School counselors and unified educator-counselor identity: A data informed approach to suicide prevention

By: Carrie A. Wachter Morris, Kelly L. Wester, Connie T. Jones, and Saron Fantahun

Wachter Morris, C. W., Wester, K. L., Jones, C. T., & Fantahun, S. (2021). School counselors and unified educator-counselor identity: A data informed approach to suicide prevention. *Professional School Counseling, 24*(1b), 1-9. https://doi.org/10.1177/2156759X211011909

*****© 2021 American School Counselor Association. Reprinted with permission. No further reproduction is authorized without written permission from SAGE. This version of the document is not the version of record. Restricted to non-commercial and no derivative uses. *****

Abstract:

School counselors are vital in crisis prevention and intervention. In this article, we discuss the unified educator–counselor identity as it informs the suicide prevention work of school counselors, illustrated with a data-based case example from a quantitative study based in one high school. This case example includes a decision tree to show how school counselors can use data to understand the suicide prevention and intervention needs of a diverse student body in their own schools.

Keywords: data-driven decision making | decision tree | educator–counselor identity | school counselor identity | suicide prevention

Article:

School counselors are uniquely positioned in the schools, charged with helping all students with academic, career, and social/emotional development (American School Counselor Association [ASCA], 2019). School counselors do this through creating and implementing a comprehensive school counseling program that meets the needs and challenges of every student in the school. This is a tall order because students come to school with a wide range of concerns, needs, and challenges, all nested within the needs and challenges of the school as an organization. However, given the current context of the COVID-19 pandemic and ongoing racial unrest within the United States, school counselors face even greater urgency in providing services to their students and schools. These concerns include challenges related not only to the physical health and safety of students, teachers, and staff as we continue to see the ongoing effects of the COVID-19 pandemic but also to their psychological safety, which is also impacted by the pandemic (Reger et al., 2020). Concurrent with those concerns is ongoing exposure of long-standing racial inequities present not only in the economic and health disparities laid bare by the pandemic but also in the trauma of witnessing footage or hearing coverage of the deaths of Black and Brown people at the hands of law enforcement.

Although preventative practice is often school counselors' goal, providing responsive services—particularly to acute crises—is also a significant part of their work (ASCA, 2019). With the

continued effects of the COVID-19 pandemic and ongoing calls to end racial injustice, the crisis stabilization and antiracism work of school counselors are increasingly salient, particularly as students are returning to schools that closed suddenly due to COVID-19 in spring 2020. Concurrent with the need to provide ongoing support to students and schools, school counselors also need data-driven, evidence-based practices not only to build and maintain a comprehensive school counseling program but also to identify groups of students who may need additional support. Conceptualizing school counselors as professionals situated as educators while oriented as counselors (Levy & Lemberger-Truelove, 2021) is consistent with their work in crisis intervention. It is also helpful in identifying and addressing ongoing needs for students specific to the current time—including anti-racist work and social justice—so that comprehensive school counseling programs can truly serve the needs of all students.

In this article, we highlight the ways that the unified educator–counselor role is present in crisis-related work including the school counselor's role in suicide prevention and intervention, in social justice, and in collaboration and teaming. First, we discuss cultural trends in youth suicide, which may be further exacerbated by the twin pandemics of racial injustice and COVID-19. Then, we illustrate a practical approach to suicide prevention in the schools, proposing a decision tree that could serve as a model for how school counselors can use their identity as educator–counselor to identify and respond to suicide risk in schools, highlighting decision points informed by data. Finally, we share implications for practice.

School Counselors as Educators: Use of Data to Inform

Data collection is already a part of what many schools do—to report student learning outcomes, monitor student needs, and assess areas for improvement. Part of any comprehensive school counseling program is assessment (ASCA, 2019). Although "data" may still be a four-letter word to some, collecting, analyzing, and reporting data are vital to implementing and evaluating programming for comprehensive school counseling programs (ASCA, 2019). ASCA describes four primary purposes for which school counselors need to use data: (a) needs assessments, (b) monitoring student progress to close the opportunity gap, (c) program evaluation, and (d) demonstrating effectiveness of the comprehensive school counseling program (see https://www.schoolcounselor.org/school-counselors/professional-development/asca-u-specialist-trainings/school-counseling-data-specialist). Thus, using data to continuously assess the effectiveness of a comprehensive school counseling program is part of what all school counselors need to do to maintain and build upon their programs.

