2021

Adolescent Suicide Prevention through Education and School Partnerships

Melissa Wieland

COUN 6785: Social Change in Action:

Prevention, Consultation, and Advocacy

Adolescent Suicide Prevention through Education and School Partnerships

Melissa Wieland

Contents

OVERVIEW

Keywords: Adolescent Suicide Prevention, Malheur County, Oregon, School Suicide Prevention

Adolescent Suicide Prevention through Education and School Partnerships

Goal Statement: My goal for this portfolio is to increase prevention and education efforts in collaboration with the education system to decrease suicide risk, ideation, and behavior.

Significant Findings: Reports from adolescents in Malheur County indicate that suicidality is a significant problem with higher than (state) average rates of suicidal ideation (Boyd, et al., 2017). The lack of resources in rural areas make accessing mental health services difficult. As a result, the school system is a good place to provide much needed prevention programs to support student mental health. This portfolio will discuss adolescent suicide prevention through the utilization of an evidence based, school-based program that seeks to connect prosocial adults with diverse students to change the culture and climate of their schools.

Objectives/Strategies/Interventions/Next Steps: The proposed next steps for this project include the following:

1. Conduct a needs assessment across Malheur County middle and high schools.
2. Use results from needs assessment to develop and implement interventions at the individual, group, and community level.
3. Meet with administrators and superintendents to share data and obtain “buy-in” for the Sources of Strength program.
4. Recruit and train adult advisors and peer leaders to implement Sources of Strength within schools throughout the county.

5. Encourage regular campaigns through Sources of Strength, spreading messages of hope, help, and strength across our schools and communities.

INTRODUCTION

Adolescent Suicide Prevention through Education and School Partnerships

Suicide is the second leading cause of death in Oregon for children and young adults ages 10-24. Malheur County, the area where I live and work, has higher than (state) average numbers for suicidal ideation and behavior in middle school aged students. However, the trend shifts when these same students are surveyed in 11th grade, showing mostly lower than state averages for suicidal ideation and behavior (Boyd, et al., 2017). There appears to be a discrepancy in perhaps coping ability, resources, or mental health support for 8th grade students in Malheur county. This portfolio will describe some of the unique challenges of this rural area and describe a plan for bringing awareness and prevention efforts to our local schools.

PART 1: SCOPE AND CONSEQUENCES

Adolescent Suicide Prevention through Education and School Partnerships

While adolescent suicide is a problem statewide, the trends describing middle school students in Malheur County are especially troubling. The target population for this portfolio will be middle school students. Each year, Oregon students in 8th and 11th grade complete a Healthy Teens Survey. In 2017, 33.1% of 8th grade students in Malheur County reported feeling sad or hopeless every day for two weeks; the state average was 30.1%. When asked if they'd ever seriously thought about attempting suicide, 16.9% of 8th graders reported "yes." This percentage is the same statewide. In regard to suicide attempts, 7.1% of 8th graders in Malheur County report

one attempt (compared to a state average of 4.5%). 2.9% reported 2-3 attempts (compared to 2.7% statewide) and 1.3% reported 4 or 5 attempts (compared to 0.5% statewide) (Boyd, et al., 2017). Rates of depression and suicide in middle school students have steadily increased over the last several years. In 2015, 26.7% of 8th graders reported depressive symptoms, 16.2% reported suicidal ideation, and 8.2% reported a suicide attempt. In 2019, these numbers climbed to 31.5% reporting depressive symptoms, 19.9% reporting suicidal ideation, and 10.4% reporting suicide attempts (Boyd, et al., 2017).

There is only one hospital in Malheur County and the sole community mental health clinic often has months long waiting lists for mental health services. The county hospital, Saint Alphonsus Medical Center, conducted a community health needs assessment in 2020. Malheur County residents rated mental health and stress among middle and high school aged youth as a high concern (57.3% of respondents). They also rated suicide as a high concern (58.1% of respondents). The percentages were similar for concerns regarding mental health and stress among low-income families and the homeless, and real or perceived stigma associated with seeking mental health care (Saint Alphonsus Medical Center-Ontario, 2020).

