

# Lessons Learned from Ten Years of Using School-Based Screenings for Suicide Postvention

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*Adolescent suicide rates are rising, particularly for adolescent girls, and increasing numbers of adolescents experience the suicide of a classmate, peer, or friend. School social workers can play an important role in suicide prevention with this age group. This article will describe one agency's experiences conducting universal screenings in schools in thirteen communities in the Northeast United States as a component of an organized postvention plan following student suicide deaths. These communities ranged from urban areas to affluent suburban communities. Students (N = 9,984) were screened in middle schools, junior high schools, and high schools. Of the students screened, 12.6 percent screened positive. These students were more likely to be female (67.2%) and not currently receiving treatment (57.6%). The agency's experiences will be described, including barriers and strategies for working with school staff, administrators, teachers, and parents; lessons learned; and recommendations for school screenings.*

**Keywords:** *adolescent suicide, postvention, school-based screenings, suicide, universal screening*

Suicide is a significant public health issue for adolescents. In the United States, suicide is the second leading cause of death for youth ages fifteen to twenty-four and the third leading cause of death for youth ages ten to fourteen (Centers for Disease Control and Prevention [CDC], 2015).

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Adolescent suicide is a growing public health issue. Currently, rates of adolescent suicide are at a thirty-year high (CDC, 2017). The suicide rate for adolescent girls doubled from 2007 to 2015, with the largest increase for the youngest girls (ages 10 to 14; CDC, 2017). The suicide rate for adolescent boys increased by 30 percent during the same time period. These rising rates mean that more schools experience the death of a student by suicide and that suicide is a growing concern for school social workers.

Losing a peer, classmate, or friend to suicide increases an adolescent's own risk of dying by suicide (Abrutyn & Mueller, 2014; Nanayakkara, Misch, Chang, & Henry, 2013; Swanson & Colman, 2013). Approximately 2 to 5 percent of youth suicide deaths are connected to a peer's suicide (Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990). An adolescent's risk of a suicide attempt is greater when he or she was exposed to a friend's suicide attempt or death in the past twelve months (Randall, Nickel, & Colman, 2015). In addition to increasing the risk of suicide, the suicide death of a peer increases an adolescent's risk of depression and anxiety for up to three years after the death (Brent, Moritz, Bridge, Perper, & Canobbio, 1996; Randall et al., 2015; Swanson & Colman, 2013). Exposure to suicide seems to have the largest impact on younger adolescents (12 to 13 years of age) as their risk of suicide after exposure to a peer's suicide death is greater than that of older youth (Swanson & Colman, 2013).

Adolescents often do not disclose their suicidal thoughts and behaviors to an adult, making identification of these youth a challenge (Mojtabai & Olfson, 2008). School-based universal screenings are an effective way to identify students with depression, suicidal thoughts, and behaviors (Gould et al., 2005; Robinson et al., 2011, 2013), and universal screenings are recommended by many suicide prevention experts (Mazza, 1997; Miller, Eckert, DuPaul, & White, 1999; Shaffer & Craft, 1999; Swanson & Colman, 2013). In contrast, schools and parents tend to be less supportive of universal screenings, and their concerns can become barriers to implementation of screenings. School social workers can play a unique role in a school system as advocates for universal screenings. Although many experts recommend screenings, little research has explored the use of universal screenings in a systematic way, including feasibility, effective approaches, cost effectiveness, validity and reliability of screening tools, and use of these tools across different types of schools and students (Mann, Apter, & Bertolote, 2005; Miller, Eckert, & Mazza, 2009). This article will describe one agency's screening procedures during ten years of screening, including characteristics of students identified, barriers encountered, and lessons learned.

**Literature Review**

Voluntary school-based screenings are an important suicide prevention approach for adolescents. Universal screenings, defined as screenings of all students in one grade or in the school, not just those identified as high risk, are often used by schools to identify students who are at risk for suicide. Universal screenings are conducted in a variety of ways (Cooper, Clements, & Holt, 2011). Some schools offer routine universal screenings. For example, they may conduct screenings at the start of each spring term (Husky, Sheridan, McGuire, & Olfson, 2011) or in the ninth grade each year (Husky et al., 2011; Torcasso & Hilt, 2017). Alternatively, schools may conduct screenings as one component of a postvention plan following student death by suicide. The research literature on screenings primarily discusses routine universal screenings versus those that are conducted following a suicide or cluster of suicides in the school or community (Robinson et al., 2013).

