Suicide Intervention in Schools: If Not School Counselors, Then Who?

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Suicide Intervention in Schools: If Not School Counselors, Then Who?

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Youth suicide rates continue to rise each year. School counselors play an essential role in preventing suicide within K–12 schools. After the publication of the article "Suicide Assessments: The Medical Profession Affirms School Counselors' Truth" (Stone, 2021), some confusion surfaced regarding professional school counselors' responsibilities and liabilities around issues of suicide. To provide clarification, we discuss the role and training of school counselors and provide evidence for their place in suicide risk assessment. Ethical implications and previous legal cases are provided to inform the profession. Training/supervision recommendations for counselor educators are also discussed.

Keywords: suicide assessment, school counseling, suicide intervention, suicide risk assessment

In her article "Suicide Assessments: The Medical Profession Affirms School Counselors' Truth," Stone (2021) raised a critical issue regarding professional school counselors' responsibilities and liabilities around issues of suicide. Stone stated that school counselors are not equipped to assess for suicide and that by doing so, are elevated above medical professionals and set up for liability issues. Stone also contends that suicide risk assessment tools are used to make predictions instead of being used to identify clinical concerns. Although Stone highlighted some valid points, we respectfully disagree with some major points and hope to engage the greater school counseling and school counselor educator communities around fully preparing school counselors to provide skilled suicide prevention, assessment, and intervention services within K–12 schools. School counselors play a vital role in helping to identify students at risk for suicide. School counselors often have established relationships with students and can access them easily. School counselors have also received the same suicide assessment training as their clinical mental health peers.

Prevalence and Statistics

One important point to consider, which goes unaddressed in Stone (2021), is that, statistically speaking, it is highly likely that every school counselor will serve students who are experiencing suicidal thoughts or behaviors. The statistics on suicide prevalence in children and adolescents are daunting. This has been an ongoing public health issue in the United States — and beyond — that cuts across demographics of students served (e.g., age, race, ethnicity, gender or sexual identities, socioeconomic status) or location of the school setting (e.g., rural, suburban, urban, geographic region). Suicide is the second leading cause of death in individuals between ages 10–19 (Centers for Disease Control [CDC], 2020). The United States saw an increase of 57.4% in deaths by suicide between 2007–2018 (Curtin, 2020). Although the full report for suicide rates in 2019 and 2020 have yet to be released, the CDC has published some preliminary data that indicates that, despite the decrease of suicide rates overall, rates have continued to increase for ages 10–35. Available demographic information shows increased suicide rates among individuals identifying as Indigenous and Native American, Black, or Latinx (Curtin, 2020). From 2019 to 2020, deaths by suicide for individuals ages 10–24 increased more than 40% for Hispanic females, 30% for Black females, 23% for Black males, and 20% for Hispanic males.

It is also important to note that individuals identifying as part of the LGB community have

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rates of suicidal ideation that are five times higher than their heterosexual peers, and rates of suicide attempts are three times higher (see CDC, 2016, 2020). Individuals identifying as transgender or gender nonbinary also have significantly higher rates of suicide attempts, compared to their cisgender peers. More than half (50.8%) of adolescents identifying as female-to-male, 41.8% of adolescents identifying as neither female nor male, and nearly 30% of adolescents identifying as male-to-female (29.9%) or questioning (27.9%) report suicide attempts (see Toomey et al., 2018). This compares to 17.6% of cisgender adolescent females and 9.8% of cisgender adolescent males who report suicide attempts (Toomey et al., 2018). In addition, LGBTQ youth of color reported higher rates of attempting suicide than their white peers, with Black transgender and nonbinary youth reporting the highest rates; 59% of youth in this category reported seriously considering suicide and 26% reported attempting suicide (Trevor Project, 2021).

