Karen B. Salmon, Ph.D.
State Superintendent of Schools

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TO: Members of the State Board of Education

FROM: Karen B. Salmon, Ph.D.

DATE: July 26, 2016

SUBJECT: Suicide Prevention/Intervention and Human Trafficking Pilot Initiative

PURPOSE:

The purpose of this agenda item is to provide information to the State Board of Education regarding the Maryland State Department of Education's efforts to address student suicide and human trafficking. The presentation will address the following questions:

1. How is the Maryland State Department of Education (MSDE) addressing these issues?
2. What lessons has MSDE learned as it implements initiatives to address these issues?
3. Moving forward, what are the next steps to ensure the desired outcomes?

BACKGROUND/HISTORICAL PERSPECTIVE:

The Maryland State Department of Education's Division of Student, Family, and School Support, Student Services and Strategic Planning Branch is primarily responsible for the implementation and oversight of Code of Maryland Regulations (COMAR) 13A.05.05, *Programs of Pupil Services*. The Pupil Services Program focuses on health, personal, interpersonal, academic, and career development of students and includes guidance, pupil personnel, school psychology, health services, school safety, and school completion. Suicide and human trafficking prevention/intervention are issues that fit within the auspices of Pupil Services.

Suicide Prevention/Intervention

Pursuant to §7-501 through §7-504 of the Education Article, Annotated Code of Maryland (passed by the Maryland General Assembly in 1986), schools are required to establish youth suicide prevention programs that include staff development, classroom programs of instruction, crisis intervention, and other related policies and procedures. From 1986 to 2006, funds were distributed through MSDE to Local Education Agencies (LEAs) to support suicide prevention programming in schools. In addition, Maryland received funds through the federal Garrett Lee

Smith Memorial Act. Funding from that program are now managed by the Department of Health and Mental Hygiene, Behavioral Health Administration (DHMH).

Human Trafficking Prevention/Intervention

Human trafficking is the buying and selling of people for various purposes, including (but not limited to) sex, labor, and domestic servitude. Human trafficking has been a federal crime since passage of the Trafficking Victims Protection Act of 2000. In 2007, the Maryland Human Trafficking Task Force was established by the U.S. Attorney's Office, the Attorney General of Maryland, and the State's Attorney for Baltimore City to serve as the lead investigative, prosecutorial, and victim services coordinating body for anti-human trafficking activity in the State of Maryland. As a result, Maryland now has a network of service providers, law enforcement, and first responders, who are trained and equipped to address human trafficking.

Family Law §5-704, *Child Abuse and Neglect*, mandates child abuse be reported by health practitioners, police officers, educators, and human service workers. In 2012, House Bill 860 was passed, which amended §5-704 to include human trafficking and child pornography. As a result, educators are mandated reporters of human trafficking and child pornography in addition to other instances of child abuse and neglect. Students are often the targets for traffickers and educators, when properly trained, are uniquely positioned to identify and report suspected trafficking. Beginning in 2013, MSDE engaged in internal dialogue to think strategically about how to address the issue and in 2014, expanded that dialogue to external stakeholders for the purpose of building a pilot program that would provide a comprehensive prevention and intervention human trafficking education program.

EXECUTIVE SUMMARY:

MSDE is working with its partners and stakeholders to implement initiatives and supports for prevention and intervention with regard to youth suicide and human trafficking.

Suicide Prevention/Intervention

MSDE has supported suicide prevention/intervention efforts in various ways since the passage of youth suicide prevention legislation in 1986. More recently, MSDE has participated on the Governor's Commission on Suicide Prevention, the Suicide Prevention and Early intervention Network, provided information in partnership with DHMH and local school systems to Directors of Student Services, School Health Officers, Supervisors of School Psychological Services, Supervisors of Pupil Personnel and Social Work, and School Counseling Supervisors. In addition, MSDE has provided information on Kognito, which is a collection of self-paced computer modules for school staff designed to educate them on psychological distress, including signs of suicide. MSDE is also a recipient of the Maryland Advancing Wellness and Resilience in Education (MD-AWARE) grant, which is designed to train Maryland educators, families, and community members in Youth Mental Health First Aid. Baltimore County Public Schools, Dorchester County Public Schools, and Somerset County Public Schools are currently part of

this pilot program although personnel from other school systems have been trained through the grant.

Preventing youth suicide is a multi-agency endeavor. Moving forward, MSDE will work more closely with other State agencies to be more proactive regarding the collection of data regarding youth suicides. Additionally, MSDE will compile a list of evidence-based resources for local school systems and schools regarding intervention/prevention.

Human Trafficking Prevention/Intervention

MSDE, in conjunction with the Araminta Freedom Initiative, Governor's Office of Crime Control and Prevention, Maryland Center for School Safety, and the American Federation of Teachers, is initiating a Human Trafficking Pilot Program to address this issue. The goal of the pilot is to provide a comprehensive prevention and intervention human trafficking education program in Baltimore City Public Schools, Baltimore County Public Schools, and Prince George's County Public Schools. The pilot would include 10 schools in each of the aforementioned LEAs.

Key components of the pilot include training, reporting procedures, tracking reported incidents, identification of students with high-risk factors, referrals to student support services, support for school personnel, and production of a final report, which will contain findings and offer recommendations for statewide implementation.

Moving forward, MSDE will implement processes and procedures to monitor existing policy, develop a guidance document on human trafficking based on analysis of the pilot data, and continue to review and monitor legislation for human trafficking.

ACTION:

For information only.

Attachments

MARYLAND STATE DEPARTMENT OF EDUCATION
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Suicide Prevention/Intervention and Human Trafficking