The consequences of these trends are significant. If prevention efforts are not put into place and implemented with fidelity, we will continue to lose young people to suicide and fail to meet their mental health needs. Suicide causes significant physical, emotional, and financial impacts. Non-fatal suicide attempts may result in permanent physical injury or disfigurement for the individual and psychological injury to the individual and those who care about them. Suicide may also result in contagion, particularly among young people. The Centers for Disease Control and Prevention (CDC) report that suicides and suicide attempts cost the country more than $70

billion per year (CDC, 2021). My goal is to increase prevention and education efforts in collaboration with the education system to decrease suicide risk, ideation, and behavior.

PART 2: SOCIAL-ECOLOGICAL MODEL

Adolescent Suicide Prevention through Education and School Partnerships

There are both risk and protective factors associated with adolescent suicide and suicide risk. The social-ecological model looks at risk and protective factors in each of these domains: individual, peer, family, school, community, and culture. Increased protective factors in each of these domains serve as a buffer to risk factors. May, Czyz, and West (2020) report that there is a significant increase in suicidal ideation between the ages of 12 and 17, marking the teenage years as an especially vulnerable time.

Risk factors

A feeling of hopelessness is resoundingly the primary risk factor that distinguishes adolescents who experience suicidal ideation or behavior from adolescents who attempt suicide (Taliaferro & Muehlenkamp, 2013). Research by Taliaferro and Muehlenkamp (2013) on nearly 70,000 9th and 12th grade students reported that the prevalence of suicidal ideation and suicide attempt is highest in non-white, 9th grade females who qualify for free lunch (live in poverty) and do not live with both biological parents. Additional risk factors include childhood physical and/or sexual abuse, parental substance abuse, same-sex sexual experience (particularly for females), body image issues, substance use and abuse, mental health diagnoses, bullying and physical altercations, running away from home, dating violence, self-injury, and family dysfunction (Taliaferro & Muehlenkamp, 2013). Each of these risk factors could be felt at the individual level, the peer level, the family, school, cultural, or community level and they may vary based on biological sex. For example, for males, cigarette smoking is a significant risk

factor and for females, physical and sexual abuse, same-sex sexual experiences, and a greater feeling of hopelessness are significant. The more risk factors an adolescent has, the more likely they are to engage in suicidal behavior or action. Adolescents who experience enduring family conflict and/or substance abuse issues are more likely than their peers without these chronic issues to attempt suicide (Taliaferro & Muehlenkamp, 2013). However, many of these risk factors can be mitigated by protective factors.

Protective factors

There is an adage that it takes only one caring adult in the life of a child to make a difference. This common saying is backed up by a wealth of research which indicates that connectedness is a strong protective factor, particularly parental connectedness. Additional protective factors include connections to non-parental adults, school engagement and safety, involvement in extracurricular activities and/or sports, academic achievement, and supportive friendships (Taliaferro & Muehlenkamp, 2013). Just as with risk factors, protective factors can be present in all domains of the social-ecological model. Protective factors at the individual level might include positive self-concept and self-esteem, a sense of personal responsibility and success at school. At the peer level, protective factors can include a strong, prosocial peer group that avoids risky behaviors or being part of a team or a club. Protective factors at the school level include positive adult mentors and teachers within the school environment, opportunity for transportation to school, free breakfast and lunch, and a safe school community. At the community level, protective factors might include a safe neighborhood, outdoor spaces to explore and enjoy, opportunities for extracurricular activities, access to faith-based organizations, and supportive community leaders. Cultural protective factors may differ based on cultural traditions, norms, and values but could include opportunity to share, explore, and

celebrate ones' culture openly and freely without fear (SAMHSA, n.d.). Protective factors lower the likelihood of negative impact on the lives on young people. Additionally, protective factors reduce the impact of risk factors and counteract some of their effects (SAMHSA, n.d.).