Although not all prevalence rates for deaths by suicide have been compiled yet for the COVID-19 era, another recently released CDC report of mental health–related emergency department (ED) visits in adolescents allude to alarming trends. The report examined data during three distinct 4-week periods during the pandemic. Despite the initial decline in ED visits for suspected suicide attempts in Spring 2020 (March 29–April 25, 2020) as compared with the same period in Spring 2019, the numbers have increased substantially since then — particularly in females ages 12–17 (Yard et al., 2021). In Summer 2020 (July 26–August 22, 2020), ED visits for suspected suicide attempts for youth ages 12–17 was 22.3% higher than during the corresponding dates in 2019. During Winter 2021 (February 21–March 20, 2021), the mean number of suspected suicide attempts receiving medical attention in an emergency department had increased 39.1% over the comparable period in 2019 (Yard et al., 2021). While EDs did report higher rates in males (3.7%), the primary driver of the sharp increase in ED visits for suspected suicide attempts was in adolescent females, whose mean ED visits for suspected suicide attempts were 50.6% higher in Winter 2021 than the same time period in 2019 (Yard et al.,

2021). At this time, there is not any other demographic information beyond age group and binary sexual identity available regarding the identities of adolescents seen in the EDs. Although these data are incomplete, they do highlight a concerning trend upward in suicidal behavior in adolescents, and school counselors must be prepared to identify and support children, adolescents, and their families, who might be struggling with issues related to suicide.

We need to view these statistics within the context of the dual pandemics of COVID-19 and racial injustice that have been ongoing both in the United States and globally. There is a high likelihood of suicidality continuing to impact our school-aged youth as a whole, but also differently, based on disparities in access to mental and physical health supports, ongoing trauma, violence, and other community-based factors. Thus, it is important for school counselors to understand the needs of the students and school community whom they serve, so as to be able to build in prevention efforts and minimize the possibility that they might overlook individual students or student communities in need of support. It is vital, therefore, that school counselors are able to competently assess and intervene with students experiencing suicidal thoughts and behaviors, as issues related to suicide risk are an unavoidable part of being a school counselor.

The School Counselor's Position

Stone (2021) mentioned several major points in her article that we want to highlight — as we agree with them. First, guardians or caregivers of K–12 students who have been assessed for suicide risk should be informed that the assessment has taken place. This is in line with American School Counseling Association (ASCA) Ethical Standard A.9 (2016) as well as the ASCA position statements (2020) related to suicide prevention/awareness and suicide risk assessment. The only time that any other action should be considered is if the abuse or neglect of the caregiver is the reason given by the student for their suicidal ideation — and in lieu of reporting the suicide risk to the caregiver, a call would need to be placed to child protective services

(ASCA, 2020). School counselors collaborate with parents and guardians as a regular part of their work. Families make many of the important decisions regarding services for students who are struggling, so school counselors should work to form supportive relationships with the students' families in order to help students get assistance. School counselors are aware of their ethical obligations to not release a student who is a danger to themselves without proper support (ASCA, 2016; A.9.c.). If parents/guardians refuse to get help for their child, and the school counselor believes they are at risk of hurting themselves, child protective services may need to be contacted.

Second, when communicating with the caregiver, school counselors who engage in suicide assessment with a student should never inform that caregiver that there is no risk. They recognize they should use risk assessments with caution, which is also identified in ASCA's ethical standards (2016; A.9.b.). Even a risk assessment with a low/moderate/high risk categorization does not indicate that there is zero risk. Every level implies that there is a risk present. Risk assessment tools are not designed for or appropriate for predicting suicidal behavior (Lopez-Morinigo et al., 2018).

Finally, we also concur that school counselors need to practice within their scope of competence. The ASCA Ethical Standards for School Counselors (2016) specifically references the importance of ongoing professional development and training (see section B.3). This would imply that if part of the job responsibilities of a school counselor falls outside of their scope of competence, but within their role as school counselor, it is incumbent on them to seek out professional development to acquire those skills.

It is the point around that primary issue of scope of practice that we disagree with in the Stone (2021) article. Stone stated that "school counselors have a very limited role in suicidal ideation." In fact, ASCA ethical standards identify that school counselors provide effective and responsive interventions to student needs (ASCA, 2016; A.1.h.) and take appropriate steps whenever there is a situation of serious and foreseeable harm to self and others (ASCA, 2016; A.9.). School counselors trained under Council for the Accreditation of Counseling and Related Educational Programs (CACREP) 2009 and 2016 accreditation standards have been trained in suicide assessment. For example, in the 2016 CACREP standards, suicide assessment is specifically mentioned in 2.F.7.c as part of the core CACREP standards for all specialty areas. Thus, the expectation is that school counselors are as clinically equipped to assess suicide risk as their clinical mental health-oriented peers. The primary difference would be in the postassessment intervention, as school counselors often have time constraints that impact the ability to provide the targeted individual follow-up that a community-based counselor would be able to provide. In stating "never allow parents to believe that the title of school counselor carries with it clinical skills and qualifications in assessing suicide," Stone (2021, para. 13) sends a message to school counselors that we are somehow less than our peers in other settings regarding issues for which we have received comparable — or identical — training as those same peers.