**Universal Screenings**

The primary benefit of universal screenings is that they facilitate the identification of high-risk youth, allowing school social workers to connect them with appropriate treatment services. Although some of the youth identified during screenings may already be in treatment, other youth disclose depression, suicidal thoughts, and behaviors for the first time. Husky and colleagues (2011), in a review of routine screenings ( $N = 2,488$ ) in six suburban Wisconsin high schools, found that 20 percent screened positive, meaning that they were considered at risk for suicide. Of these students, 74 percent were not receiving treatment services but 76 percent did follow through on treatment referrals. These high follow-through rates are consistently demonstrated by research on screenings.

Gould and colleagues (2009) conducted a longitudinal study of students who screened positive ( $N = 317$ ) during routine school-based screenings in six New York State high schools. When they screened positive, 72 percent of the at-risk students were not in treatment. Although students with a previous suicide attempt were in treatment at higher rates, more than half (58%) were not receiving treatment. Sixty-nine percent of students who screened positive followed through with treatment referrals. In a third study of routine universal screenings, Torcasso and Hilt (2017) looked at three years of screenings of ninth graders ( $N = 193$ ) in one primarily white (84.6%) Midwestern high school. Of these students, 21 percent screened positive and 53 percent of those with positive screenings accessed new support services as a result. In addition,

this school saw a significant decrease in the numbers of students reporting suicidal thoughts and behaviors over a three-year period.

Some researchers have explored the use of universal screenings in urban schools. Urban schools tend to have higher rates of positive screens than more affluent suburban schools. Hallfors and colleagues (2006) conducted a feasibility study of universal screenings ( $N = 1,323$ ) in large urban high schools ( $N = 10$ ) in the Southwest and Pacific Coast of the United States. These schools were in racially diverse urban communities with high rates of poverty. Twenty-nine percent of the students screened positive. In a second study, Brown and Grumet (2009) evaluated the outcomes of a grant-funded program to screen urban youth of color in schools ( $N = 13$ ) in Washington, DC. Of the 229 youth screened, 45 percent screened positive.

#### Barriers to Screenings

Although screenings can identify at-risk students and link them with support services, stakeholders tend to perceive screenings as less acceptable than two other types of suicide prevention programs: curriculum-based education and in-service staff training. In a random survey of members of the National Association of Secondary School Principals ( $N = 185$ ), principals described screenings as significantly less acceptable than these other two types of suicide prevention approaches (Miller et al., 1999). In a similar study, Eckert, Miller, DuPaul, and Riley-Tillman (2003) surveyed a random sample of members of the National Association of School Psychologists ( $N = 211$ ), who rated the screening program as significantly less acceptable and significantly more intrusive than the other two types of suicide prevention programs. These opinions were echoed by school superintendents in a random survey of members of the American Association of School Administrators ( $N = 210$ ; Scherff, Eckert, & Miller, 2005).

Preliminary research suggests that adolescents may have similar feelings about screenings. Eckert, Miller, Riley-Tillman, and DuPaul (2006) surveyed first year college students ( $N = 662$ ), asking them to compare the three types of suicide prevention programs. Study participants perceived screening programs as less acceptable than the alternatives. Whitney, Renner, Pate, and Jacobs (2011) used qualitative interviews with principals ( $N = 7$ ) to explore these feelings in more depth. Although these principals all agreed that suicide prevention in schools is critical, they believed that universal screening was not a good option, in part because of a lack of parental support. Some were concerned that

students would be at higher risk of suicide due to the screening. Others identified a lack of mental health resources for students who screened positive. Clearly, if schools are to adopt a universal screening approach, outreach to school administrators, staff, and parents is necessary (Peña & Caine, 2006). School social workers may be able to support agencies in navigating this outreach.

Parents also can be resistant to universal screenings. This resistance can lead to lower levels of student participation. For example, in the study by Husky and colleagues (2011) of routine universal screenings of ninth graders ( $N = 2,488$ ), 29 percent of parents refused consent and another 15 percent did not return signed consents. In another study of screenings, only half of parents (52%) consented (Torcasso & Hilt, 2017). Parental refusal is lower for passive consent. Scott and colleagues (2010), in a study of high school students ( $N = 2,583$ ) in seven New York high schools, used passive consent; the rate of parental refusal was only 7 percent. Students refuse consent at much lower rates than parents. In fact, Husky and colleagues (2011) found that only 0.2 percent of youth in their study denied consent. Although obtaining parental consent is key to effective universal screenings, no research has examined strategies to obtain consent or to evaluate the relative effectiveness of various strategies.

