# SUICIDE PREVENTION GUIDELINES

Virginia Board of Education

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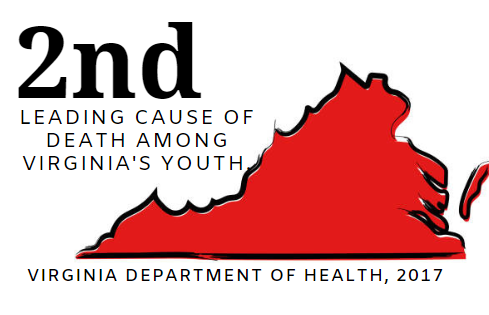
## Background

The 1999 General Assembly passed Senate Bill 1250 (S. Newman) directing the Board of Education, in cooperation with the Department of Behavioral Health and Developmental Services, and the Department of Health, to develop guidelines for licensed school personnel to use in contacting parents or, if conditions warrant, the local or state service agency when they believe a student is in imminent risk for attempting suicide. These guidelines were to include (1) criteria to assess the suicide risks of students, (2) characteristics to identify potentially suicidal students, (3) appropriate responses to students expressing suicidal intentions, (4) available and appropriate community services for students expressing suicidal intentions, (5) suicide prevention strategies which may be implemented by local schools for students expressing suicidal intentions, (6) criteria for notification of and discussions with parents of students expressing suicidal intentions, (7) criteria for as-soon-as practicable contact with parents, (8) appropriate sensitivity to religious beliefs, and (9) the legal requirements and criteria for notification of public service agencies. The guidelines were originally disseminated to school personnel in October 1999.

The 2000 General Assembly passed Senate Joint Resolution 148 (Houck) directing the Virginia Department of Health, with the assistance of the Virginia Commission on Youth, the Department of Behavioral Health and Developmental Services, the Department of Education, the Virginia Council on Coordinating Prevention, survivor groups, and other interested individuals, to develop a comprehensive youth suicide prevention plan. The Virginia “Youth Suicide Prevention Plan” (House Document 29, 2001) recommended that the Virginia Department of Education revise the Suicide Prevention Guidelines to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact has occurred. That revision was adopted by the Board of Education in 2003.

In 2000, *Virginia Code* [§ 9.1-184](https://law.lis.virginia.gov/vacode/title9.1/chapter1/section9.1-184/) created the Virginia Center for School and Campus Safety (VCSCS), located within the Department of Criminal Justice Services (DCJS), Division of Law Enforcement, to focus on improving and enhancing safety by addressing topics which affect Virginia law enforcement, schools, and institutions of higher education. The VCSCS is a resource and training center for information and research about national and statewide safety efforts and initiatives in K-12 schools and institutions of higher education. Through *Virginia Code* [§ 9.1-184](https://law.lis.virginia.gov/vacode/title9.1/chapter1/section9.1-184/), the VCSCS developed [*Threat Assessment in Virginia's Public Schools: Model Policies, Procedures, and Guidelines*](https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/law-enforcement/threat-assessment-model-policies-procedures-and-guidelinespdf.pdf) to provide schools with a model policy for the establishment of threat assessment teams, including procedures for assessment and intervention procedures for students whose behavior poses a threat to the safety of school staff or students. The *Model Policies* also include procedures for referrals to community services boards or health care providers for evaluation or treatment, when appropriate. Effective July 1, 2016, Virginia public schools were required to establish threat assessment teams.

To revise the guidelines, the Virginia Department of Education (VDOE) convened representatives from the aforementioned agencies, school division personnel, representatives from suicide prevention and mental health advocacy groups, and parents. The development process included the review of strong local policies, aligned with the latest research, and identified best practices for a national framework ([American Foundation for Suicide Prevention –AFSP- Model School Policy for Suicide Prevention](https://afsp.org/our-work/education/model-school-policy-suicide-prevention/)).



Youth suicide is a significant problem in both Virginia and the Nation. According to the Centers for Disease Control and Prevention (CDC) and the Virginia Department of Health’s [2017 OCME Report](http://www.vdh.virginia.gov/content/uploads/sites/18/2019/04/Annual-Report-2017.pdf), suicide is the **second** leading cause of death among young people ages 10-24. It is critically important that school divisions have policies and procedures in place to prevent, assess the risk of, intervene in, and respond to youth suicidal behavior. In an effort to protect the health and safety of all students, the Governor’s Children’s Cabinet Student Safety Workgroup recommended that the Virginia Department of Education (VDOE) update and disseminate the *Virginia Suicide Prevention Guidelines* to all school divisions in a timely manner in collaboration with the Virginia Department of Health (VDH), the Virginia Department of Behavioral Health and Developmental Services (DBHDS), and the Virginia Center for School and Campus Safety (VCSCS). In addition to the revised guidelines, VDOE maintains a [Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-) that includes suicide prevention strategies, screening tools, sample forms, and other resources. Once disseminated, agencies will be directed to update their model policies, training, and guidance documents to reflect the updated guidelines.

The Governor’s Children’s Cabinet Student Safety Workgroup recommended that the updated guidelines address: suicide prevention and intervention; screening; risk factors; messaging to students, staff, and parents and caregivers about recognizing and reporting behaviors; how and where to report concerning behaviors; engaging students during key transitional periods when data indicate that suicide rates are higher; how to engage students who may be experiencing suicidal thoughts; how to support students returning to school after treatment; postvention; and how to engage with students after a member of their community has died by suicide.

## Introduction

Schools are a key setting for suicide prevention. Teachers, mental health providers, and all other school personnel who interact with students can play an important role in keeping them safe (VDH, 2019). School personnel have a legal and ethical responsibility to recognize and respond to suicidal thinking and behavior. Schools must have clear policies and procedures for what to do, as well as trained school-employed mental health professionals and crisis response teams. Although many suicidal children and adolescents do not self-refer, most show some warning signs. **Never ignore these signs.** Suicide prevention should be an integral component of a multi-tiered system of mental health and safety supports (National Association of School Psychologists, 2019).

The best way to prevent suicide is to use a combination of efforts that work together to address different aspects of the problem. The key components are:

* + Promoting emotional well-being and connectedness among all students. Social supports and connections are key protective factors against suicide;
  + Identifying students who may be at risk for suicide and assist them in getting help; and
  + Being prepared to respond when a suicide death occurs through postvention.

