



# Model School District Policy For Suicide Prevention

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**SECTION 1:**  
**Introducing the**  
**Model School**  
**District Policy on**  
**Suicide**  
**Prevention**

## Acknowledgments

*This document draws on the best practices in crisis prevention and the knowledge and experience of experts in the field. Primary sources for this document include [Preventing Suicide: A Toolkit for High Schools by the Substance Abuse and Mental Health Services Administration](#) and [After a Suicide: A Toolkit for Schools by the American Foundation for Suicide Prevention](#) and the Suicide Prevention Resource Center ([www.sprc.org](http://www.sprc.org)).*

*The model school district policy on suicide prevention can be found on The Trevor Project website, <http://www.thetrevorproject.org/pages/modelschoolpolicy>. This model policy was developed with support from the following organizations.*

**The American Foundation for Suicide Prevention (AFSP)** is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. To fully achieve its mission, AFSP engages in the following Five Core Strategies: 1) fund scientific research, 2) offer educational programs for professionals, 3) educate the public about mood disorders and suicide prevention, 4) promote policies and legislation that impact suicide and prevention, and 5) provide programs and resources for survivors of suicide loss and people at risk, and involve them in the work of the Foundation. Learn more at [www.afsp.org](http://www.afsp.org).

**The American School Counselor Association (ASCA)** promotes student success by expanding the image and influence of professional school counseling through leadership, advocacy, collaboration and systemic change. ASCA helps school counselors guide their students toward academic achievement, personal and social development, and career planning to help today's students become tomorrow's productive, contributing members of society. Founded in 1952, ASCA currently has a network of 50 state associations and a membership of more than 33,000 school counseling professionals. Learn more at [www.schoolcounselor.org](http://www.schoolcounselor.org).

**The National Association of School Psychologists (NASP)** represents more than 25,000 school psychologists who work with students, educators, and families to support the academic achievement, positive behavior, and mental wellness of all students. NASP promotes best practices and policies that allow school psychologists to work with parents and educators to help shape individual and system wide supports that provide the necessary prevention and intervention services to ensure that students have access to the mental health, social-emotional, behavioral, and academic supports they need to be successful at home, at school, and throughout life. Learn more at [www.nasponline.org](http://www.nasponline.org).

**The Trevor Project** is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24. Every day, The Trevor Project saves young lives through its accredited, free and confidential phone, text and instant message crisis intervention services. A leader and innovator in suicide prevention, The Trevor Project offers the largest safe social networking community for LGBTQ youth, best practice suicide prevention educational trainings, resources for youth and adults, and advocacy initiatives. Learn more at [www.thetrevorproject.org](http://www.thetrevorproject.org).

## Foreword

This document outlines model policies and best practices for school districts to follow to protect the health and safety of all students. As suicide is the third leading cause of death among young people ages 10-19, it is critically important that school districts have policies and procedures in place to prevent, assess the risk of, intervene in, and respond to youth suicidal behavior. This document was developed by examining strong local policies, ensuring that they are in line with the latest research in the field of suicide prevention, and identifying best practices for a national framework. The language and concepts covered by this policy are most applicable to middle and high schools (largely because suicide is very rare in elementary school age children). Protecting the health and well-being of students is in line with school mandates and is an ethical imperative for all professionals working with youth. Because it is impossible to predict when a crisis will occur, preparedness is necessary for every school district. In a typical high school, it is estimated that three students will attempt suicide each year. On average, a young person dies by suicide every two hours in the US. For every young person who dies by suicide, an estimated 100-200 youth make suicide attempts. Youth suicide is preventable, and educators and schools are key to prevention.

Louisiana made a serious commitment to suicide prevention by becoming the second state to adopt the Jason Flatt Act. In 2008, the Louisiana Legislature passed House Bill 719, Act 219 also known as the “Jason Flatt Act of Louisiana”. The Jason Flatt Act of Louisiana requires local school systems to provide annual suicide prevention education training to all certificated school system personnel and to adopt a policy on student suicide prevention. As a result of the mandatory trainings, school system employees who interact with students on a regular basis are better able to identify and refer those who are at risk for suicide. Likewise by requiring districts to adopt and implement suicide prevention policies, procedures are more likely to be comprehensive, standardized and founded on research and best practices in suicide prevention, intervention, and postvention.

## Rationale

According to the Center for Disease Control, suicide is the third leading cause of death among young people between the ages of 10 and 24. In Louisiana, suicide is the third leading cause of death for ages 15-34, the fourth leading cause of death for ages 10-14 and those ages 34-54. On average, one person dies by suicide approximately every 13 hours in the state. This alarming statistic reaches across all ethnic, economic, social and age boundaries. Suicide has a tremendous and traumatic impact on surviving family members, friends, and the community at large. Suicide generally does not materialize in isolation and is often associated with undiagnosed mental illness, such as depression. Other risk factors may include, but are not limited to, alcohol or substance abuse, victimization by peers, feelings of hopelessness, history of trauma or abuse, or the loss of a relationship.

The [Louisiana Caring Communities Youth Survey \(CCYS\)](#) provides important prevention information about school-aged youth. The survey is administered every two years in more than 500 schools to students in grades 6, 8, 10, and 12. The purpose of the survey is to assess students' involvement in problem behaviors as well as their exposure to risk and protective factors. Beginning in 2012, the CCYS added several questions about suicide. The 2014 data reveals the percentage of students in grades 8, 10 and 12 who admitted to ever having considered suicide clustered around 25%. The percentage of students in grades 8, 10, and 12 who admitted to ever having attempted suicide ranged from 8% - 10%. This indicator represents a slight increase across grade levels compared to the 2012 report.

Research has documented depression and other mental health conditions can be risk factors for suicide. The CCYS estimates the mental health needs of students by screening for psychological distress. The 2014 report reveals approximately 1/5 or 20% of students in grades 6, 8, 10, and 12 had scores that indicated the need for mental health treatment services. The data for 2014 represent an increase across all grade levels compared to 2012, the initial year for this measure. The CCYS also surveyed students for depressive symptoms. The statewide data for 2014 reveals approximately 2/3 or 66% of students in grades 6, 8, 10, and 12 have scores consistent with moderate depressive symptoms.

## **Purpose**

The Model School District Policy was developed as a tool to develop and implement comprehensive policies on suicide prevention. The model provides school districts with best practices, recommended language, commentary, and resources. The model policy offers guidance to school districts about how to address legislative mandates for suicide prevention programs. The purpose of the Model Policy is to protect the health and well-being of all district students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide.

Districts can use the Model Policy as a guide to draft new policies or amend existing ones based on the unique needs of the youth populations they serve. It is important that each district develops and implements programs consistent with the following principles:

- a) physical, behavioral, and emotional health are integral components of a student's educational outcomes,
- b) suicide is the leading cause of death among young people,
- c) schools have an ethical responsibility to take a proactive approach in preventing deaths by suicide, and
- d) schools have a role in providing safe and supportive environments that foster positive development by being sensitive to individual and societal factors that place youth at greater risk for suicide.

As emphasized in the National Strategy on Suicide Prevention, preventing suicide depends not only on suicide prevention policies, but also on a holistic approach that promotes healthy lifestyles, families, and communities. Thus the district suicide prevention policy should serve as an extension of state and local programs and policies that support the emotional and behavioral well-being of youth.

**SECTION 2:**  
**Essential  
Information  
about Youth  
Suicide  
Prevention**



## **Terms and Definitions Associated with Suicide Prevention Programs and Policies**

### **Assessment:**

A comprehensive evaluation usually performed by a clinician, to confirm suspected suicide risk in a patient, estimate the immediate danger, and decide on a course of treatment.

### **At Risk or High Risk:**

A student who is defined as high risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral to a mental health professional and parental/guardian contact as documented in the following procedures.

### **Behavioral Health:**

As defined by SAMHSA, behavioral health refers to the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, mental illnesses, and/or mental disorders.

### **Cluster:**

A group of suicides or suicide attempts, or both, that occurs closer together in time and space than would normally be expected in a given community.

### **Crisis Response Team:**

A multidisciplinary team of primarily administrative, mental health, safety professionals, and support staff who are prepared, trained, and ready to address crisis preparedness, intervention, response and recovery.

### **Evidence-based practices:**

Suicide prevention activities that have been found effective by rigorous scientific evaluation.

### **Gatekeeper training:**

Programs that teach individuals who routinely have personal contact with many others in the community (i.e. “gatekeepers”) to recognize and respond to people at potential risk of suicide. Thus faculty and staff are considered the gatekeepers in school settings.

### **High Risk:**

See definition of At Risk above

### **Local Education Agency (LEA):**

A local school system pursuant to local board of education control and management.

## **Terms and Definitions Continued**

### **Mental health:**

A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

### **Postvention:**

Activities following a suicide to help alleviate the suffering and emotional distress of the survivors, and prevent additional trauma and contagion.

### **Prevention:**

Activities implemented prior to the onset of an adverse health outcome (e.g., dying by suicide) and designed to reduce the potential that the adverse health outcome will take place.

### **Protective factors:**

An attribute, characteristic, or environmental exposure that decreases the likelihood of a person's developing a disease or injury (e.g., attempting or dying by suicide) given a specific level of risk. For example, depression elevates a person's risk of suicide, but a depressed person with good social connections and coping skills is less likely to attempt or die by suicide than a person with the same level of depression who lacks social connections and coping skills. Social connections and coping skills are protective factors, buffering the suicide risk associated with depression and thus helping to protect against suicide.

### **Risk assessment:**

An evaluation of a student who may be at risk for suicide, conducted by the appropriate school staff (e.g., school psychologist, school counselor, or school social worker). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

### **Risk factors:**

Personal or environmental characteristics that increase the likelihood that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. Risk factors should not be confused with warning signs.

### **Screening:**

A procedure in which a standardized tool, instrument, or protocol is used to identify individuals who may be at risk for suicide. Also see *Assessment*.

## **Terms and Definitions Continued**

### **Self-harm:**

The act of deliberately and intentionally injuring one's own body, such as cutting or burning. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

### **Suicide:**

Death caused by self-directed injurious behavior with intent to die as a result of the behavior.

Note: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death.

### **Suicide attempt:**

A non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

### **Suicidal behavior:**

A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide. Also includes preparatory behavior such as buying a gun, hoarding pills, writing a suicide note, etc.