PART 3: THEORIES OF PREVENTION

Adolescent Suicide Prevention through Education and School Partnerships

National Cancer Institute (2005) states, "theory provides a road map for studying problems, developing appropriate interventions, and evaluating their successes" (p. 5). There are several social change theories that can be applied to suicide prevention programs. The theory that I think fits best with implementation of a suicide prevention model in Malheur County is Social Cognitive Theory (SCT). Social Cognitive Theory integrates concepts from cognitive, behavioral, and emotional models to explore the likelihood of behavior change based on three main factors: 1) self-efficacy, 2) goals, and 3) outcome expectancies. SCT asserts that individuals can change behaviors even when faced with adversity if they have a good sense of self-efficacy (National Cancer Institute, 2005). Coined by Albert Bandura, SCT is an evolution of Social Learning Theory (SLT), which asserted that individuals learn from their own experiences and from the experience of observing others.

Social Cognitive Theory has six primary concepts: reciprocal determinism, behavioral capability, expectations, self-efficacy, observational learning (modeling), and reinforcements. Reciprocal determinism is the central concept of SCT and refers to the interactions and influences that occur between behavior, personal factors, and the environment. Behavioral capability is exactly what it sounds like- an individual's capability of performing a behavior. Expectations refers to the expected consequences that will occur based on an action. Bandura emphasized the importance of self-efficacy in behavior change. Self-efficacy is ones' belief in

their own effectiveness or ability to engage in behavior. Observational learning or modeling is a concept which states that individuals learn from the experiences and observations of others. Finally, reinforcements are behavioral responses that determine whether a behavior will continue or not (National Cancer Institute, 2005).

Each of the concepts in SCT can be related to the evidence-based suicide prevention program, Sources of Strength. Reciprocal determinism is built into this program, which focuses on eight core sources of strength that are directly related to suicide prevention. These sources of strength are family support, positive friends, mentors, healthy activities, generosity, spirituality, physical health, and mental health. Behavioral capability is mastered in this program, which uses peer leaders and adult advisors to promote messages of hope, help, and strength. Expectations are modeled by peer leaders and adult advisors who lead their school community in messaging campaigns that promote protective factors (Sources of Strength, n.d.). There is an emphasis put on self-efficacy, with teens effectively utilizing the power of peer influence to change norms, promote diversity and acceptance, and increase help seeking behavior. Petrova, et al. (2015) state, "peer leaders demonstrating healthy and successful coping behaviors can increase the spread of positive change through natural adolescent social networks" (p. 652). Adolescents and teens who are not involved as peer leaders learn these new norms through observational learning and engagement and reinforcements are set up naturally through this program to promote intrinsic motivation (Sources of Strength, n.d.).

Based in part on Bandura's Social Learning Theory (now Social Cognitive Theory, or SCT), Sources of Strength considers itself a "radical, upstream suicide prevention model" that has been shown to increase youth and adult connectedness, increase school engagement, increase the referrals of suicidal friends to supportive adults, and increase positive perceptions of adult

support (Sources of Strength, 2021). This program enhances protective factors and seeks to reduce risk factors using a positive, health seeking model that is focused on hope, help, and strength. Sources of Strength's use of peer support and modeling has also effectively been demonstrated to benefit students with a history of suicidal ideation (Petrova, et al., 2015). In fact, modeling of positive coping behavior rather than giving behavioral directives may decrease emotional reactivity when addressing an emotionally charged issue like adolescent suicide. Use of peer leaders is not a new concept and in other programs, it has been shown to reduce high risk sexual behavior and substance abuse. In one randomized trial, Sources of Strength was shown to increase school wide help seeking norms and improve perceptions of adult support in a four-month period (Petrova, et al., 2015). Sources of Strength is a program that would benefit students, schools, and the community at large.

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Adolescent Suicide Prevention through Education and School Partnerships

The target problem for this portfolio is adolescent suicide, with a broad population of adolescents or teens. Two subgroups of this broad population that are especially vulnerable to the risk factors that contribute to adolescent suicidality are adolescents who belong to the LGBTQIA+ community and racial or ethnic minority youth.