As emphasized in the [National Strategy on Suicide Prevention](https://theactionalliance.org/our-strategy/national-strategy-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. Suicide prevention is considered part of a positive school climate. In a positive school climate, students are engaged, feel connected to their school and community, are provided equitable learning opportunities, and feel safe. School divisions are encouraged to assess their readiness to manage suicidal crises. A sample readiness form is included on [VDOE’s Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-).

Virginia school divisions are mandated to have threat assessment teams to assess and intervene with individuals whose behavior may pose a threat to the safety of school staff or students (*Code of Virginia* § 22.1-79.4). The Suicide Prevention Guidelines are meant to serve in conjunction with the [*Threat Assessment in Virginia's Public Schools: Model Policies, Procedures and Guidelines*](https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/law-enforcement/threat-assessment-model-policies-procedures-and-guidelinespdf.pdf)*,* and are intended to offer additional guidance to school threat assessment teams when addressing threats to self. Threat assessment teams can be leveraged to comprehensively address threats to others and threats to self. It is important to note that conducting a threat assessment for threats to self is a flexible process that requires oversight and guidance from a school mental health professional. More information about this process is detailed in Section 2 of these guidelines.

Model policies and best practices for Virginia school divisions were developed in an effort to protect the health and well-being of all Virginia students by helping school divisions develop procedures to effectively prevent, assess the risk of, intervene in, and respond to suicide. While the guidelines are comprehensively outlined, the policy language is modular and may be used to draft local school division policy based on the unique needs of each division.

As resources vary in Virginia school divisions, these guidelines are not intended to be prescriptive. However, every school division has the capacity to implement assessment and prevention procedures. **Any policy developed by the local school division should be reviewed and distributed annually, included in all student and teacher handbooks, and available on the school website.** The language and concepts covered by this policy are mostly applicable to middle and high schools (largely because suicide is very rare in elementary school-aged children). However, it is important that any school division policy modify procedures for managing threats to self in elementary aged students using developmentally appropriate language. Local school divisions should ensure that suicide prevention programs are linked as closely as possible with professional mental health resources in their community. Strategies designed to increase referrals of at-risk adolescents and young adults can be successful only to the extent that trained mental health professionals are available and mechanisms for linking at-risk persons with resources are operational. Establishing relationships with community resources prior to an event is key.

The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an updated list of [Resources for Suicide Prevention](https://www.sprc.org/resources-programs). Links to these and other resources are included in the [VDOE’s Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-).

**Three Layers: 
1. Prevention- efforts to create awareness, reduce the stigma around mental health and identify those in need of support. School-Wide Awareness Practices for: Students, Staff, Families and Communities. Proactive Procedures for Identifying Students in Need of Support.
2. Intervention: Responding when a student is having suicidal thoughts and supporting their needs. Responding and Assessing Threat, Safety Planning, Documenting, Planning for a Return to School
3. Postvention: Responding after a death by suifice in the school community. Crisis Team Considerations, Supporting and Monitoring Students, Messaging Considerations.**

## Section 1: Suicide Prevention

It is essential that school divisions have policies in place to respond to students at risk of suicide (such as how to interview a student making suicidal threats) before implementing schoolwide strategies to identify students at risk of suicide. Identifying students who are at risk of suicide is more likely to prevent suicide when the procedures that ensure that at-risk students receive appropriate services are in place. After school divisions have suicide response policies in place, they can implement other suicide prevention strategies. Guidance for responding to suicidal threats can be found in Section 2 of this document.

### School-Wide Awareness and Best-Practices

Any prevention plan should include the methods available for students, teachers, staff, parents, and community members to report concerning behaviors. School divisions may consider the use of a reporting system, such as [SaySomething](https://www.saysomething.net/) or [Safe2Tell](https://safe2tell.org/?q=home) that provide an anonymous way for students, parents, school staff, and community members to report concerns regarding their safety or the safety of others.

Schools should be continually engaged in suicide prevention activities throughout the year. Student and community messaging can occur through a variety of mediums including posters, social media campaigns, school announcements, and bulletin boards. The [Virginia Department of Health’s Suicide Prevention Electronic Tool Kit for Schools](http://www.vdh.virginia.gov/suicide-prevention/) includes a variety of resources for messaging.

### Professional Development for School Staff

Staff trainings should be conducted by trained mental-health professionals (such as school counselors, school psychologists, school social workers, or community mental health personnel). When trainings are provided by an outside agency or program, school-employed mental health professionals should be involved in the design and delivery to ensure alignment with local policies and procedures.

**Professional development for staff should include the following components:**

1. Identifying and addressing common myths about suicide;
2. Understanding protective factors;
3. Recognizing risk factors & warning signs of youth suicide;
4. Responding to students and procedures for reporting concerns (emphasis on immediate referrals and student supervision);
5. Providing a brief overview of the threat assessment process (including re-entry plans);
6. Identifying mental-health resources in building and community; and
7. Cultivating a climate with connections between students and adults who are approachable and trusted.

The following resources, from the Suicide Prevention Resource Center, are helpful to better understand the [*Role of Teachers in Preventing Suicide*](https://www.sprc.org/resources-programs/role-high-school-teachers-preventing-suicide-sprc-customized-information-page) and the [*Role of High School Mental Health Providers in Preventing Suicide*](https://www.sprc.org/resources-programs/role-high-school-mental-health-providers-preventing-suicide-sprc-customized). Additionally, the [Virginia Department of Health](http://www.vdh.virginia.gov/suicide-prevention/) (VDH) provides free brochures for teachers, parents, and peers about suicide prevention. For more information, please visit [VDOE’s Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-).

### Professional Development for Threat Assessment Teams

School mental health professionals and staff who will conduct andparticipate in threat assessments for threats to self need additional annual training. Additionally, refresher training should occur throughout the year and be reviewed after each threat assessment. Reviews should consider accuracy and lessons learned.

**Threat Assessment team training for threats to self should include the following:**

1. Discussion about the implementation process for assessment;
2. Opportunities to discuss:
   1. Table-top case studies,
   2. Factors that may complicate the assessment procedure,
   3. Roles and responsibilities in the process,
   4. Family engagement, and
   5. Student reentry;
3. Opportunities to practice:
   1. Student interviewing, and
   2. Completing forms and plans;
4. Documentation procedures;
5. Resource mapping of available mental-health supports (both inside and outside of the school setting); and
6. The school’s crisis plan for postvention response.

