Virginia Board of Education

SUICIDE PREVENTION GUIDELINES FOR VIRGINIA PUBLIC SCHOOLS

2020

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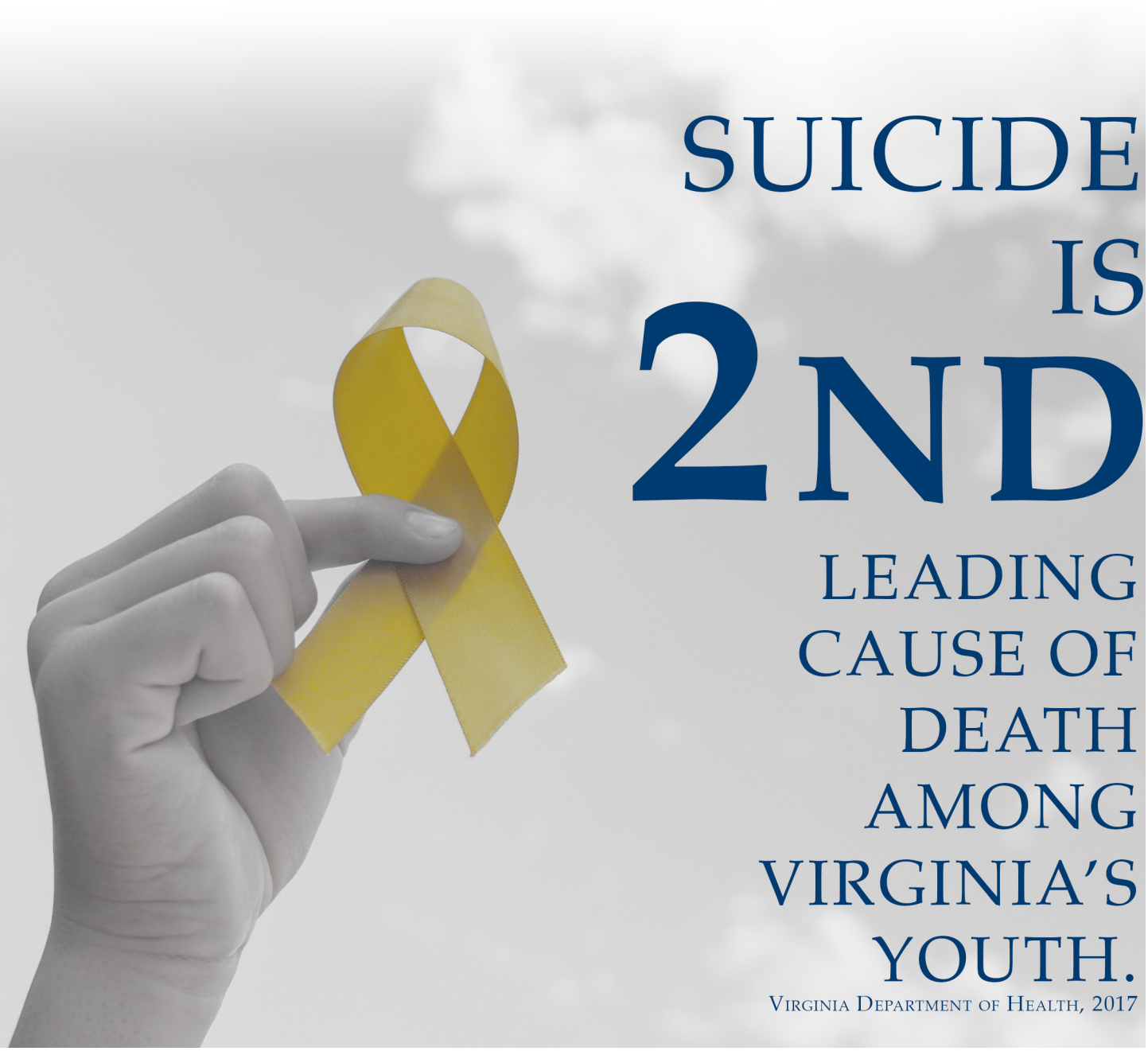
PREFACE