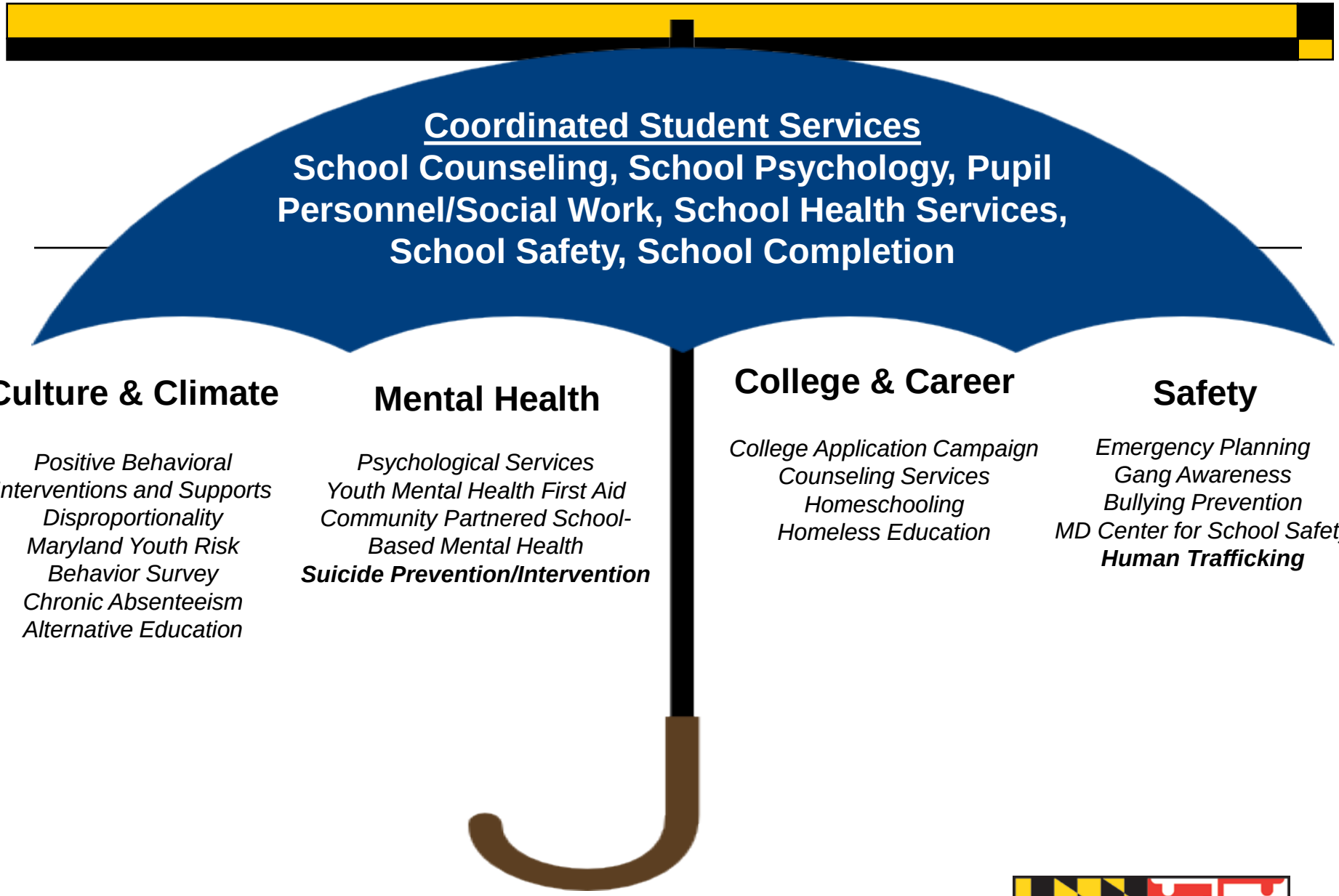
Presentation to the Maryland State Board of Education

July 26, 2016

Walter Sallee, Director, Student Services and Strategic Planning
Deborah Nelson, Section Chief , School Safety and Climate
Robert Schmidt, Behavior Specialist, Talbot County Public Schools
Michael Ford, School Safety Specialist

Presentation Objectives

- To provide an overview of MSDE initiatives to address suicide prevention/intervention and human trafficking.
- To share lessons learned regarding these initiatives.
- To share future goals with regard to these initiatives.


Coordinated Student Services
School Counseling, School Psychology, Pupil Personnel/Social Work, School Health Services, School Safety, School Completion
Culture & Climate
Positive Behavioral Interventions and Supports
Disproportionality
Maryland Youth Risk Behavior Survey
Chronic Absenteeism
Alternative Education
Mental Health
Psychological Services
Youth Mental Health First Aid
Community Partnered School-Based Mental Health
Suicide Prevention/Intervention
College & Career
College Application Campaign
Counseling Services
Homeschooling
Homeless Education
Safety
Emergency Planning
Gang Awareness
Bullying Prevention
MD Center for School Safety
Human Trafficking
Student Services Reviews
Comprehensive Master Plan

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Suicide Prevention/Intervention

In Maryland…

- Suicide is the 2nd leading cause of death for students who are 10 to 14 years of age.

- Suicide is the 3rd leading cause of death for students who are 15 to 24 years of age.

American Foundation for Suicide Prevention (2015). *Suicide: Maryland 2015 Facts and Figures.*

Maryland Youth Risk Behavior Survey

2014 HIGH SCHOOL DATA

Percentage of Maryland youth who:	2005	2007	2009	2011	2013	2014
Felt sad and hopeless	29.7%	23.2%	25.1%	25.4%	27.0%	26.8%
Male	21.5%	15.5%	20.2%	19.2%	19.7%	18.7%
Female	38.1%	30.7%	30.1%	31.4%	34.2%	35.0%
Seriously considered attempting suicide during past year	17.4%	13.2%	14.5%	16.2%	16.0%	15.9%
Made a suicide plan during past year	12.2%	10.2%	11.6%	12.6%	12.5%	12.7%

MSDE Suicide Prevention/ Intervention Initiatives

- **Collaboration and partnership with:**
  - Governor's Commission on Suicide Prevention to develop, implement, and monitor a state-wide, multi-agency plan.
  - Suicide Prevention and Early Intervention Network (SPIN) to implement Kognito, which are self-paced computer modules for school staff.
  - Division of Special Education/Early Intervention to provide more intensive supports to students with identified needs.
  - Educational and Behavioral Community of Practice (CoP) to coordinate and align efforts to educate and raise awareness about mental health.
  - LEAs to provide targeted training and technical assistance and to identify best practices.
  - Community partners to implement MD-AWARE (Advancing Wellness and Resilience in Education) to train educators to identify and provide resources for mental health concerns with students.

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Local Best Practice: Yellow Ribbon Campaign

Talbot County Public Schools
Easton, MD

Talbot County Public Schools' Yellow Ribbon Suicide Prevention Program (Education, Prevention, Intervention, Assessment, and Supports)

Primary Prevention - designed to reduce the likelihood of a problem ever developing:

- Yellow Ribbon Cards/empowering students "It's ok to Ask 4 Help and Be A Link Save A Life."
- training school staff and students grades 6-12 classroom presentation
- school mental health clinicians
- articles on signs & symptoms of depression
- 24/7 hotline phone numbers
- School mental health referrals
- monitor school data trends for resource allocations and updated national trends

Secondary Prevention - timely interventions directed towards those at high risk:

- school crisis teams/school mental health clinicians
- school mental health referrals
- assist parents/support groups/resources
- train designated staff on conducting suicide risk assessments
- 24/7 hotline phone numbers
- Risk Identification Suicide Kit (RISK), Mobile Crisis, and ER/Behavioral Health

Tertiary Prevention - postvention programming to reduce risk for survivors:

- support groups
- school crisis teams/interagency volunteers/Hospice
- staff/student/parent debriefings
- refocus how to "Be A Link & Save A Life"

