School Mental Health
https://doi.org/10.1007/s12310-026-09878-y

REVIEW PAPER

Suicide Prevention in K-12 Schools: Introduction to the Special Issue

Kurt D. Michael[1,2] · Amy Brausch[3]

Received: 24 April 2026 / Accepted: 27 April 2026
© The Author(s) 2026

Abstract

Suicide remains a leading cause of death among youth in the United States, with disproportionately elevated risk in rural communities. Schools represent a critical and underutilized setting for suicide prevention, offering a practical avenue to overcome barriers related to access, workforce shortages, and service fragmentation. This special issue is informed by decades of school-based clinical and research experience and highlights the need for a comprehensive, multi-tiered approach to suicide prevention in schools and underscores the urgent need to expand research and practice at the tertiary level. Strengthening partnerships among schools, researchers, and community mental health systems will be essential to advancing effective, equitable, and scalable interventions. Collectively, the contributions in this issue aim to catalyze continued progress in addressing youth suicide within K–12 settings.

Keywords Suicide prevention · School mental health · Tertiary intervention

In 2024, suicide was the second leading cause of death among youth aged 10 –19 according to CDC's Web-based Injury Statistics Query and Reporting System (WISQARS). Non-fatal suicidal behaviors are also alarmingly common. The 2023 Youth Risk Behavior Survey (YRBS) found that approximately 20% of high school students seriously considered suicide in the past year, and 9% reported at least one suicide attempt (CDC, 2024). These national trends are concerning for youth overall, but risk is even higher among adolescents in rural communities compared to their urban peers (Ivey-Stephenson et al., 2020). A comprehensive analysis of data from 1996 to 2010 found that suicide rates among rural youth and young adults aged 10–24 were approximately twice those of their urban counterparts (Fontanella et al., 2015).

Despite the clear need to address youth suicide across settings and geographies, several well-documented barriers persist. These include a limited and unevenly distributed mental health workforce, transportation challenges, perceptions that treatments are ineffective or unacceptable, and widening economic disparities, and inequities in healthcare coverage (Michael et al., 2023). One effective strategy to mitigate these barriers is to deliver services where youth already spend most of their time—schools. Embedded school mental health (SMH) partnerships provide direct, equitable access to mental health care and suicide-focused prevention within K–12 settings, reducing logistical obstacles and increasing engagement (Michael et al., 2015).

The impetus for this special issue stems from decades of on-the-ground work and conducting research in schools for Drs. Michael and Dr. Brausch. Although many K–12 educators are willing to implement primary (universal) suicide prevention programs (e.g., Sources of Strength, Erica's Lighthouse), and to a lesser extent selected (secondary) interventions, indicated (tertiary) supports remain far less common. This gap reflects several persistent concerns: the belief that asking about suicide may increase risk; uncertainty about whether acute risk management, non-fatal attempts, and postvention fall within schools' scope of practice; and fears related to legal liability.

Concerns about suicide assessment in schools are not supported by the evidence. Data from the Youth Risk Behavior Survey (YRBS) consistently show that a substantial proportion of youth report suicidal thoughts and behaviors each

✉ Kurt D. Michael
kurt@jedfoundation.org

[1] The Jed Foundation, 745 Fifth Avenue, Suite 500, New York, NY 10151, USA

[2] Appalachian State University, North Carolina 28608 Boone, USA

[3] Western Kentucky University, Kentucky 42101 Bowling Green, USA

Published online: 22 May 2026

year. Although the YRBS is anonymous and not designed to detect acute risk, research demonstrates that asking young people directly about suicide does not increase risk (Dazzi et al., 2014). In fact, such inquiry is associated with benefits such as reduced distress among high school students (Gould et al., 2005) and fewer suicide attempts following participation in school-based prevention programs at three-month follow-up (Aseltine et al., 2007).

Moreover, surveys such as the YRBS can help school staff justify and scale system-level prevention efforts. The greater challenge is not whether to ask, but what to do when elevated risk is identified. This tension is especially pronounced in rural and under-resourced communities, where referral options and access to higher levels of care are limited.

Dr. Michael confronted these realities early in his career as a new assistant professor in rural Appalachia in 1999. Through partnerships with local school districts, his team conducted a series of assessments—including the YRBS—to better understand youth risk. The results were striking: 12-month rates of suicidal thoughts and behaviors, including non-fatal attempts, were two to three times the national average (Michael et al., 2009).