Youth suicide is, and has been for several years, a significant concern in Virginia and across the nation. According to the Centers for Disease Control and Prevention (CDC) and the Virginia Department of Health's 2017 OCME Report, suicide is the second leading cause of death among young people ages 10-24. Since 2013, suicide rates have increased for adolescents between the ages of 10 and 24. Each year, approximately eight percent of high school students attempt suicide and three percent make a suicide attempt that necessitates medical treatment. The number of children ages 5-17 that have been hospitalized for suicidal thoughts or behavior has doubled in the last decade. As many as one of six high school students has seriously considered suicide. Additionally, suicide or suicide attempts by school staff or family members of students can have a significant effect on the safety and well-being of students at school. Over 75 percent of persons engaging in suicidal behaviors have engaged in behaviors (e.g., warning signs) that caused concern for their well-being. Therefore, it is critically important that school divisions have policies and procedures in place to prevent, assess the risk of, intervene with, and respond to youth suicidal behavior.



BACKGROUND

The 1999 General Assembly passed Senate Bill 1250 (S. Newman) enacting *§ 22.1-272.1*, 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 Virginia 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, the Virginia Assembly enacted Code of Virginia *§ 9.1-184* creating the Virginia Center for School and Campus Safety (VCSCS), located within the Department of Criminal Justice Services (DCJS), 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.

Since July 1, 2013, as per Code of Virginia *§ 22.1-79.4*, Virginia public schools have been required to "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." These school policies must be consistent with the model policies developed by the Virginia Center for School and Campus Safety (the Center) in accordance with *§ 9.1-184*." It is important to note that the threat assessment statute defines the duties of threat assessment teams to include providing guidance to students, faculty, and staff regarding recognition of threatening or aberrant behavior that may represent a threat to the community, school, or self. Further, upon a threat assessment team making a preliminary determination that a student poses a threat to self or others, the threat assessment team has responsibilities for immediate notification to senior school administration.

As required by the Code of Virginia *§ 9.1-184*, the VCSCS developed Threat Assessment in Virginia's Public Schools: Model Policies, Procedures, and Guidelines 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 may pose 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. Therefore, it is important that VCSCS guidance regarding recognition of threatening or aberrant behavior (including threat to self) and guidance regarding threat assessment team processes in cases involving student threats to self be

consistent with VDOE guidance regarding the prevention and intervention with students at risk for suicide or self-harm.

In 2019, in an effort to further 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).

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.

To revise the guidelines, the Virginia Department of Education (VDOE) convened representatives from the state agencies mentioned above, school division personnel, representatives from suicide prevention and mental health advocacy organizations, 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 District Policy on Suicide Prevention).

INTRODUCTION

Schools are key settings for suicide prevention, intervention, and postvention. Most children and youth spend most of their day in school where caring and trained adults are available to help them. 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, as well as other indicators of concern. Although many suicidal children and adolescents do not self-refer, most show some warning signs. Never ignore these signs. Schools must have clear policies and procedures for suicide prevention, intervention, and postvention, as well as trained school-employed mental health professionals and crisis response teams. Suicide prevention should be an integral component of a comprehensive, multi-disciplinary, and 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, preventing suicide depends not only on suicide prevention policies, but also on a holistic approach that promotes healthy lifestyles, families, and communities. Thus, these guidelines are intended to be paired with other policies, procedures, and efforts that support the emotional and behavioral well-being of youth inside and outside of the school building. Suicide prevention is one aspect of building and sustaining 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.

Model policies and best practices for the Suicide Prevention Guidelines for Virginia Public Schools were developed in an effort to support and enhance 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. School divisions are encouraged to develop partnerships with their local community services board to ensure a community approach to suicide prevention, intervention, and postvention.

