

# MODEL SCHOOL DISTRICT POLICY ON SUICIDE PREVENTION

Model Language,  
Commentary, and  
Resources

THE **TREVOR** PROJECT



AMERICAN FOUNDATION FOR  
Suicide Prevention



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### KEY:

Model Policy Language

Commentary

**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).

## INTRODUCTION

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.<sup>1</sup>

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 model is comprehensive, yet the policy language is modular and may be used to draft your own district policy based on the unique needs of your district. 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). Model policy language is indicated by shaded text on white background, and sidebar language – to provide additional context that may be useful when constructing a policy – is indicated by white text on shaded background.

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.<sup>2</sup> Youth suicide is preventable, and educators and schools are key to prevention.

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, this model policy is intended to be paired with other policies and efforts that support the emotional and behavioral well-being of youth.

Please refer to the included Resources Section for additional information. If you would like support in writing a policy for your own district or you have questions, please contact Alison Gill, Government Affairs Director at The Trevor Project (202-204-4730 or Alison.Gill@thetrevorproject.org), or Nicole Gibson, Manager of State Advocacy and Grassroots Outreach at the American Foundation for Suicide Prevention (202-449-3600, ngibson@afsp.org).

## PURPOSE

The purpose of this 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. The district:

- (a) recognizes that physical, behavioral, and emotional health is an integral component of a student's educational outcomes,
- (b) further recognizes that suicide is a leading cause of death among young people,
- (c) has an ethical responsibility to take a proactive approach in preventing deaths by suicide, and
- (d) acknowledges the school's role in providing an environment which is sensitive to individual and societal factors that place youth at greater risk for suicide and one which helps to foster positive youth development.

Toward this end, the policy is meant to be paired with other policies supporting the emotional and behavioral health of students more broadly. Specifically, this policy is meant to be applied in accordance with the district's Child Find obligations.

## 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 need to be informed and actively involved in decisions regarding their child's welfare. Parents and 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.

Parents and guardians can also contribute to important protective factors – conditions that reduce vulnerability to suicidal behavior – 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 other vulnerable youth populations. Educators can help to protect LGBTQ youth by ensuring that parents and guardians have resources about family acceptance and the essential role it plays in youth health.<sup>3</sup>

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## DEFINITIONS

1. **At 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, as documented in the following procedures.

2. **Crisis team** A multidisciplinary team of primarily administrative, mental health, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention/response and recovery. These professionals have been specifically trained in crisis preparedness through recovery and take the leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.

3. **Mental health** A state of mental and emotional being that can impact choices and actions that affect wellness. Mental health problems include mental and substance use disorders.

4. **Postvention** Suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.

5. **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.

6. **Risk factors for suicide** Characteristics or conditions that increase the chance 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.

7. **Self-harm** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Can be categorized as either nonsuicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

8. **Suicide** Death caused by self-directed injurious behavior with any 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.

9. **Suicide attempt** A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

10. **Suicidal behavior** Suicide attempts, intentional injury to self associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

11. **Suicide contagion** The process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides.

12. **Suicidal ideation** Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.

## SCOPE

This 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.

## 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 needs of students.<sup>4</sup>

## RISK FACTORS AND PROTECTIVE FACTORS

**Risk Factors for Suicide** are characteristics or conditions that increase the chance that a person may try to take her or his life. Suicide risk tends to be highest when someone has several risk factors at the same time.

The most frequently cited risk factors for suicide are:

- Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)
- Problems with alcohol or drugs
- Unusual thoughts and behavior or confusion about reality
- Personality traits that create a pattern of intense, unstable relationships or trouble with the law
- Impulsivity and aggression, especially along with a mental disorder
- Previous suicide attempt or family history of a suicide attempt or mental disorder
- Serious medical condition and/or pain

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 for Suicide** are characteristics or conditions that may help to decrease a person's suicide risk. While these factors do not eliminate the possibility of suicide, especially in someone with risk factors, they may help to reduce that risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them.

Protective factors for suicide include:

- Receiving effective mental health care
- Positive connections to family, peers, community, and social institutions such as marriage and religion that foster resilience
- The skills and ability to solve problems

Note that protective factors do not entirely remove risk, especially when there is a personal or family history of depression or other mental disorders.