Some experts argue against universal screening due to a lack of school and community resources to support students who screen positive (Hallfors et al., 2006; Joe & Bryant, 2007; Mazza, 1997). Although the screenings themselves do not require extensive staff support, all students who screen positive (20 to 45 percent of students) must be evaluated promptly (Brown & Grumet, 2009; Hallfors et al., 2006; Husky et al., 2011; Torcasso & Hilt, 2017). Many school social workers are overburdened with large caseloads and students coping with significant problems (Hayden & Lauer, 2000; Joe & Bryant, 2007). Hallfors and colleagues (2006) in their study of universal screenings ( $N = 1,323$ ) found that school staff stopped screenings when 29 percent screened positive due to the lack of resources for evaluation and follow-up services. The authors suggested that one option to resolve this issue is to use a less sensitive screening tool because only half of the students screening positive reported high levels of depression and/or suicidal thoughts and behaviors. Another option is to bring community mental health professionals into the school to support school social workers (Torcasso & Hilt, 2007). The cost may be a deterrent for some school districts (Scott et al., 2010) or communities may not have sufficient mental health resources (Katz et al., 2013).

One concern about universal screening is that it may increase students' risk of dying by suicide (Gould et al., 2005; Joe & Bryant, 2007; Miller et al., 1999; Whitney et al., 2011), reflecting the persistent myth that asking individuals about suicide will increase their distress, perhaps even worsening their suicidal thoughts and behaviors. In order to refute this concern, Gould, Greenberg, Velting, and Shaffer (2003) conducted a randomized controlled study with students ( $N = 2,342$ ) in six New York high schools. Classes were randomly assigned to two groups, one that completed a survey with questions about suicide and another that did not. Two days later, all the students took a second survey that measured suicidal thoughts. The students in the experimental group, who had been asked about suicide, were no more likely to report suicidal thoughts than the students who were not asked about suicide. In fact, high-risk students (e.g., those with depression, substance use disorders, or a previous suicide attempt) in the experimental group, who had been asked about suicide, were less distressed and reported fewer suicidal thoughts than those who were not asked about suicide. Although this research effectively demonstrated that asking students about suicidal thoughts and behaviors does not increase their risk (Gould et al., 2005; Scott et al., 2010), this concern continues to linger among mental health professionals and school personnel alike (Gould et al., 2005; Joe & Bryant, 2007; Katz et al., 2013; Whitney et al., 2011).

### **Riverside Trauma Center's Universal Screening Program**

Riverside Trauma Center, a nonprofit agency, receives funding from the state departments of mental and public health to provide trauma response services to communities, schools, or organizations following natural disasters, violent events, or unexpected deaths. The organization often works with schools that have experienced student death from suicide, following postvention protocols that are listed in the Suicide Prevention Resource Center's best practices registry (Berkowitz, McCauley, & Mirick, 2011; Berkowitz, McCauley, Schuurman, & Jordan, 2011).

These postvention protocols include verifying the facts of the death; coordinating resources; sharing information; supporting those impacted by the death; identifying those at risk for suicide; planning commemoration activities; providing education on grief, depression, posttraumatic stress disorder, and suicide; screening for depression and suicide; connecting individuals to resources; soliciting ongoing feedback from all stakeholders; and developing a postvention plan. This article has focused

on one component of active postvention, suicide prevention education and voluntary universal student screenings. When schools are interested in an organized prevention and screening program, Riverside Trauma Center uses the Signs of Suicide (SOS) curriculum, which has a strong evidence base. The program includes education about depression and suicidal thoughts and behaviors and a screening for depression and suicide. It improves suicide-related knowledge and decreases suicide attempts for middle and high school students (Aseltine & DeMartino, 2004; Aseltine, James, Schilling, & Glanovsky, 2007; Katz et al., 2013; Schilling, Lawless, Buchanan, & Aseltine, 2014).

With the SOS program, students watch a brief video about depression and suicide. Then they take a pencil and paper version of the Brief Screen for Adolescent Depression (BSAD; Lucas, 2001), a seven-item measure that includes questions about lack of energy; decreased interest in activities; changes in thinking (e.g., less clearly or less quickly); feeling not as good looking, competent, or smart as others; and specific questions about suicidal thoughts and behaviors. Students are also asked to respond to three additional items:

1. Name a trusted adult both in and out of school that you can turn to as your personal contact.
2. Would you like to speak to a counselor about anything that has been discussed during the program?
3. Are you currently being treated for depression?