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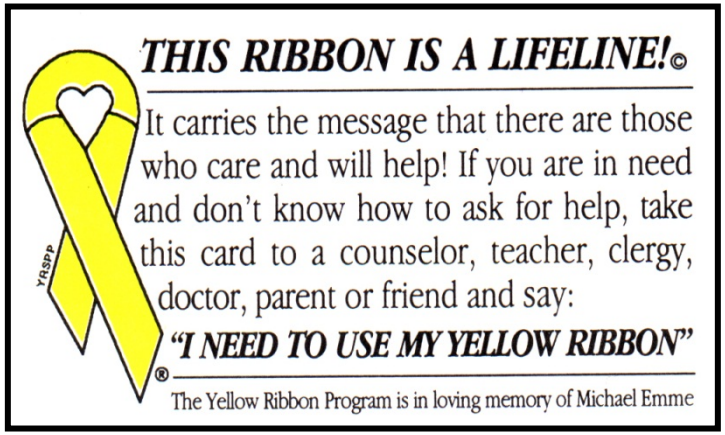
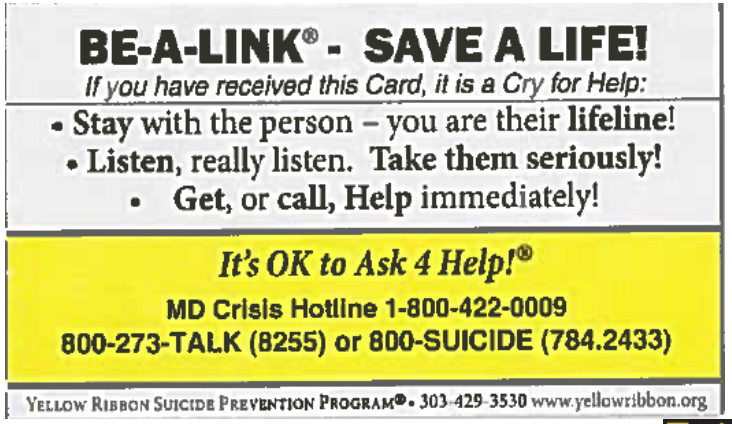
Talbot County Public Schools
Yellow Ribbon Suicide Prevention Program

2004/05	6
2005/06	4
2006/07	5
2007/08	6
2008/09	3
2009/10	4
2010/11	11
2011/12	7
2012/13	3
2013/14	4
2014/15	6
2015/16	4

63 (avg. 5.25)





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Lessons Learned: Suicide Prevention/Intervention

- This is a multi-agency, interdepartmental, and community issue requiring partnerships to develop a comprehensive response.

- Universal initiatives, by themselves, are not enough to change the incidents of student depression and suicide.

- Partnerships with LEAs are essential for creating change.

Future Goals: Suicide Prevention/Intervention

- To maintain and create more strategic partnerships focused on youth suicide prevention/intervention.
- Develop evidence-based resources and guidance to address intense, strategic student interventions.
- Identify and share LEA best practices for youth suicide prevention/intervention.
- Develop a centralized data collection system on suicide attempts and completions.

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Human Trafficking

Definition of Human Trafficking

Human trafficking is buying and selling of people for various purposes, including, but not limited to sex, labor, and domestic servitude. Trafficking cases always contain three elements:

- Force
- Fraud
- Coercion

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Maryland Legislative History

- Family Law §5-704 *Child Abuse and Neglect* mandates child abuse be reported by health practitioners, police officers, educators, and human service workers.

- In 2012, §5-704 was amended to include human trafficking and child pornography.

- ***As a result:***
  - Educators are mandated reporters of human trafficking and child pornography in addition to other instances of child abuse and neglect.

Human Trafficking Initiatives

- Partnerships with Araminta Freedom Initiative, Governor's Office of Crime Control and Prevention, Maryland State Department of Education, Center for School Safety, and the American Federation of Teachers.

- Professional Development to increase awareness with Directors of Student Services, student support personnel, and school-based staff.

- Human Trafficking Pilot program designed to provide child sex trafficking prevention and intervention information to 10 schools each in Baltimore City, Baltimore County, and Prince George's County Public Schools.

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Lessons Learned: Human Trafficking

- Education is essential for awareness and prevention.
- Collaboration with other agencies and community partners is critical for providing wraparound services to student victims.
- Properly trained school staff (e.g., classroom teachers) are the first to recognize warning signs of trafficking and abuse.

Future Goals: Human Trafficking

- Continue education through the development of a guidance document on child abuse/human trafficking based on the analysis of the pilot data.

- Continue collaboration with state agencies and community partners to provide ongoing training and support for victims.

- Implement processes and procedures to monitor legislation and existing policies for child abuse/human trafficking (e.g. Safe Harbor Law).

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CHILDREN & SCHOOLS

A JOURNAL OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Perception of School Danger among Rural Youths

Integrating Suicide Prevention Program into School Mental Health System

Experiences of Religious Minorities in Public School Settings

NASW PRESS

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Children & Schools Advance Access published October 25, 2014

Integrating a Suicide Prevention Program into a School Mental Health System: A Case Example from a Rural School District

Robert C. Schmidt, Aidyn L. Iachini, Melissa George, James Koller, and Mark Weist

Youth suicide is a growing public health concern. As schools are becoming a key entry point for preventing and addressing youth suicide, the integration of suicide prevention efforts into existing school mental health (SMH) systems is becoming even more important. Unfortunately, as schools expand and adapt their existing SMH systems to meet this need, little guidance is available to them regarding how to do this. This article shares a case study documenting one rural school district's efforts to initiate, implement, and evaluate a suicide prevention program (Yellow Ribbon Ask 4 Help) through integration into the district's existing SMH system. Data were collected from 5,949 sixth- to 12th-grade students over four academic years, and changes were tracked in relationship to students' knowledge and help-seeking behaviors to support peers with suicidal thoughts. Data also capture the reasons students gave for experiencing suicidal thoughts, and the prevalence of these reasons. This case study suggests the feasibility of integrating a suicide prevention program into an existing SMH system and offers strategies for other schools to consider in their efforts. Implications for school social workers developing programs to prevent and address suicide among students through connections to SMH systems also are discussed.

KEY WORDS: *school mental health; suicide; suicide prevention*

Youth suicide is both a national public health priority (U.S. Department of Health and Human Services [HHS], 2001) and one of the most compelling challenges schools face (Miller & Eckert, 2009; Miller, Eckert, & Mazza, 2009). According to the Centers for Disease Control and Prevention (CDC, 2011), suicide is the fourth leading cause of death in 10- to 14-year-olds and the third leading cause of death in 15- to 24-year-olds. Recent statistics continue to highlight the prevalence of youth suicide nationwide, with 15.8 percent of ninth- to 12th-grade students having contemplated suicide and 12.8 percent having made a suicide plan in the past year (Eaton et al., 2012). Estimates suggest more than 7 percent of adolescents have made a suicide attempt in the past year, and for every 100 to 200 suicide attempts one suicide is completed (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

In reviewing young people's suicidal ideation and attempts, a number of risk factors have been examined. Research highlights increased risk for suicide attempts among females; individuals with mental health, substance abuse, and health problems; and those with family discord, a history of abuse, and other negative life events (Borowsky, Ireland, & Resnick, 2001). Suicide risk also is greater among individuals living in rural areas, with the gap widening in recent decades (Singh, Azuine, Siahpush, & Kogan, 2013). Developmental differences in suicide risk across adolescence are less well understood (Hacker, Suglia, Fried, Rappaport, & Cabral, 2006). Although older adolescents have a higher risk of suicide, and risk factors for suicide appear to differ by age, these appear to be consistent with developmental changes of adolescence.

