement was expressed as a risk and protective factor. Students may perceive parents as sources of stress, either directly or indirectly. Utilizing parents as an intervention entailed the SBMHP educating them on risk factors, such as warning flags, and linking them to community resources.

During participant interviews, they were questioned about their perspective on the necessity of SRA and MTSS. When questioned if they thought the process of SRA and MTSS was necessary, 100% of the participants said yes. Some participants noted, "I think it can be done at an organic level." Instead of a formal process, the participants stated that staff and teachers' connections and relationships with students would trigger the need for interventions when a student was at risk or "falling off." ESSA law requires evidence-based interventions to address

differentiated student needs, including suicide risk. Several states and national professional organizations have included requirements for schools to deal with risk factors by implementing thorough suicide prevention policies and procedures. One of the intents of laws introducing MTSS and similar systems was designed to ensure students receive what they need. By implementing general education programs under the MTSS framework criteria, many students' needs were addressed, preventing a potential referral to a more restrictive program. As many participants indicated, some students' issues are not special education issues. However, without preventive and intentional interventions to address the issues, the pipeline to special education continues to be overburdened. Student placement into special education surpasses the federal ratio of general education to exceptional education student ratio, particularly impacting marginalized students.

One risk factor that participants discussed as troublesome was team members' "not staying in their lane." Issues such as suggestions of inappropriate interventions and confusion on the assignment of responsibilities, particularly follow-up actions, were noted as "not staying in their lane." Additional risk factors identified throughout the interviews included further data collection methods, including reviewing academic records. Increased administration of SRA at the end of the semester was observed and remarked as triggering stressors and emotional dysregulation. Therefore, reviewing grades and progress reports is a risk factor when collecting data for SRA or tiered interventions. Other participants used a similar method of periodically reviewing the "D and F" list of students.

Admittedly, most participants report that they did not consider risk factors as a strategy to employ within-tiered interventions as a universal strategy or Tier 1. Instead, risk factors were considered more often as part of a Tier 2 or Tier 3 response but usually from a safety

perspective, not necessarily as a tiered intervention to support or meet the students where they were. The participants emphasized the importance of collecting data about risk factors. It was noted that essential to assessments was "a good bio psychosocial assessment across many settings." Eight participants spoke of the importance of students' engagement in groups and clubs and teaching self-regulation strategies and emotional vocabulary to students to diminish risk factors and poor coping skills identified in the results of SRA with minimal risk levels.

Research Question 3

The third research question, *What are the experiences of SBMHP with protective factors when conducting SRA,* was answered in Theme Three: Belongingness and the Importance of Connections, Sub-theme Six: Adult Connections and Sub-theme Seven: Parent Connections. While interventions were viewed as important, the implementation of tiered interventions was expressed as an idea but not necessarily a goal when addressing how to support the results of an SRA. As Participant Nine shared, “In an ideal situation, MTSS would pair perfectly with SRA - depending on the level, interventions could be matched.”

Joiner’s ITS (2005) outlines three components that lead to suicide. The components of ITS align with the function of protective factors to decrease vulnerabilities. Protective factors are frequently disregarded in studies yet play a crucial role in decreasing vulnerabilities to suicidal behavior (Haghish et al., 2024). Participants’ elaboration of the function of protective factors was vague, and they did not recognize interpersonal dynamics specifically as a factor contributing to protectiveness during an SRA. However, the theme of belongingness highlights how the intricate dynamics of interpersonal relationships were interwoven in SBMHP experiences.

Participant Two encapsulated the general consensus among many participants regarding protective factors. Participant Two elaborated: “It is important (to students) to have a team or at

least someone in the school building who understands that their feelings are valid". Staying current and being aware of trends is one method to address protective factors. Thus, leading to measure that validate student's feeling. These efforts were viewed as powerful.

In this study, participants identified several protective factors. Participants shared their thoughts of students viewing parents as sources of support which created a protective factor. Participant Four linked parental access to resources and educational level as a factor contributing to the favorable view of parents as protective factor by their student. Other protective factors that included relationships were interpersonal protective factors and individual personal factors.

SBMHP acknowledged that the interview process might be prolonged for students lacking coping skills. Furthermore, participants emphasized the need to prevent inadvertently escalating students' level of risk by not recognizing the limitations of the students' coping and problem-solving skills. Participants advocated the value of effective coping and problem-solving skills among students. Coping skills were mentioned in several interviews as a protective factor. The absence of these coping skills was considered an indicator of deficiencies in these areas during the SRA process. The indicators included statements of harm made in frustration, language acquisition, or proficiency concerns such as receiving Special Education Language Services or English as a Second Language.

In the interviews, participants expressed that their understanding of several protective factors was learned outside of their professional training and a product of trial and error, such as providing a snack to a student before attempting to conduct a risk assessment or walking around the school trail while completing an SRA. Participants conveyed disappointment in the amount of training offered in training programs and professional settings. Participants note if they did receive training in graduate school, it was a lecture, and the time allocated for this topic was not

adequate to prepare SBMHP to be competent in aligning or selecting protective factors as part of the process of conducting an SRA.

Many participants mentioned that utilizing basic mental health principles is crucial to successfully strengthening protective factors. Participant Seven described the importance of the utilization of basic mental health principles by SBMHP. Participant Seven stated:

> Basic Mental Health Principles are essential to being available to understand that we, as SBMHP, do not have to agree with the issue but acknowledge in a safe manner it is how the student is feeling.

Basic mental health principles not only applied to SBMHP but to students in regards to increasing protective factors by strengthening problem-solving and coping skills. The synergy of the school-based team was noted to be an important protective factor. Several participants shared that the competence, compassion, dedication, and respect shared among team members contributed to a cohesive approach to providing students with optimal care both during the SRA process and the selection of interventions in the MTSS process. As one participant summed it up, "if we can show hope and support for each other, the student may believe we can support and are trustworthy." Participants in this study agreed that support from teachers and administration was invaluable for SBMHP

A significant and incredibly impactful protective factor mentioned in the interviews was that people who are around students show caring. Participants remarked that even more important than having the solution was showing that you care. Participant Twelve summed it up as such: "the single most protective factor is whether others around the student care and can invest in a process that displays caring even if they don't know the solution." Active engagement with students while in the school building was viewed as a protective factor, as most participants

noted. Participants elaborated that if relationships are built prior to the crisis and if the student feels a sense of safety with the SBMHP it increases the likelihood that the validity of the response to questions asked is authentic; these sentiments were expressed among all middle and high school participants.