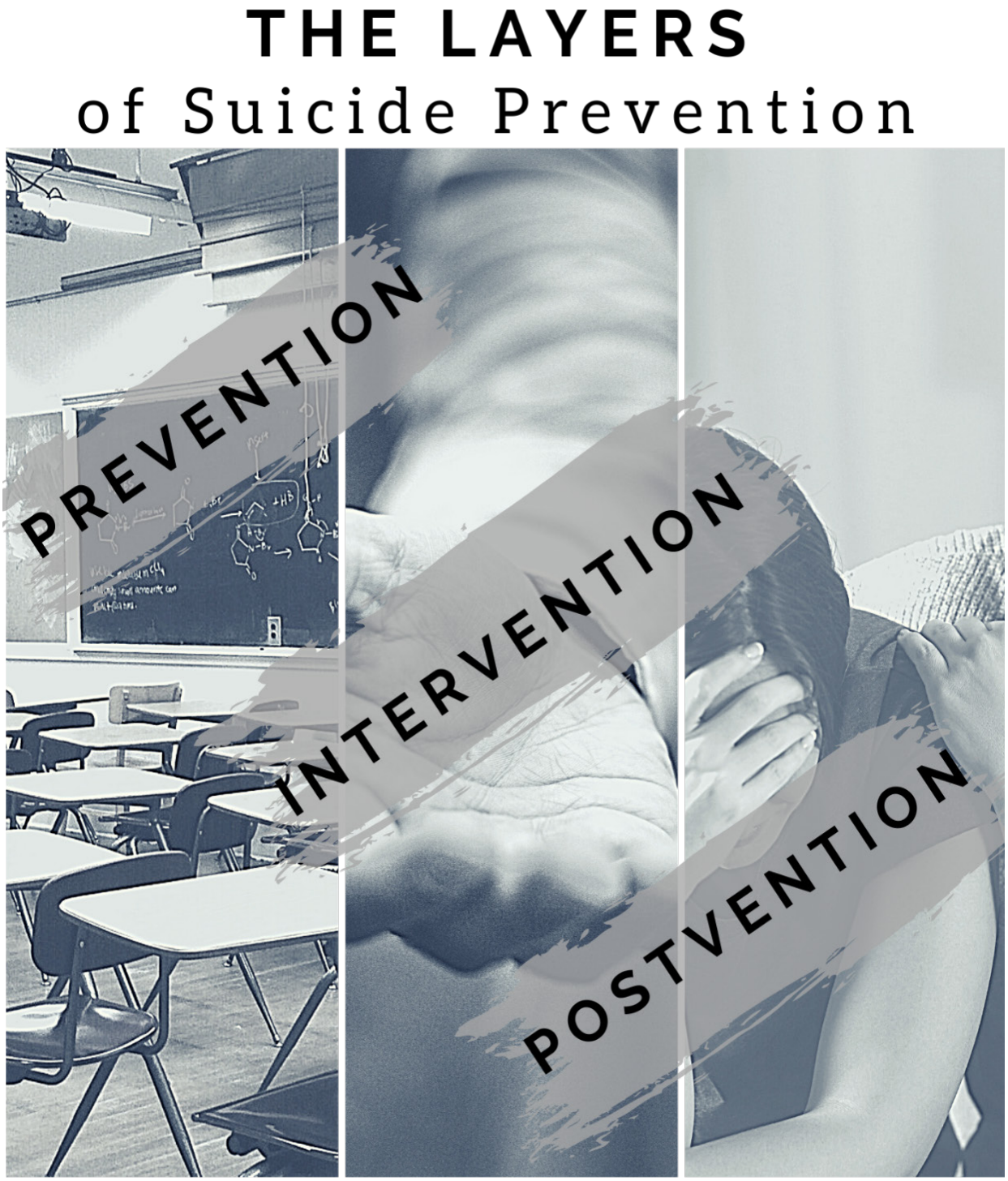
As resources vary in Virginia school divisions, these guidelines are not intended to be prescriptive. These guidelines represent standards of practice for suicide prevention, intervention, and postvention in schools and may be used to draft local school division policy and procedures, based on the unique need of each division.

Any such policy developed by the local school division should be reviewed and disseminated at least annually, included in all staff, student, and parent/guardian 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 schools modify programs for identifying, assessing, and managing suicide risk in elementary aged students using developmentally appropriate language. Local school divisions should ensure that school-based 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 students can be successful only to the extent that they are applied consistently, trained mental health professionals are available and involved, and students at risk are linked with relevant resources. It is critical that schools work to establish and sustain effective working relationships with community resources prior to the occurrence of critical events.