Screenings are reviewed by the school staff and agency clinicians. Students who screened positive or asked to speak to a counselor are identified and aggregate data collected (e.g., frequency of positive screenings, gender, and age), and then the screening forms are destroyed. Screenings do not become part of a student's permanent school record. The program is conducted as part of a routine school time block; it should be presented in a standard class setting or as part of an advisory group meeting. The program is best administered by familiar school staff (e.g., teachers, guidance counselors, and school social workers).

Students screen positive if they answered yes to one of the suicide questions or if they answered yes to four or more questions on the depression screen. These screened-in students meet with an agency clinician or school staff member (e.g., school social worker or psychologist) for further assessment of their responses. This is not a formal diagnostic evaluation but rather an extended in-person screening meeting used to further establish potential risk and to make referrals for further evalua-

tion and treatment if needed. After any student meets in person with a counselor, a parent or guardian is notified and necessary referrals are made.

### **Experience with Screenings**

Since 2008, Riverside Trauma Center has conducted screenings in thirteen communities in the Northeast United States. Aggregate data (e.g., number of positive screens, age/grade, and gender) were collected from each of these screenings to return to each school system. For several screenings, only a portion of those who screened positive was collected, so descriptive characteristics are not available for all 9,984 students. The authors received institutional review board approval to use these anonymous data in this article. The communities ranged from affluent primarily white suburbs to urban racially diverse areas. Within these communities, 9,984 students in sixteen high schools and twelve middle/junior high schools were screened (see Table 1). Females (49.7%) and males (50.3%) were equally represented. Most students (95.7%) were not in treatment.

As shown in Table 1, 12.3 percent ( $n = 1,228$ ) screened positive. For those students for whom the descriptive characteristic was collected, the following descriptive statistics were calculated. Approximately half (46.6%) of those who screened positive were in middle/junior high school: 12.5 percent were sixth graders, 21.1 percent were seventh graders, and 13.0 percent were eighth graders. Of the 53.6 percent in high school, 19.8 percent were freshmen, 16.9 percent sophomores, 9.4 percent juniors, and 7.5 percent seniors. More female students (67.2%) than male students (32.8%) screened positive. The majority of the students had an adult in school (78.2%) or out of school (83.2%) with whom they could talk. Most (74.4%) were not currently in treatment. Another 668 students (6.7%) requested to meet with a clinician to talk about the material. Most of these were younger students (59.6% were sixth and seventh graders).

### **Discussion**

Through experience with universal school-based screenings, our agency learned important lessons about how to engage parents and school personnel in the process. Preparatory work with school personnel such as teachers, principals, guidance counselors, and school social workers was key to overcoming parental resistance. Before contacting any parent about the program, our agency staff met with school administrators,



**Table 1. Characteristics of screening participants**

Characteristic	All students screened		Students screened positive	
	<i>n</i> (%)	<i>M</i> ( <i>SD</i> )	<i>n</i> (%)	<i>M</i> ( <i>SD</i> )
<i>N</i>	9,984		1,228	
Grade	8,820		1,068	
6	1,009 (11.4)		133 (12.5)	
7	1,872 (21.2)		225 (21.1)	
8	1,071 (12.1)		139 (13.0)	
9	1,660 (18.8)		211 (19.8)	
10	1,651 (18.7)		180 (16.9)	
11	854 (9.7)		100 (9.4)	
12	703 (8.0)		80 (7.5)	
Age (yr)	6,629	14.5 (2.0)	811	14.5 (1.98)
Gender	6,684		839	
Male	3,359 (50.3)		275 (32.8)	
Female	3,325 (49.7)		564 (67.2)	
No. of suicides	9,517	2.01 (0.91)	1,180	1.9 (0.87)
Time since first suicide death (mo.)	9,517	32.7 (22.6)	1,180	33.7 (23.02)
Time since last suicide death (mo.)	9,517	21.9 (21.2)	1,180	23.9 (22.6)
Death in the past 6 months?	9,517		1,180	
No	5,430 (57.1)		651 (55.2)	
Yes	4,087 (42.9)		529 (44.8)	
In treatment?	9,485		950	
No	9,075 (95.7)		707 (74.4)	
Yes	410 (4.3)		243 (25.6)	
Adult contact in school?	7,737		927	
No	1,030 (13.3)		202 (21.8)	
Yes	6,707 (86.7)		725 (78.2)	
Adult contact out of school?	7,768		929	
No	606 (7.8)		156 (16.8)	
Yes	7,162 (92.2)		773 (83.2)	

talked to school staff, and addressed their concerns with the process. The concerns highlighted by previous research on school-based screenings (Eckert et al., 2003; Miller et al., 1999; Scherff et al., 2005; Whitney et al., 2011) were reflected in conversations with school personnel. However, we found that sharing the relevant research findings, including

information about iatrogenic risk as well as our own experience in other schools, can be effective in increasing buy-in to the process. We frequently encourage administrators to speak with peers in other schools where we have conducted postvention and screenings.