Summary

This chapter provided the research results and findings from SBMHP lived experience in aligning SRA results within an MTSS. Individual portraits of the 12 SBMHP appeared, and a group description of similarities and differences through demographic information, interview responses, focus group, and reflective journal entries. An analysis of the data revealed three themes. All three themes explored the experience of identifying tiered interventions and aligning the interventions to suicidal risk levels. These three themes represented the lived experience of school counselors, school psychologists, and a school nurse, highlighting their individual and collective understanding of SRA and MTSS. In Chapter Five, I will summarize the findings and discuss the results, implications, delimitations, and limitations. After that, I will offer recommendations for future research.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this qualitative, phenomenological study was to describe SBMHP experience in aligning multi-tiered interventions or MTSS following the SRA process when working in a K-12 school setting. Individual interviews, focus groups, and reflective journal writing were used to capture participants' experiences.

Given this study's conceptual framework, SBMHP's understanding of aligning interventions with SRA results is significant. Bronfenbrenner's Social-Ecological Model (SEM) theory emphasizes the importance of examining and addressing all elements of a student's environment, including the macro, mezzo, and micro systems, in order to gain a comprehensive understanding of and effectively intervene in suicide risks (Wofford et al., 2019). According to Joiner's ITS theory, an individual's susceptibility to engaging in suicide behavior is influenced by vital interpersonal factors and their acquired capability, as stated by Singer et al. (2019). When viewed collectively, these theories indicate the success of interventions aimed at reducing the risk of suicide behavior delivered within an MTSS framework, which can be influenced by the understanding of SBMHP. The input of SBMHP individuals who have delivered SRA was explicitly solicited, as they are assumed to possess expertise in delivering interventions. The experience of SBMHP who have administered SRA was explicitly solicited, as they are assumed to possess competence in delivering interventions.

The significance of this research study directly relates to school nurses, school social workers, school counselors, school psychologists, administrators, and policymakers at all levels, local, state, regional, and national, as well as educational stakeholders, including parents, teachers, students, and the community.

This study was guided by three research questions:

RQ1: What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?'

RQ2: What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?

RQ3: What are the experiences of SBMHP with protective factors when conducting SRA?

This chapter provides a concise overview of the study's findings and discusses the theoretical, empirical, and practical implications of these findings, drawing on relevant literature and theory. The study's delimitations and limits are outlined, and suggestions for future research are provided.

Summary of Findings

This qualitative, phenomenological study describes how SBMHP expressed their lived experience with aligning multi-tiered interventions (MTSS) with the results of an SRA, reflecting the factors that contributed to the alignment or misalignment and the effectiveness of the interventions. There are studies surrounding the training of SBMHP on suicide prevention (Brown & Edwin, 2024) as well as SBMHP roles within the MTSS framework (Marsh & Mathur, 2020). However, a gap exists in the literature regarding the experiences of SBMHP when aligning SRA results within an MTSS framework. Therefore, this study focused on the need to consider the lived experience of SBMHP in selecting interventions to improve their knowledge base and understanding. Additionally, it provided data that supports the enhancement of SBMHP skills in dealing with suicidal behavior. This research study allowed SBMHP to

describe their experiences selecting multi-tiered interventions, following an SRA at the elementary, middle, and high school levels.

Twelve participants met the criteria for this study and completed the demographic questionnaire and semi-structured interviews. Five participants participated in the focus group, and 10 participants participated in the reflective questionnaire journal writing. The resultant data was analyzed using the modified Van Kaam analysis method, which included four analytical and three descriptive steps (Moustakas, 1994). Three themes arose from the resulting data analysis. Theme 1: *SRA within an MTSS Framework,* Theme 2 was *Risk and Protective Factors*, and Theme 3 was *Belongingness and the Importance of Connections.* Within these themes, the participants' responses answered the research questions.

The Research Questions

The study intended to understand the lived experience of the SBMHP question by addressing three research questions. The first research question was: *What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA?* The second research question was: *What are the experiences of SBMHP with students' risk factors when selecting tiered interventions?* The third research question was: *What are the experiences of SBMHP with protective factors when conducting SRA?* Three primary themes and seven sub-themes arose from the data that applied to the research questions. The three themes were Theme 1: *SRA within an MTSS*, Theme 2: *Risk and Protective Factors*, and Theme 3: *Belongingness and the Importance of Connections.*

Research Question 1

The first research question, *What are the experiences of SBMHP when aligning MTSS with a completed school-based SRA,* was answered in all three themes. The intent of research

question one was to ascertain the overall experiences of SBMHP concerning the selection of multi-tiered interventions that aligned with the outcomes of an SRA. The study revealed that participants do not align MTSS with completed school-based SRA. The data shows that participants want to participate in an MTSS framework aligned with a completed SRA. However, currently, SBMHP does not work within such a framework due to several factors. It can be concluded that SBMHP engages in some level of informal tiered interventions. Participants identified student safety as a defining characteristic of their experiences. Most participants alluded to approaching the selection of interventions from a preventative or holistic framework. Admittedly, most participants had not aligned risk levels within an MTSS framework. However, several participants indicated that tiered interventions are organic and that a formal process is not necessary to ensure the safety of students. With that, most participants agreed that interventions within an MTSS framework ensure that students receive appropriate intervention with the appropriate intensity and are being monitored for effectiveness. Participants acknowledged the benefit of data gathering in terms of the effectiveness and efficiency of SRA and selecting interventions. However, SBMHP expressed high levels of apprehension at the cost of the benefit of aligning to an MTSS, which most likely would add to their already existing overburdened list of responsibilities. All participants considered approaching students' needs from an MTSS framework the most effective approach based on current research.

Research Question 2

The second research question, *What are the experiences of SBMHP with students' risk factors when selecting tiered interventions*, sought to elicit how SBMHP considered circumstances that increased students' suicide risk level and thus influenced the selection of intervention in the SRA process. When speaking of risk factors, most participants classified the

factors on a continuum according to the level of imminent risk to the student. Of paramount importance to SBMHP was the safety of students, which was mentioned as surpassing procedures, SRA, and was the ultimate intervention. During the interviews, it was observed that many of the risk factors identified in the SRA were taken into account while creating safety plans for students and presented during the reentry meeting.

