

# Task Force Report

## Suicide Prevention and Trauma-Informed Care Task Force

12/16/2013



## Iowa Department of Education

Grimes State Office Building  
Des Moines, IA 50319-0146



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## **Senate File 446, Division XXI, Section 109**

The Department of Education shall work with the Departments of Human Services and Public Health in developing recommendations for required training of persons who hold a license, certificate, authorization, or statement of recognition issued by the Board of Educational Examiners and who provide services to students. The recommendations shall address training of such persons on suicide prevention and trauma-informed care. In developing the recommendations, the department shall consult with stakeholders, including but not limited to mental health professionals, school administrators, school nurses, and guidance counselors. For purposes of this section, “trauma-informed care” means services that are based on an understanding of the vulnerabilities and triggers of individuals who have experienced trauma, recognize the role trauma has played in the lives of those individuals, recognize the presence of trauma symptoms and their onset, are supportive of trauma recovery, and avoid further traumatization. The department shall submit a report to the governor and general assembly providing findings and recommendations on or before December 15, 2013.

## Task Force Membership

Gladys Noll Alvarez, Trauma-Informed Care Project Coordinator, Orchard Place, Des Moines

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## **Non-Voting Task Force Membership**

Mike Cormack, Policy Liaison, Iowa Department of Education, Des Moines

## 2013 Meeting Schedule

Date	City	Facility	Time
September 20	Des Moines	Iowa Department of Education/Grimes Building	2 to 4 p.m.
October 24	Des Moines	Iowa Department of Education/Grimes Building	2 to 4 p.m.
November 1	Des Moines	Iowa Department of Education/Grimes Building	8:30 to 10:30 a.m.
November 26	Des Moines	Iowa Department of Education/Grimes Building	8:30 to 10:00 a.m.

## Executive Summary

Pursuant to Senate File 446, Division XXI, Section 109, the Iowa Department of Education, in partnership with the Department of Human Services and the Department of Public Health, convened a task force to develop recommendations regarding suicide prevention and trauma-informed care training of persons who hold a license, certificate, authorization, or statement of recognition issued by the Board of Educational Examiners and who provide services to students. As provided in the legislation, this task force consisted of school administrators, school nurses, guidance counselors, and mental health professionals.

The task force conducted its first meeting on September 20, 2013, and met subsequently on October 24, November 1, and November 26. The task force approved this report on December 9, 2013, which is hereby submitted. This report summarizes the charge from the General Assembly, describes the work of the task force, provides an overview of suicide prevention and trauma-informed care, and makes recommendations for legislative action.

The task force received information from the Suicide Prevention Resource Center's Best Practices Registry, the National Registry of Evidence-Based Program and Practice, Suicide Prevention Resource Center/American Federation for Suicide Prevention Evidence-Based Practices Project, and Recommendations for Reporting on Suicide through the Media Project. The task force received additional information from presentations about trauma-informed care, youth suicide data in Iowa and the federal youth suicide prevention grant received by the Department of Public Health in October 2013, and the Board of Educational Examiners licensure process. Task force members reviewed data and gathered information at four meetings and four subcommittee sessions. Individual members gathered additional research to share with both subgroup and task force members.

The task force focused its work in two areas:

1. Recommendations regarding required suicide prevention training for persons who hold a license, certificate, authorization, or statement of recognition issued by the Board of Educational Examiners and who provide services to students.

The task force recognized the critical role schools can play in reducing youth suicide in Iowa by: a) establishing critical protocols on how to respond to students at high risk for suicide and how to respond when a death by suicide has occurred; and b) providing evidence-based, universal suicide prevention training to all school staff who work with children and youth.

2. Recommendations regarding training on trauma-informed care for school staff pre-K through 12<sup>th</sup> grade. The task force recognizes trauma-informed care as an organizational structure and framework for giving providers and others information, strategies, and supports to: understand all types of trauma; understand the impact trauma has on social/emotional/cognitive development; awareness of the symptoms and triggers of those who have experienced trauma; develop skill in supporting the students and staff; and recognize and avoid actions that are likely to re-traumatize these individuals.