Data collection is vital to doing needs assessment and program evaluation to determine the overall direction of the school counseling program, and disaggregating data to look for additional trends might also help identify additional needs that may not have risen to school counselors' attention. One such area that could benefit from this need and focus for school counselor responsive services is youth suicide.

Suicide Statistics and the School Counselor's Role in Suicide Prevention and Intervention

Suicide has long been a significant public health concern for adolescents and is currently the second leading cause of death for youth ages 10–24 (Centers for Disease Control and Prevention

[CDC], 2020). Although youth suicide has been a concern for the past several decades, the suicide rate among ages 10–24 increased 56% between 2007 and 2017 (Curtin & Heron, 2019), and it continues to rise (CDC, 2020). Suicide might first conjure the thought of a school counselor providing counseling services—after all, suicidality is an immediate mental health–related concern for youth—but it is equally important that the educator role remains activated. For example, ASCA (2020) has two position statements regarding suicide, one on suicide prevention and awareness and a second on suicide assessment. The role in prevention and awareness specifically elevates the unified educator–counselor position, in that school counselors "provide parents/guardians with referral resources for students (Stone, 2018). School counselors work to raise awareness of suicide and suicide ideation, train school personnel and create opportunities to identify resources available for school personnel (Desrochers & Houck, 2013)" (ASCA, 2020, p. 79). Thus, in this position statement, the school counselor is called to work within the educator role, while concurrently "recogniz[ing] the threat of suicide among children and adolescents and striv[ing] to create a supportive environment" (ASCA, 2020, p. 79). Specifically, ASCA takes the position that school counselors "support best practice in suicide prevention to reduce suicide risk in children and adolescents and are part of a collaborative team who respond when students are identified as at-risk for suicide" (ASCA, 2020, p. 83).

Although youth suicide rates are a concern across racial and ethnic groups, trends in recent years have provided further clarity on populations that may be at increasing risk. For example, in the most recent Youth Risk Behavior Surveillance Study (YRBSS) results, youth identifying as lesbian, gay, or bisexual (LGB)—or who are unsure of their sexual identity—had higher prevalence rates of reporting seriously considering suicide, making a plan for suicide, attempting suicide, and making a suicide attempt that required medical care (CDC, 2020). Specifically, students who report as LGB are three times as likely to contemplate suicide and five times as likely to attempt suicide as their heterosexual peers (CDC, 2016).

Specific to gender identity, the American Academy of Pediatrics reported strikingly high rates of attempted suicide in youth who identify as transgender or gender nonbinary, with more than half (50.8%) of adolescents who identified as female to male, two in five adolescents identifying as neither exclusively male nor female (41.8%), and nearly three in 10 adolescents who reported being male to female (29.9%) or questioning (27.9%) reporting making a suicide attempt (Toomey et al., 2018). This compares with 17.6% of cisgender female adolescents and 9.8% of cisgender male adolescents who report making an attempt (Toomey et al., 2018).

Specific to racial and ethnic differences in suicidality, White youth overall—and White male students specifically—reported higher levels of seriously considering suicide than their peers in other ethnic and racial groups (CDC, 2020), leading to White youth often being seen as the group of youth most at risk of suicide (Bridge et al., 2015). That said, Black youth overall—and Black female students specifically—reported a higher prevalence of suicide *attempts* than their peers from other racial or ethnic backgrounds (CDC, 2020). Similarly, Lindsey and colleagues (2019), in a nationwide study concerning high school students, found that suicide attempts increased by 73% for Black adolescents between the years of 1991 and 2017, and suicide attempts by White youth decreased. This increase is greater than the 56% increase in suicide rate for 10- to 24-year-old youth overall reported by Curtin and Heron (2019), revealing an increased risk for Black female adolescents. Researchers have shown a higher rate of suicide attempts and ideation

among Black girls than Black boys and a higher rate of suicide completion by Black boys in comparison to Black girls (Lindsey et al., 2019). Bridge and colleagues (2018) found that among Black boys, the risk of suicide is elevated among those aged 5–11.