Participants felt that the data-gathering process and the questioning were critical to ascertaining risk and protective factors. Participants were particularly concerned about the absence of coping/problem-solving skills as a significant risk factor. Inadequate coping skills often lead to an inaccurate elevation or false-positive elevation of suicide risk, triggered by expressions of frustration or impulsiveness. However, participants agreed that the necessity for interventions was genuine and ongoing, whether it involved teaching calming strategies or emotional vocabulary.

Research Question 3

What are the experiences of SBMHP with protective factors when conducting SRA? Research question three was to determine how SBMHP assessed the students' skills, strengths, and available resources of students to help them cope with situations that may raise the risk of participating in suicidal conduct. Participants spoke of how most SRA protocols queried for protective factors and integrated the information in assigning a risk level. The findings of the interviews, focus groups, and journals suggest a link between interventions aimed at strengthening or remediating protective factors, decreased suicidal risk levels, and increased academics and attendance. Results show that participants valued the concept of protective factors and frequently sought a deeper understanding of these protective factors when conducting an SRA, which was viewed as an essential priority in the process. Protective factors were

considered organically formulated rather than developed through a systematic process. The participants conveyed a strong feeling of duty to prioritize the safety of learners. Participants identified multiple categories that served as protective factors, with a significant emphasis on interpersonal ties. The presence of parental and adult connections, as well as participation in groups or clubs, were considered to have a significant impact in either preventing or deterring involvement in suicidal behavior. Participants are unfamiliar with the principles of Joiner's ITS. Although when the components of ITS were shared, some participants felt that the components were in line with their current practice and thoughts regarding the development, maintenance, and prevention of suicide behavior.

Discussion

This section will look at the relationship of the findings with the theoretical and empirical literature. The discussion sheds light on the relationships between the study's finding and the information presented in the literature review. Through this discussion, the study's impact on existing research can be determined.

Relationship of Findings to Theoretical Literature

This study of SBMHP experiences aligning SRA results within an MTSS was approached through a conceptual framework consisting of an Ideation-to-Action Theory: Joiner's ITS (2005) and a Public Health Approach: Bronfenbrenner's SEM (1979). Together, these theories established the connection between SBMHP experience with tiered interventions and suicide risk levels results.

Succinctly, Joiner's ITS (2005) asserts that suicidal behavior occurs when individuals develop the inclination and ability to move from suicidal thoughts to suicide attempts or completed suicides. His theory suggests that the interruption of suicidal behavior through

interventions can cause enough disruption to change the trajectory of the evolution of suicidal behavior, thus preventing or decreasing the engagement in suicidal behavior. Participants often cited these disruptions, including protective interventions and interpersonal connections, when mentioning tiered interventions implemented with students. At the same time, Bronfenbrenner's SEM (1979) public health theory outlines how a student's ecological communities impact a student's development. This study aligns with SEM theory, which suggests that the procedures and SBMHP are significant in selecting multi-tiered interventions that promote healthy development and mental well-being, focusing on preventive efforts.

The current study extends and sheds new light on theories informing the topic of utilizing a holistic or MTSS framework to meet student's needs in decreasing suicide risk. Analyzing the experiences of SBMHP efforts to intervene with tiered suicidal prevention interventions illuminates the need to understand the complexity of the multiple systems that affect students even before learning can occur. SEM promotes a comprehensive understanding of the interplay between these factors, what puts students at risk for poor outcomes, and what protective factors prevent students from engaging in suicidal behavior. A preventive framework allows for critical thought and analysis of the complexity of suicidal behavior while giving an opportunity to see the students and how they interact as individuals within relationships with others within the school setting. This analysis can be accomplished by surrounding the students with competent SBMHP who provide as much intervention as possible to safeguard their well-being and support whatever systems they need around them to create optimal outcomes. Intervention categories were not aligned along a continuum of escalating support as in an MTSS or tiered system. However, interventions emerged from the collective experiences of SBMHP within this study.

ITS is a prominent theory in how suicidal behavior develops and suicide prevention through *thwarted belongingness, perceived burdensomeness,* and *acquired capability.* However, only two participants could recall learning about or hearing about this theory in graduate training, professional, or personal development. Nevertheless, participants expressed the importance of addressing all three components of the theory throughout their interviews, focus groups, or reflective journals.

Participants stated the critical need to foster school connectedness to reassure students that they are *seen* to disrupt the feelings of *perceived burdensomeness.* A recurring theme addressed *is knowing* a student through daily engagement and effective data gathering. The implications of these activities inform the level of support the student may need. This recommendation of SBMHP is vital as another component of ITS is addressed: *acquired capability.* The study illuminates the significance of *connections* in disrupting thoughts of thwarted belongingness. It was recognized that connections with adults and within school functioned as protective factors. In contrast, risk factors were reduced when students purposefully connected with others, and accountability measures, including the implementation of safety plans, were regularly checked for progress. These findings are consistent with previous studies on the connection between schools and communities, indicating that individual viewpoints and support systems from both peers and adults serve as effective safeguards against suicidal behaviors (Marraccini et al., 2022).

The research literature suffered from a deficiency in understanding how suicide evidence-based interventions can be applied and implemented in contexts like schools (Krishnamoorthy et al., 2022). SBMHP experience aligning tiered interventions with SRA and the lack of research on SBMHP utilization of MTSS following an SRA. The primary objective of MTSS is to

respond to the individual needs of every student by establishing a secure and encouraging learning atmosphere through a research-backed framework that incorporates multiple systems (NASP, 2016). All participants in this study agree on the goal of MTSS. Participants would concur that completing SRA is elemental to assessing the needs of the student, as noted in previous research (Gould et al., 2009).

When the participants were asked if they aligned SRA results with tiered interventions, the overwhelming answer was “no.” The participants did not lack motivation to use an MTSS, as they unanimously acknowledged its benefits. Nevertheless, participants highlighted various obstacles that hindered integrating the results of tiered intervention with the outcomes of an SRA, such as implementation challenges, training limitations, lack of knowledge, and time constraints. Previous studies have shown that the effective implementation of MTSS relies on the proficiency and abilities of the personnel delivering the (Robinson et al., 2023; Eagle et al., 2015). The participants' failure to collaborate and operate as a team goes against the research that suggests incorporating implementation efforts into existing projects and promoting collaboration and teamwork (Briggs, 2017).