### **Suicide contagion:**

Suicide risk associated with the knowledge of another person's suicidal behavior, either first-hand or through the media. Suicides that may be at least partially caused by contagion are sometimes called "copycat suicides." Contagion can contribute to a suicide cluster. Community and media education is vitally important to reduce this risk.

### **Suicidal ideation:**

Any self-reported thoughts or fantasies about engaging in suicide-related behavior.

### **Warning Signs:**

Behaviors and symptoms that may indicate that a person is at immediate or serious risk for suicide or a suicide attempt.

## Suicide Risk and Protective Factors

**Risk Factors** are personal or environmental characteristics or conditions that are associated with increased likelihood of suicide. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors can be used to identify youth who may be vulnerable to suicide. The most frequently cited risk factors for suicide are:

- Mood disorders including depression (feeling down in a way that impacts daily life) and bipolar disorder (severe mood swings)
- Problems with alcohol or drugs
- Unusual thoughts and behavior or confusion about reality
- Personality traits that lead to intense, unstable relationships
- Impulsivity, aggression, or anti-social behavior
- Severe school discipline (suspension/expulsion) or legal problems (arrest/incarceration)
- Previous suicide attempt or history of suicide behavior among family or friends
- Serious medical conditions and/or chronic pain
- Capacity to engage in self-injurious behavior
- Trauma, abuse or neglect, domestic violence
- Significant loss, traumatic grief, recent exposure to suicide

It is important to bear in mind that the large majority of people with mental disorders or other suicide risk factors do not engage in suicidal behavior.

**Protective Factors** are characteristics or conditions that reduce the probability of suicide. The capacity to cope positively with the effects of risk factors is referred to as resilience. Programs and policies implemented by schools to enhance protective factors are an essential element of suicide prevention. Strengthening these factors also protects students from other problem behaviors including violence, substance abuse, delinquency, and school drop-out. This list summarizes the protective factors identified by research.

- Individual characteristics and behaviors including self-esteem, temperament, belief in the moral order, interpersonal skills, healthy coping, and problem solving
- Bonding with family fostered by positive parental involvement, healthy discipline practices, support for prosocial norms, and cultural/religious/spiritual values
- Interacting with prosocial peers
- Safe and supportive schools that provide students with opportunities and rewards for prosocial involvement
- Having positive connections in the community
- Access to effective medical and behavioral health care

Note that the presence of protective factors does not eliminate the risk of suicide, especially when there is a personal or family history of depression or other mental disorders.

## **Youth Groups Associated with Elevated Risk for Suicide**

### **1. Youth living with mental and/or substance use disorders**

While the large majority of people with mental disorders do not engage in suicidal behavior, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bi-polar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are important risk factors for suicidal behavior among young people. The majority of people suffering from these mental disorders are not engaged in treatment; therefore school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk.

### **2. Youth who engage in self-injury or have attempted suicide**

Suicide risk among those who engage in self-injurious behavior (cutting, burning, scratching the skin, picking at wounds, deliberate bruising) is significantly higher than the general population. NSSI or non-suicidal self-injury is a complex coping behavior that occurs in response to acute emotional distress. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow up care.

### **3. Youth placed in out-of-home settings**

Youth involved in the juvenile justice or child welfare systems have a high prevalence of many risk factors for suicide. Young people involved in the juvenile justice system die by suicide at a rate about four times greater than the rate among youth in the general population. Though comprehensive suicide data on youth in foster care does not exist, one researcher found that youth in foster care were more than twice as likely to have considered suicide and almost four times more likely to have attempted suicide than their peers not in foster care.

### **4. Youth experiencing homelessness**

For youth experiencing homelessness, rates of suicide attempts are higher than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorders, and post-traumatic stress disorder. One study found that more than half of runaway and homeless youth have had some kind of suicidal ideation.

### **5. American Indian/Alaska Native (AI/AN) youth.**

In 2009, the rate of suicide among AI/AN youth ages 15-19 was more than twice that of the general youth population. Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma.

## **More Youth Groups Associated with Elevated Risk of Suicide**

### **6. Youth who identify as LGBTQ (lesbian, gay, bisexual, transgender, or questioning)**

The CDC finds that LGB youth are four times more likely, and Questioning youth are three times more likely, to attempt suicide as their straight peers. The American Association of Suicidology reports that nearly half of young transgender people have seriously considered taking their lives and one quarter report having made a suicide attempt. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ which elevate the risk of suicidal behavior for LGBTQ youth.

### **7. Youth bereaved by suicide**

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.

### **8. Youth living with medical conditions and disabilities**

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive styles that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

### **9. Youth with learning disabilities**

Students diagnosed with learning disabilities experience academic difficulties and sometimes failure. Some youth with learning problems experience peer rejection, social exclusion, and bullying. Studies indicate there is an increased risk of depression among students with learning disabilities compared to their peers. Preliminary research points to a higher risk of suicide.

### **10. Impact of Gender, Race, and Age**

Although females attempt suicide more frequently than males, almost four times as many males die by suicide. Compared to other groups, white males have the highest rates of suicide. Recent statistics show an increase in suicide among young African American males, ages 15-24.

The risk of suicide increases with age. Elementary-age students rarely die by suicide but do experience thoughts of suicide and engage in suicide behaviors. Middle school youth report higher rates of suicidal ideation, planning, and attempts. Death rates are highest among older adolescents and young adults.

## Warning Signs for Suicide

Warning signs are indications that someone may be in danger of suicide, either immediately or in the near future.

*Warning Signs for Suicide Prevention* is a consensus statement developed by an expert working group brought together by the American Association of Suicidology. The group organized warning signs by degree of risk, and emphasized the importance of including clear and specific direction about what to do if someone exhibits warning signs. [Click Here](#) for list of warning signs.

This consensus statement describes the general warning signs of suicide. Warning signs differ by age group, culture, and even individual.

The recent advent of social media has provided another outlet in which warning signs may be exhibited. The differences in how and where warning signs may be exhibited demonstrate the importance of adapting gatekeeper training for the age group and cultural communities with whom the gatekeepers will be interacting.

### **Warning Signs for Suicide and Corresponding Actions**

Seek immediate help from a mental health provider, 9-1-1 or your local emergency provider, or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) when you hear or see any one of these behaviors:

- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves – seeking pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person

Seek help by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral if you witness, hear, or see anyone exhibiting one or more of these behaviors:

- Hopelessness – expresses no reason for living, no sense of purpose in life
- Rage, anger, seeking revenge
- Recklessness or risky behavior, seemingly without thinking
- Expressions of feeling trapped – like there is no way out
- Increased alcohol or drug use
- Withdrawal from friends, family, or society
- Anxiety, agitation, inability to sleep, or constant sleep
- Dramatic mood changes

**If you or someone you know is in a suicidal crisis, call 1-800-273-TALK (8255) for the National Suicide Prevention Lifeline.**

## **Bullying and Suicide**

The relationship between bullying and suicide is highly complex, as is the relationship between suicide and other negative life events. Research indicates that persistent bullying can lead to or worsen feelings of isolation, rejection, exclusion, and despair, as well as to depression and anxiety, which can contribute to suicidal behavior in those at risk. Research also suggests that young people who are already at heightened risk for suicide are also at increased risk for involvement in bullying.

It is important to remember that most students who are involved in bullying do not become suicidal. While studies have shown that young people who are bullied and those who bully others are at heightened risk for suicidal behavior, youth who exhibit both pre-existing risk for suicide (namely the existence of depression, anxiety, substance use or other mental disorders) and who are concurrently involved in bullying or experiencing negative life events are at the highest risk. Individuals who are bullied in the absence of other risk factors have far fewer negative outcomes than those with pre-existing risk for suicide. Youth who bully are also at risk and their behavior may reflect underlying mental health problems.

It is imperative to convey safe and accurate messages about bullying and suicide to youth, especially to those young people who may be at risk for engaging in suicide behavior. Suggesting that suicide is a natural response to bullying, or providing repeated opportunities for at-risk students to see their own experiences of bullying, isolation, or exclusion reflected in stories of those who have died by suicide, can increase contagion risk by contributing to thoughts that frame suicide as a viable solution. Idealizing young people, who complete suicide after being bullied, or creating an aura of celebrity around them, may contribute to an at-risk youth's drawing the illogical conclusion that suicide is the only way to have a voice or to make a difference to others.

Whenever possible, discussions on bullying and suicide should focus on prevention and encourage help-seeking behavior.

Reference: "The Relationship Between Bullying and Suicide: What We Know and What It Means for Schools", Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. <http://www.cdc.gov/violenceprevention/youthviolence/bullyingresearch/index.html>





**SECTION 3:**  
**Overview of**  
**Model District**  
**Policy**

**\*\*\*\*\***

**Prevention**  
**Module**

## Overview of the Model Policy

The model policy is organized into three modules: Prevention, Intervention, and Postvention.

The **Prevention** module specifies the completion of these five projects:

1. Designation of suicide prevention coordinators at the district and school level to assist with planning and implementation of the policy and to serve as points of contact
2. Annual mandatory professional development for all school staff on suicide awareness, risk factors and warning signs, and procedures for referring students who may be in crisis
3. Additional training for school employed mental health professionals who will be charged with assessing, supporting, and referring students for mental health services
4. Developmentally appropriate prevention content for students integrated within the health curriculum
5. Annual publication and distribution of the policy in all student and teacher handbooks and on the district website

The **Intervention** module requires the development and implementation of the following policies:

1. Procedures for assessment and referral of at-risk youth
2. Procedures on parental notification and involvement
3. Protocols for responding to suicide attempts that occur in school and out of school
4. Re-entry procedures for students returning after a mental health crisis

The **Postvention** module stipulates developing procedures to carry out these essential functions:

1. Providing protocols for the crisis team to follow after a suicide death
2. Handling interactions with the family with dignity and respect
3. Preserving the safety of students and avoiding suicide contagion
4. Facilitating responsible, appropriate communications with the media and the community

## Scope

This model policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school sponsored out-of-school events where school staff are present. This policy applies to the entire school community, including educators, school and district staff, students, parents/guardians, and volunteers. This policy will also cover appropriate school responses to suicidal or high risk behaviors that take place outside of the school environment.