### Student Suicide Prevention Education

Students are introduced to concepts, such as mental illness and depression in the [2020 Proposed Health Education Standards of Learning](http://www.doe.virginia.gov/boe/meetings/2019/10-oct/item-j.docx). Students learn about different emotions and how to respond to them, identify the mental health providers that are in the school, and when to seek support. Suicide prevention education programs expand on those concepts. Students learn about suicide, its warning signs, and how to seek help for themselves or others. Suicide prevention information provided for students should be selected very carefully and utilize evidence-based programs. School-based mental health professionals should be involved in the selection and delivery of any suicide prevention programs provided to students. School teams should regularly assess suicide prevention programs to ensure their effectiveness and relevance.

Suicide is best discussed in a classroom setting being led by a school mental health professional with the teacher present and attentive. Consideration should be made for encouraging student engagement, including opportunities for student questions, and monitoring of student reactions. Therefore, **school assemblies on suicide alone are not considered best practice.**

**Student suicide prevention programs should help students:**

1. Identify risk factors and warning signs of suicide in self and others;
2. Develop coping strategies;
3. Identify trusted adults in the school and community that can help;
4. Reduce stigma associated with mental illness;
5. Identify and address common myths about suicide;
6. Incorporate social-emotional learning; and
7. Build protective factors.

In accordance with [*Virginia Code* § 22.1-207.2:1.](http://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+CHAP0581+pdf) , “*school division policies must ensure that parents have the right to review materials that contain graphic sexual or violent content used in any suicide prevention program and that the parent of the child participating shall be provided written notice of his right to review the material and his right to excuse his child from participating in the part of such program utilizing such material.”*

### Suicide Prevention Education for Families & Communities

Families and communities play an important role in suicide prevention. When communities have knowledge about the risks of suicide, protective factors that reduce risk, and resources, they can support vulnerable youth and promote building social connectedness.

**Community and family suicide prevention programs should help participants:**

1. Identify risk factors and warning signs of suicide;
2. Identify protective factors;
3. Identify mental-health resources in the school and in the community;
4. Identify procedures for obtaining assistance for suicidal students both at school and in the community (including local emergency services contact information);
5. Reduce stigma associated with mental illness;
6. Identify and address common myths about suicide;
7. Learn to talk to children about suicide; and
8. Learn how to reduce teenagers' access to lethal means (e.g., locking up firearms and storing medication safely). Lethal means safety programs, such as [Lock and Talk](http://www.lockandtalk.org/) are available and may be used.

### Comprehensive Prevention Strategies

The following strategies are part of a comprehensive approach to suicide prevention and should be included in training programs. These strategies are offered in no particular order.

* Screen Students

According to guidance developed under SAMHSA leadership with input from experts in the field of youth suicide prevention,“Whenever possible, community suicide prevention efforts should begin with a strategic planning effort that assesses the local context and the available resources to address the problem. Due to the nature of suicidal behaviors, the strategic planning process should result in a comprehensive prevention approach.” SAMHSA provides recommendations to be considered when implementing [school-based suicide risk screening](https://www.sprc.org/sites/default/files/resource-program/Recommendations%20for%20School-Based%20Suicide%20Prevention%20Screening.pdf).

Mental health screening and practices should be incorporated into any existing school-wide initiatives, such as Positive Behavioral Intervention Supports (PBIS) or Virginia Tiered Systems of Supports (VTSS). Implementing a tiered approach to screening and intervention of mental health concerns may reduce negative outcomes. [SAMHSA's Ready, Set, Go](https://www.samhsa.gov/sites/default/files/ready_set_go_review_mh_screening_in_schools_508.pdf) provides additional guidance for mental health screening in schools.

**Screening programs.** A questionnaire or other screening instrument is given to all students to identify students that may require further assessment and treatment. Repeated assessment can be used to measure changes in attitudes or behaviors over time, to test the effectiveness of a prevention strategy, and to detect potential suicidal behavior. Examples of evidence-based screening measures are included on [VDOE’s Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-).

* Know the Warning Signs for Suicide

**Warning signs** are signs and indicators that someone may be in danger of harming themselves and requires an immediate referral to the threat assessment team. Warning signs can include but are limited to:

* Talking/writing about or making plans for ending their life/suicide;
* Expressing hopelessness about the future;
* Displaying severe/overwhelming emotional pain or distress;
* Attempts to acquire lethal means (i.e., gun, pills, rope); and
* Showing worrisome behavioral cues or marked changes in behavior, which could include:
  + - Withdrawal from or changing in social connections/situations;
    - Changes in sleep (increased or decreased);
    - Anger or hostility that seems out of character or out of context; and
    - Recent increased agitation or irritability.

**A suicide attempt or suicidal behavior** is a serious warning sign. This can include self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A mixture of ambivalent feelings such as a wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not indicative of a less dangerous warning sign. 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 is considered suicidal behavior.

Suicidal ideation is another warning sign for teams to be aware of. This is when a person is 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 considered suicidal ideation and should be taken seriously.

* Recognize Self-harm Behaviors

**Self-harm** is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. It can be categorized as either non-suicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide. The risk of both suicide attempts and suicide is significantly higher in those who have engaged in non-suicidal self-injury (NSSI). Among those with a history of NSSI, 70 percent have attempted suicide at least once and 55 percent have attempted suicide several times.

* Recognize Risk Factors for Suicide

Suicide **risk factors** are 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. Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause, and considering multiple levels of focus from the individual, relationship, community, and society is a useful framework for viewing and understanding suicide risk and protective factors.

**Risk Factors** can exist at any of the following levels:

* **Individual level:** history of depression and other mental illnesses;

hopelessness, substance abuse, certain health conditions, difficulty adjusting during transitional periods, previous suicide attempt, bullying, violence victimization and perpetration, and genetic and biological determinants;

* **Relationship level:** history of high conflict or violent relationships, sense of isolation and lack of social support, family/loved one’s history of suicide, and financial and work stress;
* **Community level:** inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications); and
* **Societal level:** availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness.

(The above risk factors are from [*Preventing Suicide: A Technical Package of Policy, Programs, and Practices by the Center for Disease Control, 2017)*.](https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf)

* Identify and Monitor Vulnerable Student Populations

It is important for school divisions to be aware of vulnerable student populations that are at elevated risk for suicidal behavior as these students may require additional resources and/or supports. For students within vulnerable populations, building protective factors through social-emotional or other targeted practices may help them develop strategies to reduce their risk of suicide. Vulnerable populations are based on various factors that may include those described below.

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 bipolar (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. School staff may play a pivotal role in recognizing and referring students to treatment that may reduce risk.

1. **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.

1. **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.