Relationship of Findings to Empirical Literature

The latest research on youth suicide in the school context primarily examined preventive and accessibility strategies. Participants were mostly aware of prevention programs such as Signs of Suicide but lacked a grasp of tiered prevention strategies beyond universal prevention curriculums and Tier 2 and Tier 3 strategies. According to O'Connell et al. (2009), there is a lack of comprehensive programs in schools that focus on preventing and managing mental health and behavioral emergencies. Although MTSS systems are recommended, the lack of qualitative research on integrating an SRA evaluation into an MTSS framework when evaluating participant

interviews means no clear guidance exists. This lack of guidance is revealed in the interview data, which shows consistent division in participants' perceptions of what the research supports.

This study's findings indicated that most participants highlighted the absence of structured protocols, such as follow-up procedures, for the initial findings of the SRA. Beyond standard SRA protocols for the initial steps of engaging students at risk for suicidal behavior and safety plans, the participants noted a lack of standardized procedures. The study findings also indicate that when participants tried to access training or literature, they found limited research available on implementing models of a framework merging mental health and tiered intervention. This study was conducted to address the gap in the literature related to this problem. In this study, the results of SRA are aligned with a multi-tiered response as a lived experience. This section will focus on the relationship between the empirical literature reviewed and the information revealed in the data analysis of this study.

Prior studies have investigated the efficacy of tiered interventions largely as a means of suicide prevention. Tiered interventions were noted to be effective (Van Der Feltz-Cornelis et al., 2011). Previous studies focused on teachers or individual service providers such as school psychologists, school nurses, school counselors, and teachers delivering interventions. The present study endorsed the delivery of interventions individually by mental health professionals as well as a few professionals noted they worked collaboratively on Crisis Teams, Student Support Teams, or Trauma Teams. Most of the participants in this study commented that they did not intentionally tier interventions or work collaboratively with other SBMHP.

All participants expressed insufficient or no training when addressing training in aligning SRA with an intervention or utilizing tiered interventions for social-emotional, behavioral, or mental health. These findings align with previous research on training conducted by Miller and

Reynolds (2021). The outlined goal of school-based SRA to identify and refer to appropriate mental health does not align with current federal and state mandates to provide a comprehensive approach to suicide prevention. Participants viewed that their responsibility included the two goals but included more steps than identification and referral. Participants discussed the importance of grade-level social-emotional lessons and small group and individual counseling that targeted problem-solving strategies.

Research suggests that schools are uniquely positioned to act as protective factors (Exner-Cortens et al., 2021). Participants suggest that the school environment can also be a source of risk factors. Most participants acknowledged the pivotal role teachers play in suicide-related interventions, as noted in previous research. The current study confirmed this thought and highlighted the pivotal role of parents and all adults in the school environment. Navigating the school environment can be challenging. Having supportive, knowledgeable, and available adults and peers can serve as critical interventions regardless of the suicide risk level of students.

Previous research has examined several risk and protective factors. Although this study did not examine safety plans and protective factors within an MTSS, participants noted that student safety was of utmost importance, and safety plans were the interventions most participants preferred when addressing protective factors. Poor coping skills, group/club involvement, and adult and parent connections were cumulative factors most participants considered a priority in conducting an SRA or selecting tiered interventions. Interventions that improve coping skills and increase group/club involvement add to the sparse literature available regarding protective variables. According to Breux and Boccio (2019), research indicates that parents are reluctant to support the implementation of suicide prevention measures in schools due to concerns about potentially inducing suicidal thoughts. The study identified parents'

reluctance as a risk factor and recommended educating them about these risks as a way to encourage more effective and adequate responses from parents. The current study supports these recommendations as a solution to address parents' hesitation. Few studies address factors that affect the most vulnerable student and low-risk students; in this study, participants spoke about behaviors they observed in students that seemed to elevate their risk level or frequency of referrals to evaluate risk levels.

Moving beyond research focusing only on prevention and Tier 1 universal interventions, this study shows a lack of difference between participants' Tier 1 and Tier 2 interventions. The significant difference in moving to Tier 3 was the engagement of community resources or involuntary referral to health agencies. It is through understanding the risk and protective factors of suicidal behavior, such as depression, anxiety, hopelessness, perceived burdensomeness, and other at-risk emotional and behavioral factors, that appropriate interventions will meet the needs of the individual student. By listening to the lived experience of SBMHP, ways to apply a research-based holistic preventive framework can be implemented to improve the functioning of mental health professionals in the schools while improving safety and diminishing the youth's suicidal behavior.

Implications

This section sets forth the theoretical, empirical, and Christian worldview implication of the study. This study brought to light several key implications spanning theory and practice for SBMHP.

Theoretical Implications

This study was grounded in two prominent theories commonly applied to suicide prevention and educational tiered interventions research: Joiner's ITS and Bronfenbrenner's

SEM. Both come together to suggest that the success of intervening with youth suicidal behavior through such initiatives as MTSS is determined, at least in part, by SBMHP understanding of a holistic, systematic response to students' needs surrounding suicidal behavior. Findings in this study revealed that participants lacked a holistic, systematic understanding of students' needs regarding suicidal behavior.

The results confirmed that studying MTSS and SRA was meaningful to the existing body of research. This study broadens awareness of the rise of suicide among youth. It expands the field of school-based mental health providers and underscores the need for competent professionals and tiered interventions to address the youth suicide crisis. Research guiding tiered interventions for preventing and supporting suicidal behavior in schools is virtually nonexistent. The findings have significant theoretical, empirical, and practical implications for MTSS and youth suicide within the school environment. The researcher’s study addressed the need to recognize protective and risk factors that significantly impact students in the school setting. It can be leveraged to support changes to local systems and practices that impact the well-being of students and families, so prompting schools/districts to engage in further assets planning.

Several of the participants shared that they experienced an exorbitant amount of paperwork and responsibilities that were stressful. Additionally, participants expressed that they did not feel skilled enough to address some of the clinical issues that many students were dealing with beyond suicidal behavior. It is essential that SBMHP voices are heard and actions are activated to improve the work conditions of SBMHP. Many participants chose the profession based on suggestions and exposure to other SBMHP. Maslow’s hierarchy of needs provides a lens to explain the importance of considering the basic needs of SBMHP as a means to retain and cultivate an atmosphere of respect and value for its needs.