Given the prevalence of suicide and factors associated with greater risk among the adolescent population, schools are well positioned to address this critical public health issue. In response to federal (Individuals with Disabilities Education Improvement Act of 2004 [P.L. 108–446]) and state policies (Katulak, Brackett, & Weissberg, 2008), school systems have started developing and expanding their SMH systems to support student learning and promote healthy youth development (Adelman & Taylor, 2004). Some also have started adapting their existing school mental health (SMH) systems to

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ensure inclusion of prevention programs and strategies to address youth suicide (Weiss & Cunningham, 2006).

YOUTH SUICIDE PREVENTION IN SCHOOLS

Offering suicide prevention in schools has long been advocated (Mazza, 1997; Miller & DuPaul, 1996), but the topic has received more attention in recent decades. This is likely because of an increasingly prominent focus on the role of schools in supporting student mental health (Kalafat, 2003), calls for proactive approaches to supporting student success and healthy development (Lieberman, Poland, & Cassel, 2008), shifts from individualized services to more population-based approaches to service delivery (Doll & Cummings, 2008), and federal calls to prioritize suicide prevention (HHS, 2001). Nevertheless, a recent comprehensive review of suicide programs in schools identified that in more than two decades there has been very little research to provide evidence for programming (Miller et al., 2009). Currently, very few suicide prevention programs are identified by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices; one of the most widely recognized, however, is SOS Signs of Suicide (Aseltine & DeMartino, 2004).

Integrating Suicide Prevention and SMH Efforts

The expansion of SMH systems to meet the mental health needs of students has often preceded efforts to specifically target and prioritize suicide prevention in schools (Weist, 1997). This is unfortunate, as many existing structures and processes advocated for within SMH programs are foundational to youth suicide prevention. For example, priorities around early identification, prevention, and intervention are important for both SMH systems and youth suicide prevention efforts. As national priorities emphasize the importance of prevention and promotion to students' academic achievement, this has led many schools to engage in schoolwide efforts to promote important protective factors, like school connectedness (Anderson-Butcher, Amorose, Iachini, & Ball, 2011). Given that it is also a protective factor related to youth suicide, schools and districts need to consider how current SMH efforts can strategically address or connect to suicide prevention approaches (also see Cooper, Clements, & Holt, 2011).

Early intervention strategies implemented as part of SMH systems also are critical for preventing youth suicide. For example, early intervention strategies necessitate having systems that use screening for early identification and then support placement or referrals for appropriate services. As such, these early identification and referral systems can be expanded to also support identification of students at risk for suicide (Bridge, Goldstein, & Brent, 2006). Research shows that signs and symptoms of developing mental health problems may appear years before the onset of disorder (Merikangas et al., 2010). This is also true of the signs of depression and suicidal thoughts and behaviors that precede suicidal attempts, making early identification critical to prevention. Building capacity for student identification and referral processes often includes several types of educational trainings for school staff, such as "gatekeeper" trainings that focus on supporting adults (for example, teachers, counselors, and school staff) ineffectively identifying youths in crisis and referring them to the appropriate school or community mental health resource (Cooper et al., 2011). Further, early identification systems require data to be used in determining who might be at risk for academic or other challenges at school as a way to direct students to the appropriate program, service, or intervention. Schoolwide suicide screening tools (Reynolds & Mazza, 1999) exist that can be implemented as part of these existing data collection processes. It is important that schools identify how to practically implement these and consider the capacity for treatment, crisis intervention, and referrals for intensive supports.

As schools and districts adopt priorities around suicide prevention, a number of strategies can be integrated into existing prevention and early identification systems. These can be used alone or in combination; different suicide prevention strategies may include gatekeeper training, curriculum-based programs, enhancement of protective factors, and schoolwide suicide screening (Cooper et al., 2011). One of the most widely recognized and empirically supported suicide prevention programs, SOS, is an example of a program that integrates a combination of strategies (Aseltine & DeMartino, 2004). SOS is a two-day program that uses both educational training and screening within its design.

Many other suicide prevention strategies are available, and systems should accommodate all students' needs depending on intensity of needed supports, but there is little guidance on evidence-based programs for schools (Miller et al., 2009). Moreover, because schools choose suicide prevention strategies, they must consider how they can be integrated into existing programming.

CASE STUDY: RURAL MARYLAND SCHOOL DISTRICT

Since 1999, a school district comprising nine schools located in rural Maryland has implemented a comprehensive SMH system. Three years after the inception of this system, school and community interest in suicide prevention increased when 18 students in a single high school were identified as suicidal, expressing intent to act on thoughts of self-harm, following the loss of a classmate to suicide. First, the school district petitioned the superintendent and the Board of Education to gain additional support to augment their existing SMH program to target suicidal ideation and behavior. This strategic process also included conducting teacher and staff trainings to improve student identification by educating personnel on the signs and symptoms of depression and suicidal ideation (King, Price, Telljohann, & Wahl, 1999).

In addition, both SMH and school staff realized that youths were more likely to share their suicidal thoughts with peers than with adults. To address this barrier and to support youths' help-seeking behaviors, the district reviewed different suicide prevention programs. Ultimately, the Yellow Ribbon Suicide Prevention Program (YRSPP) was chosen because it specifically addressed promoting communication about suicidal thoughts to adults. YRSPP also allowed the SMH team to proactively offer help to distressed students and to provide universal education and awareness about signs and symptoms of suicidal ideation. Although YRSPP has raised some concern in the past because of its limited evidence base (Beautrais et al., 1996), it is now identified within the Suicide Prevention Resource Center's Best Practices Registry, with some support for positive impacts (Freedenthal, 2010). Notably, the two primary strategies integrated within YRSPP (that is, education and screening) are the key elements included in SOS, an evidence-based suicide prevention program listed on SAMHSA's National Registry.

The mission of YRSPP is to prevent youth suicide through "empowering individuals and communities through leadership, awareness, and education" and to reduce the stigma associated with suicide (YRSPP, 2008). Specifically, YRSPP offers two trainings—"Ask 4 Help! Suicide Prevention for Youth" and "Be a Link! Suicide Prevention Gatekeeper Training." The Ask 4 Help program component includes a standardized curriculum as a means to provide students with knowledge to increase help-seeking behaviors for themselves or on behalf of other students through the use of the Yellow Ribbon Suicide Prevention Card. This card provides three steps for students to take, to help either themselves or others, as well as immediate access to a list of national hot line phone numbers (Emme, Brooks, Wright, & Hartfelder, 2000).