It is well researched and documented that sexual minority youth (i.e. youth who identify as LGBTQIA+) have a greater prevalence of suicidality. Blashill, et al. (2021) report that sexual minority youth have earlier onset of suicidal ideation, behavior, and attempt, compared to their heterosexual peers, often as young as 9-10 years old. Additionally, childhood suicidal ideation and behavior (non-suicidal self-injury or self-injurious behavior) is associated with an increased risk of suicide attempt (Blashill, et al., 2021). Prevention efforts that promote diversity and focus

on LGBTQIA+ acceptance are desirable and utilized by sexual minority youth more often than crisis services that are not directly linked to or affiliated with the LGBTQIA+ population (Blashill, et al., 2021). Protective and inclusive school climates have been shown to reduce the incidence of suicidality among sexual minority youth (Blashill, et al., 2021).

Molock, et al. (2014) report "there are significant differences in the rates of suicide deaths and suicide behaviors in different racial and ethnic groups in the United States" (p. 2). Hispanic or Latinx adolescents have the highest rates for suicide ideation, and African American teens (both male and female) have shown rates of suicide attempt in recent years that exceed rates of their Caucasian peers (Molock, et al., 2014). These rates may be due in part to the protective and risk factors that differ in racial and ethnic minority groups and/or the stigma associated with help-seeking behavior in different cultures. Risk factors that are unique to racial and ethnic minority students may include experiencing racism and discrimination, acculturative stress associated with poor mental health, language barrier, reduced access to mental health services due to a variety of factors (citizenship status, insurance, distrust of the western medical model, location, etc.) and stigma associated with help-seeking behavior. Prevention programs that are informal or indirect may be especially beneficial for minority youth. Additionally, prevention programs that incorporate community resources, including clergy, teachers, community leaders, family members, and peers, may be especially beneficial to youth whose culture is more collectivistic (Molock, et al., 2014).

Prevention programs can increase their cultural relevance by promoting diversity, acceptance, and inclusion. Suicide prevention models, particularly those with an emphasis on peer support, should include individuals that represent every culture at their school (Molock, et al., 2014). Including racial, ethnic, and sexual minority students in school and community

prevention efforts can help to destigmatize help-seeking and increase tolerance and acceptance among diverse populations. While white, middle-income individuals make up only five percent of the world's population, the majority of suicide intervention and prevention programs are built using this population (Molock, et al., 2014). A much larger prevention effort would be conducting research related to suicidality on a more diverse population in order to gain a better understanding of how to help individuals while utilizing a culturally sensitive lens.

Ethical Considerations

The American Counseling Association (ACA) outlines several ethical guidelines that counselors should adhere to when engaging in prevention work and advocacy. Section A.7.b. states that client consent must be obtained prior to engaging in advocacy efforts (ACA, 2014). When working with minors, counselors must also disclose limits of confidentiality with adolescent clients and their guardians per section B.5. Additional relevant ethical guidelines include nondiscrimination clauses (section C.5.) and cultural sensitivity (section E.5.b.). Nondiscrimination means that a counselor will not engage in or condone discrimination for any reason. Cultural sensitivity in ethical counseling recognizes that counselors strive to understand the lived experiences of their clients through a culturally relevant lens (ACA, 2014). In assessing prevention programs, counselors must also recognize that oftentimes, standardized assessments have not been normed with culturally diverse populations. As a result, counselors must consider diversity and multicultural relevance in data collection and interpretation (per section E.8).

PART 5: ADVOCACY

Adolescent Suicide Prevention through Education and School Partnerships

Suicide is preventable but prevention and intervention efforts have space for advocacy and growth in all domains. The Multicultural and Social Justice Counseling Competencies

(MSJCC) (2015) offers an approach that infuses theory, practice, and research into action. This section will focus on barriers that impede prevention efforts and potential for advocacy at the institutional, community, and public policy levels.

At the institutional level, one of the greatest obstacles to partnering with schools in suicide prevention is removing barriers to mental health support and access, and destigmatizing help seeking. In the state of Oregon, the ratio of school counselors to students is 1:500+, more than double the recommended ratio of 1:250, per the American School Counselor Association (ASCA). This ratio of 1:500+ is true for the more populated areas of Malheur County but there are also several more remote areas of the county that have no access to school or mental health based counselors unless that access is virtual (Patel & Clinedinst, 2018). Due to the rural, border setting of Malheur County, transportation can be a barrier for many individuals seeking treatment. The MSJCC states that competent counselors at the institutional level must connect privileged and marginalized students with supportive individuals, employ social advocacy, collaborate to address issues of power, privilege, and oppression, and balance systems of care (Multicultural and Social Justice Counseling Competencies, 2015). Many of these competencies at the institutional level can be met with the Sources of Strength program that was outlined in the theories of prevention section. This program can be implemented at any level but implementation at the school level may provide opportunity for more frontier-rural areas to join larger rural areas in connecting to prevent suicide and promote connection.