Empirical Implications

Based on its empirical foundation, the study's results have major significance for key stakeholders such as state chief school officers, state and local school boards, state governors and lawmakers, district administrators, and SBMHP. It is important to focus on the training and proper implementation of MTSS for social-emotional, behavioral, and mental health issues due to the legal implications and potential consequences for LEAs that fail to comply and infringe on students' rights, as outlined in legislation like ESSA and IDEA.

Analysis of the data revealed various conceptions of targeted and tiered intervention. Some participants knew MTSS from an academic service delivery model perspective, while others were familiar with it from a behavior service delivery model perspective. Participants tended to identify the SRA process of assessing a risk level as the total process of addressing suicidal behavior. Although participants grasped the different levels of support, their explanations of interventions for each tier did not demonstrate a clear connection to variations in intensity, progress monitoring, data-driven decision-making, or collaborative teamwork and support processes (Sailor et al., 2021).

The limited available research suggests that tiered interventions are effective in addressing the youth suicide crisis, and SBMHP is vital in the holistic implementation, monitoring, and follow-up associated with an MTSS. Graduate schools must ensure that mental health professionals possess a comprehensive understanding of preventive paradigms in the setting of mental health. They should go beyond providing universal Tier 1 interventions for suicidal behaviors.

Moreover, research has repeatedly shown the importance of school-based SRA and MTSS in students' success. All participants agreed on the benefits and effectiveness of both SRA

and MTSS. Considering the participants' frustration and opinions regarding the time limits, paperwork load, and lack of quality training, district stakeholders should analyze the connection between the program's effectiveness and implementation science. Forman and Crystal (2015) identified several essential components for implementing MTSS, such as a supportive organizational structure, effective leadership, stakeholder engagement, training, and technical assistance.

Furthermore, this study raised essential questions about how SBMHP collaborative teamwork could be improved in schools. Participants expressed positive outcomes when team cohesion was achieved. Voicing apprehensions about teamwork with colleagues who misunderstood their roles or lacked the necessary skills may prove detrimental to student success over time. Brown-Chidsey and Bickford (2015) confirmed that a team approach is essential for tiered interventions and enhances the likelihood of maintaining progress, implementing strategies, and achieving long-term success.

The data revealed multiple possibilities for policy and practice implications. The policy has a significant impact on the curriculum design for training programs. Consequently, it is essential to assess policies and make required updates regularly. Policy improvements should be made to inform and prepare future SBMHP to serve kids who engage in suicidal conduct effectively. The findings of this study have major implications for practice and training in aligning tiered intervention with SRA.

Implications for Practice and Training

While numerous theoretical and empirical study findings necessitate substantial modifications to current procedures, there are also practical consequences that can be addressed more readily. The subjects included in this study are a subset of the general population of

SBMHP in the United States. However, it is possible for district stakeholders to deduce that there are several deficiencies in the alignment of SRA results with tiered interventions in SBMHP.

Given that SBMHP are present in the school environment on a daily basis, it is logical to assume that they are particularly well-positioned to address students' risk of suicide within the MTSS framework. Nevertheless, the participants discovered that they were ill-equipped to accomplish this task, either due to a deficiency in graduate program and professional development training or because of limitations on their available time. Administrators and school districts should assess the time dedicated to effectively implementing academic and behavioral interventions. They should also evaluate the unequal distribution of resources between academic interventions and suicide and mental health interventions. School districts are required to offer pertinent and prompt professional development. It is imperative for federal, state, and educational agencies to guarantee that SBMHP are provided with the time and resources to effectively address the needs of their students through systematic programming.

Christian Worldview Implications

Suicide is not new. In 2 Samuel, Ahithophel succumbs to suicide. However, many students will never feel the love of Christ or understand that God’s plans are for them to prosper and not to harm them. Plans to give them hope and a future (Jeremiah 29:11, KJV). As one participant mentioned, the students are “under attack.” Without adults standing in the gap, providing intercessors to meet students where they are with interventions, we risk youth never experiencing the love of Christ. Interventions that offer a pathway to recovering from life challenges and crises. Without these interventions, many students will succumb to the darkness of this world. The Christian worldview is centered around the Word of God. From this foundation, the primary reason for existence is to love and serve God. Jesus Christ exemplified

love through his actions. Jesus took time to bless and pray for children, recognizing and illustrating their value. SBMHP can convey a similar message of love through conversations and resources.

Youth is a time that is characterized by humility and childlike faith. The Body of Christ has an obligation to reach the youth and share the importance of a personal relationship with Jesus Christ. In contemporary culture, there is an abundance of trends and influences that have a detrimental impact on our young people, burdening them with baggage that they carry with them to school every day. The baggage ultimately weary them down and steals all the light that illuminates hope and faith until the youth feels that death and darkness are better than the light of life. Similarly to how Jesus Christ offers grace and mercy to anyone who seeks Him, SBMHP has the chance to imitate Christ's actions by reaching out to students and offering grace and mercy through interventions, such as building relationships, to demonstrate the significance and worth of their lives. Interventions that bring stability, guidance, security, and optimism in an environment that can sometimes provide very limited support in such aspects. Hope and community are two protective factors that the body of Christ may provide to youths. Adopting a Christ-centered worldview broadens students' perspectives on the concept of hope. Interventions represent optimism. In a similar manner to how Jesus provided hope to the woman at the well, he offered her water that would forever satisfy her thirst and grant her eternal life (John 4:13-14, KJV). A woman who was deemed undeserving of an intervention by many. My Christian worldview has a significant influence on every part of my life and is interpreted through the lens of God's love. Therefore, it is plausible that my worldview may have influenced the data analysis and findings.

Delimitations and Limitations

Delimitations

The purpose of this study was to explore the experiences of SBMHP in aligning SRA results within an MTSS, an area lacking in research studies. Boundaries were established to expressly exclude individuals who did not have expertise in delivering SRA within the last five years in order to capture the lived experiences of the population outlined in the study's purpose. SBMHP provides students with access to resources and professionals who are highly skilled in addressing suicidal behaviors within a school setting. SBMHP have played a crucial role in the introduction of MTSS in schools. The recruitment criteria led to the removal of teachers and support staff experiences that could have provided valuable insights for this study.