1. **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.

1. **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. 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.

1. **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.

1. **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.

1. **Military youth**

A large study in California found that adolescents with parents or siblings serving in the military are at increased risk for suicidal ideation, feeling sad or hopeless, and depression. These risks increase if the family members in the military are deployed. The deployment of a family member was associated with a further increase in the likelihood of an adolescent’s feeling sad or hopeless, or of experiencing depressive symptoms. The authors report that “among ninth and eleventh graders, reporting two or more family member deployments was associated with a 34 percent increase in the odds of suicidal ideation compared with those with no deployment experience.” (Benbenishty, R., et al. 2014.)

* Plan for Key Transitional Periods

When students return to school after a threat assessment or after hospitalization, threat assessment teams must bridge the transitions from inpatient care, emergency department, primary care, or home to school. This transition is discussed in great detail in the “*Supporting* *Students Returning to School after Treatment”* section.

There is a need to expand suicide prevention efforts during transition periods from one school to another (due to either grade promotion or relocation). During these transitions, protective factors such as access to supportive adults or peer groups may be unintentionally removed. Schools should discuss how they can communicate with receiving schools during these transitions to ensure that students who have been at-risk of suicide in the past are monitored or provided supports. Young adults (i.e., late high school into post-secondary or college) experience a substantially higher suicide rate. More prevention efforts should be targeted toward young adults at high risk for suicide.

## Section 2: Suicide Intervention

### Responding When Students are Experiencing Suicidal Thoughts

When a student is referred due to threats to self, the student will remain supervised for their safety and be seen by a mental health professional on the same school day to assess risk and determine the need for mental health intervention. The mental health professional will conduct a risk assessment as part of the threat assessment process.

### Conducting a Threat Assessment for Threats to Self

When an individual makes a threat or engages in concerning communications or behaviors that suggest the likelihood of a threatening situation, the school division’s Threat Assessment Guidelines shall be followed. The goal of the threat assessment process is to take appropriate preventive or corrective measures to maintain a safe and secure school environment, to protect and support potential victims, and to provide assistance, as needed, to the individual being assessed. The Suicide Prevention guidelines are meant to serve in conjunction with the *Threat Assessment in Virginia's Public Schools: Model Policies, Procedures, and Guidelines,* and are intended to offer additional guidance to school threat assessment teams when addressing threats to self.

#### Threat Assessment Team

In accordance with [§ 22.1-79.4. of the *Code of Virginia*](https://law.lis.virginia.gov/vacode/22.1-79.4/), the school threat assessment team should include personnel with expertise in counseling (e.g., a school counselor, a school psychologist, and/or a school social worker), instruction, school administration (e.g., a principal or other school administrator), and law enforcement (typically a school resource officer). Other staff, such as school nurses, community services board counselors, therapeutic day treatment counselors, or other community members may serve as regular members of the team, or they may be consulted during the threat assessment process, as appropriate, and as determined by the team. When conducting a threat assessment for threats to self, school personnel with expertise in counseling (i.e. school mental health professionals) would likely lead and manage the team response while maintaining communication and consultation with team members.

#### Assessment Steps

The following steps are suggested best practices for assessing a threat to self. In some cases not all six steps will be necessary and the order in which each step is carried out may vary depending on the nature of the situation. This list is not meant to be prescriptive, instead it is meant to highlight the different components that can occur during the threat assessment process when addressing threats to self.

1. **Identify Student of Concern or Referral.** A referralis received by a member of the threat assessment team. A student may be referred to the threat assessment team by any of the following sources:

* teacher,
* parent/family,
* another student,
* administrator,
* community member,
* student self-report, or
* a suicide screening.

1. **Case Management.** The team should determine which member will serve as case manager. The case manager will ensure that all necessary assessment components are completed. The case manager will serve as a liaison between the student/family and school staff. Thus, the identified case manager needs to be someone available to the student in the school setting.Additionally, the case manager should be someone with proficient training in suicide risk assessment and crisis intervention.
2. **Gather Information.** Conducting a threat assessment is a team process, which requires the expertise of many professionals. The student interview is the most critical piece of information to be gathered. In the context of the threat assessment process, the [suicide risk assessment](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml) conducted with the student is analogous to the student interview.

The **student interview** is conducted by one or more school mental health professionals with training in suicide risk assessment and crisis intervention. In some divisions, student interviews may be conducted by community mental health professionals, if an agreement (i.e., Memorandum of Understanding) has been established. Sample student interview questions are included on [VDOE’s Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-).

The person conducting the student interview should ask about both thoughts of harming self and thoughts of harming others. The person conducting the student interview should be sensitive to the student’s cultural and religious beliefs. The student interview should include questions to determine:

* + The student’s risk factors, warning signs, and protective factors;
  + The student’s intent to carry out suicide as to frequency, duration, and intensity of suicidal thoughts;
  + If the student has a plan (When? Where? How?); and
  + If the student has a history of suicide attempts and/or self-injury.

Ideally, the student interview is as collaborative as possible. Part of the role of the mental health professional is to help the student participate in the conversation, to better understand their own thoughts of suicide, and to contribute to safety planning. As a result, a person with thoughts of suicide will often uncover uncertainty about dying, connections to life, and reasons to plan for safety (even if only for the short term). These key strategies increase the likelihood that the student will feel personally invested in staying safe.

In addition to the student interview, the team will determine the need for additional information to gather, which may include a review of student records and interviews with teachers, peers, parents, and others as warranted by the situation. This information can be compiled by any member of the threat assessment team.

1. **Team Consultation.** Team consultation is an integral part of every assessment. The school mental health professional who conducted the student interview along with relevant team members review the information and data collected to make a preliminary determination of risk threat. Some situations may require that the full-team be convened to support a thorough review. The team discusses impressions and ideas and determines if more information is needed. Always assure the safety of the student. Have another adult observe the student at all times if the team feels the student is at risk for self-harm. Teams should also consider if sending the student home via their normal transportation mode is a safe option or whether a parent/guardian needs to pick them up.
2. **Parent/Guardian Contact.** Parent contact occurs following the collection and review of the data and the conclusion of the student interview. In accordance with [Virginia Code 22.1-272.1/](https://law.lis.virginia.gov/vacode/title22.1/chapter14/section22.1-272.1/), “*the parents of any student in imminent risk of suicide, shall, as soon as practical, be contacted*.” Parent contact should be considered in almost every case regardless of the outcome of the suicide risk assessment. The parent should be contacted the day the assessment is conducted and should be told the team’s assigned risk level, what that means, and recommended next steps. However, *“if the student has indicated that the reason for being at imminent risk of suicide relates to parental abuse or neglect, this contact shall not be made with the parent but instead, notify the local department of social services.”*

The parent can be interviewed to gather additional information needed to complete the assessment and to gauge the parent’s ability and intent to follow recommendations. Consider whether information from the parent interview changes the preliminary determination of risk level. For example, learning that the parent has seen concerning behaviors at home may change the Team’s determination of risk level. Participation by the School Resource Officer (SRO) can be helpful to assist with educating families about lethal means safety.