It is important for school districts to be aware of student populations that are at elevated risk for suicidal behavior based on various factors:

**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

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important risk factors for suicidal behavior among young people.<sup>5</sup> 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-harm or have attempted suicide.** Suicide risk among those who engage in self-harm is significantly higher than the general population. 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 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.<sup>6</sup>

**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.<sup>7</sup>

**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.<sup>8</sup> Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see [http://www.nctsn.org/nctsn\\_assets/pdfs/AI\\_Youth-CurrentandHistoricalTrauma.pdf](http://www.nctsn.org/nctsn_assets/pdfs/AI_Youth-CurrentandHistoricalTrauma.pdf).

**6. LGBTQ (lesbian, gay, bisexual, transgender, or questioning) youth.** 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.<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup>

**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.<sup>12</sup>

## PREVENTION

**1. District Policy Implementation** A district level suicide prevention coordinator shall be designated by the Superintendent. This may be an existing staff person. The district suicide prevention coordinator will be responsible for planning and coordinating implementation of this policy for the school district.

Each school principal shall 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. All staff members shall report students they believe to be at elevated risk for suicide to the school suicide prevention coordinator.

**2. Staff Professional Development** All staff will receive annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention.

The professional development will include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities.

## BEST PRACTICE: SUICIDE PREVENTION TASK FORCE

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 such a 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. Some school districts may choose to limit the activities of the task force to one or two years, as needed. Once the task force has expired, the district suicide prevention coordinator can assume the role of maintaining the list of community suicide prevention resources. Other school districts may choose to continuously maintain a core task force to maintain current standards and information and to educate new staff.

## 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 (e.g., <http://www.apa.org/pi/lgbt/resources/guidelines.aspx>).

Additional professional development in risk assessment and crisis intervention will be provided to school employed mental health professionals and school nurses.

### 3. 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, 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.

4. **Publication and Distribution** This policy will be distributed annually and included in all student and teacher handbooks and on the school website.

## 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, 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.

For youth at risk:

1. School staff will continuously supervise the student to ensure their safety.
2. The principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.
3. 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, and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local Emergency Department, but in most cases will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider.
4. Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

## IN-SCHOOL SUICIDE ATTEMPTS

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 transportation can be received, following district emergency medical procedures.
2. School staff will supervise the student to ensure their safety.
3. Staff will move all other students out of the immediate area as soon as possible.
4. If appropriate, staff will immediately request a mental health assessment for the youth.
5. 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.
6. Staff will immediately notify the principal or school suicide prevention coordinator regarding in-school suicide attempts.
7. The school will engage as necessary the crisis team to assess whether additional steps should be taken to ensure student safety and well-being.

## RE-ENTRY PROCEDURE

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 other designee will be identified to coordinate with the student, their parent or guardian, and any outside mental health care providers.
2. The parent or guardian will provide documentation from a mental health care provider that the student has undergone examination and that they are no longer a danger to themselves or others.
3. The designated staff person will periodically check in with student to help the student readjust to the school community and address any ongoing concerns.

## 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.<sup>13</sup> Research also suggests that young people who are already at heightened risk for suicide (see page 3, Risk Factors and Protective Factors) 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 other negative life events are at 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 completing suicide. 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 illogical thoughts that suicide is the only way to have a voice or to make a difference for others.

Whenever possible, discussions on bullying and suicide should center on prevention (not statistics) and encourage help-seeking behavior.

## RELEVANT STATE LAWS

There are numerous types of state laws, both positive and negative, that can affect risk factors for suicidal behavior among youth. A number of states limit the ability for young people to receive access to necessary mental health care. These laws can either limit access based on age, by requiring youth under 18 to receive parental permission before seeking mental health care, or by limiting mental health confidentiality – which can be an especially damaging problem for LGBTQ youth. Conversely, mandated suicide prevention training for school personnel can have a positive effect by ensuring that all school staff members have an understanding of suicide risk and the referral process. While currently less than half of all states require school personnel to receive suicide prevention training, the majority of the laws that are in existence were adopted during the 2012 and 2013 legislative sessions, suggesting a trend toward more state legislatures considering and adopting these laws moving forward.

Anti-bullying and nondiscrimination laws can also affect risk factors for suicidal behavior. While the majority of states have adopted some form of anti-bullying and harassment legislation, not all states specifically prohibit bullying and harassment on the basis of sexual orientation and gender identity. In addition, laws that stigmatize or isolate LGBTQ youth, often called “no promo homo” laws, can affect school climate in damaging ways. These laws prohibit educators from discussing LGBTQ people or issues in school or require these issues to be discussed in negative and stigmatizing ways. Research has shown that in states with these laws, LGBTQ students are more likely to hear homophobic remarks from school staff, less likely to report having supportive educators, and less likely to report that intervention by educators to prevent bullying and harassment is effective.<sup>14</sup>

## 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 911.
2. Inform the student’s parent or guardian.
3. Inform the school suicide prevention coordinator and principal.