Following the investigation of these two areas, it became clear to the task force that merely asking schools to serve a gatekeeper role (identifying students at risk for suicide), is only a first



step in effective suicide prevention. Key questions were: ***What do schools do once they identify students who are at risk? What supports are available to assist vulnerable students, families and teachers? Where do schools go to get answers to these questions?*** Therefore, it is the consensus of the task force members that teachers and other school-based personnel need ongoing assistance, information, and resources to fulfill this responsibility. Expecting each teacher, school, and district to research and develop these resources on their own is unreasonable. Instead, a way to coordinate these efforts and to provide support for schools in implementing best practices is needed. Thus, the following recommendations are made:

## Recommendations

- 1) Require districts to adopt protocols for helping students at high risk of suicide, and in responding to a suicide death (postvention). Model protocols, based on research, will be developed by the Iowa Center for Suicide Prevention.
- 2) Fund training in evidence-based suicide prevention and evidence-based trauma-informed care for all school personnel who work with children (pre-K-12) in addition to those who are licensed, certified, authorized, or receive a statement of recognition issued by the Board of Educational Examiners. It is further recommended that school districts be responsible for providing this training with guidance and support from the Department of Education within a time frame determined in Iowa Administrative Rule. The content of this training will be determined by the Department of Education and monitored through the school accreditation process.
- 3) Establish and fund an Iowa Center for Suicide Prevention, with at least four funded suicide prevention specialists. Once students are identified as at risk for suicide, school personnel must have the resources and supports to make decisions that will lead to the most positive outcome possible. The specialists will each serve one-fourth of the state.

This Center will provide ongoing support to Iowa's schools with information, resources, and evidence-based suicide prevention and trauma-informed care training content in a coordinated and comprehensive way. The creation of the Center will allow a student, regardless of where they reside in the state, to receive the same high-quality suicide prevention, intervention and support. The Center will provide leadership and support to schools and coordinate this work across other state departments, area education agencies, community groups and private organizations.

Initial primary focus of this Center shall be on supporting schools with implementation of suicide prevention programs and development of trauma-informed learning environments. Thus, initial responsibilities of this Center will include, but are not limited to:

- a) Through intentional collaboration with suicide prevention coordinators and initiatives across state departments, this Center will lead a public-private coalition of state and local agencies, community groups, organizations including area education agencies, and individuals with the goal of supporting statewide suicide prevention, awareness, intervention, and resources.
- b) Infuse best practices and current research into approved, evidence-based suicide prevention and evidence-based trauma-informed care training for school personnel.
- c) Develop a tiered training protocol (universal - all school personnel; targeted - personnel who need more knowledge and skill, such as school nurses, school counselors, administrators; and intensive - one or two school personnel in each school to guide the suicide prevention efforts and support staff).
- d) Develop model protocols to assist schools in suicide prevention and postvention.
- e) Develop recommendations for social/emotional learning programs and supports for schools.
- f) Encourage content to be included in pre-service teacher training.

**Long-term goals of this Center include:**

- a) Coordination of a comprehensive community effort of suicide prevention to identify and develop supports for students at risk of suicide.
  - b) Developing evidence-based training.
  - c) Identification of unmet needs in school and community social/emotional learning supports.
  - d) Support schools in providing suicide prevention and trauma-informed care.
  - e) Through community involvement, identify resources for students identified as at risk for suicide.
- 4) The above recommendations will be implemented beginning July 1, 2015.
  - 5) A total financial appropriation of \$500,000 will fund the Iowa Suicide Prevention Center, including the four suicide prevention specialists, support position, and activities (e.g., training materials, travel, train-the-trainer meetings, resource website development).

## Background

***According to the Center for Disease Control, suicide is the third leading cause of death among teenagers in the United States. In Iowa, suicide is the second leading cause of death for this age group.*** According to the Iowa Youth Survey (2012) 13 percent of Iowa's youth in grades 6, 8, and 11 ( or 13,772) reported they have seriously thought about killing themselves within the past twelve months; and 7 percent (or 7,415) of these young people reported they actually developed a plan to do so. Therefore, it is a significant concern that suicide in Iowa among school-age youth is more prevalent than in the nation as a whole.