In this school district, Ask 4 Help trainings were implemented by a SMH staff member, within sixth- to 12th-grade classes across the district. Following approval at each school, these trainings lasted approximately 25 minutes and students received a Yellow Ribbon Card, a silicone wrist bracelet with the phrase "It's OK to Ask 4 Help with the Maryland (MD) Youth Crisis Hotline," and a T-shirt with the phrase "Be A Link Save-A-Life with the MD Youth Crisis Hotline." Both the bracelet and the T-shirt included the hot line phone number.

Collection of data also was prioritized by the district to understand the prevalence of youth suicidal thoughts within the district, the reasons youths gave for having suicidal ideations, and any changes in students' knowledge and behaviors across the years of program implementation.

METHOD

Procedures

Because the project sought to collect data on youth suicidal ideation, actions, and program responses, it was reviewed and approved by a community advisory board acting as an independent research review board. Passive parental consent forms and copies of the 10-item project survey were mailed to each individual household of students in grades six through 12 one month before the survey. Parents or guardians were given a phone number to call regarding participation, including if they wished to decline participation on behalf of their students.

The Ask 4 Help trainings were offered during individual classes between February and May each

academic year from 2007 through 2012. At the beginning of each Ask 4 Help training, students were asked to complete a 10-item knowledge survey that contained a one-item suicide ideation screening question. The training was then implemented, and students completed the same knowledge survey after the training ended. Student surveys were then collected by the SMH staff member, who addressed student responses to the suicide ideation screening question. If a student responded to the screening question indicating that they had ever experienced suicidal thoughts, or if a student erased his or her answer, left blank, or had illegible marks in the area for answering that question, an SMH staff member met individually to interview that student and to determine appropriate next steps (for example, further evaluation, psychiatric hospitalization) with the student's parent or another legal guardian.

The Ask 4 Help program was offered during the 2007–2008, 2009–2010, 2010–2011, and 2011–2012 school years. Data were not collected in 2008–2009 because of an intensive review of the program. Please note that because the program was conducted annually, student repetition in completing the program, survey, and assessment was not tracked.

Participants

Data were collected from 5,949 students in grades six through 12 who participated in the Ask 4 Help trainings in the district (see Table 1 for demographic information). Fifty-two percent of students receiving the prevention program were in grades six through eight in the district ($n = 3,107$); the remaining 48 percent ($n = 2,842$) were students in high school, in grades nine through 12. On average 1,487 (minimum: 974, maximum: 1,722) students participated each year; students across all six grades were included each year, except during the 2009–2010 academic year. Tenth- through 12th-grade students did not participate because of an unrelated tragic loss of a student that required SMH resources to be shifted to respond to this crisis and provide long-term support for students and staff.

Measures

Student knowledge related to suicide, help seeking, and specific aspects of the YRSPP program (for example, effectiveness of the Yellow Ribbon Card) were measured with nine items. The measure was created for the purpose of evaluating the knowledge students gained by participating in the suicide prevention program; items are listed in Table 2. Screening for student suicidal ideation was also measured. One item was included within the 10-item knowledge survey to serve as a suicide screening question: "Have you ever had thoughts of hurting yourself?" Response options for this item included 1 = within the past year, 2 = within the past few days, and 3 = never.

RESULTS

Suicidal Risk and Suicidal Ideation

Data from the single-item suicide screening question were analyzed to document the prevalence of youth suicidal ideation each year. During the four academic years in which data were collected, 670 youths (11 percent of participants) reported having thoughts of hurting themselves within the past year or the past few days. Of these youths, 46 percent were male. With regard to race or ethnicity, 70 percent ($n = 471$) of the students were Caucasian, 21.4 percent were African American, 6 percent were Hispanic, 2 percent were Asian, and 0.3 percent were American Indian.

Students who indicated in the suicide screening item to have had thoughts of suicide were interviewed by a behavioral specialist for further assessment. During the suicide risk assessment, six students expressed having current suicidal ideation. These students' families were immediately contacted, referred to the local emergency room for further evaluation, and provided additional supports connecting them to available mental health services. Of the remaining identified students, 107 reported suicidal ideation within the past few days but no current suicidal thoughts; these students were referred for additional mental health services. Seventy-four percent ($n = 79$) of the parents or guardians of the 107 students identified and referred actually consented to and accessed these SMH services. Across the four years, yearly rates in the percentage of students reporting suicidal thoughts showed a decreasing trend: 14.34 percent of students reported suicidal thoughts in 2007–2008, 12.73 percent in 2009–2010, 9.07 percent in 2010–2011, and 9.29 percent in the 2011–2012 school year.

Reasons for Suicidal Thoughts

As part of the suicide risk assessment conducted by the behavioral specialist, students were asked to

Table 1: Demographic Information for Students in Rural Maryland School District across Four Years of Study

	N (%)				
Variable	**2007–2008 (*N* = 1,722)**	**2009–2010 (*N* = 974)**	**2010–2011 (*N* = 1,553)**	**2011–2012 (*N* = 1,700)**	**Total across Program Years (*N* = 5,949)**
Grade					
6	268 (15.56)	275 (28.23)	272 (17.51)	271 (15.94)	1,086 (18.26)
7	266 (15.45)	221 (22.69)	266 (17.13)	229 (13.47)	983 (16.52)
8	262 (15.21)	242 (24.85)	253 (16.29)	281 (16.53)	1,038 (17.45)
9	337 (19.57)	236 (24.23)	246 (15.84)	262 (15.41)	1,080 (18.15)
10	250 (14.52)	0 (0)	241 (15.42)	303 (17.82)	794 (13.35)
11	206 (11.96)	0 (0)	190 (12.23)	189 (11.12)	585 (9.83)
12	133 (7.72)	0 (0)	85 (5.47)	165 (9.71)	383 (6.44)
Ethnicity					
Caucasian	1,274 (73.98)	729 (74.85)	1,120 (72.12)	1,232 (72.47)	4,355 (73.21)
African American	350 (20.33)	195 (20.02)	357 (22.99)	311 (18.29)	1,213 (20.34)
Hispanic	83 (4.82)	44 (4.52)	68 (4.38)	107 (6.29)	302 (5.08)
Asian	15 (0.87)	6 (0.62)	8 (0.52)	50 (2.94)	79 (1.33)
Gender					
Female	831 (48.26)	494 (50.72)	786 (50.61)	856 (50.35)	2,967 (49.87)
Male	891 (51.74)	480 (49.28)	767 (49.39)	844 (49.65)	2,982 (50.13)
Suicidal thoughts	247 (14.34)	124 (12.73)	141 (9.07)	158 (9.29)	670 (11.26)

express what factors contributed to their suicidal thoughts (see Table 3 for summaries of reasons given). The most prevalent reasons that students reported were related to family problems (54.48 percent), feeling bullied (10.75 percent), and grief or loss (8.66 percent). Considering the reasons for suicidal thoughts based on student's grade level, although the most prevalent reason for each of the seven grade levels was family problems, the second most prevalent reason differed for students in middle school versus high school (see Table 4). Among middle school students, feeling bullied was the second most prevalent reason, whereas for high school students it was grief or loss for each grade level (except for students in 12th grade, who reported a breakup with boyfriend or girlfriend).