1. **Determine Risk.** Evaluate the information gathered to determine whether the student poses a threat of harm to self. The risk levels below are intended to assist with decision-making and are aligned to the [*Threat Assessment in Virginia's Public Schools: Model Policies, Procedures, and Guidelines*](https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/law-enforcement/threat-assessment-model-policies-procedures-and-guidelinespdf.pdf). However, school divisions may choose to use a different suicide risk model when evaluating levels of risk. Always err on the side of safety and prevention and ***when in doubt, choose the higher risk and/or threat level.***

#### Determinethe Risk-Level

***Take every warning sign or threat of self-harm seriously.***

**No risk**

*The student does not appear to pose a threat of violence or serious harm to self.*

Students with no risk of suicide may be referred when something the student says or writes is construed as a threat to self. The assessment may suggest that a comment was taken out of context, and there is no indication of a mental health concern. The student is connected socially, is well supported by his family, and teachers report no concerns.

***Students identified at any level of suicide risk should receive some type of mental health intervention or support.***

**Low risk**

*The student does not appear to pose a threat of violence or serious harm to self and underlying issues can be resolved easily.*

Students with a low risk of suicide display warning signs of suicide and/or express thoughts of killing themselves with no intent to act on these thoughts. The threat is vague or indirect. For example, the student may say, *“I just want to die”* or “*I wish I were never born.''* The threat lacks detail. For example, the student may say, *“I will take an overdose of three Aspirins.”* You feel the threat was made without thought or planning. The student is connected socially, and has a good support system, but there may be mental health concerns. An intervention or support plan should be developed and the parent may be contacted depending on individual circumstances.

**Moderate risk threat**

*The student does not appear to pose a threat of violence or serious harm to self at this time, but exhibits behaviors that indicate a continuing intent and potential for future violence or serious harm to self/others; and/or exhibits other concerning behavior that requires intervention.*

Students with a moderate risk of suicide could display suicidal ideation or behavior with an intent or desire to die. There is a more direct and concrete threat but it does not seem like something the student will act on. For example, the student may say, *“I thought about hanging myself but I don’t want to die.”* The student may have given some thought about how to carry out the threat, but no clear steps have been taken or planned. For example, the student may say, *“My dad has a gun but I don’t know where the bullets are or how to load it”* or *“I don’t know what will happen tonight because no one will be home.”* A safety plan should be developed, the parent(s) contacted, and the student should be referred for immediate crisis counseling or hospitalization. The parent(s) should not be notified if the student has indicated that the reason for being at risk of suicide relates to parental abuse or neglect*.* In such a case, the local department of social services is contacted instead.

**High risk threat**

*The student appears to pose a threat of violence, exhibiting behaviors that indicate both a continuing intent to harm and efforts to acquire the capacity to carry out the plan, and may also exhibit other concerning behavior.*

Students with a high risk of suicide may perceive little or no availability of support and may have taken steps toward carrying out a plan. For example, the student may say, *“I’ve unlocked the window of my third story bedroom and I’m going to jump.”* The student could display suicidal ideation or behavior with an intent or desire to die. The student’s threat is direct, specific, and plausible. For example, the student may say, *“I’m going to take all of my mom’s pills.”* A safety plan should be developed, the parent(s) contacted, and the student should be referred to crisis counseling and/or for hospitalization for immediate help. The parent(s) should not be notified if the student has indicated that the reason for being at imminent risk of suicide relates to parental abuse or neglect*.* In such a case, the local department of social services is contacted instead.

**Imminent threat**

*The student appears to pose a clear and immediate threat of serious violence to self and may also exhibit other concerning behavior that requires intervention.*

Students at this risk level likely display suicidal ideation with an intent to die. Imminent threat indicates that you believe serious violence will happen within the next 24 hours if steps are not taken to prevent it. For example, the student may say, *“I’m going home today and cutting my wrists,”* or *“When I get home I will be alone and I am going to get a gun from the gun safe, load it, and shoot myself.”* The student may perceive little or no availability of support. A safety plan should be developed, parent(s) contacted, and the student should be referred to crisis counseling and/or for hospitalization for immediate help. The parent(s) should not be notified if the student has indicated that the reason for being at imminent risk of suicide relates to parental abuse or neglect*.* In such a case, the local department of social services is contacted instead.

### Safety Planning, Interventions, and Protective Factors

A **safety plan** is a list of coping strategies and sources of support developed by the student and parent, if available, in collaboration with a mental health professional and other available team members. As part of the team review, the case manager should ensure that a safety plan is developed. The Suicide Prevention Resource Center has developed a [Safety Planning Guide](http://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.pdf) to guide clinicians through this process. The safety plan outlines the steps necessary to keep the student safe from harming themselves and should include:

1. Warning signs that a crisis may be developing;
2. Internal coping strategies that the student can use;
3. The people and places that improve the student’s mood and make them feel safe;
4. The trusted people the student can go to for help in a crisis;
5. Who to contact in an emergency (available 24/7); and
6. The immediate steps the student can take during a suicidal crisis.

[The National Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/) **1-800-273-TALK (8255)** is available 24 hours a day, 7 days a week.

#### Building Protective Factors in a Safety or Intervention Plan

**Protective factors** are those “*environments, supports, and behaviors that act opposite to risk factors. The more protective factors that are present, the less likely a young person is to develop a mental health or substance use disorder*.” (Youth Mental Health First Aid Training Manual, 2015, National Council for Behavioral Health and the Missouri Department of Mental Health). When students are identified as having risk factors, there should be efforts to build those students’ protective factors. The skills and strategies that children and teens gain through social and emotional learning (SEL) have been shown to increase protective factors and reduce risk factors associated with suicide*.* Effective SEL develops skills in problem solving, conflict resolution, nonviolent ways of handling disputes, as well as a sense of connectedness; all of which serve as protective factors for youth against suicide and other self-destructive behaviors during transitions or crises. Further, by implementing SEL in schools, students, teachers, and administrators are more aware of and skilled in identifying and responding to mental health issues when the behavior first presents itself.