Trauma, or adverse childhood experiences (ACEs), are experiences that harm an individual's functioning in social, cognitive and emotional areas and disrupt the safe and supportive environments children need in order to grow and thrive. ACEs fall into two categories: Childhood Abuse (physical abuse, psychological abuse, and sexual abuse) and Household Dysfunction (substances abuse, member imprisoned, mental illness, adult violence, and parental separation or divorce). Based on Felitti and Anda's initial ACEs study (Felitti, et.al.,1998), the occurrence of suicide attempts increased with the number of adverse childhood experiences. When compared to respondents with no ACEs, there was an 80 percent increase in attempted suicide with just one ACE and an 1120 percent increase with four or more ACEs. In the Iowa ACEs report completed in 2012 over half of Iowa adults (55 percent) experienced at least one ACE. This complete report is found in Appendix A.

Suicide is considered a major, yet preventable, health problem in the United States and is related to mental illness, substance abuse, chemical imbalance, brain disease and other related issues. Therefore, it is important to note that trauma is ***only one*** of many factors that influence suicide risk. As shown from the ACEs' study statistics, there is, however, a significant increased risk of suicide in school-age youth who have experienced traumatic events, and between 66 percent and 80 percent of all attempted suicides could be attributed to ACEs (Felitti, et.al., 1998). While trauma-informed care will address this large group of young people, suicide prevention must be targeted toward ***all*** of Iowa's school-age youth. As cautioned in the 2012 National Strategy for Suicide Prevention, a report of the U.S. Surgeon General, (2012) "Just as suicide has no one single cause, there is no single prevention activity that will prevent suicide. **To be successful, prevention efforts must be comprehensive and coordinated across organizations and systems at the national, state..., and local levels.**"

A trauma-informed approach uses general knowledge about trauma to understand how toxic stress impacts learning, behavior, and relationships, and to modify student supports. Because early trauma creates changes in the brain and body, stress responses, commonly known as "fight, flight, or freeze" responses, become activated over and over again in a maladaptive way. Children impacted by trauma have more difficulty sitting still, focusing, and following directions (Harris, 2013). In other words, there is a strong and relevant correlation between trauma and learning/behavior problems (Burke, 2011).

***"Understanding trauma is not just about acquiring knowledge.  
It's about changing the way you view the world."  
Bloom, 2007***

A trauma-informed approach changes how an organization (or school) thinks about and responds to those who are, or may be at risk for, experiencing trauma. In a sense, this knowledge changes the lens through which we observe a child's behavior, shifting the questions we ask from "What's wrong with that child?" to "What has that child experienced and what is the best response?" (Bornstein, 2013). Viewing a child's actions through a trauma-informed lens further helps educators understand **why** a student may act out or withdraw. Thus, we understand the child's behavior may not be "an act of willful disobedience," but rather a neurological and physical response to stress. Schools may then design more supportive and successful school-based interventions (e.g., creating safety through positive, supportive relationships).

On the national level, many schools have implemented universal social and emotional learning (SEL) programs. Both SEL and trauma-informed care build healthy relationships between adults and children, foster positive peer relationships, help students feel connected to school, create safe and supportive school environments, and teach essential social and emotional skills. Three key emotional skills (problem-solving, emotional regulation, and support-seeking) have specifically been found effective in reducing suicide risk among young people (Khurana & Romer, 2012). While identifying students with risk factors such as depression or suicidal ideation is a critical gatekeeper role, prevention efforts must additionally emphasize helping students learn these skills so they do not develop these risk factors.

Trauma-informed care\* can remediate the impacts of trauma and mitigate trauma's negative effects. Furthermore, an interesting by-product of trauma-informed care is improved academic outcomes (Harris, 2013). For example, in schools implementing SEL programming, an average academic gain of 11 percent was shown over a three-year time period (Durklak, et.al., 2011). While not the primary charge of this task force, this additional, positive outcome should not be ignored. These neuroscientific insights into trauma-informed care and social emotional learning provide new ways to reduce the academic achievement gap. As stated by Blodgett (2012), "If schools are to improve academic outcomes, addressing complex trauma should be central to their educational mission."

\*It is important to note that trauma-informed care is not a mental health intervention. Therefore, it must be clarified that this approach is not intended to meet the varied mental health needs of children and youth in the school setting.