Yellow Ribbon Program and Help-Seeking Knowledge and Behaviors

To explore changes in student knowledge about suicide and help-seeking behaviors, student responses on the knowledge survey were examined across all four school years (see Table 2). Together, these data suggest improvement in students' knowledge because of the program. For example, students gained knowledge related to the Ask 4 Help program. There was a larger percentage of correct responses by students for all items related to program knowledge after completing the training session. In addition, students' knowledge about suicidal ideation and help seeking increased. For example, students were asked questions regarding why people contemplate suicide and where they should go for help if someone is expressing suicidal thoughts. Again, there were larger percentages of correct responses by students after they completed the program session.

The district also was interested in considering the longer-term influence on student behaviors, and therefore SMH staff tracked student help seeking through the use of the Yellow Ribbon (YR) Card. Twenty-one students used their YR Card across the four years data were collected, presenting it to someone to access the school's mental health program. This included six students during the 2007–2008 school year, three students during 2008–2009 (the nonimplementation year), four students during 2009–2010, and eight students in 2011–2012.

DISCUSSION

The purpose of this article was to provide a case example documenting how one rural school district selected and implemented a youth suicide

Table 2: Percentage of Students with Correct Responses before and after Implementation of the Yellow Ribbon Suicide Prevention Program (YRSPP)

Knowledge Items	Before (%)	After (%)
1. Feeling depressed usually means feeling		
(a) Sad, happy, laughing		
(b) Smiling, being with friends, having fun		
(c) **Irritable, hopeless, alone, sad**	96.4	99.4
2. Most important tool used in the YRSPP:		
(a) Yellow Ribbons		
(b) Yellow Ribbon Card		
(c) **Knowledge**	60.9	97.2
3. People do not want to end their lives, but want to end their		
(a) Job		
(b) Problems		
(c) **Pain**	47.3	95.0
4. If I feel sad, lonely, or just feel stuck, "It's OK to Ask 4 Help" from		
(a) **Trusted adult/friend**		
(b) No one		
(c) Keep it a secret	97.3	98.4
5. I know what to do if a friend tells me they are thinking about hurting themselves[a]		
a. Yes, I do	72.4	76.7
b. I think I do	20.8	17.3
c. Not sure	6.5	5.5
6. If a friend hands me their Yellow Ribbon Card, I will		
a. Stay with my friend unless they have a weapon		
b. Listen/take them seriously		
c. Get help immediately		
d. **All the above**	71.9	94.4
7. 24-Hour Crisis Hot Lines		
(a) Closed weekends		
(b) **Someone to talk to**		
(c) Helps with homework	96.0	98.3
8. If I began having thoughts about hurting myself, I would		
(a) Not tell anyone		
(b) Tell a friend to keep it a secret		
(c) **Tell my parent, guidance counselor, teacher, or a trusted adult**	83.4	96.7
9. What should you do if a friend tells you they want to hurt themselves?		
(a) Not take it serious		
(b) Keep it a secret		
(c) **Tell an adult & get help for your friend or family member**	96.7	98.9

Note: Correct answers are in bold

[a]There is no correct answer to this question, so percentages of all responses are given.

prevention program through their existing SMH system and evaluated these efforts. Results show the promise and feasibility of this approach to integrating a suicide prevention program into existing SMH programming districtwide. Moreover, the implementation of the program resulted in positive changes in students' knowledge and behavior related to youths seeking help on behalf of their peers.

This school district was able to identify between nine and 12 percent of youths across the four years who indicated having suicidal thoughts within the past few days or within the past year, and connect these students and their families to services. Also, consistent with the literature on risk factors associated with youth suicide, many students reported family problems, grief or loss, and being bullied as reasons associated with suicidal thoughts (Bridge et al., 2006). These findings also highlighted how related efforts in schools should also focus on these important issues.

Limitations

The school district selected to implement YRSPP because of fit and program priorities. YRSPP is recognized and registered as a "best practice" by the Suicide Prevention Resource Center, with some

Table 3: Self-reported Reasons for Suicidal Thoughts (*N* = 670)

Reason Given	*n* (%)
Family problems	365 (54.48)
Feeling bullied	72 (10.75)
Grief or loss	58 (8.66)
Breakup with boyfriend or girlfriend	27 (4.03)
History of mental illness	27 (4.03)
Peer problems	15 (2.24)
School problems	11 (1.64)
Physical, psychological, or sexual abuse	1 (0.15)
Other	3 (0.45)
Neighborhood problems	1 (0.15)
Financial problems	1 (0.15)
False positives[a]	89 (13.28)

[a]Students initially indicated suicidal ideation but when followed up with during the assessment, indicated that they had no suicidal thoughts.

evidence of positive impacts (Freedenthal, 2010), and consists of key elements identified in SOS, an evidence-based suicide prevention program; however, an expanded evidence base is needed. The empirical support for feasible, acceptable, and effective suicide prevention programs for schools to implement is emerging. Continued research is needed on this program and others to ensure that suicide prevention programs are practical and effective and can be modified to the individual needs of each school's current mental health program. Similarly, the use of psychometrically sound survey instruments and a suicide screener would be ideal to duplicate, without diminishing from the current conclusions drawn. Growing literature indicates the need to continue bridging the research-to-practice gap in SMH and to understand the factors that contribute to SMH practitioners' review and selection of evidence-based programming (George, Taylor, Schmidt, & Weist, 2013). Given the case study nature of this research, caution regarding the generalizability of these findings is warranted. Nevetheless, lessons learned from implementing YRSPP and collecting data provide insight around potential factors to consider when implementing programs that help schools to systematically prevent youth suicide.

Table 4: Two Most Prevalent Reasons Given for Suicidal Thoughts, per Grade

Grade Level	Reasons Given for Suicidal Thoughts (%)
6	Family problems (54)
	Feeling bullied (14)
7	Family problems (46)
	Feeling bullied (12)
8	Family problems (55)
	Feeling bullied (11)
9	Family problems (48)
	Grief or loss (10)
10	Family problems (58)
	Grief or loss (8)
11	Family problems (50)
	Grief or loss (12)
12	Family problems (51)
	Breakup with boyfriend or girlfriend (11)

Implications for Practice

This study highlights not only the prevalence of youth suicide within one rural school district, but also how nonacademic barriers to learning, such as family problems, grief or loss, and being bullied may affect students' overall mental health and life success. School social workers and other SMH practitioners should continue addressing these barriers to learning by working with youths reporting difficulty or challenges in these areas. School social workers might consider what, if any, youth suicide prevention strategies are currently being implemented in their district, or how strategies might be incorporated into existing prevention, early intervention, and treatment efforts as part of the broader SMH system. Supporting and advocating for policy and program development for youth suicide prevention, bullying prevention, and improvements in school climate enhances a continuum of care to support students' needs.