Limitations

In the research design, the study was limited to a sample of 12-15 participants. Sixteen participants responded to my inquiry, but only twelve teachers completed the required steps for participation. The sample's variability may have reduced the results' generalization power as the study focused on the lived experience of 12 SBMHP. Participants came from various professional specializations (school nurse, school counselor, school psychologist, LPC) and years practicing range (less than one year- 25 plus years), a number of campuses served (1- 4+), and from diverse academic backgrounds. The only criterion that was homogenous in this sample was that all participants had worked as school-based mental health providers within the past five years and had administered an SRA. Due to the diversity in the sample, the results of this study may have lacked generalization depth, ultimately limiting the certainty of my results. This study also limited the way in which the participants were recruited. Participants were self-selected or

recruited through snowball sampling, potentially biasing the results to be more suicide and MTSS-informed than the average sample of SBMHP.

An additional limitation is the biased interpretation of the data analysis and results. Although triangulation was used (Creswell & Poth, 2017), I remained the sole analyst of the transcripts. In this way, researcher bias may be present in the quote selection and analysis, ultimately influencing how themes were developed and how research questions were answered.

Recommendations for Future Research

Given the study's findings, as well as its delimitations and limitations, additional research is recommended. MTSS is to be implemented by all stakeholders, including teachers and support staff and integrated across academics, social-emotional and behavioral interventions. This research focused on SBMHP and social-emotional and mental health interventions. Thus, further studies should be conducted with teachers and support staff to support interventions to address all components of the whole child.

This study did not aim to assess the actual effectiveness of participants and the fidelity with which they implemented tiered interventions. Quantitative descriptive research should be undertaken to establish the relationship between SRA results and the choice of follow-up actions. These results would provide valuable information for professional development programming and may influence its funding.

The graduate training of future SBMHP can significantly influence the probability of broad and sustainable implementation of MTSS (Forman & Crystal, 2015). Researchers should take into account the lived experiences of SBMHP while addressing suicidal behavior among students within an MTSS framework. Future research should prioritize amplifying their

experience to contribute a fresh perspective to the current body of literature, training, and service delivery.

Summary

This qualitative phenomenological study focused on SBMHP experiences with aligning SRA results within an MTSS framework. Joiner's Interpersonal Theory of Suicide and Bronfenbrenner's Social-Ecological Model theories served as the theoretical framework for this study. Because ESSA and IDEA outline the expectations for districts to implement tiered intervention to address the whole child, including social-emotional and mental health concerns, districts are charged with ensuring that SBMHPs are equipped with the knowledge and skills they need to be effective. As indicated through the study's conceptual framework and empirical base, SBMHP understanding of suicidal behavior interventions and holistic view of the student is a crucial determinant of the effectiveness of a systematic implementation of targeted interventions like MTSS.

Results from the study revealed that participants had no experience aligning tiered interventions with SRA results. Numerous studies exist about content areas and the effectiveness of MTSS. Studies that explored suicide behavior and school response utilizing an MTSS framework were not found. While a response to suicidal behavior was the intent of this study, from the interviews, it was abundantly clear that a response to social-emotional and mental health concerns such as emotional regulation, anxiety, and depression was needed as well.

It is clear that an understanding of interventions that increase protective factors and diminish risk factors is needed to mitigate the public health crisis surrounding youth suicide. However, SBMHP lacks the readiness to offer tiered interventions to support mental health concerns, and they also feel insufficiently trained to implement, collect, monitor, and evaluate

data to intervene with students at different degrees of suicide risk effectively. SBMHP has indicated that the graduate preparation programs are not up to par, and adequate professional development is lacking. SBMHP stated that their roles in the schools hindered the adoption of an MTSS, as recommended by organizations like NASP and ASCA, in order to manage suicidal conduct inside an MTSS effectively. SBMHP acknowledges that they are overburdened, inadequately trained, and tasked with doing the most with the most challenging students. Additional support is required to help SBMHP implement relevant and efficient programming that positively benefits students.

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Appendix A: IRB Approval Form

Appendix B: Consent Form

Consent

Title of the Project: Alignment of Multi-Tiered Support Systems Following a School-Based Suicide Risk Assessment: Exploring the Lived Experiences of School-Based Mental Health Professionals
Principal Investigator: Lorraine May, doctoral candidate, Liberty University School of Education

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be school-based mental health professional. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of this qualitative, phenomenological study is to explore SBMHP's experience in aligning multi-tiered interventions or MTSS following the SRA process when working in a K-12 school setting across the United States. The researcher seeks to understand school-based mental health perspectives on the aligning multi-tiered interventions following a SRA.

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. Participate in a recorded thirty-forty-five minute interview.
2. Serve in a focus group with four to six other school-based mental health professionals. Approx. one hour
3. Journal a reflective questionnaire prompt approximately fifteen to thirty minutes.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include the potential for legislative, state, and local changes in the field of school-based mental health supports that promote increased evidence-based interventions for suicidal behaviors.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.

What are the costs to you to be part of the study?

To participate in the research, you will need to pay for nothing.

Does the researcher have any conflicts of interest?

The researcher serves as a School Psychologist for DoDEA. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Loraine May. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted]. You may also contact the researcher's faculty sponsor, name, at email.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record and video-record me as part of my participation in this study.

_____
Printed Subject Name

_____
_____
Signature & Date

Appendix C: Participant Recruitment Email

Dear XXX

As a doctor student in the School of Behavioral Science at Liberty University. I am conducting research as part of the requirements for a doctorate of education. The purpose of my research is to explore SBMHP's experience in aligning multi-tiered interventions or MTSS following the SRA process when working in a K-12 school setting across the United States. I am writing to invite eligible participants to join my study.

Participants must be a school-based mental health professional and have completed an SRA. If willing, participants will be asked to complete a one-on-one virtual interview, a virtual focus group with participants, and complete a questionnaire, either recording them on a cell phone/electronic device or written. It should take approximately three hours to complete the procedures listed. Identifying information will be requested as part of this study, but the information will remain confidential using pseudonyms.

To participate, click on the link, and complete the Google Form. I will then contact you via email. If you have any questions, please contact me at [redacted].