These data were a clear call to action, particularly given that most identified youth were not receiving any mental health care. These data also revealed a serious quandary: a life-threatening problem revealed through screening in a setting and location with limited—or nonexistent—access to services for those at risk. In response, Dr. Michael's lab began developing embedded school mental health partnerships to address the need directly. When university general counsel was consulted, however, the initial question was, "Why do you want to do this?"—a reflection of legitimate concerns about liability. Yet the alternative—identifying a critical problem and doing nothing—was equally untenable. Our response was clear and well-justified for three reasons: it addressed a critical community need, created clinical training opportunities for students, and expanded interdisciplinary research opportunities for faculty and trainees.

Given the urgency—and the team's capacity as licensed providers with expertise in school-based mental health and suicide care—they began by focusing on students at the tertiary (indicated) level. While school mental health (SMH) partnerships were not new, there was little guidance on how to address acute suicide risk within K–12 settings. Consequently and in collaboration with local educators in the early 2000s, the team developed what later became the Assessment, Support, and Counseling (ASC) Centers in the southeastern United States. This model was designed explicitly to overcome common barriers to accessing mental health and suicide-focused care in rural communities (Michael et al., 2009).

ASC Center staff include licensed mental health clinicians, school personnel, administrators, and graduate trainees (e.g., clinical psychology, social work, marriage and family therapy) under faculty supervision, who deliver services during the school day (Michael & Ramtekkar, 2022). Core services include crisis assessment and intervention, consultation, individual cognitive-behavioral therapy, and psychoeducational groups (Sale et al., 2014). Historically, ASC Centers have reached approximately 10–30% of enrolled students annually across one or more of these service modalities (Michael, 2020).

Students are referred to the ASC Center for a range of concerns, most commonly depression, anxiety, attention-deficit disorders, suicidality, and substance misuse (Michael, 2020). Across multiple studies and program evaluations (Albright et al., 2013; Kirk et al., 2019; Michael et al., 2016), 65–80% of students receiving services reported clinically significant reductions in distress and related symptoms and improvements in academic outcomes (Michael et al., 2013) at post-treatment and follow-up.

In addition to addressing broad mental health needs, the ASC model emphasizes the assessment, treatment, and management of youth with suicidal thoughts and behaviors—particularly given elevated rates in rural communities. Over the past 10–15 years, ASC clinicians and researchers have implemented systematic crisis intervention protocols (Michael et al., 2015), with a strong focus on reducing access to lethal means, especially firearms (Capps et al., 2019), a key risk factor among rural adolescents (Spark et al., 2021). In 2016, ASC Centers further strengthened care for high-risk youth by adopting the Collaborative Assessment and Management of Suicidality (CAMS), an empirically supported approach to suicide assessment and treatment (Jobes et al., 2016), now integrated into routine practice (Jobes et al., 2019).

Although much of the evidence for CAMS comes from adult samples, research with adolescents is growing. Studies demonstrate feasibility and acceptability within an ongoing randomized controlled trial (Adrian et al., 2021), psychometric support for the CAMS Suicide Status Form (SSF; Brausch et al., 2020), and associations between SSF items and key clinical correlates in adolescent samples (Romanowicz et al., 2013).

In addition, ASC clinicians administered CAMS to 86 youth referred for acute suicide risk between 2017 and 2021 across three rural Appalachian ASC Centers (Holt, 2023). Findings indicated that CAMS was a feasible and acceptable approach to comprehensive suicide risk assessment in school settings (Holt, 2023) with descriptive and correlational results consistent with prior work (Brausch et al., 2020).

Dr. Brausch's experience with K–12 schools has largely come through research on suicide risk among middle and high school students. As a first-year graduate student, she coordinated a project involving regular visits to an urban Illinois high school to collect self-report data on suicide risk and protective factors. Despite a 45-min commute each way, the partnership functioned seamlessly: space was consistently available, the school psychologist facilitated logistics, students were called to participate, and risk cases were reviewed prior to departure.

Years later, upon starting her own lab, the contrast was striking. Many schools were unresponsive or hesitant to engage in research on student suicidality, and university IRBs expressed discomfort with directly assessing suicidal thoughts in adolescents. This experience underscores the extensive, often invisible groundwork necessary to build and sustain a trusted school partnership to support this work.

In her current role, Dr. Brausch has led three large school-based studies of adolescent suicide risk (Brausch & Woods, 2019; Brausch et al., 2022, 2026). Building these partnerships required years of behind-the-scenes effort to identify schools willing to engage in suicide risk assessment, refer at-risk students, and provide ongoing access to time and space.

Variability across schools in comfort with and willingness to address suicide has been substantial. Experiences have ranged from school mental health staff expressing confusion when receiving referrals—despite prior training—to settings where any indication of suicide risk triggered immediate student removal until parents obtained "clearance" from an external provider, even in resource-limited rural areas. In contrast, some rural schools, often shaped by personal experience with suicide loss, have highly engaged principals and counselors who are comfortable with risk assessment.