The way in which youth suicide prevention strategies are incorporated into existing SMH systems also is important to consider in practice. For example, the school system in this study decided to implement multiple strategies (that is, gatekeeper training, youth training, and screening or assessment) to address youth suicide prevention, targeting different stakeholders' groups. In addition, screening was strategically included as part of the training implementation process in this district.

Although the use of screening is a key component of suicide prevention programs, such as SOS and YRSPP, schools and SMH programs often lack the capacity to conduct broad mental health screening of students with adequate follow-ups. Reporting on a task force of the American School Health Association, Weist, Rubin, Moore, Adelsheim, and Wrobel (2007) discussed many challenges of mental health screening in schools, with major problems

being poor resources and infrastructure support to adequately conduct the screening, analyze data, and provide timely services to students. Weist et al. (2007) indicated that one potential strategy to overcome these challenges is a sequential plan, conducting screenings one school at a time, with the local community rallying around that school at the time of the screen to ensure adequate follow-up of students.

More broadly, school social workers might consider barriers and facilitators within their school district related to youth suicide prevention. For example, not all schools have mental health professionals trained in suicide prevention. A recent study found that school social workers believed their graduate training did not prepare them with the knowledge and skills necessary to work with suicidal youths (Singer & Slovak, 2011). Similarly, a study of school psychologists reported that 86 percent had counseled one or more students who had threatened or attempted suicide, but only 22 percent felt graduate training prepared them to intervene proactively with suicidal youths (American Association of Suicidology, 2008). Unfortunately, in-service trainings for SMH staff focus on academic-oriented issues, leaving little time for other important topics such as mental health or youth suicide (Paternite et al., 2006). Suicide among our nation's youths continues to escalate at an alarming rate. Overcoming challenges to incorporate suicide prevention into SMH continues to be a priority for school social workers and other SMH staff. CS

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Free Online Behavioral Health Professional Development Training Opportunities for School-Based and Early Childhood Staff (Last updated 3/29/2016)

Program	Description	Audience	Time	Continuing Education
Community-Partnered School Behavior Health Modules	The Community-Partnered School Behavioral Health Implementation Modules provides a range of strategies, resources, and tools necessary to establish, maintain, and expand effective student behavioral health programs. These modules focus specifically on supporting student social, emotional, behavioral and academic progress via a community-partnered approach to school behavioral health. https://mdbehavioralhealth.com/training	School-Based Clinicians, Educators, Student Support Staff, Evaluators, Administrators, Program Leaders	*30-60 min/module (15 modules)*	Yes (Behavioral Health providers)
Interprofessional Training Program for Military Connected Families	The Interprofessional Training Program for Military Connected Families modules are designed to help youth-serving staff to better understand and to be aware of unique considerations, skills, and resources that can help to support the success of military connected families.	Educators, Mental Health and Substance Use Providers, and Child and Adolescent Health Providers	*14 modules ranging from 30 to 60 minutes*	Yes. Behavioral Health Providers
Kognito for Educators **Kognito - Step In, Speak Up! To Support LGBTQ Students**	Kognito is an innovative state-of-the art, interactive avatar-based online suicide prevention and mental health training. These trainings help to build skills and motivation to identify, approach, and refer students exhibiting signs of suicidal ideation, substance use/abuse, and psychological distress, including depression and anxiety, to relevant support services on and off the school campus. http://md.kognito.com/	Elementary, Middle and High School Teachers and Other School-Based Personnel	*45-60 min/module (3 modules)*	Yes (Educators, 1.0 CE)
Maryland Behavioral Health Integration In Pediatric Primary Care (BHIPP)'s Children's Health and Emotional Care Learning Community (CHECKup)	CHECKup is designed to create a learning experience that offers the latest information and tools, and also supports providers' efforts to implement best practices, in compliance with national standards. This is funded by MSDE Race to the Top funds. It can be used as a self-guided training, with web resources to support training. It has content for primary care providers that would also be very useful for school nurses, Early Childhood Mental Health providers, as well as early childhood education providers. Videos are embedded in the Prezi presentations and soon stand-alone videos will be available. http://www.mdbhipp.org/checkup.html	Primary Care Providers, School Nurses, Early Childhood Mental Health providers and Consultants, Early Childhood Education Providers	*Varies depending on topic and purpose*	No

Program	Description	Audience	Time	Continuing Education
The Maryland Early Intervention Program (EIP)	The Maryland Early Intervention Program (EIP) covers the early identification and intervention for adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. There are 10 modules in the series. https://mdbehavioralhealth.com/training	School Staff, Primary Care Providers, Behavioral Health Providers, Families, Advocates	*30-60 minutes per module (5 hours total/ 10 modules)*	No
Maryland Learning Links	Maryland Learning Links provides online resources for educators, providers and families of children birth to 21 with disabilities. Topics include but are not limited to professional development modules, resources, blogs, communities of practice, universal design for learning, family engagement, evaluation/assessment, IEP/IFSP development and more. http://marylandlearninglinks.org/	School-based Staff, Providers, Families	*Variable depending on topic/purpose*	No
Maryland Social Emotional Foundations for Early Learning (SEFEL)	Maryland Social Emotional Foundations for Early Learning (SEFEL) promotes social and emotional development. When children have appropriate pro social behavior they do better in school and in life. Skills include empathy and listening, following routines and following directions. There are 3 Infant and Toddler Modules and 4 Preschool Modules. https://theinstitute.umaryland.edu/sefel/index.cfm	Teachers and Caregivers	*Modules are self-paced and include resource materials 6.5 hours per module*	Core of Knowledge Certificates given for each set of modules
Mental Health Modules for Educators	The Mental Health to Support Student Learning modules advance basic mental health proficiency for educators and other school-based professionals working with children and youth. The learner has access to seven modules related to student mental health (e.g., student development and mental health, understanding internalizing concerns, understanding externalizing concerns, data-based decision making). https://mdbehavioralhealth.com/training	Middle and High School Educators	*1 hour/module 7 hours total*	Yes (Educators, 1.0 CE)