Barriers at the community level area similar to barriers at the institutional level. There is a lack of access to mental health services and stigmatization remains a factor in seeking and obtaining support services. Additionally, I think that in rural areas (and possibly in all areas, regardless of population) reputations are difficult to change. The community mental health

provider (CMHP) in Malheur County has had a poor reputation for quite some time, with families refusing to access their services due to past bad experiences. There is also a significant lack of qualified mental health providers to meet the community need, leaving school counselors responsible for managing unrealistic caseload numbers and students/clients whose needs often exceed the capacity of a school counselor. I recently had a conversation with the Crisis Prevention Administrator of the county CMHP, and he shared that this clinic/provider recently completed some restructuring, and they are hoping to collaborate with providers in the education sector to build their reputation back up and increase access to services for all community members, but particularly adolescents (D. Tovar, personal communication, April 14, 2021). I believe that an advocacy effort in the community can include positive promotion of local services and collaboration with mental health providers. Coordination of care and communication among care communities can promote cohesiveness in providing prevention and crisis intervention related to suicide. This idea also falls in line with the MSJCC's effort to examine community norms, values, and regulations that hinder growth and development (Multicultural and Social Justice Counseling Competencies, 2015).

Oregon is a divided state. Traditionally very liberal, representation for the more conservative part of the state (Malheur County and other rural counties) is limited. Currently, there is a group of individuals who are seeking to turn Malheur County and other more conservative parts of Oregon into "Greater Idaho," moving the state border to join a state that has more conservative values. There are various reasons for this push, but one of the biggest reasons is that people do not feel like their voices are heard at the state level. That being said, a school counselor from our small community was recently elected as the Oregon School Counselor Association (OSCA) secretary, boosting rural representation. The Multicultural and Social

Justice Counseling Competencies (2015) highlights that at the public policy level, counselors seek out and participate advocacy through collaboration to improve state, local, and federal policies. I believe that local school counselors and mental health providers can collaborate with this counselor to promote rural issues specific to suicide prevention and intervention at the state level.

REFERENCES

American Counseling Association (2014). 2014 ACA Code of Ethics. Retrieved from https://www.counseling.org/Resources/aca-code-of-ethics.pdf

Blashill, A. J., Fox, K., Feinstein, B. A., Albright, C. A., & Calzo, J. P. (2021). Nonsuicidal self-injury, suicide ideation, and suicide attempts among sexual minority children. *Journal of Consulting and Clinical Psychology*, 89(2), 73–80. https://doi-org.ezp.waldenulibrary.org/10.1037/ccp0000624

Boyd, R., Sanders, E., Rivers, W., Barbour, I., Ngo, D. (2017). *Oregon Healthy Teens Survey.* Oregon Health Authority. https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2017/County/23_Malheur.pdf

Centers for Disease Control and Prevention (CDC). (21 January, 2021). *Suicide prevention.* https://www.cdc.gov/suicide/facts/index.html

County Health Rankings & Roadmaps (2018). How healthy is your community? Robert Wood Johnson Foundation. Retrieved from http://www.countyhealthrankings.org/.