*To those who have lost their lives by suicide,  
To those who struggle with thoughts of suicide,  
To those who have made an attempt on their lives,  
To those caring for someone who struggles,  
To those left behind after a death by suicide,  
To those in recovery, and  
To all those who work tirelessly to prevent suicide and suicide attempts in our nation.*

**We believe that we can and we will make a difference.**

U.S. Surgeon General's Report, 2012



The American Foundation of Suicide Prevention conducted a review of the state's suicide prevention initiatives in 2012. Iowa was the only state in the nation without any statewide suicide activity (American Foundation for Suicide Prevention 2012, Appendix B). Legislation has been passed by several states (e.g., Tennessee, Massachusetts, Wisconsin, others) recommending or requiring training in suicide prevention for school personnel as part of a comprehensive suicide prevention plan. As observed in the map above, three states (California, Colorado, Nevada) fund an Office of Suicide Prevention, a state government office dedicated to suicide prevention. Four of the six states bordering Iowa (South Dakota, Minnesota, Wisconsin, and Illinois) have a public-private coalition with at least one paid staff person. Twelve states implement suicide prevention initiatives through coordination across state departments. As a result of the loss of grant funding, Iowa was the only state in 2012 with **no** statewide suicide prevention activity.

This changed this year, when in October 2013, the Iowa Department of Public Health received a \$440,000 per year (three-year) grant from the Substance Abuse and Mental Health Administration (SAMHSA) to promote suicide prevention efforts for youth and young adults (10-24). This grant will be used to implement evidence-based screening and assessment for suicide risk statewide by substance abuse treatment programs. The grant will also offer free, evidence-based, web-based gatekeeper training (Kognito) for all middle and high school educators (grades 6-12) in Iowa. The last goal of the grant is to educate youth through a social media

campaign and increase referrals to services for substance use and co-occurring mental health problems. The activities are to be coordinated with the Your Life Iowa program, established last year as a resource for Iowans seeking help and information about bullying and youth suicide prevention. Despite these prevention efforts, however, Iowa still does not have a full-time person dedicated to coordinating a comprehensive suicide prevention effort across state departments and agencies.

The task force recommendations coordinate with the Iowa Department of Public Health effort, as well as with Iowa's Mental Health Re-Design. The Children's Disability Service Workgroup Final Report issued in November 2013 identifies the core values and guiding principles of the Systems of Care that have been adopted by the Department of Human Services for the children's mental health and disability system. These guiding principles include the domain of "Prevention, Early Identification, and Early Intervention." Training of educational staff in suicide prevention and trauma-informed care promotes these core values and principles and offers opportunities for cross-agency collaboration among the state departments that provide education, services, and supports to children and their families.

## Conclusion

Suicide is a serious public health problem that brings pain, suffering, and loss to Iowa's youth, families, and communities. Task force members fully support the recommended action required to prevent suicide and save lives. Task force members respectfully submit this report and welcome the advice and support of the Governor and General Assembly in addressing the identified needs and opportunities.

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## Appendices

### Appendix A: Adverse Childhood Experiences in Iowa: A New Way of Understanding Lifelong Health: Findings From the 2012 Behavioral Risk Factor Surveillance System

This ***Adverse Childhood Experiences in Iowa*** report shares 2012 survey data on Adverse Childhood Experiences (ACEs) in our state's population. Funded by a grant from Mid-Iowa Health Foundation, this analysis was commissioned with the goal of increasing awareness and understanding of the prevalence and health concerns of ACEs among the general public, professionals and policy makers. This report may be found at the following link:

[www.iowaaces360.org/uploads/1/0/.../iowa\\_aces\\_360\\_pdf\\_web\\_new.pdf](http://www.iowaaces360.org/uploads/1/0/.../iowa_aces_360_pdf_web_new.pdf)

## Appendix B: State Offices of Suicide Prevention and Initiatives



**Overview:** This project reviews suicide prevention initiatives enacted at the state level. This review is intended to help advocates, volunteers, and other interested stakeholders consider whether their state’s existing suicide prevention initiative structure is adequately meeting their unique prevention needs. States are split into six different categories dependent on the acting body of the state initiatives, color-coded by category on the “State Suicide Prevention Initiatives” map.

### **States with a free-standing state government Office of Suicide Prevention**

While a free-standing state government office dedicated to suicide prevention would appear an ideal coordinating body for sustaining suicide prevention programs, the reality is that many states lack the funding for such an office. Only 3 states (California, Colorado, Nevada) are presently able to sustain an Office of Suicide Prevention.