Despite the studies and literature that discuss the increased suicide rate among Black youth, suicide is not often explored, assessed for, and identified in Black youth (Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, 2019; Joe, 2006). Black youth also may be hesitant to disclose suicidal ideation, suicide attempts, and depression (Bridge et al., 2015) due to the cultural mistrust of mental health providers and those in authority, for fear of appearing "weak," and not having access to resources (Lindsey et al., 2019). Many factors may influence the increased suicide rate among Black youth, such as aggressive school discipline measures related to racism and lack of social support (Bridge et al., 2015). Because of the research identifying Black youth as a high-risk group for suicide and suicidal behavior, it is vital that the K–12 school environment, and particularly school counselors, be aware of the current trends of suicide concerning this marginalized and often overlooked population.

Part of the hypothesis posed for the increasing youth suicide rates in the past decade is the rise of social media and, along with it, a rise in cyberbullying and a reduction in time spent communicating face-to-face (Twenge et al., 2018). Thus, with the necessity of social distancing and reduction in group activities implemented to reduce the spread of COVID-19, these trends may be exacerbated in the present and near future. Similarly, with the increasing erosion of rights of LGBTQIA+ individuals, trauma due to ongoing racial injustice and police violence, and the disproportionate impact of COVID-19 on the physical, emotional, and economic health of marginalized communities, understanding the suicide prevention and intervention needs of our youth is crucial, both generally and within specific populations that might be at increased risk.

In the remainder of this article, we walk through a decision tree around suicide prevention and response, using data from one school to highlight how school counselors can look at their own data to help identify potential areas of need at their own schools—a need that is likely to continue, given the constellation of issues facing the United States in the present and near future. Although the case example presented here is part of a larger study, the school counseling team at the school was the prime mover in partnering with the researchers who collected data, which exemplifies how to collaborate with outside experts to serve students.

Case Example

This case example is given not as a traditional empirical article but rather uses data that could be collected by school counselors to highlight how they can act as both counselor and educator to meet student needs around crisis prevention and intervention and address social justice through the use of data. This case example also highlights the benefits of collaboration and teaming, another key aspect of providing a comprehensive school counseling program. It demonstrates not only how school counselors can use larger aggregate data but also how data can be disaggregated to identify and address needs or concerns among specific subgroups within the school building. In disaggregating data, a school counselor breaks down the data or information into smaller subgroups based on categories (e.g., students in sports or extracurriculars, grade level) or

identities (e.g., race or ethnicity, sexual orientation; National Center for Mental Health Promotion and Youth Violence Prevention [NCMHPYVP], 2012). Aggregated data can provide overall information about what may be occurring in the school, while disaggregated data may help inform school counselors about programming needs for different subpopulations in the school based on presenting concerns and grounded in data (NCMHPYVP, 2012).

Context

A student support team, including the student success coordinator in charge of school counseling for one school district in the southeast United States, was seeing what appeared to be an increase in self-directed violence (SDV; including suicidal thoughts and behaviors as well as nonsuicidal self-injury [NSSI]) in the student body, particularly in one high school. Efforts to advocate for additional resources to meet these needs had not come to fruition within the school district, and the student support team was hoping to get a sense of the scope and nature of the SDV within this high school so that they could use data to inform other school stakeholders and potentially increase the resources to support students struggling with suicide or NSSI.

The school success coordinator used her network to solicit outside help collecting the type of data she needed and collaborated with several university faculty to collect data. All research processes were approved by university and district institutional review boards. A research team consisting of the first and second authors collected quantitative data around SDV (suicidal thoughts, suicidal behavior, and NSSI), depression, trauma, coping, and school engagement, at two time points: January 2019 and April 2019. Information in this article is drawn from the first time point in January, focusing on SDV, depression, and school engagement. We selected these items because the surveys and information could be collected by either a school counselor or through a partnership with external researchers and could be examined using skills and tools readily available to school counselors to make school-level decisions around the needs of the student body regarding suicide.

Survey Packets

Each student received a survey packet with pencil-and-paper assessments. They were asked to listen to a standardized video that walked them through the informed consent process and were then given time to complete assessments if they chose. Each measure is listed below.

Suicide risk was assessed with the Suicidal Ideation Scale (SIS; Rudd, 1989). The SIS is a 10-item Likert-based scale that asks students to rate the degree to which they have had suicidal ideation, behaviors, and/or attempts within the previous week. A person who scores 15 or above is considered someone at serious suicidal risk (Rudd, 1989). The SIS has been shown to have strong evidence of validity and reliability (Luxton et al., 2011; Rudd, 1989).