Program	Description	Audience	Time	Continuing Education
Mental Health Training Intervention for Health Providers in Schools (MH-TIPS)	The Mental Health Training Intervention for Health Providers in Schools (MH-TIPS) is a 3 module training series aimed at enhancing school health provider mental health competence in promoting student mental health and managing the needs of students with or at risk for emotional and behavioral difficulties that may interfere with learning. https://mdbehavioralhealth.com/training	School Nurses	*Approximately 1 hour/module (3 modules)*	Yes (Continuing Education Credits for school nurses)
Military Child Education Coalition	The Military Child Education Coalition assists professionals in fields such as education, health care, and child care in learning the most recent research-informed methods for supporting military-connected children and youth. www.militarychild.org	School-based Staff, Providers, Families	*Varies depending on course*	Yes (but cost for CEUs)
National Child Traumatic Stress Network	The National Child Traumatic Stress Network (NCTSN) has developed professional development training and resources, with a goal of raising the standard of care and improving access to services for traumatized children, their families and communities. There are two training courses especially relevant to school staff. • Schools & Trauma, http://learn.nctsn.org/enrol/index.php?id=50 • Young Children and Trauma: Service System Collaborations (Topic 6 - Head Start), http://learn.nctsn.org/enrol/index.php?id=37	School-based Staff, Child Serving System Staff	*Approximately 1.5 hours/module (12 modules)*	No
Office of the Administration for Children and Families Early Childhood Learning and Knowledge Center (ECLKC)	The ECLKC– Head Start offers an array of resources to promote teacher development, effective practice, and a successful transition to kindergarten for young children. The site includes 15 minute in-service Suites and a link to Teacher Time: Webinars for Preschool Teachers. Examples of webinars include: *It's a Big Problem! Teaching Children Problem Solving Skills* and *Help Me Calm Down!, Teaching Children How to Cope with Their Big Emotions*. http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/	Early Childhood Staff and Preschool and Kindergarten teachers	*Approximately 15-60 minutes*	No

Program	Description	Audience	Time	Continuing Education
Social Emotional Learning Self-Assessment Survey	Provided by the American Institutes for Research, the self-assessment tool can be used individually or as part of a professional learning activity for school staff to reflect on their social emotional learning knowledge and skills. http://www.gtlcenter.org/sel-school	School-based Staff	*Approximately 30-45 minutes*	No
Trauma-Focused-Cognitive Behavioral Therapy (Medical University of South Carolina)	Offers a free web-based learning course to train individuals in trauma-focused cognitive-behavioral therapy https://tfcbt.musc.edu/	School-based Behavioral Health and Health Staff	*Approximately 30-60 minutes per module (8 modules)*	No
Treatment Services and Adaptation Center for Resiliency, Hope and Wellness in Schools	The Treatment and Services Adaptation Center (https://traumaawareschools.org/traumaInSchools) has developed a series of free, online trainings to support trauma-informed schools and school-based behavioral health providers serving trauma-exposed youth • Psychological First Aid (PFA) for Schools – Listen, Protect, Connect, Model and Teach, https://traumaawareschools.org/pfa • Bounce Back, http://bouncebackprogram.com • Cognitive Behavioral Intervention for Trauma in Schools (CBITS), http://cbitsprogram.org • Support for Students Exposed to Trauma (SSET), https://ssetprogram.org	School-based (K-12) behavioral health providers (Bounce Back/CBITS); School counselors/Teachers (SSET); All school staff (PFA)	*Approximately 8 hours/course (3 courses)*	Yes (Continuing education credits for behavioral health providers)
The Youth Co-Occurring Disorders (COD) Training for Behavioral Health Providers	The Youth Co-Occurring Disorders (COD) Training for Behavioral Health Providers seeks to disseminate information to the public and to mental health professionals on co-occurring mental health/substance abuse disorders and to train clinicians on how to support the behavioral health of youth and their families. https://mdbehavioralhealth.com/training	Mental Health, Health, and Substance Use Providers	*Approximately 1 hour/module (19 modules)*	Yes, up to 24.5 CEUs for mental health and substance use providers)

Lillian M. Lowery, Ed.D.
State Superintendent of Schools

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MEMORANDUM

TO:

FROM: Walter J. Sallee, MPA
Interim Executive Director,
Division of Student, Family, and School Support (DOSFSS)

Carmen A. Brown, LCSW-C
Branch Chief, Interagency Collaboration
Division of Special Education and Early Intervention Services (DSE/EIS)

DATE: August 17, 2015

SUBJECT: **Kognito – Online, Avatar-Based, Interactive Training on Student Mental Health and Suicide Prevention**

The Maryland State Department of Education (MSDE) is pleased to announce the release of professional learning activities to elementary, middle, and high school educators, as well as other school-based staff across Maryland. MSDE highly encourages the school workforce to take advantage of these trainings to increase knowledge and skills related to youth mental health.

Kognito is an innovative, interactive, avatar-based, online suicide prevention and mental health training. These online simulations teach K-12 school personnel how to identify, approach, and refer students exhibiting signs of suicidal ideation, substance use/abuse, and psychological distress, including depression and anxiety. Referrals can then be made to appropriate support services on and off the school campus. These professional learning resources are available at no cost to schools in Maryland. See a 3-minute video here or access flyer here.

At-Risk Training Simulation Fast Facts:

- Takes 45-60 minutes on average to complete
- Can be completed online in one or multiple sittings
- Includes practice role-play conversations building skills to talk with students
- Is available at over 40% of K-12 schools in the United States

Many schools are scheduling this training now on their 2015-16 professional learning calendars.

Please choose one of the following Professional Learning Options:

Option ONE – Interactive Lesson Plans & Modules

1. Utilize the thirty minute professional learning module, lesson plan and resources to introduce Kognito to school based staff. Please see enclosed scripted PowerPoint, lesson plan and suggestions for more details.
2. After the presentation, send this link to your school staff: http://kognito.com/maryland and have them create an account to complete the online modules. Specify a date for completion of the online simulations.
3. Participants fulfilling requirements may earn a Continuing Professional Development Credit (Educators) or Continuing Education Units (Psychologists, Social Workers, Nurses, Professional Counselors, Therapists, and Residential Child Care Program Professionals). Participants should go to http://kognito.com/maryland for details.
4. If you would like to coordinate a follow-up discussion with your staff, click on the orange "Tips & Resources" button to find email templates, slides, and facilitator guides.

Option TWO – Independent On-Line Training (See enclosed flyer)

1. Inform your staff about the availability of these trainings.
2. Send this link to your school staff: http://kognito.com/maryland and have them create an account to complete the online modules. Specify a date for completion of the online simulations.
3. Participants fulfilling requirements may earn a Continuing Professional Development Credit (Educators) or Continuing Education Units (Psychologists, Social Workers, Nurses, Professional Counselors, Therapists, and Residential Child Care Program Professionals). Participants should go to http://kognito.com/maryland for details.
4. Coordinate a follow up discussion with your staff, click on the orange "Tips & Resources" button to find email templates, slides, and facilitator guides.

If you have additional questions, please contact Deborah Nelson, Specialist for School Psychological Services, DOSFSS via email deborah.nelson@maryland.gov or Nancy Feeley, Lead Specialist, Interagency Collaboration DSE/EIS, directly via email nancy.feeley@maryland.gov .