### **States with a public-private coalition with at least one paid staff position**

In these states, existing state departments, related nonprofits, and other community stakeholders work together on suicide prevention, with at least one paid staff member. Often, this staff member is a state employee whose job entails coordinating the efforts of the coalition. This category includes both those states whose coalition is mandated by statute or a governor, as well as those states whose coordinator may not have an explicit job title related to the coalition, but clearly works almost exclusively on coalition activities. Currently, 17 states operate suicide prevention initiatives using this model.

### **States with a public-private coalition without a paid staff position**

In these 10 states, existing state departments, related nonprofits, and other community stakeholders work together on suicide prevention. This includes both those states whose coalition is mandated by statute or a governor, as well as those states whose coalition is more of a grassroots effort. In these states, there is no single staff member, state or private, employed to oversee the coalition’s activities. Idaho is one such example of a coalition mandated by the governor which is made up of legislators, representatives from public departments and nonprofit agencies, a survivor, and mental health professionals.

### **States with coordinators within existing departments**

States in this category have up to 2 suicide prevention coordinators that oversee statewide suicide prevention activity. While they may occasionally partner with other departments or organizations, there is no formal statewide coalition in place. One example is Wyoming, where there is one “Suicide Prevention Initiative Coordinator” within the Department of Health. There are 12 states using this model.

### **States with a youth suicide prevention plan/initiative only**

Currently 6 states and DC have plans or programs in place that cover only youth suicide prevention. This category includes those states which have planned for activities across the lifespan, but due to limited funding and interest have only been able to maintain youth programs.

### **States with no suicide prevention activity**

Currently 1 state, Iowa, lacks coordinated statewide suicide prevention activity, due to a recent ending of funding.

### **States without enough information to categorize**

Arizona did not respond to inquiries about statewide suicide prevention activities.

The information included in this project may assist in conversations at the state level for improved programs, policies, and/or legislation. Each state is outlined in individual fact sheets (available upon request) with information providing the history, current activity, legislation, funding, state-specific suicide data, contact information for the state's suicide prevention office, division, or organization, and contact information for other suicide prevention organizations in the state. The initiatives, programs, or organizations profiled are ones that appear to have a direct link to the production and facilitation of their state's suicide prevention plan and activities.

**Critique:** While a free-standing government Office of Suicide Prevention appears to be an ideal structure for statewide suicide prevention efforts, few states have the funding to sustain such an initiative. Based on personal conversations with individuals participating in statewide suicide prevention, it is clear that well-coordinated efforts by public-private coalitions are an extremely effective means by which to implement the goals of a suicide prevention plan. These coalitions seem to be especially effective when they have a paid, full-time staff member to coordinate their efforts. Coalitions use existing state resources efficiently, and are therefore able to accomplish a wide variety of activities with minimal financial resources. Coordinators help coalitions to direct their efforts to the areas in which they are most needed and serve as a vehicle for communication about the coalition's activities to the public. Suicide prevention coordinators within existing departments also seem to be very effective, though they typically lack the funding that full departments carry, as well as the access to existing resources that formal coalitions have.

Though suicide prevention initiatives across the country are in some ways very effective in carrying out the goals of the statewide plans as evidenced by personal conversation with those individuals leading the initiatives, it is clear that they are limited by a lack of funding and instability of funding. Suicide prevention efforts suffer greatly when grants, which have funded staff positions, programs, and other vital resources, are lost. This lack of funding also prevents state programs from utilizing prevention efforts that reach across the lifespan, as well as limiting the communities who receive access to prevention materials. Overall, it is clear that there are dedicated individuals, agencies, departments, and organizations working to prevent suicide nationwide, and currently their efforts are limited by the resources available to them.

**Methodology:** Initial information was retrieved through web searches. The SPRC's state information page was consulted first, and subsequently the state plan was reviewed for background and history information. Any state agency that was a sponsor of the plan was consulted online and investigated for any current activities or initiatives it may be enacting. Subsequently, at least one person within all involved agencies, departments, and organizations was contacted via email or phone to solicit a more updated description of current activities and funding and clarification on the history and its influence on present initiatives. Specific feedback was collected regarding the drafted history, activities, legislation, and funding sections of the final state pages. The legislation listed on these pages was derived from state legislative reports compiled by AFSP. It was augmented when appropriate with other legislation found through agency sites or web searches. The funding sources were compiled based on provisions in the state plan, information on agency/department/organization websites, and SPRC listings. Contact information collected during the original web search was verified and included in the final state page.