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.

## 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 on “means restriction,” limiting the child’s access to mechanisms for carrying out a suicide attempt. Staff will also seek parental permission to communicate with outside mental health care 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. If contact is delayed, the reasons for the delay should be documented.

## POSTVENTION

### 1. 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 the following 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 cause of 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.
- 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 need for or scale of postvention activities may be reduced.
- c) **Share 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 the 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. The crisis team may prepare a letter to send home with students that includes facts about the death (with the input and permission of the parent or guardian), information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available.

## 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 was 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>.

- 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. In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting students who generate concern.
- 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 as needed. In concert

## MESSAGING AND 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, or
- when the headlines about specific deaths are framed dramatically (e.g., “Bullied Gay Teen Commits Suicide By Jumping From Bridge”).

Research also shows that suicide contagion can be avoided when the media report on suicide responsibly, such as by following the steps outlined in “Recommendations for Reporting on Suicide” at [www.reportingonsuicide.org](http://www.reportingonsuicide.org).

Contagion can also play a role in cases of self-harm behavior. These behaviors may originate with one student and can spread to other students through imitation. 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 may 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. Refer to the American Foundation for Suicide Prevention’s “After a Suicide” resource listed in the Resources section for sample notification statements for students and parents/guardians, sample media statements, and other model language.

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.

with parents or guardians, crisis team members will refer to community mental healthcare 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.

2. **External Communication** The school principal or designee will be the sole media spokesperson. Staff will refer all inquiries from the media directly to the 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.

## RESOURCES

### GUIDEBOOKS AND TOOLKITS

“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  
<http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf>

“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)

“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>

“Trevor Resource Kit” – The Trevor Project  
<http://www.thetrevorproject.org/pages/intro-to-trevor-resource-kit>

“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>

### SCHOOL PROGRAMS

“Signs of Suicide Prevention Program (SOS) – Screening for Mental Health, Inc.  
<http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/>

“American Indian Life Skills Development/Zuni Life Skills Development” – University of Washington  
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=81>

“Lifeguard Workshop Program” – The Trevor Project  
<http://www.thetrevorproject.org/LWP>

“More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel” – American Foundation for Suicide Prevention  
<http://morethansad.org>

### CRISIS SERVICES FOR STUDENTS

National Suicide Prevention Lifeline: The Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis or their friends and loved ones. Call 1.800.273.8255 (TALK). Callers are routed to the closest possible crisis center in their area.  
<http://www.suicidepreventionlifeline.org>

The Trevor Lifeline: The only nationwide, around-the-clock crisis intervention and suicide prevention lifeline for lesbian, gay, bisexual, transgender, and questioning young people, 13-24, available at 1.866.488.7386.

TrevorChat: A free, confidential, secure instant messaging service that provides live help to lesbian, gay, bisexual, transgender, and questioning young people, 13-24, through <http://www.TheTrevorProject.org>

### RELEVANT RESEARCH

“Youth Risk Behavior Surveillance System” – Centers for Disease Control and Prevention. Monitors health-risk behaviors among youth, including a national school-based survey conducted by CDC and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.  
<http://www.cdc.gov/healthyyouth/yrbs/index.htm>

2012 National Strategy for Suicide Prevention: A report by the U.S. Surgeon General and the National Alliance for Suicide Prevention outlining a national strategy to guide suicide prevention actions. Includes up-to-date research on suicide prevention.  
[http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full\\_report-rev.pdf](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf)

### WORKING WITH THE MEDIA

“Talking About Suicide & LGBT Populations” – Gay & Lesbian Alliance Against Defamation, Movement Advancement Project, American Foundation for Suicide Prevention, The Trevor Project, et al.  
<http://www.thetrevorproject.org/sites/default/files/Talking%20About%20Suicide%20and%20LGBT%20Populations.pdf>

“Recommendations for Reporting on Suicide” – American Foundation for Suicide Prevention, et al.  
<http://reportingonsuicide.org/>

## END NOTES

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## 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 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 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. For a more detailed review of policy changes, please see the district's full suicide prevention policy.



THE **TREVOR** PROJECT

[thetrevorproject.org](http://thetrevorproject.org)



[naspweb.org](http://naspweb.org)



[schoolcounselor.org](http://schoolcounselor.org)



AMERICAN FOUNDATION FOR  
Suicide Prevention

[afsp.org](http://afsp.org)