Depression was assessed with the Center for Epidemiologic Studies Depression Scale–Revised (CESD-R; Eaton et al., 2004). The CESD-R is a 10-item instrument to assess for depression and depressive disorders. Participants rate symptoms of depression on a scale from 0 to 3, producing a range of scores from 0 to 30, with higher scores indicating a higher level of depression. A score of 10 or more would be considered depressed. For the current sample, Cronbach's α was .83.

School engagement was assessed using the Student Engagement Inventory (SEI; Appleton et al., 2006), a 35-item instrument to measure students' psychological and cognitive engagement in school, overall and in three specific areas (teacher–student relationship, peer support, and family support for learning). Responses are scored on a Likert-type scale from 1 to 4, and the Sum Scale ranges from 35 to 150. Cronbach's α for the current sample was .93.

All information was collected anonymously such that researchers would be unable to identify individual students from their survey responses. All students were given information about resources both at the school and in the community in case they became distressed during or after responding to the survey.

Participants

All students in Grades 9–12 (n = 1,450) were invited to participate in the January survey. Of those invited, no students were opted out by their caregivers, 69 students were absent, and 20 were off campus for a school-related activity the day of the survey. A total sample size of 1,081 students responded to the survey, a 74.5% response rate from the entire student body. This left 280 students who may have opted out of the survey or who were not present when the survey was administered. Of the 1,081 students who responded, 1,068 (98.8%) identified their grade; slightly more than one third (n = 380; 35.2%) were in ninth grade, 267 (24.7%) in 10th grade, 203 (18.8%) in 11th grade, and 218 (20.2%) in 12th grade.

Participants were invited to also report their gender, sexual, and racial identities. Nearly all of the students reported their gender identity (n = 1,075; 99.4%), sexual identity (n = 1,002, 93.1%), and racial/ethnic identities (n = 1,068; 98.8%). Half of the sample responding to gender identity identified as female (540; 50.0%), 496 (45.9%) identified as male, 18 (1.7%) identified as transgender, 21 (2.0%) reported that they were unsure of their gender identity, six (0.6%) actively declined to state gender identity, and another six (0.6%) did not respond to the question. The majority of students identified as heterosexual (n = 770, 71.6%), with 46 (4.3%) identifying as gay, lesbian, or homosexual; 12 students as bisexual (11.3%), 45 (4.2%) indicating they were unsure of their sexual identity at the time of the survey; and 19 (1.8%) actively declining to state. Of those students responding to the question about racial/ethnic identity, 630 (58.3%) identified as White/Caucasian, 240 (22.2%) as Black/African American, 39 (3.6%) as Asian/Asian American, five (0.5%) as Native American/American Indian, 20 (1.9%) as Hispanic/Latinx, and 134 (12.4%) as other/multiracial.

Decision Tree and Data

To further demonstrate how school counselors can utilize the educator–counselor identity to work toward suicide prevention and intervention in the schools, we work through a decision tree to show multiple ways to address suicide prevention and intervention illustrated with the data from this particular school. This process does not have necessarily correct answers, so much as decision points that allow school counselors with an educator–counselor identity to identify how to reach students in a multitiered system of support (MTSS) manner who might be at particular risk of suicide.

Decision Point 1: Is Suicide an Issue Within My Particular Student Population?

Overall prevalence statistics from the United States suggest that youth suicide is a large-scale public health issue and has been for decades (see CDC, 2020). Although this is the case, we can use the data to determine whether the prevalence of students at serious suicide risk is comparable at this school to national prevalence rates. When looking at the survey results, 1,038 students responded to the Suicide Ideation Scale (SIS). The mean score of the school on the SIS falls below the clinical cutoff score of 15 (M = 12.98, SD = 5.81, range 10–50). This is good news overall but only gives the broad picture rather than how many students might be at risk.

To look at the suicide risk in more detail, we need to look at the number of students who reported scores on the SIS at or above 15, which is the clinical threshold for serious suicide risk (Rudd, 1989). Nearly 20% (n = 209; 19.4%) of student respondents indicated they were at serious suicidal risk at the time of the survey. This means that approximately one of every five students was at serious suicidal risk within the previous week. As a comparison, nationally, 18.8% of youth had seriously considered suicide in the previous 12 months (CDC, 2020).