Similarly, suggesting that school counselors tell parents "I am not qualified to accurately assess, as it takes multiple approaches and means from the mental health and medical field" (Stone, 2021, para. 17) is also problematic because it minimizes the expertise and experience of school counselors. Similarly, the concerning assertion feeds into a damaging narrative that somehow, despite being charged with supporting the academic, career, and social-emotional development of all children in our buildings, the mental health challenges of those children are off-limits because they are too difficult. This is at odds with guidance offered by a number of researchers about the work that school counselors conduct around suicide prevention, assessment, and intervention in the schools, including attention to suicide protective factors (Stutey et al., 2021), using data to inform suicide prevention (Wachter Morris et al., 2021), ethical issues in suicide prevention (Gallo, 2017), suicide postvention (Fineran, 2018), school counselors' self-efficacy in suicide assessments (Douglas & Wachter Morris, 2015; Gallo, 2018), gatekeeper training models that allow

school counselors to train teachers and other adults in the school (Gibbons & Studer, 2008), and development of comprehensive, school-based suicide prevention programming (Granello & Zyromski, 2018).

We also want to provide clarification regarding whether suicide risk assessment tools are marketed to predict suicide. That is not the case. Risk assessment tools are just that — assessments that help provide clarity around a person's level of risk *at the time they are assessed*. In fact, the creators of several prominent suicide risk assessments explicitly state that they are not tools to predict suicide and should be seen as a single piece of an ongoing risk assessment process (Granello, 2010). Researchers have suggested that, as suicide assessment is not an exact science and uncertainty is a key factor in determining potential suicide risk (see Granello, 2010; Simon, 2006), clinical judgment is imperative in working with clients who may be at risk. Particularly when a school counselor or other mental health clinician is developing experience in suicide risk assessment, consultation around cases involving potential suicide risk is a vital part of the process — but not one that precludes the use of a suicide risk assessment as part of the information gathering and risk assessment process (Granello, 2010; Simon, 2006). The American Psychiatric Association developed practice guidelines for the assessment of individuals with suicidal behaviors, but even they advise using clinical judgment when interpreting these tools (Jacobs & Brewer, 2004), underscoring the importance of using more than a single assessment to inform the potential suicide risk of an individual.

Legal Considerations

Stone's (2021) article highlights a few of the legal cases that have involved school districts to support her argument against assessing for suicide — specifically, the *Eisel v. Montgomery County Board of Education* court case (1991). In this case, however, the courts ruled that school counselors had a duty to notify the parents of a 13-year-old student who made suicidal statements to her classmates and later died by suicide. The courts cited the *in loco parentis* doctrine, which states that educators

legally stand in place of parents and have a duty to exercise reasonable care to protect a student from harm. This instance exemplifies a case where the school counselors did *not* notify the parents that the student had made suicidal statements. Based on ethical mandates, school counselors have an obligation to inform parents through personal contact (ASCA, 2016; A.2.l.). In *Rogers v. Christina School District* (2012), the school once again failed to notify the parents of the child's suicidal ideation. In addition, the individual working with the student was not a school counselor, but rather was a behavior interventionist contracted with the school. Other cases that have gone to court and have had implications for school counselors involved employees who *failed* to notify parents of a student's written or verbal threats of suicide (Portner, 2000; Simpson, 1999). In some of these cases, schools were found liable because of their failure to notify parents, further demonstrating the school's legal responsibility to help keep students safe. Although the field has advanced since these tragic cases, it is important that we understand the details of the cases and the implications for the field of school counseling.

Based on legal and ethical obligations, the message is clear: School counselors should be intervening with students who show any warning signs of potential harm to self. School counselors need to gather information that will help inform them of the student's current mental status, level of risk, and possible means of harm. Once the information is gathered, the school counselor can institute best practices such as consulting with other professionals, gathering resources, and most importantly and in most cases, notifying parents or guardians. Assessing suicide is, at its simplest level, asking if a student is considering suicide. Depending on school policy, the counselor may use a risk assessment tool, as it provides a helpful structure and checklist of common questions regarding access to means, previous attempts, and current thinking. The school counselor can use the information gathered to communicate details about the student's well-being to parents and possibly other health professionals (after a release of information is signed). The risk assessment tool

should *not* be used to predict the likelihood of suicide, but to gather important information about a person's current mental state that can be shared with others who are part of making decisions with or on behalf of the student. As mentioned in school counseling ethical codes, caution should always be taken when talking with parents about the information gathered from a risk assessment. School counselors should also follow school protocols. Suicide risk is fluid; therefore, the school counselor should never downplay the risks involved or communicate that it is a guarantee of safety.