## Suicide Prevention Requirements under Louisiana Law

Local education agencies (LEA) shall adopt a policy on student suicide prevention. Such policies shall be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts and shall, at a minimum, address procedures relating to suicide prevention, intervention, and postvention. *The model school district policy for suicide prevention clarifies the duties of districts and schools and provides guidance on how best to meet legislative requirements.*

**R.S. 17.416.15** requires each school to have a crisis management and response plan, approved by the local public school board, and reviewed annually. *The model policy directs School Crisis Response Plans to include provisions for dealing safely and effectively with students at risk for suicide, suicide attempts at school or away from school, and suicide deaths that impact the school community.*

**R.S. 14.416.13 and R.S. 17.416.15** require local school boards to adopt policies relative to harassment, intimidation, and bullying by students, and allows local boards to implement zero-tolerance policies. *This statute is relevant to suicide prevention since research indicates that being involved in bullying in any way is one of several important risk factors that appears to increase the likelihood of suicide among youth.*

**R.S. 17.282.3** requires the State Department of Education in cooperation with state and local agencies to develop a state youth suicide prevention plan, to be implemented by the local school district. *The model policy is a comprehensive, evidence-based framework that can be used by state officials, school boards, districts, and schools to develop effective suicide prevention programs, policies, and procedures.*

**R.S. 17.437.71** requires that all public school teachers, counselors, principals and other school administrators participate annually in at least two hours of in-service training in suicide prevention. *The model policy requires professional development so that educators and other school staff have the training necessary to be able to identify, support, and refer students who are vulnerable to suicide.*

**Act 27** of the 1994 Legislature requires that every student in grades K-9 receive a minimum of sixteen contact hours and every student in grades 10-12 receive a minimum of eight contact hours, every school year in substance abuse/prevention education, incorporated into a comprehensive school health program. *As applied to suicide prevention, research indicates that youth who are able to cope and solve problems in healthy ways are less likely to engage in suicide-related behavior. School prevention programming that strengthens protective factors and fosters the development of resilience reduces the risk of suicide.*

## Understanding Confidentiality As It Relates To FERPA

### Confidentiality

The fundamental intent of confidentiality is to protect a person's right to privacy by ensuring that matters disclosed not be relayed to others without the informed consent of the client. Confidentiality is an ethical responsibility of mental health providers to safeguard unauthorized disclosures of personal information that is learned during the course of treatment.

### FERPA

**FERPA** (*Family Educational Rights Privacy Act*) is a Federal law that protects the privacy of student education records.

According to the U.S. Department of Education, **FERPA** gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, **FERPA** allows schools to disclose those records, without consent, to the appropriate officials in cases of health and safety emergencies.

In some situations, school administrators may determine that it is necessary to disclose personally identifiable information from a student's education records to appropriate parties in order to address a health or safety emergency. **FERPA's** health or safety emergency provision permits such disclosures when the disclosure is necessary to protect the health or safety of the student or other individuals.

This exception to **FERPA's** general consent requirement is limited to the period of the emergency and generally does not allow for a blanket release of personally identifiable information from a student's education records. Rather, these disclosures must be related to an actual, impending, or imminent emergency.

## **Prevention Module**

### **Suicide Prevention Coordinators**

A district level suicide prevention coordinator will be designated by the Superintendent. This may be an existing staff person such as the director of counseling services. The district suicide prevention coordinator will be responsible for planning and coordinating implementation of this policy for the school district.

Each school principal will designate a school suicide prevention coordinator to act as a point of contact in each school for issues relating to suicide prevention and policy implementation. This may be an existing staff person. Suicide prevention efforts are generally led by school counselors or other school employed mental health professionals. The success of any suicide prevention programs relies on the participation, support, and active involvement of the entire school community. All staff members are obliged to report students they believe to be at risk for suicide to the school suicide prevention coordinator.

### **Best Practice: Suicide Prevention Task Force**

Although it is not required by the Model Policy, it is recommended that school districts establish a suicide prevention task force in conjunction with adopting a suicide prevention policy. Such a task force should consist of administrators, parents, teachers, school employed mental health professionals, representatives from community suicide prevention services, and other individuals with expertise in youth mental health, and be administered by the district suicide prevention coordinator. The purpose of the task force is to provide advice to the district administration and school board regarding suicide prevention activities and policy implementation. In addition, the task force can help to compile a list of community resources to assist with suicide prevention activities and referrals to community mental health providers. School districts may choose to limit the activities of the task force to one or two years, as needed, or to keep the task force operational to maintain current standards, to keep up with new research and developments, and to educate and train new staff. If the term of the task force is allowed to expire, the district suicide prevention coordinator will assume responsibility for maintaining standards.

### **Professional Development**

All certificated school system personnel shall receive annual training on youth suicide prevention. Although the law requires training for all certificated school system personnel only, schools are strongly encouraged to provide annual training for all staff members (certified and classified) about the importance of suicide prevention. It is important to keep records of all who have received such training.

Suicide prevention training shall include risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources about youth suicide prevention. The training will also include additional information regarding groups of students at elevated risk for suicide. The training will emphasize the importance of referring at-risk students immediately to the school suicide prevention coordinator or the designated mental health professional or principal.

## Prevention Module

### **Specialized Training for School Counselors and Other Mental Health Professionals**

Most experts agree that a process by which people at risk for suicide can be identified and referred to treatment is an essential component of a comprehensive suicide prevention program. Thus it is vitally important that the school suicide prevention coordinator and the counselors or other mental health professionals responsible for intervening with students in crisis be trained to conduct a suicide risk assessment. A high quality assessment is likely to lead to more effective intervention and better outcomes for the youth.

Suicide assessment usually refers to a comprehensive evaluation done by a qualified mental health professional to determine if suicidal ideation, intent, plan, and access to means are present, as well as risk and protective factors, in order to identify what steps are needed to promote the safety of the student. Although assessment can involve structured questionnaires, they also can include a more open-ended conversation with a student. An example of a scientifically validated screening and assessment tool is the [Columbia – Suicide Severity Rating Scale \(C-SSRS\)](#).

A complementary approach to assessment is the use of screening tools to promote the early identification of students at risk for depression and suicide. Suicide prevention experts use the term ‘suicide screening’ to refer to a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide. Suicide screening can be done independently or as part of a more comprehensive health or behavioral health screening and may be done orally (with the screener asking questions), with pencil and paper, or using a computer. [Signs of Suicide](#) (SOS) is an example of an evidence based program on the best practices registry which provides a screening and educational package for use with students.

### **Other Trainings for Parents and Students**

*SAMHSA's Preventing Suicide: A Toolkit for High Schools* recommends using a multifaceted approach to training in which the following components are implemented in a particular sequence. The order is necessary so schools can establish protocols and procedures first before there is a systematic effort to identify and intervene with students who may be at risk for suicide.

- PRIORITY - Protocols for helping students at possible risk of suicide (Intervention Module)
- PRIORITY - Protocols for responding to a suicide death (Postvention Module)
- Faculty and staff suicide prevention trainings
- Parent education about behavioral health promotion and suicide risk
- Student education and involvement in behavioral health promotion and suicide prevention
- Screening students for suicide risk to facilitate early identification, support, and referral

Like all school personnel, parents and students need to have suicide prevention information that includes prevalence, warning signs, risk and protective factors, groups at increased risk, emergency response, and how to access mental health treatment. Training parents and students encourages active and informed participation in a comprehensive suicide prevention program.

## **Prevention Module**

### **Youth Suicide Prevention Programming**

Developmentally-appropriate, student-centered education materials will be integrated into the curriculum of all K-12 health classes. The content of these age-appropriate materials will include: 1) the importance of safe and healthy choices and coping strategies; 2) how to recognize risk factors and warning signs of mental disorders and suicide in oneself and others; and 3) help-seeking strategies for oneself or others, including how to engage school resources and refer friends for help. In addition, schools may provide supplemental small-group suicide prevention programming for students.

Schools can consult SAMHSA's National Registry of Evidence-Based Prevention Practices (NREPP) or the Suicide Prevention Resource Center's Best Practices Registry (BPR) for information about student programs.

### **Publication and Distribution**

This policy will be distributed annually and included in all student and teacher handbooks and on the school district website.

#### *Sample Language for Student Handbook*

Protecting the health and well-being of all students is of utmost importance to the school district. The school board has adopted a suicide prevention policy which will help to protect all students through the following steps:

- 1) Students will learn about recognizing and responding to warning signs of suicide in friends, using coping skills, using support systems, and seeking help for themselves and friends. This will occur in all health classes.
- 2) Each school will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources.
- 3) When a student is identified as being at risk, they will be assessed by a school employed mental health professional who will work with the student and help connect them to appropriate local resources.
- 4) Students will have access to national resources which they can contact for additional support, such as:
  - The National Suicide Prevention Lifeline –1.800.273.8255 (TALK), [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)
  - The Trevor Lifeline – 1.866.488.7386, [www.thetrevorproject.org](http://www.thetrevorproject.org)
- 5) All students will be expected to help create a school culture of respect and support in which students feel comfortable seeking help for themselves or friends. Students are encouraged to tell any staff member if they, or a friend, are feeling suicidal or are otherwise in need of help.
- 6) Students should also know that because of the life or death nature of these matters, confidentiality or privacy concerns are secondary to seeking help for students in crisis.
- 7) Please visit the district's website for the full suicide prevention policy.

## **Other Factors Associated with Suicide Prevention**

### **Impact of School Climate**

Schools should ensure that they maintain a positive and safe school climate. Fostering a feeling of connectedness between the students and the school, providing an opportunity for students to become involved in school activities, and ensuring an overall safe environment for all students are essential protective factors. Many activities designed to prevent violence, bullying, and the abuse of alcohol and other drugs may also reduce suicide risk among students.

Schools should set high expectations on all staff and students to behave respectfully and kindly to one another. In a positive school climate, all students are respected, supported, and feel comfortable approaching an adult when confronted with problems. Youth with disabilities, learning differences, sexual/gender identity differences or cultural differences are often the targets of bullying. Bullying among students must be taken very seriously since research has shown that bullying is one of several important risk factors associated with higher rates of suicidal ideation and behavior.