Although the 19.4% of student reporting scores on the SIS that indicate serious suicide risk may not seem much higher than the 18.8% reported by the YRBSS, there are a few key distinctions. First, the students reporting serious suicide risk on the SIS were reporting on the previous week, whereas the YRBSS participants reported on the previous calendar year. Second, the measures are somewhat different, with the YRBSS asking about seriously considering suicide (18.8%), making a suicide plan (15.7%), making an attempt (8.9%), and making an attempt requiring medical treatment (2.5%), whereas the SIS asks about desires, believes, and actions including self (e.g., attempts to kill oneself, telling someone they wanted to kill themselves) and others (e.g., belief that others would be better off if the student died). The data that result from this decision point could help the school counselor advocate for the need to allocate resources to support suicide prevention programming at the school, given the overall need for suicide prevention and intervention programming among the student body.

One of the first decisions the school counselor needs to make is how suicide prevention programming can be implemented via the MTSS framework in their school. To begin, what will suicide prevention look like in a school-wide setting (Tier 1 intervention based on data from Decision Point 1), and what will be done once a smaller population of students express an elevated risk? Does the intervention for those students need to be in a smaller group setting (Tier 2) and/or in an individual setting (Tier 3)? In other words, do specific populations of students have higher prevalence of suicide risk and need a more directed intervention, or would the school be best served with suicide programming that reaches every student equally?

Decision Point 2: What Population(s) of Students Should Suicide Prevention Programming Reach?

If considering a Tier 2 intervention based on the 209 students who are at serious suicidal risk, one of the first questions a school counselor might have is, “Who are these students? How do I identify or determine which students in my school are at risk?” Exploring demographic

information or racial, ethnic, and cultural identities may be one way to determine which students may need more targeted interventions.

Decision 2a: What are the specifics about the students who report being at serious risk?

Of the 209 students who reported being at risk, the mean SIS was 22.32 (*SD* = 7.31). More than half of the students reporting being at serious suicide risk are female (*n* = 115, 55%). Approximately one third are male (*n* = 73, 34.9%), 11 identify as transgender (5.3%), seven reported being unsure of their gender (3.3%), and three declined to state or identify their gender (1.4%).

Regarding racial/ethnic identity of students reporting serious suicide risk, the majority identified as White (*n* = 113, 54.1%), and just over 20% identified as African American/Black (*n* = 44, 21.1%). Nine students at serious suicide risk identified as Asian/Asian American (4.3%), seven students identified as Hispanic/Latinx (3.3%), two students identified as Native American/American Indian (1%), and 33 identified as other/mixed/multiracial (15.8%). One student at serious suicide risk did not report racial/ethnic identity.

We also looked at the sexual orientation of respondents who reported serious suicide risk. In this case, a majority (*n* = 109, 52.2%) identified as heterosexual, with just over a quarter (*n* = 55, 26.3%) identifying as bisexual. Seventeen (8.1%) identified as gay or lesbian, 10 (4.8%) reported being unsure of their sexual orientation, six (2.9%) declined to identify their sexual orientation, and 12 (5.7%) did not respond to the question.

Finally, in looking at the grade of the students who reported serious suicide risk, not much difference was evident across grade levels. Approximately, one quarter of students who reported being at serious risk of suicide were in each grade (see Table 1).

Table 1. Students at Serious Suicide Risk, by Grade.

Grade	*n*	Percentage
Ninth grade	50	23.9
Tenth grade	54	25.8
Eleventh grade	47	22.5
Twelth grade	58	27.8

Decision Point 2b: How could the school counselor look at students at serious suicidal risk within the context of these same identity groups within the larger school?

At first glance, the numbers above suggest that the most at-risk group would be White heterosexual females because both White students and female students have the largest percentages reporting being at serious risk of suicide. However, another way of looking at this data is to focus on the overall size of the groups within the school. For example, while there are more White heterosexual females at serious suicide risk than other groups, there are also more White heterosexual females in the student body.