Molock, S. D., Smith, A., Jeffries, D., & Jean, D. (2014). The role of culture in suicide prevention in adolescents. *International Journal of Behavioral Consultation & Therapy*, 9(3), 2–6. https://doi-org.ezp.waldenulibrary.org/10.1037/h0101632

Multicultural and Social Justice Counseling Competencies. (2015). Retrieved April 10, 2021, from http://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=20

National Cancer Institute (2005). *Theory at a glance: A guide for health promotion practice.* Washington, DC: U.S. Department of Health and Human Services: National Institutes of Health. https://cancercontrol.cancer.gov/sites/default/files/2020-06/theory.pdf

Patel, P. & Clinedinst, M. (2018). *State-by-state student to counselor ratio maps by school district.* National Association for College Admissions Counseling. https://www.nacacnet.org/globalassets/documents/publications/research/researchstateratiosreport.pdf

Petrova, M., Wyman, P. A., Schmeelk-Cone, K., & Pisani, A. R. (2015). Positive-Themed Suicide Prevention Messages Delivered by Adolescent Peer Leaders: Proximal Impact on Classmates' Coping Attitudes and Perceptions of Adult Support. *Suicide and Life: Threatening Behavior*, 45(6), 651–663. https://doi-org.ezp.waldenulibrary.org/10.1111/sltb.12156

Saint Alphonsus Medical Center-Ontario (2020). *Community Health Needs Assessment.* https://www.saintalphonsus.org/assets/documents/chna/ontario/chna-ontario-2020.pdf

Sources of Strength (n.d.). *Sources of strength executive summary.* Retrieved April 4, 2021. https://sourcesofstrength.org/discover/evidence/

Substance Abuse and Mental Health Services Administration (SAMHSA): *Risk and protective factors.* Retrieved from https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

SCHOLARWORKS CONTRIBUTOR AGREEMENT

ScholarWorks Publication Consideration

ScholarWorks makes the intellectual output of the Walden University community publicly available to the wider world. By highlighting the scholarly and professional activities of our students and faculty, ScholarWorks' rich repository encourages new ideas, preserves past knowledge, and fosters new connections to improve human and social conditions.

If you would like your portfolio from your Counseling 6785 course to be considered for submission to ScholarWorks, please review the ScholarWorks Contributor Agreement below and agree to the terms and conditions.

Acceptance of the policies and terms of the ScholarWorks Contributor agreement

- will not impact your grade
- will not guarantee publication

ScholarWorks Contributor Agreement

To administer this repository and preserve the contents for future use, *ScholarWorks* requires certain permissions from you, the contributor. By making a submission to *ScholarWorks*, you are accepting the terms of this license. However, you do not give up the copyright to your work. You do not give up the right to submit the work to publishers or other repositories.

By including an email contact below, you hereby grant Walden a limited license to review the Submission for the purposes of review of scholarly content; to distribute the Submission to the public on the Website; to make and retain copies of the Submission; and to archive the Submission in a publicly accessible collection.

You agree to defend, indemnify and hold Walden harmless from and against any and all claims, suits or proceedings, demands, losses, damages, liabilities and costs and expenses (including, without limitation, reasonable attorney's fees) arising out of or resulting from the actual or alleged infringement of any patent, trademark, copyright, trade secret or any other intellectual property right in connection with any Submission.Walden will not be required to treat any Submission as confidential.For more information, see the Contributor FAQ.

By executing this Agreement, you represent and agree that:

- You are the author or of the submitted work or you have been authorized by the copyright holder, and the submission is original work.
- You hold the copyright to this document and you agree to permit this document to be posted, and made available to the public in any format in perpetuity.
- The submission contains no libelous or other unlawful matter and makes no improper invasion of the privacy of any other person.
- The submission will be maintained in an open access online digital environment via the *ScholarWorks* portal. Because works on *ScholarWorks* are openly available online to

anyone with internet access, you do not hold Walden University responsible for third party use of the submission.

ScholarWorks (the Website) is owned and maintained by Walden University, LLC (Walden). All content that you upload to this Website (a Submission) will be available to the public. You represent and warrant that you have the right to upload any such Submission and make it available to the public.

I have read the Scholarworks agreement above, and I agree to have my COUN 6785 portfolio document considered for inclusion in Scholarworks; I also grant my permission for representatives from Walden University to submit this work on my behalf.

By signing again below, I agree to allow my email contact information below to be included in the published document, so that others may contact me about this work.

SIGNATURE: Melissa Wieland
DATE: 5/7/2021
DIRECT EMAIL ADDRESS: melissa.wieland@waldenu.edu