### **Importance of School Based Mental Health Supports**

Access to school-based mental health services and supports directly improves students' physical and psychological safety, academic performance, cognitive performance and learning, and social-emotional development. School employed mental health professionals (school counselors, school psychologists, school social workers, and in some cases, school nurses) ensure that services are high quality, effective, and appropriate to the school context. School employed mental health professionals are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health services are properly and effectively infused into the learning environment. These professionals can support both instructional leaders' and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning. Having these professionals as integrated members of the school staff empowers principals to more efficiently and effectively deploy resources, ensure coordination of services, evaluate their effectiveness, and adjust supports to meet the dynamic needs of their student populations. Improving access also allows for enhanced collaboration with community providers to meet the more intense or clinical behavioral health needs of students.

### **Parental Involvement**

Parents and guardians play a key role in youth suicide prevention, and it is important for the school district to involve them in suicide prevention efforts. Parents/guardians can contribute important protective factors that can reduce risk for suicide. Parents/guardians need to be informed and actively involved in decisions regarding their child's welfare. Parents/guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with professional help when necessary. Parents/guardians should be advised to take every statement regarding suicide and wish to die seriously and avoid assuming that a child is simply seeking attention.





## **SECTION 4:**

# **The Intervention Module**

## **Intervention Module**

The **Intervention** module of the model school district policy for suicide prevention requires the development and implementation of the following policies:

1. Protocols for assessment and referral of at-risk youth
2. Procedures on parental notification and involvement
3. Protocols for responding to suicide attempts that occur in school and out of school
4. Re-entry procedures for students returning after a mental health crisis

### **Implementation of the Model Policy**

As stated in the Prevention section, the success of the school's suicide prevention program depends on the active involvement of all personnel. Typically it is the school counselor or other school employed mental health professional that takes the lead in suicide prevention, assessment and referral. The counselor or designated mental health professional works in collaboration with the school suicide prevention coordinator and the principal. The faculty and staff are trained to recognize and report students believed to be at risk for suicide to the suicide prevention coordinator or designee.

Most school systems already have teams responsible for student health and behavioral health issues, such as a Student Assistance Team or a Crisis Response Team. If so, consider adding suicide prevention to the mission of the Team, secure training, and assign responsibility for selected action steps from the procedures and protocols as appropriate.

### **Assessment and Referral**

When a student is identified by a staff person as potentially suicidal, (i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, etc.) the student will be seen by a school employed mental health professional *within the same school day* to assess risk and facilitate referral. If there is no mental health professional available, a school nurse or administrator will fill this role until a mental health professional can be brought in.

### **Intervention Protocol for At-Risk Youth**

Both the Model School District Policy and the SAMHSA Preventing Suicide Toolkit outline the same basic action steps to respond to youth at risk for suicide. The term "at risk" indicates the youth has thoughts of suicide and/or exhibits warning signs or significant risk factors but is not actively engaged in suicide behavior, such as an attempt to kill oneself.

## Intervention Module

### **Protocol for Helping Youth at Risk for Suicide**

Refer to Tool 2.B in SAMHSA's *Preventing Suicide: A High School Toolkit*.

1. School staff will continuously supervise the student to preserve personal safety.
2. School counselor or school employed mental health professional or designee will conduct a suicide risk assessment on the same day the student is identified.
3. Principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.
4. The school counselor/mental health professional or principal will contact the student's parent or guardian to warn of the possible suicide risk and to request an emergency conference to be held at school within the same day. See exception below\*.
  - a. Advise the parent/guardian of the reason for referral and risk assessment
    - i. See Parent Notification and Involvement section that follows
  - b. Explain to parent/guardian the importance of keeping the youth under direct supervision and practicing means restriction. That is removing firearms, other weapons, potentially dangerous items like knives, and alcohol and other drugs, including prescription and over the counter medications from the home.
  - c. Assist the parent/guardian with urgent referral.
    - i. When appropriate this may include calling emergency services or a mobile crisis team or the family transporting the youth to the local hospital ER.
    - ii. In most cases referral will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider.
  - d. Request the parent/guardian give written permission to discuss the student's status with the external provider. If permission is granted get signature on release form.
  - e. \* There is an exception to parent/guardian notification. If the school counselor or school employed mental health professional or principal has reason to believe that such notification will further endanger the youth, the reason(s) should be documented and the appropriate authority should be contacted immediately, such as the Dept. of Children & Family Services, Office of Child Protection Services, or the local law enforcement agency.
5. Document all contacts with student, parent/guardian, and external care provider.
  - a. See Appendix for Sample Procedures and Forms

## Intervention Module

### **Parental Notification and Involvement**

In situations where a student is assessed at risk for suicide or has made a suicide attempt, the student's parent or guardian will be informed as soon as practicable by the principal, designee, or mental health professional. If the student has exhibited any kind of suicidal behavior, the parent or guardian should be counseled to take every suicide statement and behavior seriously. They should also be instructed how to carry out "means restriction," limiting the child's access to mechanisms for carrying out a suicide attempt. The mental health professional will also seek parental permission to communicate with outside mental health providers regarding their child.

Through discussion with the student, the principal or school employed mental health professional will assess whether there is further risk of harm due to parent or guardian notification. If the principal, designee, or mental health professional believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate. The reasons for the delay should be documented and the proper authority should be notified such as child protection services and/or law enforcement.

Parents/guardians are likely to experience a complex set of conflicting emotions when they are told their child may be suicidal. Parents/guardians usually need support, information, and assistance to come to terms with their child's risk as well as the need to get professional help. School staff need to be sensitive toward the family's culture, including attitudes towards suicide, mental health, privacy, and help-seeking.

Parents/guardians can create conditions within the family that strengthen protective factors and foster resilience thus reducing the risk for suicide. This is especially true for vulnerable youth populations such as LGBTQ youth. Research from the Family Acceptance Project found that gay and transgender youth who reported being rejected by their parents or guardians were more than eight times as likely to have attempted suicide. Conversely, feeling accepted by parents or guardians is a critical protective factor for LGBTQ youth and at-risk youth groups. Educators can help to protect LGBTQ youth by connecting parents/guardians with appropriate resources.

The counselor/mental health professional is advised to follow up with the parent/guardian to ascertain whether or not care has been established with an external medical or mental health provider. If the parent/guardian has not contacted a provider, stress the importance of getting professional help and explore their reasons for not proceeding with the referral. The school counselor can offer more assistance with the referral process. If the parent/guardian refuses to seek services for a child under the age of 18 and the *counselor/school mental health professional has reason to believe the youth is in danger of suicide or self-harm, then child protective services should be notified immediately.*

## Intervention Module

### **Referrals and LGBTQ Young People**

LGBTQ youth are at heightened risk for suicidal behavior, which may be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. It is therefore especially important that school staff be trained to support at-risk LGBTQ youth with sensitivity and cultural competency. School staff should not make assumptions about a student's sexual orientation or gender identity and affirm students who do decide to disclose this information. Information about a student's sexual orientation or gender identity should be treated as confidential and not disclosed to parents, guardians, or third parties without the student's permission. Additionally, when referring students to out-of-school resources, it is important to connect LGBTQ students with LGBTQ-affirming local health and mental health service providers. Affirming service providers are those which adhere to best practices guidelines regarding working with LGBTQ clients as specified by their professional association. See the link at <http://www.apa.org/pi/lgbtq/resources/guidelines.aspx>.

### **Recommendation: Safety Plans**

In the past mental health professionals have been taught to use “no suicide” or “no harm” contracts with people at risk of suicide. These contracts have been criticized because they ask the person in crisis to promise to stay alive without supplying information, supports, or resources the person can use to preserve personal safety. Barbara Stanley and Gregory K. Brown first proposed safety planning as a brief, effective intervention to reduce the risk of suicide <http://www.sciencedirect.com/science/article/pii/S1077722911000630>.

A safety plan is written jointly by the mental health professional and the youth who is experiencing suicidal ideation, has attempted suicide, or has been determined to be at risk of suicide due to a mental health disorder and/or environmental factors. A safety plan may be done at any point during assessment, intervention, treatment, or re-entry to school. The safety plan focuses on recognizing warning signs; identifying healthy coping strategies; connecting with family, peer, and adult supporters; accessing local and national suicide prevention resources; and reducing lethal means. The mental health professional is advised to collaborate with the youth's parent/guardian about the implementation of the safety plan, especially if there is an assigned role or responsibility to be fulfilled. By engaging the youth directly in the development of the safety plan, it is more likely that the youth will commit to working the plan and staying safe.

A sample safety plan is available from the Suicide Prevention Resource Center at this link: <http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf>.

## **Intervention Module**

### **Protocol for Responding to a Student Suicide Attempt**

Refer to Tool 2.C in SAMHSA's *Preventing Suicide: A High School Toolkit*. In the case of an in-school suicide attempt, the health and safety of the student is paramount. In these situations:

1. First aid will be rendered until professional medical treatment and/or emergency transportation is provided, following district emergency medical procedures.
2. First aid will be rendered until professional medical treatment and/or transportation can be received, following district emergency medical procedures.
3. School staff will supervise the student to ensure safety.
4. Staff will move all other students out of the immediate area as soon as possible.
5. If appropriate, staff will immediately request a mental health assessment for the youth.
6. The school employed mental health professional or principal will contact the student's parent or guardian, as described in the Parental Notification and Involvement section.
7. Staff will immediately notify the principal or school suicide prevention coordinator regarding the in-school suicide attempt.
8. The school will engage as necessary the crisis team to assess whether additional steps should be taken to ensure student safety and well-being.
9. Document all contacts with student, parent/guardian, first aid/emergency responders and external mental health providers. Keep records of all actions taken.

### **Protocol for Responding to Out-of-School SUICIDE ATTEMPTS**

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member will:

1. Call the police and/or emergency medical services, such as 9-1-1.
2. Inform the student's parent or guardian if reasonably possible.
3. Notify the principal and the school suicide prevention coordinator.

If the student contacts the staff member and expresses suicidal ideation, the staff member should maintain contact with the student (either in person, online, or on the phone). The staff member should then enlist the assistance of another person to contact the police while maintaining verbal engagement with the student.

## Intervention Module

### **Guidelines for Facilitating a Student's Return to School**

Refer to Tool 2.D in SAMHSA's *Preventing Suicide: A High School Toolkit*. For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), a school employed mental health professional, the principal, or designee will meet with the student's parent or guardian, and if appropriate, meet with the student to discuss re-entry and appropriate next steps to ensure the student's readiness for return to school.