Figure 1 shows that, although many White students reported being at serious risk for suicide (18.5%, *n* = 113 of 611 students), this is actually a lower percentage than many other ethnic

groups at the school. Although this certainly doesn't negate the White students at risk, this same figure shows that 50% of students (two of four) who identified as Native American or American Indian reported being at serious risk for suicide. More than 40% of Hispanic/Latinx students (41.2% or seven of 17) also reported being at serious risk for suicide. Students who identified as Black/African American (44 of 232; 19.0%), Asian American (nine of 39; 23.1%), and multiracial (33 of 127; 26.0%) also reported higher percentages of serious suicide risk than their White peers. So, another way of examining prevention and intervention efforts could be to identify ways to provide culturally sensitive and culturally tailored outreach to different populations or to identify times when individual check-ins may allow school counselors additional interactions with students in higher risk groups and could open up the opportunity to assess for suicide if warning signs are present in those conversations.

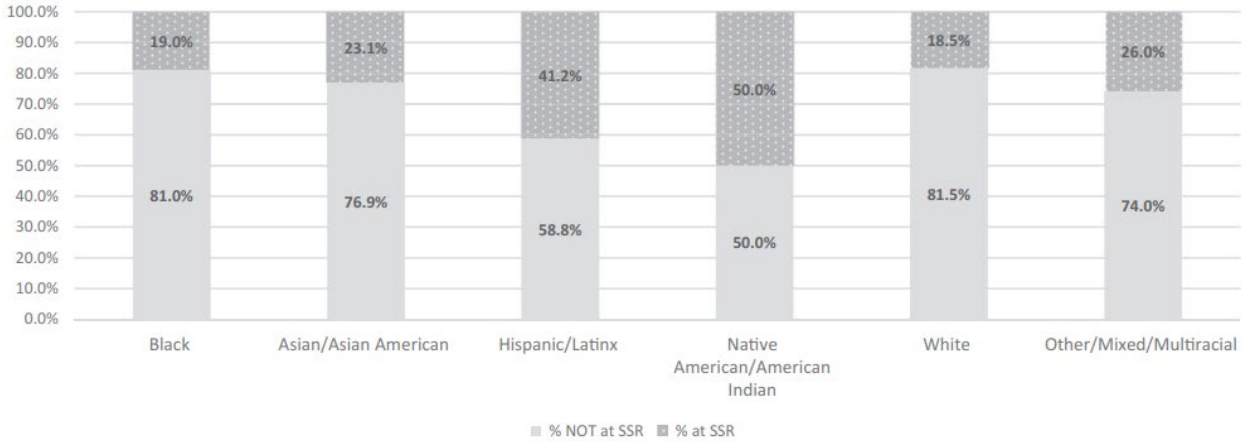

Figure 1. Percentage of students at serious suicidal risk within ethnic and racial identity groups.

Similarly, when looking at gender identity, differences are noticeable in the prevalence of serious suicide risk. For example, more than half of the students who identify as transgender (11 of 21; 52.4%) reported being at serious suicide risk. This is markedly higher than students who identified as male (73 of 496; 14.7%), female (115 of 540; 21.3%), or unsure of their gender (seven of 21; 33.3%).

Examining the individual data within the larger aggregate data from the school helps a school counselor recognize which students may need immediate assistance or who may be at a higher risk currently, which in turn can direct intervention efforts. More specifically, based on the data from this case example, a school counselor can recognize the noticeably higher rates of Native American/American Indian, Hispanic/Latinx, and transgender students at serious suicide risk but also extrapolate that this particular population at the school may have additional needs. Thus, thinking through individual or small-group interventions that could help assess these groups' further needs or barriers to services could serve as both a method of suicide prevention and a way to examine a possible need to view the work of the school counseling program and the school with a social justice lens. This can help ensure that all students—especially those who might be at particular risk—feel that they matter and have equitable access to support services at the school.

Decision Point 3: Are There Other Potentially Related Factors?

Beyond disaggregating data by demographics and examining prevalence rates through different lenses, another way to explore areas to build opportunities for suicide prevention might be to consider school engagement or other factors related to suicidality (e.g., depression). In this case example, we looked specifically at school engagement score on the SEI and at a depression inventory, and we performed correlations across all students in the school (both at serious risk and not at risk; see Table 2).

Table 2. Correlations of Suicide Risk and Other Factors Among All Students.