Drs. Brausch and Michael's experiences working with schools were key motivators for developing this special issue on suicide prevention. During the pandemic, they also began collaborating to create CAMS-4Teens, a clinician training program designed to address the scarcity of suicide-focused assessments and interventions for youth. In parallel, the latest iteration of CAMS includes a Stabilization Support Plan (SSP), which facilitates collaborative discussions with families and caregivers to reduce access to lethal means and mitigate suicide risk (Jobes, 2023).

Drs. Michael and Brausch are encouraged by the innovative work in this issue highlighting primary and secondary suicide prevention efforts in K–12 schools. Although many U.S. programs focus on screening, universal prevention, gatekeeper training, and peer support, continued research is needed to strengthen their evidence base. We also urge greater emphasis on partnerships with schools and community agencies to implement and study tertiary interventions, particularly those targeting access to lethal means, such as Counseling on Access to Lethal Means (CALM listing on the Suicide Prevention Resource Center's Best Practice Registry:https://bpr.sprc.org/program/counseling-on-access-to-lethal-means-calm/ ; Lemle, 2024).

Empirical research on tertiary supports in K–12 settings remains limited—including within this issue. Despite implementation challenges, we are optimistic the field will continue advancing effective, accessible interventions within K-12 schools. We hope this special issue serves as a springboard for disseminating and accelerating this critical work.

Funding Open access funding provided by the Carolinas Consortium.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

References

Adrian, M., Blossom, J. B., Chu, P. V., Jobes, D., & McCauley, E. (2021). Collaborative assessment and management of suicidality for teens: A promising frontline intervention for addressing adolescent suicidality. *Practice Innovations., 7*(2), 154–167. https://doi.org/10.1037/pri0000156

Albright, A., Michael, K. D., Massey, C., Sale, R., Kirk, A., & Egan, T. (2013). An evaluation of an interdisciplinary rural school mental health program in Appalachia. *Advances in School Mental Health Promotions, 6*(3), 180–202. https://doi.org/10.1080/1754730X.2013.808890

Aseltine, R. H., James, A., Schilling, E. A., & Glanovsky, J. (2007). Evaluating the SOS suicide prevention program: A replication and extension. *BMC Public Health, 7*, 161.

Brausch, A. M., Clapham, R. B., & Littlefield, A. K. (2022). Identifying specific emotion regulation deficits that associate with nonsuicidal self-injury and suicide ideation in adolescents. *Journal of Youth & Adolescence, 51*, 556–569. https://doi.org/10.1007/s10964-021-01525-w

Brausch, A. M., Kalgren, T., Littlefield, A. K., Howd, C. T., & Wildman, M. (2026). Cognitive and socioenvironmental factors associated with suicide ideation in adolescents. *Journal of Youth & Adolescence, 55*, 832–846. https://doi.org/10.1007/s10964-025-02307-4

Brausch, A. M., O'Connor, S. S., & Jobes, D. A. (2019, September). Differences in severity of suicide risk factors and reasons for living using the suicide index score in adolescent inpatients. In: *Paper presented at the 30th World Congress of the International Association for Suicide Prevention*, Derry-Londonderry, Northern Ireland, UK.

Brausch, A. M., O'Connor, S. S., Powers, J. T., McClay, M. M., Gregory, J. A., & Jobes, D. A. (2020). Validating the suicide status form for the collaborative assessment and management of suicidality in a psychiatric adolescent sample. *Suicide and Life-Threatening Behavior, 50*(1), 263–276. https://doi.org/10.1111/sltb.12587

Brausch, A. M., & Woods, S. E. (2019). Emotion regulation deficits and nonsuicidal self-injury prospectively predict suicide ideation in adolescents. *Suicide and Life-Threatening Behavior, 49*, 868–880.

Capps, R. E., Michael, K. D., & Jameson, J. P. (2019). Lethal means and adolescent suicidal risk: An expansion of the peace protocol. *Journal of Rural Mental Health, 43*(1), 3–16. https://doi.org/10.1037/rmh0000108

Centers for Disease Control and Prevention (2024). *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023*. U.S. Department of Health and Human Services.

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine, 44*(16), 3361–3363. https://doi.org/10.1017/S0033291714001299

Fontanella, C. A., Hiance-Steelsmith, D., L., Phillips, G. S., Bridge, J. A., Lester, N., Sweeney, H. A., & Campo, J. V. (2015). Widening rural-urban disparities in youth suicides, United States, 1996-2010. *JAMA Pediatrics, 169*(5), 466–471. https://doi.org/10.1001/jamapediatrics.2014.3561

Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. *Journal of the American Medical Association, 293*, 1635–1643.