If you choose to participate, you will need to sign the electronic consent document (link). The consent document will also be emailed to you after receiving your Google Form.

Sincerely,

Lorraine May
Doctoral Candidate

Appendix D: Pre-Interview/ Interest Google Form

DEMOGRAPHICS: General Information

1. Gender: (1 = male 2 = female)
2. Y N

   Do you currently work in the schools as a school-based mental health provider? If not, please describe your occupation:

   (1) university (2) private practice (3) school administrator (4) community agency (5) other (specify): _____
3. In what capacity do you serve as a school-based mental health provider?

   (1) school counselor (2) school psychologist (3) LPC/MFLC (4) social worker (5) other (specify): _____
4. How many years have you practiced as a school-based mental health provider? (1) less than 1 (2) 1-4 (3) 5-9 (4) 10-15 (5) 16-20 (6) 20-24 (7) 25+
5. What is your level of training? (1) baccalaureate (2) master's (3) specialist (4) doctorate
6. What year did you receive your advanced degree (most recent degree)? _____
7. Please indicate the # of students in your school. _____
8. Primary setting you serve: (1) elementary school (2) middle school (3) high school (4) other (5) preschool
9. Number of campuses served (1) 1 (2) 2-3 (3) 4 or more

Appendix E: Interview Questions

1. What events or experiences in your life led you to choose a school-based mental health profession?
2. Tell me about a typical SRA assessment and how you select follow-up interventions?
3. When you have been involved in SRA, what has your role?
4. What is your understanding about what best practices are in MTSS following a SRA?
5. Where do you find information regarding evidence-based tiered interventions to support suicidal students?
6. What is it like working in a multi-disciplinary team to select tiered interventions for students K-12 following a SRA?
7. How do you describe challenges concerning selecting multi-tiered interventions following a SRA?
8. What risk and protective factors do you describe as most pertinent to the SRA and MTSS process?
9. How are Joiner's perceived burdensomeness, thwarted belongingness, and acquired capability to prevent suicidal risk behavior incorporated into the participants' practice?
10. What are you likely to select as a tier one intervention(s) for SRA?
11. What are you likely to select as tier two and tier three intervention(s) for SRA?
12. Some would say that SRA and MTSS are not necessary. What would you tell them?
13. Is there anything that I have not asked that you feel is worth mentioning?

Appendix F: Focus Group Questions

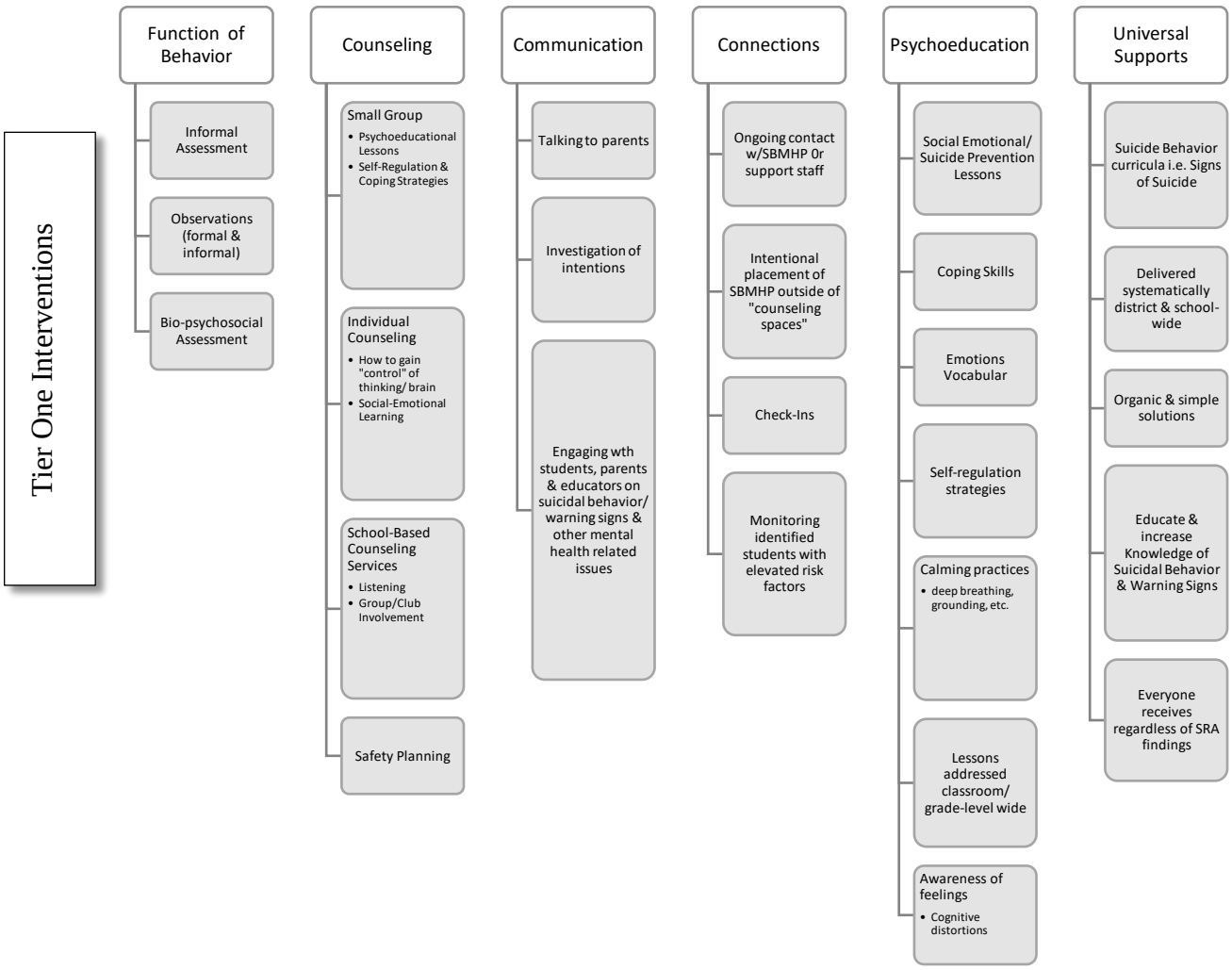
1. Please share your role and experience as a school-based mental health provider, assignment or how many schools you service and grade levels you service.
2. What is your opinion of a school-based mental health collaborative multi-disciplinary team selecting multi-tiered interventions that align with SRA results? (RQ1, RQ3)
3. Do you feel you received adequate preparation in your training program or through district provided professional development to understand how to align MTSS with SRA? (RQ1, RQ3)
4. How are Joiner's domains of thwarted belongingness, perceived burdensomeness and acquired capability prioritized in your district and school's SRA procedures? (RQ2)