**The following are some examples of student protective factors:**

* Psychological or emotional well-being, positive mood;
* Coping skills, conflict resolution, and nonviolent handling of disputes;
* Adaptable temperament;
* Strong problem-solving skills;
* Cultural and religious beliefs that discourage suicide and promote self-preservation;
* Access to and effective clinical care for mental, physical, and substance abuse disorders;
* Strong connections to family and parental involvement;
* Close friends and community support;
* Positive school experiences;
* Feeling safe at school (especially for lesbian, gay, bisexual, and transgender youth);
* A sense of connectedness to the school;
* Adequate academic achievement;
* Limited access to firearms; guns locked or unloaded, and ammunition stored and locked;
* Limited access to medications (over-the-counter and prescriptions); and
* Limited access to alcohol (since there is an increased risk of suicide by firearms if the victim is drinking).

See the Centers for Disease Control and Prevention (CDC)’s [Healthy Youth: School Connectedness](https://www.cdc.gov/healthyyouth/protective/pdf/connectedness.pdf) for strategies for increasing protective factors in youth.

#### Parent Agreement in the Safety Plan

The student’s safety plan should be shared with the parent and reviewed so the parent is aware of the content and knows what to do in case of a crisis. A parent agreement form should be used with every student that has been assessed to be at risk for suicide and should include:

1. Student’s name, date of birth, and grade;
2. Parent(s) name and phone number;
3. Date of the threat assessment for suicide;
4. Name(s) of the person(s) who conducted the student interview;
5. Mental health referral information, if made;
6. The steps that the parent is taking to keep the student safe;
7. Emergency contacts outside of school, in case of a crisis; and
8. Parent’s signature.

The form could also include community resources, school resources, and follow-up interventions. This form may be useful with any threat assessment, if the team would like to have documentation about what it has shared with the parent, and if there are specific safety factors that the parent is agreeing to do, such as securing their home by removing or locking up weapons and medications.

A copy of the parent agreement should be given to the parent and included with the threat assessment paperwork. In accordance with [§ 54.1-2969.](https://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2969/), students are able to provide consent for their own mental health treatment. If a parent refuses to sign the parent agreement form and/or refuses to follow recommendations, the team needs to consider whether this places the child in greater danger. Depending on the student's situation, the parent’s unwillingness to participate may increase the level of concern and warrant collaboration with the school resource officer, other law enforcement personnel, child protective services, or community mental health.

### Documentation

Each local school division should develop and implement documentation procedures for each threat assessment. The [*Model Policy Threat Assessment Triage Form*](https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/law-enforcement/threat-assessment-model-policies-procedures-and-guidelinespdf.pdf)(p. 33) in *Virginia’s Model Policies for Threat Assessment* is a way to consistently document all threat assessments completed. School divisions should determine where completed documentation forms are maintained in order to ensure the privacy and confidentiality of the student. School division procedures should include a method to ensure that threat assessment documentation follows students through each educational level. Records should transfer with the student from elementary to middle and middle to high school. This documentation should **not be housed in the student’s confidential educational records**. A sample documentation form is provided on [VDOE’s Suicide Prevention Webpage](http://www.doe.virginia.gov/support/prevention/suicide/index.shtml-).

Documentation of each assessment should include:

* Student’s identifying information;
* Reason for referral and referral source;
* Date of the assessment;
* Team members who participated;
* Identified case manager;
* Type of threat assessment;
* Assessed risk level/team determination;
* Person who notified the parent and when;
* Whether or not a safety plan was completed;
* Where the student was referred for crisis or mental health treatment;
* Resources given to the family; and
* Name of the person assigned to initiate a follow-up or re-entry meeting.

### Supporting Students Returning to School after Treatment

School division policies should include procedures for holding a re-entry meeting for any student returning to school following a mental health crisis. The meeting should be scheduled prior to or on the day of the student’s return to school, which may depend upon hospitalization or other interventions.

A re-entry meeting and the completion of a re-entry support plan form (for example, [*Model Policy Threat Assessment Triage Form*](https://www.dcjs.virginia.gov/sites/dcjs.virginia.gov/files/publications/law-enforcement/threat-assessment-model-policies-procedures-and-guidelinespdf.pdf)*)* should be required for any student returning to school after a mental health crisis. The case manager should contact the parent or guardian by phone or letter to arrange the meeting. If by phone, a notification letter should be given to the parent on the day of the meeting. **This meeting should also occur when a student returns from a parent/student initiated mental health treatment.**

**Who should be included in the re-entry meeting?** The team may include:

* Threat assessment team case manager;
* School psychologist, school counselor, and/or school social worker;
* School nurse;
* Student and family;
* School administrator;
* School Resource Officer (if necessary); and
* Community mental health care provider (if available).

The purpose of the meeting is to work toward identifying and addressing the issues that led to the crisis. The goals of the meeting are to update the team on progress and current student concerns, identify the needed supports for the student, and ensure safety for the student. School staff should secure a release to exchange information with the student’s mental health provider so the school and the provider can coordinate safety efforts. If the team suspects a disability, the student should be referred for section 504 or special education consideration.

After the Team identifies needed supports, they are listed in the transition plan as actions to be taken by the school, parent, or student. Persons responsible for each action should be named. The case manager has the responsibility for communicating the plan to other team members and school staff, monitoring the plan, and reconvening the team for monitoring. Team members, parents, and the student sign the plan and a copy is given to the parent and student. The plan should be attached and stored with the threat assessment, and the case manager should also keep a copy for student monitoring.

**Examples of Follow-Up Supports Include:**

* Modify the student’s schedule and course load to relieve stress;
* Work with teachers to allow make-up work to be extended without penalty;
* Arrange for tutoring or any extra academic supports that may be needed;
* Check-in with school counselor and/or other school staff at specified intervals and/or as needed;
* Allow visits to school nurse for medication monitoring; and
* Identify additional community resources for the family.

## Section 3: Postvention, After a Suicide

When a student or staff member dies by suicide, school teams must respond in an empathetic and factual way. Suicide postvention is a crisis intervention strategy designed to provide the support needed to help survivors cope with a death by suicide, reduce the risk of suicide and suicide contagion, address the social stigma associated with suicide, and disseminate information after the death by suicide of a member of the school community.