1. A school employed mental health professional or designee will be identified to coordinate with the student, the parent/guardian, and external mental health care provider to develop an individualized re-entry plan.
2. The parent/guardian will provide documentation from the medical or mental health provider that the student has undergone examination and has been discharged.
3. The school counselor/designee will periodically check in with student to help with readjustment to school and to address concerns like grades, attendance, and behavior.
4. The school counselor/designee *with the consent of the parent/guardian* will serve as a liaison for teachers and other school staff responsible for working with and supervising the student. Teachers and staff may need to be briefed about warning signs of another suicide crisis, possible side effects of medications, adjustments made to the student's schedule or workload, and referral procedures.
5. Document all contacts and keep records of all actions taken.

### **District Liability**

Schools have been sued and found liable for failing to take proper action, particularly for failing to notify parents/guardians, when a student is thought to be suicidal. The key issues in court cases have been foreseeability and negligence and have included cases in which schools did not warn parents/guardians about both verbal and written statements about suicide as well as cases in which the school failed to provide supervision and counseling for suicidal students.

Schools have also been sued over more complex issues, such as school climate and failure to reduce bullying, that were claimed to contribute to the suicide of a student. As the U.S. Department of Education Office for Civil Rights has emphasized, schools have legal obligations under anti-discrimination laws. Once a school knows or reasonably should know of possible student harassment, it must take immediate action to investigate, take steps to end the harassment, eliminate a hostile environment, and prevent its recurrence. These duties are a school's responsibility even if the misconduct also is covered by an anti-bullying policy and regardless of whether the student makes a complaint. For more information, including example cases, see <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.pdf>.



**SECTION 5:**  
**The Postvention**  
**Module**



## Postvention Module

The Postvention module stipulates developing procedures to carry out these essential functions:

1. Providing protocols for the crisis team to follow after a suicide death
2. Handling interactions with the family with dignity and respect
3. Preserving the safety of students and avoiding suicide contagion
4. Facilitating responsible, appropriate communications with the media and community

### **Crisis Response / Crisis Teams**

According to the School Crisis Response Initiative, when a suicide death affects a school a coordinated crisis response is required to assist staff, students, and families who are impacted by the death and to restore safety and order to the school environment. Schools can underestimate the full impact of the crisis or be overwhelmed by the extent and magnitude of it. Schools are better able to function in the immediate aftermath of a crisis if there is sufficient structure in place to coordinate services when the crisis occurs. Thus it is recommended that crisis teams be established at the district and school level and be provided with ongoing training to be prepared to address safety and security issues; to manage the dissemination of accurate information to school staff, students, parents, and the community; and to facilitate support services to deal with the psychological needs of students and staff. See the article, “A Model for School-Based Crisis Preparedness” at [www.ojp.gov/ovc/publications/bulletins/schoolcrisis/ncj197832.pdf](http://www.ojp.gov/ovc/publications/bulletins/schoolcrisis/ncj197832.pdf).

For details about the major tasks to be accomplished in Postvention see *After a Suicide: A Toolkit for Schools* by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center workgroups. The crisis team can also refer to Tool 3.A: Immediate Response Protocol in SAMHSA’s *Preventing Suicide: A High School Toolkit*. What follows is an outline.

### **Development and Implementation of an ACTION PLAN**

The crisis team will develop an action plan to guide school response following a death by suicide. A meeting of the crisis team to implement the action plan should take place immediately following news of the suicide death. The action plan may include these steps:

- a) **Verify the death.** Staff will confirm the death and determine the cause of death through communication with a coroner’s office, local hospital, the student’s parent or guardian, or police department. Even when a case is perceived as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the death has been confirmed as suicide but the parent or guardian will not permit the cause of death to be disclosed, the school will not share the cause of death but will use the opportunity to discuss suicide prevention with students.

## Postvention Module

### **Development and Implementation of an ACTION PLAN (continued)**

- b) **Assess the situation.** The crisis team will meet to prepare the postvention response, to consider how severely the death is likely to affect other students, and to determine which students are most likely to be affected. The crisis team will also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. If the death occurred during a school vacation, the scale of the postvention activities may be reduced.
- c) **Share the information.** Before the death is officially classified as a suicide by the coroner's office, the death can and should be reported to staff, students, and parents/guardians with an acknowledgement that its cause is unknown. Inform the faculty that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement should include basic facts of the death and known funeral arrangements (without providing details of the suicide method); recognition of the sorrow the news will cause; and information about the resources available to help students cope with their grief. *Public address system announcements and school-wide assemblies should be avoided.* A script with guidelines for answering phone calls and assisting parents/guardians who come to school should be provided to the office staff. The crisis team may also prepare a letter (with the input and permission from the student's parent or guardian) to send home with students that includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available.
- d) **Avoid suicide contagion.** It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high risk students is to prevent another death. The crisis team will work with teachers to identify students who are most likely to be significantly affected by the death. Suicide warning signs and procedures for referring students should be reviewed as needed.
- e) **Initiate support services.** Students identified as being more likely to be affected by the death will be assessed by a school employed mental health professional to determine the level of support needed. The crisis team will coordinate support services for students and staff in need of individual and small group counseling. With the knowledge and consent of parents or guardians, the crisis team will refer students to community mental health providers to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs.
- f) **Develop memorial plans.** The school should not create on-campus physical memorials (e.g. photos, flowers), funeral services, or fly the flag at half-mast because it may sensationalize the death and encourage suicide contagion. School should not be canceled for the funeral. Any school-based memorials (e.g., small gatherings) will include a focus on how to prevent future suicides and prevention resources available.

## Postvention Module

### **Suggestions for Working with the FAMILY:**

It is important to work with the family of a student who died by suicide. They will often appreciate the support of the school community, and their cooperation can be valuable for effective postvention. The principal or a representative of the school should request to visit the family in their home. It may be useful for a pair of representatives to visit together so that they can support one another during the visit. It is important to respect the cultural and religious traditions of the family related to suicide, death, grieving, and funeral ceremonies.

The school representative(s) are advised to do the following:

- Offer the condolences of the school
- Inquire about funeral arrangements, if the funeral is to be private or public, and if the family will allow students to attend
- Ask if the family can help identify youth who may be especially upset, such as siblings, cousins, extended family, friends, neighbors, or teammates
- Provide information about grief counseling services
- Briefly explain what the school is doing to respond to the death
- Ask how the family would like the youth's personal belongings returned

### **Avoiding SUICIDE CONTAGION**

Research has shown a link between certain kinds of suicide-related media coverage and increases in suicide deaths. Suicide contagion has been observed when:

- the number of stories about individual suicides increases,
- a particular death is reported in great detail,
- the coverage of a suicide death is prominently featured in a media outlet
- headlines about specific deaths are framed dramatically (e.g. "Bullied Gay Teen Commits Suicide By Jumping From Bridge").

Research shows that suicide contagion can be avoided when the media report on suicide responsibly. See "*Recommendations for Reporting on Suicide*", [www.reportingonsuicide.org](http://www.reportingonsuicide.org).

Contagion can also play a role in cases of students engaging in self-injurious behaviors. These behaviors may originate with one student and can spread to other students through imitation.

Finally, after a death by suicide it is important for schools to encourage parents/guardians to monitor their child's social networking pages. Students often turn to social networking websites as an outlet for communicating information and for expressing their thoughts and feelings about the death. Parents/guardians should be advised to monitor the websites for warning signs of suicidal behavior.

## **Postvention Module**

### **Avoiding SUICIDE CONTAGION – Memorials**

Because adolescents are especially vulnerable to the risk of contagion, in the case of a suicide death, it is important to memorialize the student in a way that does not inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying mental health issues such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that manifest as behavioral problems or substance abuse).

However, schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student's family and friends.

### **Managing EXTERNAL COMMUNICATIONS**

The district communications/public relations officer, the school principal, or designee will be the sole media spokesperson. Staff will refer all inquiries from the media directly to the principal or designated spokesperson. The spokesperson will:

- a) Keep the district suicide prevention coordinator and superintendent informed of school actions relating to the death.
- b) Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation, means of suicide, or personal family information.
- c) Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters not to make it a front-page story, not to use pictures of the suicide victim, not to use the word "suicide" in the caption of the story, not to describe the method of suicide, and not to use the phrase "suicide epidemic" as this may elevate the risk of suicide contagion. They should also be encouraged not to link bullying to suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available.

### **Planning for Long-Term Response**

Crisis Teams are advised to consider that students and staff may feel the impacts of a suicide death for an extended time. See SAMHSA's Tool 3.B: Long-Term Response Protocol. Special events like prom, graduation, sports or arts events that were associated with the deceased, as well as the anniversary of the death or the deceased's birthday may arouse grief and loss. The school should prepare to provide on-going support to siblings of the deceased as well as other vulnerable students.



## SECTION 6:

# Appendix

The following online forms found at:

<https://sites.google.com/site/icareprevention/crisis-response>

### **SAMPLE FORMS:**

Comprehensive Protocol for Managing Students in Crisis

- Flow Chart – Risk of Suicide or Self-Injury
- Flow Chart – Suicide Attempt In Progress

Basic Risk Assessment Tool

Notification of Emergency Conference Form

Safety Plan Template

Release of Mental Health Records for School Use

Crisis Intervention Guidelines:

- For Parents of Elementary School Students
- For Parents of Middle and High School Students
- For Teachers
- Crisis Referral Resource Guide

Professional Development: Suicide Prevention Training Programs

- safeTALK
- Applied Suicide Intervention Skills Training (ASIST)
- Youth Mental Health First Aid (YMHFA)

# **Comprehensive Protocol For Managing a Student in Crisis**

# Protocols for Managing the Student in Crisis

## Managing a Student at Risk for SUICIDE or SELF-INJURY

### A. Safeguard At-Risk Student

1. Staff member ESCORTS student to Principal or designated Crisis Team Member.
2. Staff member NOTIFIES Principal or CTM this is an EMERGENCY.
3. Principal or CTM maintains DIRECT SUPERVISION of student at all times until emergency conference is held and parent/guardian takes custody of child.
4. Principal or designee conducts SEARCH to be sure student does not have possession of alcohol, other drugs, or anything that could be used as a weapon.
5. Principal or designee NOTIFIES the parent/guardian of the concerns for their child's safety and the need to hold an emergency conference ASAP.
6. Principal to decide if police or emergency medical services should be contacted.