The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an updated list of Resources for Suicide Prevention. Links to these and other resources are included in the VDOE's Suicide Prevention webpage.



SECTION I: SUICIDE PREVENTION

It is essential that school divisions have policies and procedures in place to identify and assist students at risk of suicide and other behavior that impacts the health, safety, and well-being of students, staff, and the school community. The American Foundation for Suicide Prevention (AFSP), the American School Counselor Association (ASCA), the National Association of School Psychologists (NASP), and the Trevor Project collaborated to develop and disseminate the Model School District Policy on Suicide Prevention: Model Language, Commentary and Resources, 2nd Edition. The model policy includes specific, actionable steps to support school personnel in effective strategies for suicide prevention, intervention, and postvention; sample language for student handbooks; suggestions for involving parents and guardians in suicide prevention; and guidance for addressing in-school suicide attempts.

FOSTERING PROTECTIVE FACTORS

Protective factors are characteristics or conditions that may help to decrease a person's suicide risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them. These factors do not eliminate the possibility of suicide, especially in someone with risk factors. Protective factors help to create resiliency, or an ability to "bounce back" from setbacks encountered throughout life. School divisions should consider practices and programming that foster the development of protective factors as part of a larger suicide prevention plan. Protective factors for suicide may include:

- Psychological or emotional well-being, positive mood;
- Development of coping mechanisms, conflict resolution, self-care strategies, and safety plans;
- The skills and abilities to solve problems;
- Positive connections to family;
- Close friends and community support;
- Adaptive temperament;
- Access to welcoming and affirming faith-based institutions, supportive social groups and clubs;
- Presence of healthy role models;
- Cultural and religious beliefs that discourage suicide and promote self-preservation;
- Positive school experiences and feeling safe at school (especially for lesbian, gay, bisexual, and transgender youth);
- A sense of connectedness to the school;
- Access to effective clinical care for mental, physical, and substance abuse disorders;
- Restricted access to firearms; guns unloaded and locked; ammunition stored separately and locked; and
- Limited access to medication (over the counter and prescriptions); and limited access to alcohol or other illicit drugs.

See the Centers for Disease Control and Prevention (CDC)'s Healthy Youth: School Connectedness for strategies for increasing protective factors in youth.

SOCIAL CONNECTEDNESS AND SUPPORT

Positive and supportive social relationships and community connections can help buffer the effects of risk factors in people's lives. In 2011, the Centers for Disease Control and Prevention (CDC) identified promoting connectedness as its strategic direction for preventing suicide. The CDC defines connectedness as "the degree to which a person or group is socially close, interrelated, or shares

resources with other persons or groups." Connectedness can include:

- Connectedness between individuals (e.g., friends, neighbors, co-workers);
- Connectedness among family members;
- Connectedness to community organizations (e.g., schools, faith communities); and
- The connection of groups (e.g., cultural, religious or minority groups) to their cultural traditions and history.

Studies have found that rates of suicidal thoughts and suicide attempts were higher in schools where students had fewer friends and friendships were concentrated among fewer students. Rates of suicide attempts were also higher in schools where students lacked close connections to adults. In schools where close friends had bonds with the same trusted adult, attempt rates were lower (Wyman, P.A. et al., 2019).

Connectedness and support can be enhanced through programs directed at specific groups, as well as through activities that support the development of positive and supportive communities in general. Strategies for enhancing connectedness may include:

- Creating trusting and caring relationships that promote open communication among administrators, teachers, staff, students, families, and communities;
- Providing professional development and support for teachers and other school staff to enable them to meet the diverse cognitive, emotional, and social needs of students;
- Creating decision-making processes that facilitate student, family, and community engagement; academic achievement; and staff empowerment;
- Supporting the development of relationships between youth and positive adults in their lives (e.g., teachers, coaches);
- Providing education and opportunities to enable families to be actively involved in their children's academic and school life;
- Providing students with the academic, emotional, and social skills necessary to be actively engaged in school; and
- Creating and sustaining peer-delivered services and support groups.