Each school division’s suicide prevention policy or crisis plan should include guidelines for postvention to address school and community needs when a member of the school community dies by suicide. The American Foundation for Suicide Prevention (AFSP) [After a Suicide: A Toolkit for Schools](https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools/) assists schools in implementing a coordinated response to the suicide death of a student. The following principles guided the development of the toolkit.

* Schools should use consistent practices when memorializing the lives of students. For example, if your school has previously planted a tree in remembrance of a student but did not do so for a student who died by suicide, you run the risk of reinforcing the negative association that often surrounds suicide.
* Suicide contagion is the exposure to suicidal behaviors within one’s family, one’s peer group, or through media which can result in an increase of suicide or suicidal behaviors. Therefore, it is important not to inadvertently simplify, glamorize, or romanticize the student or his or her death.
* Adolescents are also resilient. With the proper information, counseling, and support from school staff, students can learn to cope with the suicide of a fellow student, process their grief, and return to healthy functioning.
* Suicide has multiple causes. However, a student who dies by suicide was likely struggling with significant concerns, such as a mental health condition, that caused substantial psychological pain even if that pain was not apparent to others. But it is also important to understand that most people with mental health conditions do not attempt suicide.

### Developing a Crisis Response

Each school’s crisis team should develop a plan to guide the school’s response following a death by suicide. The crisis team should meet immediately following news of the death by suicide and implement the plan, which may include the steps listed below.

**Verifying 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, and/or police department. Even when a case is perceived as being an obvious instance of death by 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.

**Assessing 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.

**Communicating with the family**

The school principal or designee should contact the family. That person should express sympathy as she would for any sudden death. The contact person may ask what the school can share about the student’s death. If the family is unwilling or not ready to share, help the family craft a message that they do want released in order to minimize rumors, misinformation, and speculation. Acknowledge that this is a great tragedy and assist them in understanding that crafting a message about the cause of death will help their child’s friends who are suffering.

* Ask what the school can do to support siblings.
* Ask what the school can do to support them.
* Discuss concerns they may have for siblings, friends, or acquaintances and follow up accordingly.

**Sharing 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.

**Public address announcements and schoolwide assemblies should be avoided.**

**School faculty** should be informed that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement to share with students should include:

* + - Basic facts of the death and known funeral arrangements without providing details of the death itself;
    - Recognition of the sorrow the news will cause; and
    - Information about the resources available to help students cope with their grief.

The crisis team may prepare a letter (with the input and permission from the student’s parent or guardian) to send home with students that includes:

* + - Established facts about the death;
    - Information about what the school is doing to support students;
    - Warning signs of suicidal behavior; and
    - A list of resources available.

### Supporting and Monitoring Students

Following a traumatic event, such as death by suicide, students may react with a variety of emotions. Adolescents are still struggling to manage complex emotions and may not recognize physical indicators of distress, such as sleeplessness, restlessness, and stomach upset. Students may be openly emotional, may be reluctant to talk, and may react with humor. It is important to allow students an opportunity to identify and express their feelings. Along with validating student feelings, it is important to offer practical coping strategies.

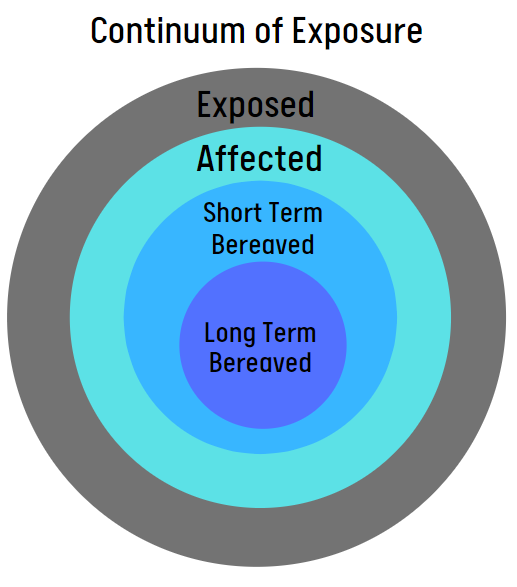
**Suicide contagion** is the process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides. To avoid this, it should be explained in the staff meeting (described above) that one purpose of trying to identify and offer support 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 present with concerns.

#### Initiating Student Supports

Students identified as being more likely affected by the death will be assessed by a mental health professional to determine the level of support needed. Those students might be sibling(s), relatives, friends, teammates, etc. of the decedent. Vulnerable student populations (discussed in Section 1: Suicide Prevention) may be more affected than the general school population. School mental health professionals in other school buildings need to be notified in case their students might be affected. Other affected youth might include students that have experienced a loss or have other suicide risk factors. The crisis team will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, crisis team members will refer students or families to community mental health providers to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs.

#### Addressing the Needs of Suicide Survivors

A suicide loss survivor “is someone who experiences a high level of perceived psychological, physical and/or social distress for a considerable length of time after exposure to the suicide of another person.” (Survivors Task Force, 2015). Research has shown that people exposed to suicide are at greater risk for mental health symptoms. When determining how to manage resources effectively and address student needs, it is important to recognize those most at risk. Researchers (Cerel, et al) developed the framework below to conceptualize the continuum of exposure and those most at risk.



* The ***exposed*** category includes absolutely anyone whose life or activities in any way intersect with a particular suicide fatality.
* The ***affected*** category is a subset of those exposed and includes everyone who has a reaction to the suicide that might require some type of assistance, whether the reaction is due to grief or some other issue, such as posttraumatic stress disorder (PTSD).
* The ***short-term bereaved*** category is a subset of those affected and includes everyone who has a reaction that is clearly related to grief, meaning that it stems from some type of personal or close relationship between the bereaved person and the deceased. The bereavement of people in this category would last for a duration that might be called “typical” in the wake of the death of a loved one by any cause.
* The ***long-term bereaved*** category is a subset of those bereaved short-term and includes all bereaved people who encounter extraordinary difficulties in the course of their grief. Their intensive bereavement is likely to endure for at least a year or longer. The individuals in this category are likely to require mental health intervention.

#### Memorializing the student

Sensationalizing the death can encourage suicide contagion. Schools should treat all student deaths in the same way. If the school has a standard protocol for memorials for student deaths (i.e., planting a tree), the school should honor a student death by suicide in the same manner. School should not be canceled for the funeral. Any school-based memorials (e.g., small gatherings) should include a focus on how to prevent future suicides and prevention resources available. School staff should not discourage spontaneous actions initiated by students to memorialize the decedent.