### B. Informal Assessment of Student who may be DANGER to SELF.

1. Purpose is to gather relevant information in order to communicate the specific needs of the student in crisis to the parent/guardian or other professional.
2. Suicide/Self-Injury Resources are provided for Counselor/CTM to interview the student. **Interview is NOT for the purpose of diagnosis.**
3. A Risk Assessment Tool *is provided* but counselor has option to select another instrument. Interview typically includes these **key indicators of risk**:
  - a. Suicidal Thoughts or Thoughts about Self-Injury
  - b. Suicide Plan or Self-Injury Plan
  - c. Means and Capacity to Carry Out Plan
  - d. Previous Attempt(s) or Pattern of Risky Behavior
  - e. Command Hallucinations\* (significant)
  - f. Mental Health Conditions or Substance Abuse
  - g. Family or Social Network History of Suicide
4. Counselor/CTM takes notes to DOCUMENT the interview.
5. Counselor/CTM completes a Safety Plan with the Student. *Form is provided.*

### C. Emergency Conference convened by Counselor with Parent/Guardian. *Form provided.*

1. Share information about risk factors identified in the interview.
2. Emphasize that the student should be kept under direct supervision at home.
3. Explain importance of monitoring access to potentially dangerous objects or substances.
4. Encourage parent to seek mental health assessment and other services as appropriate.
5. Supply list of emergency resources and mental health providers.
6. Ask parent to sign the Emergency Conference Form.

7. Request parent to sign a Release Form so that Counselor can contact mental health provider for recommendations to support the student's re-entry to school. *Form provided.*
8. Advise the parent that Child Protective Services must be notified if a parent refuses to seek services for a child under the age of 18 who exhibits signs that he/she is in danger of self-harm.
9. Issue General Guidelines and Resource List to parents. *Forms Provided*
10. School retains original documents, issue copies to parents.

**D. Re-entry Plan** to follow up with student and parent, if not hospitalized.

1. Counselor to meet with student the same day he/she returns to school.
2. Within 24 hours Counselor to contact parent to "debrief" about the emergency conference and to verify whether or not the student received services.
3. If child was seen by mental health provider, request parent to sign Release so Counselor can support the student's re-entry to school. *Form provided.*
4. Counselor to determine how many follow-up sessions to hold with student.
5. DOCUMENT all contacts with student, parent, and mental health provider.

**E. Reintegration Plan** following hospitalization.

1. Prior to the student's return, convene a meeting with the parent/guardian.
2. If parent has signed written Release, communicate with the hospital or the student's therapist or counselor for after-care recommendations.
3. Counselor to monitor the student's re-entry and serve as a contact for teachers and other staff members who need to be alert to warning signs.
4. School nurse should be notified about the student's medications or other health conditions related to the suicide attempt.
5. Teachers need to be notified if the student is to be placed on a reduced workload.
6. Counselor to maintain periodic contact with parent and mental health provider to facilitate the continuum of care.



## SCHOOL PROTOCOL FOR MANAGING STUDENTS IN CRISIS

Student has displayed RISK FOR SUICIDE OR SELF-INJURY by words or actions

### Immediately Notify Principal or Designee

Staff member maintains Direct Supervision of Student at all times until emergency conference is held

Principal or Designee  
**Interviews the Student**  
To conduct Basic Risk  
Assessment\*

If student indicates no  
intent to harm self and no  
plan,

**If a weapon is  
present, clear  
the area and  
call 911**

If student indicates a plan, a  
threat of self-harm, a history  
of mental health issues, or a  
history of prior attempts

Notify Parent or Guardian  
to attend Emergency  
Conference

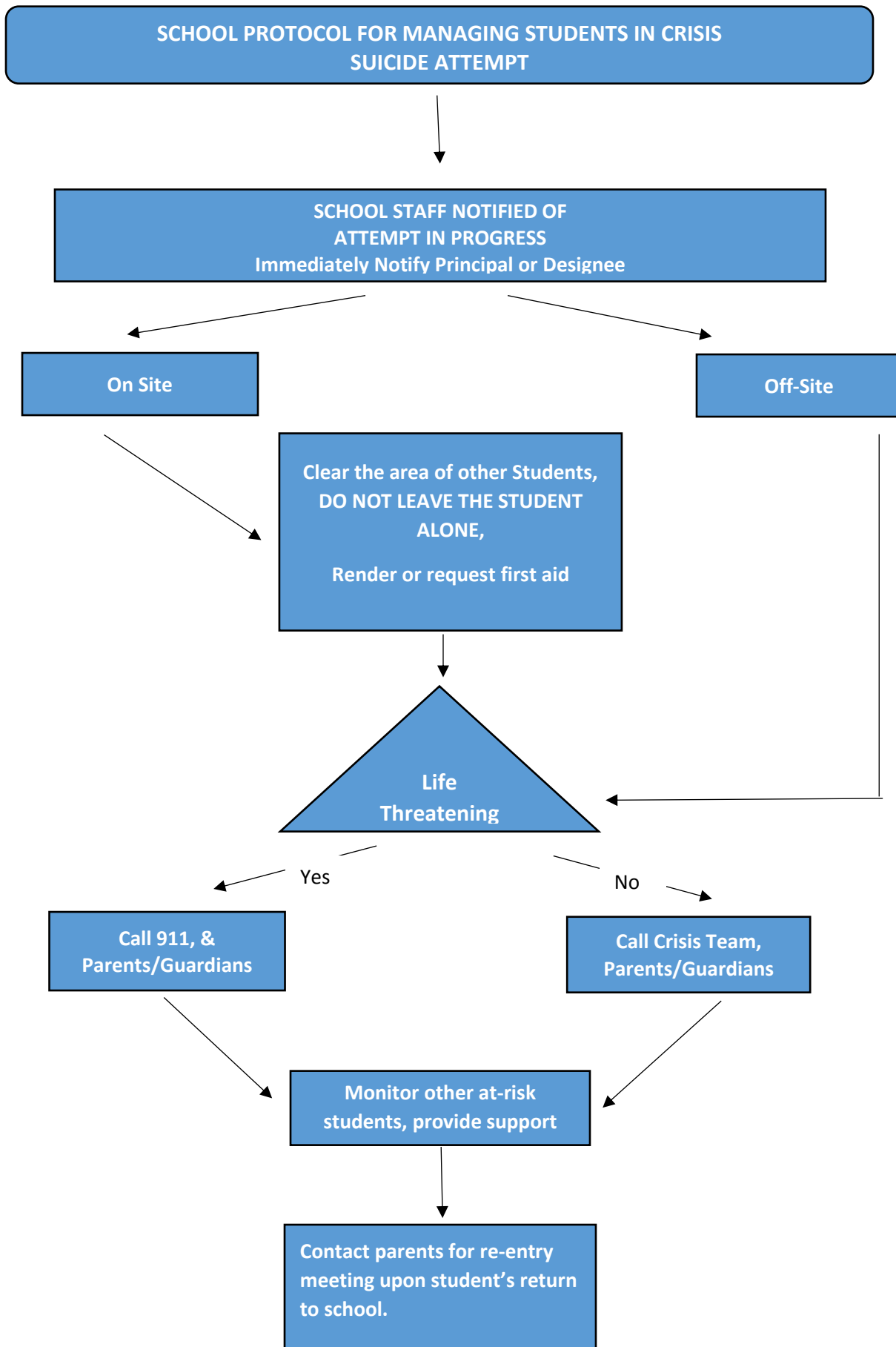
#### \*Documents:

- (1) Parent signs Emergency Conference Form.
- (2) Complete Safety Plan with student.
- (3) Issue General Guidelines Form to parents.
- (4) Provide Resource List to parents for additional support.
- (5) Request parent sign Release of Mental Health Records Form.

If crisis referral results in student receiving Mental Health Services, be prepared to initiate an individualized re-entry plan.

Supply parents with copies of all documents.

School retains original signed documents.



## **Risk Assessment Tool**

### **Part 1: Initial Questions to Ask Student**

1. Have you ever thought about killing yourself or someone else? (IDEATION)
  - a. Are you having those thoughts now? If not, when did you think about killing self/other?
  - b. How long have you been having these kinds of thoughts?
  - c. How often do these thoughts occur? Do they last or are they fleeting ideas?

**NOTE:** *Thoughts or threats alone, whether direct or indirect, may indicate LOW RISK.*

2. Have you tried to kill yourself before? (PREVIOUS ATTEMPTS)
  - a. If yes, what happened?
  - b. Have you tried to hurt yourself before like cutting, burning, etc.?
  - c. Have you been doing any risky/dangerous things that might get you hurt or killed?

**NOTE:** *Previous attempts or repetitive self-injury may indicate MODERATE RISK.*

3. Do you have a PLAN to kill yourself or someone else today? (PLAN, METHOD, ACCESS)
  - a. If yes, tell me about your plan.
  - b. How long have you been making this plan?
  - c. Do you have a METHOD to kill yourself or other?
  - d. Do you have ACCESS to firearms, other weapons, or things that can be used in a lethal manner like rope or cord, plastic garment bag, medications, etc.?

**NOTE:** *Evidence of a plan and the means to carry it out may indicate HIGH RISK.*

### **Part 2: Questions to Ask Parent/Guardian, Teachers, and Staff**

1. What warning signs initiated the referral?
2. Has the student demonstrated abrupt changes in behavior?
3. What is the support system that surrounds this child? Is child isolated or rejected?
4. Is there a history of mental illness including depression, bi-polar or other mood disorder, substance abuse, conduct or anxiety disorder?
5. Is there a history of recent grief/losses, trauma, or victimization?

# NOTIFICATION OF EMERGENCY CONFERENCE

\_\_\_\_\_  
Date

I/We, \_\_\_\_\_, parent/guardian of  
Parent/Legal Guardian Name  
\_\_\_\_\_ has been notified by  
Student Name  
school personnel at \_\_\_\_\_, that my child appears  
School Name  
to be in a state of psychological emergency, \_\_\_\_\_.  
State Emergency Type

I/We have been further advised my child should be kept under direct supervision at all times and I/We should monitor access to potentially dangerous objects or substances. I/We have been encouraged to seek a mental health assessment and additional services for my child as appropriate. I have been given a copy of the Youth Suicide Prevention Guidelines for Parents and the Crisis Referral Resource List.

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
School Personnel Title

\_\_\_\_\_  
School Personnel Title

## Notification of Safety Plan (Template)

I, \_\_\_\_\_, together with \_\_\_\_\_  
Student Name School Counselor, Principal, or Designee

have developed this plan to help me keep safe. This safety plan will be/has been reviewed with

\_\_\_\_\_, so that they can help me to follow the plan and support  
me to feel \_\_\_\_\_ Parent/Guardian Name  
better, cope safely, and stay alive.