Once a relationship is created, the school personnel can connect with families. Teachers, school social workers, and administrators who buy into the importance and effectiveness of screening use their relationships with parents to inform them of the benefits of screening, address any concerns, and explain the process, advocating strongly for the screenings. Their relationships with parents are strong and their advocacy is therefore much more effective than that of an outside agency such as ours. Schools need time to send information about the program, requests for signed permission slips, and one (or more) reminders for permission slips. Both sufficient time for planning and time and energy from school staff are required to do this work. Without buy-in from school personnel, we would not go forward with a school-wide screening program. This approach has been very effective in terms of obtaining parental buy-in for screenings. It has not been unusual to obtain signed permission slips from 90 to 95 percent of parents, especially in schools with which we have ongoing relationships. In schools where school personnel put less time and effort into this process, rates tend to be closer to 40 to 50 percent. Buy-in from students is usually high, and it is rare for a student to refuse to participate in the screening.

Given the significant consequences of suicidal behaviors, our agency, like others (Horowitz, Ballard, & Pao, 2009), chooses to err by screening in false positives versus using a less sensitive screening instrument, as some suggest (Scott et al., 2010), and missing at-risk youth. In fact, our agency's screenings allow for students to opt in and request to talk with one of the mental health professionals. An average of 7 percent of students request to speak to a counselor, but this varies by grade and school. Requests to speak to a counselor have ranged from 4 to 19 percent across communities. Younger students are more likely to request to speak to a counselor, with 17 percent of sixth graders making such a request compared to 3 percent of twelfth graders.

Positive screen rates varied by community, ranging from a high of 22.0 percent in an urban community to a low of 6.8 percent in an affluent suburban community (see Table 2). Across all schools, an average of 12.6 percent screened positive. Being able to predict a positive screen rate of approximately 10 to 20 percent allows for proper planning for the screening day, ensuring that sufficient mental health resources are available. For our screenings, several of the agency's mental health clinicians are on-site using community resources to supplement the school staff

**Table 2.** Positive screen rates by community

Community	Suburban/urban	Income (\$K)	Positive screen (%)
1	Urban	<60	15.1
2	Suburban	<60	16.5
3	Urban	<60	11.2
4	Urban	<60	22.0
5	Suburban	60–100	13.6
6	Suburban	60–100	12.8
7	Suburban	60–100	8.9
8	Suburban	60–100	19.4
9	Suburban	60–100	16.6
10	Suburban	60–100	6.8
11	Suburban	60–100	15.6
12	Suburban	>100	8.4
13	Suburban	>100	8.2

(Torcasso & Hilt, 2017). In addition to meeting with students who screen positive, clinicians meet with students to gather feedback about the program. Students are informed of this process, reducing the stigma of meeting with clinicians.

False positives do occur during screenings. Occasionally a student makes an error in completing the screen, leading to a false positive (e.g., the student checks all yes answers on the BSAD but meant to check all no's) or students answer the questions literally, registering a false positive due to a current acute stressor that has led to a busier schedule and less sleep (e.g., a busy sports season, college applications, or participation in a theater production).

When students are experiencing a chronic stressor, the clinician includes coping skills and self-care in the conversation. We do not consider false positives a problem because they allow for feedback from a broader range of students, an opportunity for some stressed students to check in, and the potential to further reduce stigma for all students meeting with the clinicians. The initial in-person meeting is not a formal diagnostic evaluation; therefore, no student is given a diagnosis.

Planning for universal screenings should include ensuring that the necessary resources are available both on the day of the screening and within the broader community for students who are found to be in need of more supports than the school is able to provide. These critical planning steps include training school personnel who will be involved in the screening process and assessing the availability of community mental health resources (Peña & Caine, 2006; Weist, Rubin, Moore, Adelsheim,

& Wrobel, 2007). Relationships with local community agencies may need to be developed and strengthened (Weist et al., 2007) and clear policies and protocols for referrals created (Peña & Caine, 2006). When community resources are lacking, there may be ways to temporarily tap into other resources. For example, the school can advocate for a short-term embedded clinician who is designated to support high-risk students. However, in some rural or semirural areas, these resources may not be available. In our agency's experience, this is the major reason why schools decide not to screen students.