Much of Stone's (2021) argument centers on the "danger" of the suicide risk assessment and the suicide risk assessment tool. As she mentioned, there are problems with risk assessment tools, even within the healthcare field. According to Rudd (2021), however, there may be a more fundamental problem, as he states: "We may not need better screening tools. Rather, we may need different tools developed for different clinical settings driven by different underlying assumptions in accordance with available data" (p. 1). The danger lies in using a tool as a powerful predictor instead of relying on other factors such as clinical decision-making, building rapport, repeated check-ins, and progress monitoring. This is a hopeful sign that more reliable practices and information will be developed soon. Although researchers are striving to improve these tools, providers acknowledge this is just one element to understanding an individual's current emotional state.

Safety Planning vs. No Harm Contracts

Another issue that has garnered some attention is related to the use of no-harm contracts with students. No-harm contracts have little support and have been shown to be detrimental in preventing suicide (Mandrusiak et al., 2006; McConnell Lewis, 2012). School districts may believe that having no-harm contracts in place will help prevent liability in court, but there is no evidence to support this. Instead, best practice would be to create a safety plan with a student and their parent that includes people to contact in an emergency, ways to keep the environment safe, coping strategies, goals, and hopeful statements. Safety planning has been well-

researched and shown to be an effective intervention (Cureton & Fink, 2019; Stanley & Brown, 2012). A focus on protective factors and other strengths-based strategies are also showing promise in the field (Cureton & Fink, 2019). However, safety plans do not serve as a tool to ensure someone is safe from ever attempting suicide and should not be communicated as such. Lastly, school counselors should document all the steps and precautions taken when working with a student who has demonstrated signs of suicidality.

Training

Stone (2021) argued that school counselors are not equipped to assess a student's level of suicide risk, but we contend that school counselors *are* trained to assess students for suicide risk. CACREP requires suicide assessment content to be integrated into counselor preparation training and coursework (CACREP, 2009, 2016). School counselors receive the same training and have the same standards in assessment as mental health counselors. Numerous studies support the efficacy of suicide assessment trainings that have been conducted for school counselors or school counselors-in-training (Gallo et al., 2018, 2021; Shannonhouse et al., 2017, 2018). The second part of this statement involves "level of risk." School counselors, like all counselors, spend a great deal of their training learning how to interpret client information (i.e., verbal, nonverbal, anecdotal) and formulate a plan to help keep them safe. For the school counselor, this involves contacting parents and relaying the information gathered. Best practice and training guidelines would call for interpreting *any* assessment tool with caution, regardless of its use (e.g. suicide, depression, wellness). Given all this, what are best practices for training school counselors around issues related to suicide among children and adolescents, suicide prevention, suicide risk assessment, and suicide intervention? How can counselor educators best train future school counselors to be prepared to embrace the ambiguity around suicide risk assessment in the schools?

Counselor educators can follow the direction and guidance from organizations such as CACREP,

ASCA, and the American Association of Suicidology (AAS) to help inform them on the knowledge, attitudes, and skills necessary for counselors-in-training (CIT) to acquire during their training programs. Relying on professional organizations will help ensure counselor educators are following the most current literature and teaching interventions that are evidence-based. CACREP's 2016 standards address suicide and risk assessment language in Section 2.F.7.c., which states that counselors know the "procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide," and in Section 2.F.5.l., which states that counselors know "suicide prevention models and strategies." The inclusion of standards for school counselors indicates the necessity for addressing this area within the school setting. In addition, competencies have been developed. ASCA's Professional Standards and Competencies designates that school counselors "respond with appropriate intervention strategies to meet the needs of the individual, group or school community before, during and after crisis response." Therefore, counselor educators and supervisors can look for opportunities to incorporate this type of material into their courses and supervision sessions.