\_\_\_\_\_  
Student's Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Signature of School Representative Date

**Part 1: I will be aware of these situations and behaviors that tend to upset me to a serious degree:**

1. 2.
3. 4.

**Part 2: I will pay attention to my warning signs (thoughts, feelings, body sensations) that I'm upset:**

1. 2.
3. 4.

**Part 3: When I notice my early warning signs I will try to calm myself down by doing the following:**

1. 2.
3. 4.

**Part 4: If I am unable to calm down on my own, I will ask for help from these safe and supportive adults:**

1. 2.
3. 4.

**Part 5: When I'm upset, my Parent/Guardian can help me by saying or doing these things:**

1. 2.
3. 4.

5. *Making the home environment safer by maintaining direct supervision of the youth; removing firearms, weapons, and poisons; and either removing or putting under secure, locked storage harmful substances such as alcohol, prescriptions and over the counter medications.*

**Part 6: If I feel that neither I nor my Parent/Guardian can keep me safe, then our crisis plan is:**

1. Call 9-1-1 for emergency services or go to nearest hospital ER, if safe to transport
2. Call the National Suicide Prevention Lifeline at 1-800-273-TALK or 1-800-273-8255
3. Call the Crisis Intervention Center Hotline, the Phone, at 1-800-437-0303.

**Release of Mental Health Records Exclusively for School Use**  
**\*\*Authorization for Use or Disclosure of Protected Health Information\*\***

**\*\*1. Authorization\*\***

I authorize \_\_\_\_\_ to disclose the protected health  
(Healthcare Provider)  
information described below to \_\_\_\_\_  
(School Employed Mental Health Professional)  
at \_\_\_\_\_.  
(School Site)

**\*\*2. Effective Period\*\***

This authorization for release of information covers the period of healthcare from:  
\_\_\_\_\_ to \_\_\_\_\_.  
(Beginning Date) (Ending Date)

**\*\*3. Extent of Authorization\*\***

*I authorize the release of my health records as it relates to mental health care or for the treatment of alcohol or drugs.*

- This medical information may be used by the person(s) I authorize to receive this information for the purpose of reintegrating the student back into the school environment.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient in the case of an emergency.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Printed name of patient or personal representative  
Relationship to patient: \_\_\_\_\_

Date: \_\_\_\_\_

**Suicide Prevention & Crisis Intervention Guidelines**  
**for**  
**Parents of Elementary School-Aged Youth**

Adapted from LA COUNTY YOUTH SUICIDE PREVENTION PROJECT & SAMHSA <http://preventsuicide.lacoe.edu>

# **Elementary School General Guidelines for Parents**

## **Youth Suicide in the United States\***

- Suicide is the third leading cause of death for youth aged 10-24 in the United States.\*
- In recent years more young people have died from suicide than from cancer, heart disease, HIV/AIDS, congenital birth defects, and diabetes combined.\*
- For every young person who dies by suicide, between 100-200 attempt suicide.\*
- Males are four times as likely to die by suicide as females - although females attempt suicide three times as often as males.\*

## **Young Children Suicide Risk Factors**

While the path that leads to suicidal behavior is long and complex and there is no “profile” that predicts suicidal behavior with certainty, there are certain risk factors associated with increased suicide risk. In isolation, these factors are not signs of suicidal thinking. However, when present they signal the need to be vigilant for the warning signs of suicide. The behaviors listed below may indicate that a child is emotionally distressed and may begin to think and act in self-destructive ways. If you are concerned about one or more of the following behaviors, please seek assistance at your child’s school or at your local mental health service agency.

### **Home Problems**

- Running away from home
- Arguments with parents/caregivers

### **Behavior Problems**

- Temper tantrums
- Thumb sucking or bed wetting/soiling
- Acting out, violent, impulsive behavior
- Bullying
- Accident proneness
- Sudden change in activity level or behavior
- Hyperactivity or withdrawal

### **Physical Problems**

- Frequent stomachaches or headaches for no apparent reason
- Changes in eating or sleeping habits
- Nightmares or night terrors

### **School Problems**

- Chronic truancy or tardiness
- Decline in academic performance
- Fears associated with school

## **Serious Warning Signs**

- Severe physical cruelty towards people or pets
- Scratching, cutting or marking the body
- Thinking, talking, drawing about suicide
- Previous suicide attempts
- Risk taking, such as intentional running in front of cars or jumping from high places
- Intense/excessive preoccupation with death



## **SUICIDE IS PREVENTABLE**

### **Here is what YOU can do:**

- **Talk** to your child about suicide. Don't be afraid. You will NOT be "putting ideas into their heads". Research shows talking openly and directly about suicide increases safety.
- **Asking for help** is the single skill that will protect your child. Help your child to identify and connect to caring adults to talk to when they need guidance and support.
- **Know** the risk factors and warning signs of suicide.
- **Remain calm.** Establish a safe environment to talk about suicide.
- **Listen** to your child's feelings. Don't minimize what your child says about what is upsetting him or her. Put yourself in your child's place; don't attempt to provide simple solutions.
- **Be Honest.** If you are concerned, do not pretend that the problem is minor. Tell the child that there are people who can help. State that you will be with him or her to provide comfort and love.
- **Be Supportive.** Children look for help and support from parents, older brothers and sisters. Talk about ways of dealing with problems and reassure your child that you care. Let children know that their bad feelings will not last forever.
- **Take Action.** It is crucial to get professional help for your child and the entire family. When you are close to a situation it is often hard to see it clearly. You may not be able to solve the problem yourself.
  - Help may be found at a suicide prevention center, local mental health agency, family service agency or through your clergy.
  - Become familiar with the support services at your child's school. Contact the appropriate person(s) at the school, for example, the school social worker, school psychologist, school counselor, or school nurse.

**If someone you know is in IMMEDIATE danger: call 9-1-1  
National Suicide Prevention Hotline: 1-800-273-8255**

\*M. Heron, D. L. Hoyert, S. L. Murphy, J. Xu, K. D. Kochanek, & B. Tejada-Vera. (2009, April). Deaths: Final Data for 2006. National Vital Statistics Reports, 57(14).

Adapted from LA COUNTY YOUTH SUICIDE PREVENTION PROJECT & SAMHSA <http://preventsuicide.lacoe.edu>

**Suicide Prevention & Crisis Intervention Guidelines  
for  
Parents of Middle and High School-Aged Youth**

## **Middle and High School General Guidelines for Parents**

### **Youth Suicide in the United States\***

- Suicide is the third leading cause of death for youth aged 10-24 in the United States.\*
- In recent years more young people have died from suicide than from cancer, heart disease, HIV/AIDS, congenital birth defects, and diabetes combined.\*
- For every young person who dies by suicide, between 100-200 attempt suicide.\*
- Males are four times as likely to die by suicide as females - although females attempt suicide three times as often as males.\*

### **Youth Suicide Risk Factors**

While the path that leads to suicidal behavior is long and complex and there is no “profile” that predicts suicidal behavior with certainty, there are certain risk factors associated with increased suicide risk. In isolation, these factors are not signs of suicidal thinking. However, when present they signal the need to be vigilant for the warning signs of suicide. In addition, they are also appropriate targets for suicide prevention programs. Specifically, these risk factors include the following:

- History of depression, mental illness or substance/alcohol abuse disorders
- Presence of a firearm or rope
- Isolation or lack of social support
- Situational crisis
- Family history of suicide or suicide in community
- Hopelessness
- Impulsivity
- Incarceration

### **Serious Warning Signs**

Warning signs are observable behaviors that may signal the presence of suicidal thinking. They might be considered “cries for help” or “invitations to intervene”. These warning signs signal the need to inquire directly about whether the individual has thoughts of suicide. If such thinking is acknowledged, then suicide interventions will be required. Warning signs include the following:

- **Suicide threats.** It has been estimated that up to 80% of all suicide victims have given some clues regarding their intentions. Both direct (“I want to kill myself”) and indirect (“I wish I could fall asleep and never wake up”) threats need to be taken seriously.
- **Suicide notes and plans.** The presence of a suicide note is a very significant sign of danger. The greater the planning revealed by the youth, the greater the risk of suicidal behavior.

- **Prior suicidal behavior.** Prior behavior is a powerful predictor of future behavior. Thus anyone with a history of suicidal behavior should be carefully observed for future suicidal behavior.
- **Making final arrangements.** Making funeral arrangements, writing a will, and/or giving away prized possessions may be warning signs of impending suicidal behavior.
- **Preoccupation with death.** Excessive talking, drawing, reading, and/or writing about death may suggest suicidal thinking.
- **Changes in behavior, appearance, thoughts, and/or feelings.** Depression (especially when combined with hopelessness), sudden happiness (especially when preceded by significant depression), a move toward social isolation, giving away personal possessions, and reduced interest in previously important activities are among the changes considered to be suicide warning signs.

### **SUICIDE IS PREVENTABLE**

#### **Here is what YOU can do:**

- **Talk** to your child about suicide. Don't be afraid. You will NOT be "putting ideas into their heads". Research shows talking openly and directly about suicide increases safety.
- **Asking for help** is the single skill that will protect your child. Help your child to identify and connect to caring adults to talk to when they need guidance and support.
- **Know** the risk factors and warning signs of suicide.
- **Remain calm.** Establish a safe environment to talk about suicide.
- **Listen** without judging. Allow for the discussion of experiences, thoughts, and feelings. Be prepared for expression of intense feelings. Try to understand the reasons for considering suicide without taking a position about whether or not such behavior is justified. Ask open-ended questions.
- **Supervise** constantly. Do not leave your child alone.
- **Ask** if your child has a plan to kill themselves, and if so, remove means. As long as it does not put the caregiver in danger, attempt to remove the firearm, knife or pills, etc.
- **Take Action.** It is crucial to get professional help for your child and the entire family. When you are close to a situation it is often hard to see it clearly. You may not be able to solve the problem yourself.
  - Help may be found at a suicide prevention center, local mental health agency, family service agency or through your clergy.
  - Become familiar with the support services at your child's school. Contact the appropriate person(s) at the school, for example, the school social worker, school psychologist, school counselor, or school nurse.