### **Limitations**

These screenings were all conducted in a Northeastern state with good access to mental health services, particularly in the more urban areas. The successes of the screening processes, including the high rates of buy-in from school administrators and parents, may be related to geographic location and may vary in other areas of the country. Research, including this research, has paid scant attention to the cultural barriers to screenings and referral and whether screening tools are a good fit with all groups (Manetta & Ormand, 2005). The majority of screening tools for depression and suicide have been normed and validated on a majority white sample, and their use with other cultural groups needs to be explored (Brown & Grumet, 2009; Manetta & Ormand, 2005). Although our agency did conduct screenings in racially, ethnically, and culturally diverse communities, information on race, ethnicity, and spoken language was not collected; therefore, it is impossible to understand the effectiveness of screenings across groups. Although these are important limitations, our agency has screened a large number of students and suggests recommendations for practice based on that extensive experience in this understudied area.

### **Recommendations for Practice**

Based on our ten years of experience, we offer the following recommendations to schools and agencies that are interested in implementing universal screenings at schools as one component of an organized postvention plan:

1. *Planning is the most important step in the process.* Effective planning can prevent many possible challenges with screenings. This planning should include collaboration with community agencies, training school personnel who will participate in the screenings,

engaging in collaborative planning with all stakeholders, exploring possible issues, examining current policies, and investigating options for follow-up care (Weist et al., 2007). Topics such as follow-up services, adequate staffing, screening form disposal, school personnel buy-in, and parental permission all need to be discussed and planned in this stage of the process.

2. *Evaluate current community resources.* In order for screening to be an effective intervention, follow-up care for students must be available in the community (Peña & Caine, 2006). To facilitate student use of referrals, school staff (perhaps one appointed school staff member, such as the school social worker) should follow up with students and their families. School administrators can advocate for temporary additional school-based resources to do this work, such as a case manager/expeditor to facilitate referrals and support students until they can be connected with outside resources.
3. *Allot adequate time for the screening process.* From the planning stage through referrals, the screening process can take weeks to months. Screenings may need to be spaced out over several days, weeks, or months to ensure that there are sufficient mental health resources on site to meet with the students who screen positive without interfering with already busy schedules and demands on school personnel. As suicide risk remains high for several years after the death of a peer (Brent et al., 1996; Swanson & Colman, 2013), repeated yearly screenings may be beneficial.
4. *Plan for sufficient in-school support.* It is important to assess the adequacy of school personnel to meet the needs of all students who screen positive (Horowitz et al., 2009). The number of screenings per day needs to be limited according to the estimated number who will screen positive and can be seen that day by clinical staff. School personnel can be trained (Weist et al., 2007) or their numbers supplemented with clinicians from community agencies (Torcasso & Hilt, 2017).
5. *Wait two to four months after a suicide to screen.* Although students may need immediate support following a suicide, our experience has taught us that it is ideal to wait two to four months after the death to conduct universal screenings. When the death is very recent, students feel “too raw” during the screening, and screenings can become a stressor for them. It is important to avoid anniversary dates (e.g., anniversary of the death) because these days are meaningful to students. They may react with anger and/or grief to screenings that are being done on this important day.

6. *Consider ways to reduce stigma.* Confidentiality of the responses must be maintained. This confidentiality will be violated if students' positive responses are exposed when they are called to meet with a clinician. Many options exist, including interviewing all students (Torcasso & Hilt, 2017) or randomly selecting some students who did not screen positive (as our agency did). A plan must be in place before screenings begin.
7. *Screen! Screenings identify students whom no one knows are at-risk.* At most schools, screenings identified at least one student who had told no adult about suicidal thoughts or behaviors, and it has not been uncommon to find students who were at significant risk of suicide. Universal screening allows those unidentified students to access services.

### **Conclusion**

Our ten years of experience conducting screenings in schools as a component of a suicide postvention plan has clearly demonstrated that, although some barriers do exist, in many school communities, universal screenings as a component of a postvention plan following the death of a student are feasible and can be completed effectively with the support of the school community. Important supports for this work are advanced preparation with the school community, including administrators, school social workers, and teachers; sufficient mental health resources; and a good working knowledge of the school (e.g., understanding of school culture, values, and goals for students). School social workers are in a unique position to be able to understand the value of universal screenings and advocate for them within the school system.

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