ENHANCE LIFE SKILLS AND RESILIENCE

Life skills are a key protective factor for suicide and include critical thinking, stress management, conflict resolution, problem-solving, and coping skills. Activities that enhance these skills can help people as they face new challenges, such as economic stress, divorce, physical illness, and aging.

Resilience is a related concept that includes traits such as a positive self-concept and optimism in addition to life skills. It is sometimes described as the ability to adapt to stress and adversity. The following are considerations for enhancing life skills and resilience:

- Teach mindfulness and stress reduction skills.
- Provide information about self-help tools and apps that promote coping.
- Identify common stressors affecting students and offer skill-building sessions designed to prevent or minimize their occurrence.
- Create an institutional culture that promotes and encourages qualities such as empathy, optimism, support, and forgiveness.
- Implement curricula for life skills and classroom behavior management.
- Provide resources and information to help people cope with life transitions.
- Encourage and support staff in modeling life skills and resilience.

SCHOOL-WIDE AWARENESS AND BEST PRACTICES

Schools should provide their school community with resources and guidance for enhancing awareness of issues related to suicide and other forms of self-harm. Both Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of School Psychologists (NASP) advocate for the use of multi-disciplinary teams for planning and coordination of suicide prevention programs as well as response to crisis situations.

Effective suicide prevention, intervention, and postvention programs require understanding, support, commitment, and engagement from all members of the school community. Any prevention plan should include the methods available for school staff, students, parents/guardians, and community members to report concerning behaviors. School divisions may consider the use of a reporting system, such as SaySomething or Safe2Tell 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 Toolkit for Schools includes a variety of resources for awareness programming. Schools work to create a culture of caring through a three-pronged approach of 1) staff training, 2) student awareness and reporting, and 3) social and emotional learning supports.

TRAINING AND AWARENESS FOR SCHOOL ADMINISTRATION AND 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). Community services boards offer suicide prevention services to include gatekeeper trainings (Mental Health First Aid, Youth Mental Health First Aid, ASIST, SafeTalk, etc.), educational resources, presentations, and lethal means safety devices. 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 suicide prevention and awareness should include the following components:

1. Cultivating a positive school climate with connections between students and adults who are approachable, trustworthy, helpful, and good role models for self-care;
2. Enhancing awareness of youth mental health and suicide concerns and trends and the role that schools play in prevention and early intervention;
3. Identifying and addressing common myths about suicide;
4. Recognizing risk and protective factors, at-risk groups, and warning signs of youth suicide;
5. Responding to students and procedures for reporting concerns;
6. Understanding the suicide risk assessment process, including safety planning; and
7. Enhancing awareness of in school and out of school mental-health resources.

The following resources can assist staff in understanding their unique roles in suicide prevention:

- Role of Teachers in Preventing Suicide, and the
- Role of High School Mental Health Providers in Preventing Suicide,

- The School Nurse's Role in Behavioral/Mental Health of Students,
- School Administrators,
- All Educators and Parents.

For additional information on the role of school staff in suicide prevention, please visit VDOE's Suicide Prevention webpage.

TRAINING FOR SUICIDE RISK ASSESSMENT TEAMS

In addition to the training for all staff, school-based mental health professionals (i.e., school counselors, school psychologists, and school social workers) who will conduct suicide risk assessments need regular training specific to standards, methods, and resources for effective assessment. Additionally, refresher training should occur on an annual basis.

Suicide risk assessment team training should include the following:

1. Discussion about the implementation process for assessment;
2. Opportunities to discuss:
    a. Table-top case studies,
    b. Factors that may complicate the assessment procedure,
    c. Roles and responsibilities in the process,
    d. Family engagement, and
    e. Student reentry.
3. Opportunities to practice:
    a. Student interviewing, and
    b. 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

In Health education courses, students are introduced to concepts such as mental illness and depression (2020 Health Education Standards of Learning). 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. Suicide risk assessment teams, including division or 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 such programs to ensure their effectiveness and relevance.