If someone you know is in **IMMEDIATE** danger: call 9-1-1  
**National Suicide Prevention Hotline: 1-800-273-8255**

\*M. Heron, D. L. Hoyert, S. L. Murphy, J. Xu, K. D. Kochanek, & B. Tejada-Vera. (2009, April). Deaths: Final Data for 2006. National Vital Statistics Reports, 57(14).

Adapted from LA COUNTY YOUTH SUICIDE PREVENTION PROJECT & SAMHSA <http://preventsuicide.lacoe.edu>

## **Suicide Prevention & Crisis Intervention Guidelines for Teachers**

## **Crisis Management & Suicide Prevention for Teachers**

### **Warning Signs:**

- Suicide threats:
  - Direct/Indirect: “I want to kill myself” or “I wish I could fall asleep and never wake up”
  - All need to be taken seriously
- Suicide notes and plans:
  - The greater (more specific) the planning, the greater the risk of suicidal behavior
- Prior suicidal behaviors
- Making final arrangements:
  - Giving away prized possessions (writing a will, making funeral arrangements)
- Preoccupation with death
  - Excessive talking, drawing, reading, or writing
- Changes in behavior, appearance, thoughts, or feelings
  - Depression, sudden happiness, isolation, giving away possessions, reduced interest in previously important activities

### **Risk Factors:**

- History of depression, mental illness, substance abuse disorders
- Presence of a firearm or rope
- Isolation, lack of social support
- Situational crises
- Family history of suicide, suicide in the community
- Hopelessness
- Impulsivity
- Incarceration

### **What I can do as a teacher/staff member:**

- **Talk** to your student, don't be afraid, you will NOT “put ideas in their head”.
- **Help** them identify caring adults to talk to when they need support and guidance.
- **Know** the risk factors.
- **Remain** calm.
- **Listen** without judgment.
- **Supervise** constantly. Do not leave the individual alone until parent or crisis intervention team member has agreed to provide appropriate supervision.
- **Ask** if they have a plan. If they do, remove means like a weapon or pills if it is safe.
- **Respond immediately.** Escort student to crisis team member, principal, assistant principal, counselor, etc.
- **Join** the crisis team and help provide essential background information that will help with assessment of the student.

**If someone you know is in IMMEDIATE danger: call 9-1-1**  
**National Suicide Prevention Hotline: 1-800-273- 8255**

## CRISIS REFERRAL RESOURCE GUIDE

### **IN AN EMERGENCY OR CRISIS: DIAL 911**

<b><u>National Suicide Prevention Lifeline</u></b> 1-800-273-TALK or 1-800-273-8255 (press 1 for veterans, press 2 for Spanish) <b><u>Lifeline Crisis Chat</u></b> <a href="http://www.crisichat.org">www.crisichat.org</a>	<b><u>Crisis Intervention Center,</u></b> The Phone Crisis Line (225) 924-3900 or 1-800-437-0303
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### **DOMESTIC VIOLENCE, ABUSE, AND SEXUAL ASSAULT RESOURCES:**

<b><u>Childhelp National Child Abuse Hotline</u></b> 1-800-4-A-CHILD (1-800-422-4453)	<b><u>National Child Sexual Abuse Helpline</u></b> Darkness to Light 1-866-FOR-LIGH or 1-866-367-5444
<b><u>National Domestic Violence Hotline</u></b> 1-800-799-SAFE (7233) 1-800-787-3224 (deaf and hard of hearing line)	<b><u>National Sexual Assault Hotline</u></b> RAINN, (Rape, Abuse & Incest National Network) 1-800-656-HOPE or 1-800-656-4673 <a href="http://www.rainn.org">www.rainn.org</a>
<b><u>LA Dept. of Children &amp; Family Services,</u></b> Reporting Line for Child Abuse & Neglect ( <a href="http://www.dcfs.la.gov">www.dcfs.la.gov</a> ) 1-855-4LA-KIDS (1-855-452-5437)	<b><u>Crisis Text Line</u></b> Text START to 741-741

## **SUPPORT RESOURCES**

### **GAY, LESBIAN, BISEXUAL, TRANSGENDER SUPPORT RESOURCES**

<b><u>GLBT National Help Center</u></b> 1-888-843-4564 1-888-246-7743 for Youth Talkline <a href="http://www.glnh.org">www.glnh.org</a>	<b><u>Trevor Project Crisis Line – LGBTQ Youth</u></b> 1-866-4-U-TREVOR or 1-866-488-7386 <a href="http://www.theTrevorProject.org">www.theTrevorProject.org</a>
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### **SELF-HELP RESOURCES AND GROUPS**

<b><u>Alcoholics Anonymous</u></b> <a href="http://www.aa.org/pages/en_US/find-aa-resources">www.aa.org/pages/en_US/find-aa-resources</a>	<b><u>Narcotics Anonymous</u></b> 1-888-GET-HOPE (438-4673) (Hopeline) <a href="http://www.na.org/meetingsearch">www.na.org/meetingsearch</a>
<b><u>Al-Anon and Alateen Family Groups</u></b> <a href="http://www.al-anon.alateen.org/local-meetings">www.al-anon.alateen.org/local-meetings</a>	<b><u>Nar-Anon Family Groups</u></b> <a href="http://www.nar-anon.org/find-a-group">www.nar-anon.org/find-a-group</a>

**PROFESSIONAL DEVELOPMENT:**  
**SUICIDE PREVENTION TRAINING PROGRAMS**

**Suicide Alertness for Everyone, (safeTALK)**

safeTALK teaches members of the community to recognize people with thoughts of suicide and to connect them to suicide first aid resources. The safeTALK workshop takes a half-day and offers a carefully crafted set of steps that makes it possible for attendees to leave the training willing and able to be suicide alert helpers. Since its development in 2006, safeTalk has been used in more than 20 countries. safeTALK is listed on the Best Practices Registry for staff education and training programs. <https://www.livingworks.net/programs/safetalk/>

**Goals & Objectives:**

It is intended that safeTALK participants will be better prepared to:

- provide practical help to people with thoughts of suicide
- be a suicide alert helper
- be aware that opportunities to help a person with thoughts of suicide are sometimes missed, dismissed and avoided
- activate a suicide alert using the TALK steps (*Tell, Ask, Listen and KeepSafe*)
- connect people with thoughts of suicide to people trained in suicide intervention

**Applied Suicide Intervention Skills Training, (ASIST)**

ASIST is a standardized two-day, two-trainer workshop designed for members of all caregiving groups. The emphasis is on teaching suicide first-aid to help a person at risk stay safe and seek further help as needed. Participants learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe plan based upon a review of risk, be prepared to do follow-up, and become involved in suicide-safer community networks. The learning process is based on adult learning principles and involves highly participatory workgroups. Graduated skills development is achieved through mini-lectures, facilitated discussions, group simulations, and role plays. ASIST is listed on the Best Practices Registry for staff education and training programs. <https://www.livingworks.net/programs/asist/>

**\*Goals & Objectives:**

It is intended that ASIST participants will be better prepared to:

1. Reflect on how their attitudes and beliefs about suicide affect their intervention role;
2. Discuss suicide with a person at risk in a direct manner;
3. Build a collaborative approach to intervention focused on safe outcomes;
4. Review immediate suicide risk and develop appropriate safe plans;
5. Demonstrate skills required to intervene with a person at risk of suicide;
6. Identify resources available to a person at risk of suicide;
7. Make a commitment to improving community resources; and
8. Recognize that suicide prevention is broader than suicide first aid and includes



life-promotion and self-care for caregivers.

\*(Based on LivingWorks Trainer's Manual, p vii)

## **Youth Mental Health First Aid, USA, (YMHFA)**

YMHFA is a framework for providing immediate help and support to a young person who may be experiencing a mental health challenge due to a mental disorder or crisis. The eight-hour training takes place over two days. Day One focuses on the prevalence of mental health disorders among young people and the symptoms associated with anxiety; depression; ADHD and other disruptive behaviors; substance abuse; eating disorders; psychosis; self-injury; and suicide. Day Two concentrates on using the five-step Mental Health Action Plan to assess the needs of youth in distress and to implement appropriate interventions for both crisis and non-crisis situations. YMHFA training is suitable for parents, administrators, teachers, school staff, DARE and School Resource Officers, truancy officers, youth-serving agencies, and other adult community members who are concerned about the welfare of adolescents and teens.

<http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/>

### **Goals and Objectives:**

1. To understand the prevalence of mental health disorders impacting youth and the need for reduced stigma associated with these conditions.
2. To recognize the emotional, behavioral, and cognitive symptoms associated with anxiety; depression; ADHD and other disruptive behaviors; substance abuse; eating disorders; psychosis; self-injury; and suicide.
3. To understand the risk and protective factors that can impact mental health and resiliency.
4. To apply the five-step Mental Health First Aid action plan to assess the needs of youth in distress and to implement appropriate interventions for crisis and non-crisis situations.

## SECTION 7: References

## **Resources, Model Policies, and Guidelines**

The Trevor Project: <http://www.thetrevorproject.org/pages/modelschoolpolicy>

“Preventing Suicide: A Toolkit for High Schools” – U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services <http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669>

“After a Suicide: A Toolkit for Schools” – American Foundation for Suicide Prevention and Suicide Prevention Resource Center [www.afsp.org/schools](http://www.afsp.org/schools)

“Guidelines for School-Based Suicide Prevention Programs” – American Association of Suicidology [http://www.sprc.org/sites/sprc.org/files/library/aasguide\\_school.pdf](http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf)

Los Angeles County Youth Suicide Prevention Project <http://preventsuicide.lacoe.edu/>

“Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel” – Maine Youth Suicide Prevention Program <http://www.maine.gov/suicide/docs/Guideline.pdf>

Texas Suicide Safer Schools: <http://www.texassuicideprevention.org/wp-content/uploads/2015/08/2015-SuicideSaferSchools-FINAL-8.10.15.pdf>

“Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender (LGBT) Children” – Family Acceptance Project <http://familyproject.sfsu.edu/publications>

National Center for School Crisis and Bereavement <http://www.stchristophershospital.com/pediatric-specialties-programs/specialties/690>

Adolescent and School Health Resources – Centers for Disease Control and Prevention, contains an assortment of resources and tools relating to coordinated school health, school connectedness, and health and academics <http://www.cdc.gov/healthyyouth/schoolhealth/index.htm>

## Other Sources

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