Assessment	1	2	3	4	5	6
1. Suicidal Ideation Scale	1.0					
2. Depression	.68**	1.0				
3. Student Engagement Inventory (SEI)	–.416**	–.523**	1.0			
4. SEI Teacher–Student subscale	–.285**	–.350**	.856**	1.0		
5. SEI Peer Support subscale	–.398**	–.506**	.725**	.499**	1.0	
6. Family Support for Learning subscale	–.375**	–.429**	.651**	.476**	.464**	1.0

**$p < .01$.

As Table 2 shows, SIS total scores were strongly and positively related to depression, and thus, implementing education or intervention on depression and emotion regulation (e.g., mindfulness and meditation, distress tolerance, social/emotional learning) may be an important way to build in school-wide suicide prevention efforts. This is an area, again, where the unified educator–counselor identity is vital because this sort of education and intervention would likely involve simultaneously providing psychoeducation while also conceptualizing and responding to clinical aspects related to mental health and social/emotional development.

Another consideration, also shown in Table 2, is that SIS scores are negatively related to student engagement in the school—both for total score and individual subscales. This means students who are at serious risk of suicide reported being less engaged in the school in several ways. Specifically, students who reported higher levels of suicidal behavior are reporting lower levels of engagement with teachers (potentially meaning teachers are less likely to spot or recognize when these students need help), less interaction with peers (which not only means potentially less social engagement but also decreases the possibility that peers will refer), and less family involvement in school learning. Another important indicator is that depression is also negatively related to all student engagement scales, so these students are withdrawing from engagement altogether—one of the many warning signs of increased risk for suicide.

School counselors can take a variety of actions in response to seeing the relationship between lower school engagement and higher levels of depression and suicide risk. Steps may be targeted (e.g., focusing on students who identify as transgender) or more general (identifying new clubs, activities, or student groups that might engage additional students) and will likely depend on the climate and culture of the school. Again, the unified educator–counselor identity is crucial here because a school counselor gathers relevant information to craft interventions for students, in services for school faculty and staff, and opportunities to engage with students, families, and the larger community.

Decision Point 4: Do Other Contexts Provide Further Information That Needs to be Addressed?

In this example case, remember that these data were collected prior to COVID-19 and prior to the killing of George Floyd and the civil unrest, and reckoning the United States is facing on racial injustice. Those things do not negate the data in this example, but they may provide additional areas that school counselors need to also assess. Ongoing COVID-19-related restrictions on activities and school closings have exacerbated feelings of isolation that were already present for youth (Czeisler et al., 2020). Those feelings of isolation, while potentially affecting all students, may have even more of an impact on specific populations. For example, as of mid-September 2020, one in 1,020 Black Americans and one in 1,220 Indigenous Americans had died of COVID-19 (https://www.apmresearchlab.org/covid/deaths-by-race). Couple this with the ongoing trauma of witnessing and experiencing racial injustice—including video footage of Black and Brown people being killed by police—and it's increasingly likely that Black and Indigenous youth may be experiencing unprecedented stress, isolation, anger, or hopelessness. Being able to assess the needs of the student body as a whole (Tier 1), within specific populations (Tier 2), and as individuals (Tier 3) requires school counselors to be able to integrate their perspectives as educator–counselors to support students, educate the school and the surrounding community, and advocate for those whose voices may be drowned out.

Conclusion

Throughout this article, we have used data to highlight how school counselors might identify whether—and to what degree—students they serve may be experiencing suicidal thoughts or behaviors. This can be intense and draining work, but it also provides the opportunity to quite literally save lives that might be lost. Through using the unified educator–counselor identity, school counselors can work to simultaneously provide prevention-based programming and targeted intervention to students, school faculty, staff, and the community to work to support students who might be at risk of suicide.

Data, such as that provided in this article, can be used to inform school counselors' decisions within their schools. Based on the data in the decision tree presented here, school counselors could support providing a school-wide intervention program focused on emotion regulation and coping strategies, given the high prevalence (19.4%) of seriously suicidal students (Decision Point 1) and the relationship of depression (Decision Point 3) explored in the aggregate school-wide data. However, disaggregating the data (Decision Point 2) to explore individual identities and demographics also revealed the need to provide more targeted intervention efforts to subgroups within the school (e.g., Tier 2 and 3 focusing on Native American students, Latinx students, and students who identify as transgender) due to the high rates of serious suicidal behaviors within these subpopulations within the school. This case example and decision tree show the myriad ways school counselors can use data within their school to inform the programming they may provide or assessment and clinical intervention they may engage in. Aggregated and disaggregated data are both important in making these decisions and determining next steps.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