Holt, K. A. (2023). Examining The Validity Of A Composite Measure Of Core Items On The CAMS Suicide Status Form (SSF) With A History Of Suicide Attempts Among A Sample Of Rural Adolescents. Appalachian State University. Thesis. https://doi.org/10.71889/5fylantbak.29868080.v1

Ivey-Stephenson, A. Z., Demissie, Z., Crosby, A. E., Stone, D. M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students – Youth Risk Behavior Survey, United States, 2019. *Morbidity and Mortality Weekly Report, 69*(1), 47–55. https://doi.org/10.15585/mmwr.su6901a6

Jobes, D. A. (2016). *Managing suicidal risk A collaborative approach* (2nd ed.). New York: Guildford Press.

Jobes, D. A. (2023). *Managing suicide risk A collaborative approach* (3rd ed.). New York: Guilford.

Jobes, D. A., Vergara, G. A., Lanzillo, E. C., & Ridge-Anderson, A. (2019). The potential use of CAMS for suicidal youth: Building on epidemiology and clinical interventions. *Children's Health Care, 48*(4), 444–468. https://doi.org/10.1080/02739615.2019.1630279

Kirk, A., Michael, K., Bergman, S., Schorr, M., & Jameson, J. P. (2019). Dose response effects of cognitive-behavioral therapy in a school mental health program. *Cognitive Behaviour Therapy, 48*(6), 497–516. https://doi.org/10.1080/16506073.2018.1550527

Lemle, R. B. (2024). Bridging the sociopolitical divide: Transforming efforts to prevent firearm suicide. *The American Psychologist, 79*(9), 1361–1375. https://doi.org/10.1037/amp0001426

Michael, K. D. (2020). Youth mental health in North Carolina. *North Carolina Medical Journal, 81*(2), 101–105. https://doi.org/10.18043/ncm.81.2.101

Michael, K. D., Albright, A., Jameson, J. P., Sale, R., Kirk, A., Massey, C., & Egan, T. (2013). Does cognitive behavioural therapy in the context of a rural school mental health programme have an impact on academic outcomes? *Advances in School Mental Health Promotion, 6*, 247–262. https://doi.org/10.1080/1754730X.2013.832006

Michael, K. D., George, M. W., Splett, J. W., Jameson, J. P., Sale, R., Bode, A. A., Iachini, A. L., Taylor, L. K., & Weist, M. D. (2016). Preliminary outcomes of multi-site, school-based modular intervention for adolescents experiencing mood difficulties. *Journal of Child and Family Studies, 25*(6), 1903–1915. https://doi.org/10.1007/s10826-016-0373-1

Michael, K. D., Jameson, J. P., Scale, R., Orlando, C., Schorr, M., Brazille, M., Stevens, A., & Massey, C. (2015). A revisions and extension Michael of the prevention of escalating adolescent crisis events (PEACE) protocol. *Children and Youth Services Review, 59*, 57–62. https://doi.org/10.1016/j.childyouth.2015.10.014

Michael, K. D., & Ramtekkar, U. (2022). Overcoming barriers to effective suicide prevention in rural communities. In L. Horowitz & J. Ackerman (Eds.), *Youth suicide prevention and intervention: Current best practices and policy implications* (pp. 153–159). Springer.

Michael, K. D., Renkert, L. E., Wandler, J., & Stamey, T. (2009). Cultivating a new harvest: Rationale and preliminary results from a growing interdisciplinary rural school mental health program. *Advances in School Mental Health Promotion, 2*, 40–50.

Michael, K. D., Yaros, A., Counts, J., & Hersh, J. (2023). Preparing school mental health providers for practice in rural communities. In S. Evans, J. S. Owens, C. P. Bradshaw, & M. D. Weist (Eds.), *Handbook of School Mental Health - Innovations in Science and Practice.* Springer.

Romanowicz, M., O'Connor, S. S., Schak, K. M., Sqintak, C. C., & Lineberry, T. W. (2013). Use of the suicide status form-II to investigate correlates of suicide risk factors in psychiatrically hospitalized children and adolescents. *Journal of Affective Disorders, 151*(2), 467–473. https://doi.org/10.1016/j.jad.2013.06.026

Sale, R., Michael, K. D., Egan, T., Stevens, A., & Massey, C. (2014). Low base rate, high impact: Responding to teen suicidal threat in rural Appalachia. *Report on Emotional & Behavioral Disorders in Youth, 14*(1), 4–8.

Spark, T. L., Wright-Kelly, E., Ma, M., James, K. A., Reid, C. E., & Brooks-Russell, A. (2021). Assessment of rural-urban and geospatial differences in perceived handgun access and reported suicidality among youth in Colorado. *JAMA Network Open*. https://doi.org/10.1001/jamanetworkopen.2021.27816

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.