In addition, counselor educators can utilize competencies that have been developed by leading suicide prevention organizations. In a review by Cramer et al. (2013), the authors evaluated core competencies from across multiple domains, including AAS, and from prolific researchers such as Rudd (2006) and Joiner (2005). Cramer et al. developed 10 core competencies and offer these as the foundation for a training framework:

- Know and manage your attitude and reactions about suicide when with a client

- Develop and maintain a collaborative, empathic stance toward the client

- Know and elicit evidence-based risk and protective factors

- Focus on current plan and intent of suicidal ideation

- Determine level of risk

- Develop and enact a collaborative and evidence-based treatment plan

- Notify and involve other persons

- Document risk, plan, and reasoning for clinical decisions

- Know the law concerning suicide

- Engage in debriefing and self-care

When considering curriculum and the format in which to teach suicide risk assessment, previous research has provided some insight. In a study by Gallo and colleagues (2021), several recommendations were made to help inform counselor educators, including self-awareness activities that allow CITs to wrestle with the concept of suicide, explore their own feelings about suicide, identify values and biases they might have around the topic, consider how to approach and talk with someone who is experiencing suicidality, and encourage discussions with peers about their reactions to these activities. In addition, integrating experiential activities, such as role-playing, have been found to improve student learning (Cross et al., 2011; Gallo et al., 2021). These types of experiences allow students to reflect on the discomfort that may come from asking someone directly about suicide. Another recommendation from Gallo and colleagues (2021) was to include role-plays with students of different ages, with varying degrees of suicide risk, and from diverse cultural groups.

In addition to core suicide knowledge content, incorporating information on cultural factors is important. Counselors who work with children and adolescents from minoritized groups have an obligation to understand how cultural factors might affect the suicide risk assessment process (Chu et al., 2019). Counselor educators can bring in content and provide experiences for CITs to better understand how minority stress, cultural sanctions, and social discord can impact youth exhibiting signs of suicide. All school counselors should strive to learn more about working with diverse groups of children, being diligent in responding to signs of racial distress and using ethical guidelines to inform their practice.

Supervision provides another opportunity to facilitate growth and development in suicide intervention skill-building with school counseling students. In addition to assigning role-plays in class, providing opportunities for CITs to conduct a supervised suicide assessment with a child/adolescent through practicum or internship would also be beneficial. It is through these real-life situations that CITs may build another level of confidence in their practice. This also allows time for supervisors to provide one-on-one feedback, answer supervisees' questions, and highlight areas of strength and growth from the assessment process. This type of immediate feedback can be invaluable to the CIT's learning. Counselor educators and supervisors can also use this opportunity to model acceptance of, and tolerance for, the uncertainty and complexity involved in suicide risk assessment (Gallo et al., 2021). Rudd and colleagues (2008) identified supervisory tasks essential for CITs to develop the 10 core competencies in suicide risk assessment listed previously. The nature of the supervisory tasks included: self-awareness, content mastery, and skill acquisition and refinement within each of the competency areas. The supervisor's responsibility is to facilitate these opportunities for CIT's during supervision sessions.

Other considerations within suicide assessment training for school counselors are children's developmental levels. Much of the literature on suicide risk assessment is based on working with adults. Yet, school counselors are aware there are special considerations in working with youth, such as brain development, higher levels of risk taking, and lack of impulse control. School counselors also consider the language they use, making sure students understand the questions being asked. Barrio (2007) suggested key elements for developmentally appropriate interviewing, including establishing rapport, finding appropriate language, and using gentle assumptions. Counselors should also consider using different modalities to help children communicate their feelings when they are not able to verbalize their thoughts or if they prefer a different method (Miller, 2018). School counselors also consider the importance of the relationship when assessing risk. They take time to listen to students, form a connection, and offer support. The level of safety a student experiences can play a huge role in their willingness to disclose their suicidality with adults (Miller, 2018). Increasing our understanding of our students' messages increases the likelihood we will do a better job assessing their suicidality.