#### Monitoring Social Media

Social media can be a useful tool to communicate with members of the community and to monitor student reactions. Social media efforts may be most effective when there is a designated member of the crisis team who is familiar with social media and in partnership with student leaders. By partnering with key students to identify and monitor the relevant social networking sites, schools can strategically use social media to disseminate information, share prevention-oriented messaging, offer support to students who may be struggling, and identify and respond to students who could be at risk. Student leaders can:

* Help identify which social media are used most frequently by the student body;
* Engage their peers in honoring their friend’s life appropriately and safely; and
* Inform school or other trusted adults about online communications that may be worrisome or inappropriate.

Students recruited to help should be reassured that school staff are only interested in supporting a healthy response to their peer’s death, not in thwarting communication. They should also be made aware that staff are available to provide support if they see a social media post that indicates someone may be at risk of suicide. (AFSP[After a Suicide: A Toolkit for Schools](https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools/)*,* 2018)

### Media Messaging about a Death by Suicide

Messaging about death by suicide needs to be carefully and thoughtfully considered. Any mention of a suicide should include prevention efforts and resources that are available. Messaging should include a positive intent that promotes hope and builds protective factors, support, and recovery. The National Action Alliance for Suicide Prevention offers a [Framework for Successful Messaging](http://suicidepreventionmessaging.org/).

The school principal or designee should be the sole media spokesperson. Staff will refer all inquiries from the media directly to the spokesperson. The spokesperson will:

* Keep the division level crisis coordinator and superintendent informed of school actions relating to the death;
* 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; and
* Answer all media inquiries. If a death by 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 deceased, 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.

For additional information, please see the American Foundation for Suicide Prevention’s [Recommendations for Reporting on Suicide](http://reportingonsuicide.org/). The media 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 (Model School District Policy on Suicide Prevention, Trevor Project).

## References

American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project - University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, Substance Abuse and Mental Health Services Administration, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Sciences. (2015). *Recommendations for Reporting on Suicide*. Retrieved from <http://reportingonsuicide.org/>.

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## Laws Relevant to Suicide Prevention

[§ 22.1-272.1](https://law.lis.virginia.gov/vacode/title22.1/chapter14/section22.1-272.1/). **Parent** **notice of a student at imminent risk of suicide.**

*Parent notice of a student at imminent risk of suicide; notice to be given to social services if parental abuse or neglect;*

*Any person licensed as administrative or instructional personnel by the Board of Education and employed by a local school board who, in the scope of his employment, has reason to believe, as a result of direct communication from a student, that such student is at imminent risk of suicide, shall, as soon as practicable, contact at least one of such student's parents to ask whether such parent is aware of the student's mental state and whether the parent wishes to obtain or has already obtained counseling for such student.*

*If the student has indicated that the reason for being at imminent risk of suicide relates to parental abuse or neglect, this contact shall not be made with the parent. Instead, the person shall, as soon as practicable, notify the local department of social services of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or the state Department of Social Services' toll-free child abuse and neglect hotline, as required by* [*§63.2-1509*](http://law.lis.virginia.gov/vacode/63.2-1509/)*. When giving this notice to the local or state department, the person shall stress the need to take immediate action to protect the child from harm.*

[§ 9.1-184](https://law.lis.virginia.gov/vacode/title9.1/chapter1/section9.1-184/). **Duties of the Virginia Center for School and Campus Safety.**

*In consultation with the Department of Education, provide schools with a model policy for the establishment of threat assessment teams, including procedures for the assessment of and intervention with students whose behavior poses a threat to the safety of school staff or students.*

§ 22.1-79.4. **Threat assessment teams and oversight committees.**

*Each local school board shall adopt policies for the establishment of threat assessment teams, including the assessment of and intervention with individuals whose behavior may pose a threat to the safety of school staff or students consistent with the model policies developed by the Virginia Center for School and Campus Safety (the Center) in accordance with §*[*9.1-184*](https://law.lis.virginia.gov/vacode/9.1-184/)*. Such policies shall include procedures for referrals to community services boards or health care providers for evaluation or treatment, when appropriate.*

*The superintendent of each school division may establish a committee charged with oversight of the threat assessment teams operating within the division, which may be an existing committee established by the division. The committee shall include individuals with expertise in human resources, education, school administration, mental health, and law enforcement.*

[§ 22.1-207.2:1.](https://law.lis.virginia.gov/vacode/title22.1/chapter13/section22.1-207.2:1/) **Parental right to review suicide prevention materials.**

*Each school board shall develop and implement policies that ensure that parents have the right to review any audio-visual materials that contain graphic sexual or violent content used in any anti-bullying or suicide prevention program. Such policies shall require that prior to using any such material, the parent of the child participating in such a program shall be provided written notice of his right to review the material and his right to excuse his child from participating in the part of such program utilizing such material.*

[§ 32.1-73.7.](https://law.lis.virginia.gov/vacode/title32.1/chapter2/section32.1-73.7/)**Lead agency for youth suicide prevention.**

*With such funds as may be appropriated for this purpose, the Department, in consultation with the Department of Education, the Department of Behavioral Health and Developmental Services, community services boards and behavioral health authorities, and local departments of health, shall have the lead responsibility for the youth suicide prevention program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining to youth suicide prevention in order to develop and carry out comprehensive youth suicide prevention strategies addressing public awareness, the promotion of health development, early identification, intervention and treatment, and support to survivors. The strategies shall be targeted to the specific needs of children and adolescents. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested persons in order to prevent youth suicide within the Commonwealth.*

[§ 37.2-312.1.](https://law.lis.virginia.gov/vacode/title37.2/chapter3/section37.2-312.1/) **Lead agency for suicide prevention across the lifespan.**

*With such funds as may be appropriated for this purpose, the Department, in consultation with community services boards and behavioral health authorities, the Department of Health, local departments of health, and the Department for Aging and Rehabilitative Services, shall have the lead responsibility for the suicide prevention across the lifespan program. The Department shall coordinate the activities of the agencies of the Commonwealth pertaining to suicide prevention in order to develop and carry out a comprehensive suicide prevention plan addressing public awareness, the promotion of health development, early identification, intervention and treatment, and support to survivors. The Department shall cooperate with federal, state, and local agencies, private and public agencies, survivor groups, and other interested persons to prevent suicide.*

[§ 54.1-2969.](https://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2969/) **Authority of minor to consent to medical treatment.**

*A minor shall be deemed an adult for the purpose of consenting to:*

*Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.*