American School Counselor Association . (2019). ASCA National Model: A framework for school counseling programs (4th ed.). https://schoolcounselor.org/About-School-Counseling/ASCA-National-Model-for-School-Counseling-Programs

American School Counselor Association . (2020). ASCA position statements. https://www.schoolcounselor.org/asca/media/asca/PositionStatements/PositionStatements.pdf

Appleton, J. J., Christenson, S. L., Kim, D., Reschly, A. (2006). Measuring cognitive and psychological engagement: Validation of the student engagement instrument. Journal of School Psychology, 44(5), 427–445. https://doi.org/10.1016/j.jsp.2006.04.002

Bridge, J. A., Asti, L., Horowitz, L. M., Fontanella, C. A., Sheftall, A. H., Greenhouse, J. B., Kelleher, K. J., Campo, J. V. (2018). Age-related racial disparity in suicide rates among U.S. youths from 2001 through 2015. JAMA Pediatrics, 172(7), 697–699. https://doi:10.1001/jamapediatrics.2018.0399

Bridge, J. A., Asti, L., Horowitz, L. M., Greenhouse, J. B., Fontanella, C. A., Sheftall, A. H., Kelleher, K. J., Campo, J. V. (2015). Suicide trends among elementary school-aged children in the United States from 1993 to 2012. JAMA Pediatrics, 169(7), 673–677. https://doi.org/10.1001/jamapediatrics.2015.0465

Centers for Disease Control and Prevention . (2016). Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12—United States and Selected Sites, 2015. U.S. Department of Health and Human Services. https://doi.org/10.15585/mmwr.ss6509a1

Centers for Disease Control and Prevention . (2020). 1991-2019 high school Youth Risk Behavior Survey data. http://nccd.cdc.gov/youthonline/

Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health . (2019). Ring the alarm: The crisis of Black youth suicide in America. https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

Curtin, S. C., Heron, M. (2019). Death rates due to suicide and homicide among persons aged 10–24: United States, 2000–2017 (NCHS Data Brief, No. 352). National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db352.htm

Czeisler, M. E., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E.,

Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. Morbidity & Mortality Weekly Report, 2020(69), 1049–1057. https://doi.org/10.15585/mmwr.mm6932a1

Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: Review and revision (CESD and CESD-r). In Maruish, M. E. (Ed.), The use of psychological testing for treatment planning and outcomes assessment: Instruments for adults (pp. 363–377). Erlbaum.

Joe, S. (2006). Implications of national suicide trends for social work practice with Black youth. Child and Adolescent Social Work Journal, 23, 458–471. https://doi.org/10.1007/s10560-006-0064-7

Levy, I. P., Lemberger-Truelove, M. E. (2021). Educator–counselor: A nondual identity for school counselors. Professional School Counselor, 24(1b).

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

Luxton, D. D., Rudd, M. D., Reger, M. A., Gahm, G. A. (2011). A psychometric study of the Suicide Ideation Scale. Archives of Suicide Research, 15(3), 250–258. https://doi.org/10.1080/13811118.2011.589720

National Center for Mental Health Promotion and Violence Prevention . (2012). Childhood trauma and its effect on healthy development. http://www.promoteprevent.org/sites/www.promoteprevent.org/files/resources/childhood%20trauma_brief_in_final.pdf

Reger, M. A., Stanley, I. H., Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019—A perfect storm? JAMA Psychiatry, 77(11), 1093–1094. https://doi.org/10.1001/jamapsychiatry.2020.1060

Rudd, M. D. (1989). The prevalence of suicidal ideation among college students. Suicide and Life-Threatening Behavior, 19(2), 173–183. https://doi.org/10.1111/j.1943-278X.1989.tb01031.x

Stone, C. (2018). Assessments and third-party software alerts for suicide ideation. ASCA School Counselor, 55(3), 6–8.

Toomey, R. B., Syvertsen, A. K., Shramko, M. (2018). Transgender adolescent suicide behavior. Pediatrics, 142(4), 1–8. https://doi.org/10.1542/peds.2017-4218

Twenge, J. M., Joiner, T. E., Rogers, M. L., Martin, G. N. (2018). Increases in depressive symptoms, suicide-related outcomes, and suicide rates among U.S. adolescents after 2010 and links to increased new media screen time. Clinical Psychological Science, 6(1), 3–17. https://doi.org/10.1177/2167702617723376