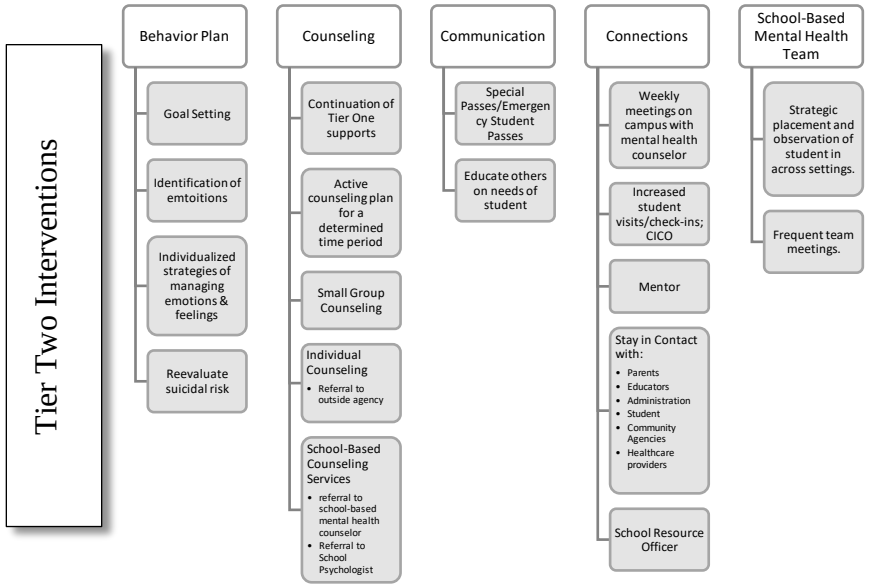
Appendix G: Reflective Questionnaire Prompt

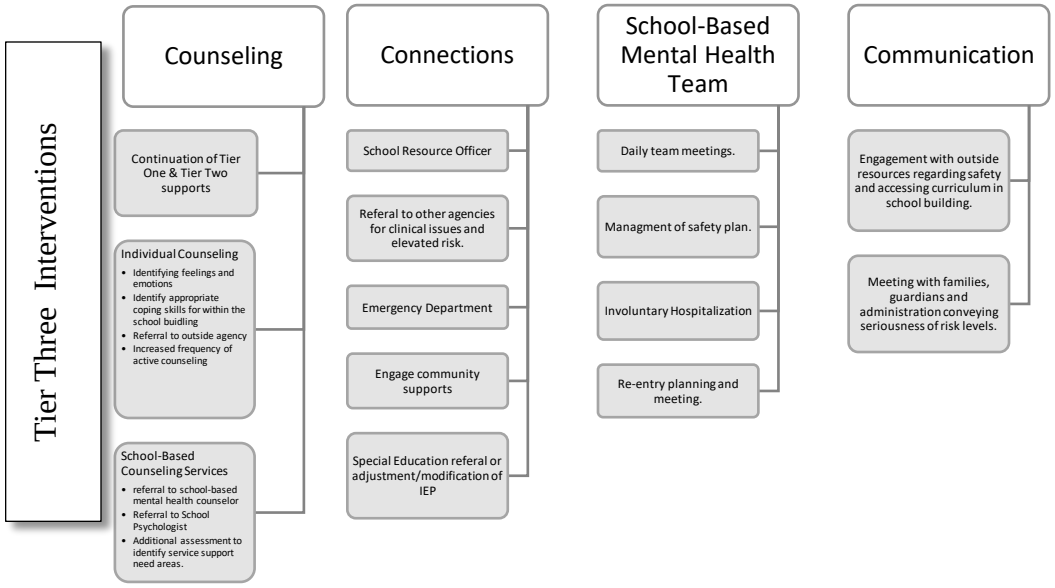
1. Joiner (2005) explains engagement in suicidal risk behavior as thwarted belongingness, acquired capability and desire for suicide. How does knowledge of this term relate to your personal experience with aligning MTSS with SRA results and working collaboratively to ensure safety and convey a message that safety is a not negotiable?

2. After completing three SRA as a multi-disciplinary team, the results indicate a low, moderate, and a high risk. What are the typical interventions you would employ in supporting the student needs at each risk level? How would the roles be delegated in selecting and implementing the interventions?

Appendix H: Participants' Recommendations for Student Tiered Supports and Strategies




Tier Two Interventions
Behavior Plan
Goal Setting
Identification of emtoitions
Individualized strategies of managing emotions & feelings
Reevaluate suicidal risk
Counseling
Continuation of Tier One supports
Active counseling plan for a determined time period
Small Group Counseling
Individual Counseling
Referral to outside agency
School-Based Counseling Services
referral to school-based mental health counselor
Referral to School Psychologist
Communication
Special Passes/Emergency Student Passes
Educate others on needs of student
Connections
Weekly meetings on campus with mental health counselor
Increased student visits/check-ins; CICO
Mentor
Stay in Contact with:
Parents
Educators
Administration
Student
Community Agencies
Healthcare providers
School Resource Officer
School-Based Mental Health Team
Strategic placement and observation of student in across settings.
Frequent team meetings.


Tier Three Interventions
Counseling
Continuation of Tier One & Tier Two supports
Individual Counseling
Identifying feelings and emotions
Identify appropriate coping skills for within the school buidling
Referral to outside agency
Increased frequency of active counseling
School-Based Counseling Services
referral to school-based mental health counselor
Referral to School Psychologist
Additional assessment to identify service support need areas.
Connections
School Resource Officer
Referal to other agencies for clinical issues and elevated risk.
Emergency Department
Engage community supports
Special Education referal or adjustment/modification of IEP
School-Based Mental Health Team
Daily team meetings.
Managment of safety plan.
Involuntary Hospitalization
Re-entry planning and meeting.
Communication
Engagement with outside resources regarding safety and accessing curriculum in school building.
Meeting with families, guardians and administration conveying seriousness of risk levels.