A final consideration for training and supervision relates to the uniqueness of the K–12 setting. While CACREP requires suicide assessment content be integrated into counselor preparation training and coursework, there is little differentiation for different settings (e.g., educational vs. clinical or community-based settings). Therefore, school counseling students may need access to content that is specific to the K–12 setting. When working within the school system, several considerations must be made. First, school counselors recognize that the school is a system and therefore requires extra effort in communicating with all stakeholders to get buy-in and to educate them on the role of the school counselor in risk management. Related to the consideration of working within a system, school counselors work as part of a team in crisis intervention. They work in collaboration with other staff, including teachers, administrators, school psychologists, school nurses, and social workers. They might also collaborate with outside entities such as local universities, religious leaders, crisis response agencies, or law enforcement. It is also beneficial for school counselors to develop relationships with outside mental health providers. Providing a list of referrals for parents and students could be helpful when needing ongoing treatment. It might also be helpful to collaborate with these providers when coordinating services within the school setting after a release of information has been shared. Understanding the uniqueness of the school setting, the interplay of stakeholders, and the complexity of suicide may be helpful in avoiding some of the tragedies of the past. However, we must all remember: No person, no matter how skilled, has the power to predict suicide.

School Counselors Should Be Versed in Suicide Prevention and Assessment

Given the large, and potentially rapidly growing, numbers of children and adolescents who may be experiencing suicidal thoughts or considering a suicide attempt, we posit that school counselors are often the individuals best positioned in K–12 schools to identify and assess suicide. Rather than shying away from this responsibility, we should embrace it as an opportunity to expand access not only to suicide prevention, but also culturally responsive suicide assessment, intervention, and postvention to the school community. School counselors are often the professionals who not only have the most training around mental health concerns, but are also physically in the building more than many other student support personnel, including school social workers, school psychiatrists, and school nurses. School counselors also have the connection not only to students, but to their families and to other adults in the building who serve as gatekeepers. If school counselors are not equipped to handle this responsibility, who is? And while we acknowledge that being the "best" qualified does not inherently mean that our training is always going to be sufficient without additional professional development, to ignore our role and our duty to children and adolescents who may be actively considering suicide would also potentially do harm, as it would leave credible threats unseen or unaddressed. Thus, we urge our school counseling professionals not only to embrace the training that they have already received, but to view suicide prevention, assessment, and intervention as areas where ongoing professional development and training is necessary.

Future Directions

We also recognize that there are areas that can be enhanced or expanded when thinking through the needs of school counselors regarding suicide prevention and intervention. We believe putting energy into these areas by developing clear language, guidelines, and professional development activities will help school counselors ethically and proactively support students who may be at risk of suicide. Our first recommendation is to adopt common language around suicide assessment and intervention in order to lessen the confusion that currently exists regarding the information school counselors are communicating to parents, administrators, and/or outside entities. Our second recommendation is to craft a role statement related specifically to the work that school counselors do regarding suicide prevention and intervention. This statement would be more specific than previous position statements developed by ASCA and it would be based on legal and ethical guidelines as well as best practices. It could provide clarity around the steps a school counselor would take before, during, and after the risk assessment process. School districts may feel better positioned as well in defining these roles for all stakeholders. Our final recommendation is to offer more resources for school counselors who work with children and adolescents who are exhibiting suicidal ideation. There are limited resources available to school counselors, especially for those who work in elementary settings. Providing information and tools in how to counsel youth, especially young children who are experiencing suicidal ideation, would be beneficial.

Leaning into working with children and adolescents who may be considering suicide is a more responsive stance than avoiding conversations about suicide or choosing not to perform suicide assessments out of fear of liability. Engaging in this opportunity and challenge strengthens the field and is squarely in line with the expertise that we bring to the schools. Most importantly, we have the potential to help save children's lives when we embrace our role as suicide prevention advocates. School counselors are the individuals in the building who have the knowledge to help our students and their families navigate these challenging, dark moments. If we are not willing to meet that need, who will be?

Conclusion

The purpose of this article is to engage school counselors in dialogue around our role in suicide prevention work and to underscore the importance of suicide prevention training in counselor education and supervision. We believe this topic continues to be of utmost importance and worth

continued discussion, and while we agree with Stone's (2021) points around ensuring communication with parents and correctly representing risk level, we disagree with her statements that minimize the skill, competence, and responsibility of school counselors related to suicide assessment. Rather, we strongly believe that school counselors not only have the training (including access to professional development), but they also have the responsibility to provide support and intervention to students at risk of suicide. We urge school counselors and school counselor educators to access existing information and intentionally build additional resources around evidence-based research, ethical practices, and developmentally and culturally relevant interventions. We encourage school counselors and counselor educators to become informed about suicide prevention work and recognize the impact we can all have on saving children's lives.

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