Suicide is best discussed in a classroom setting being led by a 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:

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

In accordance with *Code of Virginia § 22.1-207.2:1*., "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 AND 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:

- Identify risk factors and warning signs of suicide;
- Identify protective factors;
- Identify mental health resources in the school and in the community;
- Identify procedures for obtaining assistance for suicidal students both at school and in the community (including local emergency services contact information);
- Reduce stigma associated with mental illness;
- Identify and address common myths about suicide;
- Learn to talk to children about suicide; and
- 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 are available and may be used.

COMPREHENSIVE PREVENTION STRATEGIES

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. The following strategies are part of a comprehensive approach to suicide prevention and should be included in training programs.

MENTAL HEALTH SCREENING

Mental health screening and practices could 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 provides additional guidance for mental health screening in schools.

A questionnaire or other screening instrument is given to all students to identify students that may require further assessment and treatment. Repeated assessments 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.

RECOGNIZE RISK FACTORS FOR 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. The likelihood of an attempt is highest when factors are present or escalating, when protective factors and healthy coping techniques have diminished, and when the individual has access to lethal means. 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.

The CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices states that risk factors can exist at any, some, or all 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, and stigma associated with help-seeking and mental illness.

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 learning 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, but are not limited, to those described below.

YOUTH LIVING WITH MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS

While the large majority of people with mental health disorders do not engage in suicidal behavior,

people with mental health disorders account for more than 90 percent of deaths by suicide. Mental health disorders, especially 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 suicide among young people. School staff may play a pivotal role in recognizing and referring students to treatment that may reduce risk.

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.

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.

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.

LGBTQ (LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, OR QUESTIONING) YOUTH

The CDC finds that LGBTQ 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. These societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ, elevate the risk of suicidal behavior for LGBTQ youth.

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.

YOUTH LIVING WITH MEDICAL CONDITIONS AND DISABILITIES

Several 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.

YOUTH IN MILITARY FAMILIES

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. 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.)

YOUTH IMPACTED BY BULLYING

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 depression and anxiety, which can contribute to suicidal behavior in those at-risk.

KNOW THE WARNING SIGNS FOR SUICIDE AND SELF HARM

Warning signs are signs and indicators that someone may be in danger of harming themselves and requires an immediate referral for a suicide risk assessment and appropriate intervention. 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;
- Attempting 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 which teams should be aware. 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.

Non-suicidal self-injury (NSSI) is defined as directly and intentionally inflicting damage to one's own body without suicidal intent. The most common form of NSSI is self-cutting, but other forms

include burning, scratching, hitting, intentionally preventing wounds from healing, and other similar behaviors. The risk of both suicide attempts and suicide is significantly higher in those who have engaged in NSSI. Among those with a history of NSSI, 70 percent have attempted suicide at least once and 55 percent have attempted suicide several times. While non-suicidal self-injury is associated with higher risk of suicide, it is in and of itself not necessarily the same as a suicide attempt.

PLAN FOR KEY TRANSITIONAL PERIODS

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 II: SUICIDE INTERVENTION

CONDUCTING A SUICIDE RISK ASSESSMENT

The purpose of conducting a suicide risk assessment is to determine if a student poses a risk for harming themselves and is in need of additional intervention or support. The assessment should be comprehensive and include the student's risk factors, behaviors, protective factors, and circumstances within the school or community that may be contributing to the risk, as well as input from parent/guardian and other relevant adults or peers.

Many guidelines for school-based programs (e.g., SAMHSA, NASP) advocate for a multi-disciplinary approach to the suicide prevention and intervention processes. Schools that have not already done so, should consider the development and implementation of a multi-disciplinary suicide risk assessment team. School mental health professionals, in conjunction with community-based professionals, as appropriate, have primary responsibility for the direct assessment and crisis intervention with the student. However, other staff can assist mental health professionals in a variety of ways including, but not limited to:

- Gathering information to support a comprehensive assessment of the situation;
- Helping to rule out the presence of other concerns (in addition to the potentially suicidal behavior);
- Facilitating notifications to parents/guardians;
- Providing support to staff and peers impacted by the student's behavior; and
- Identifying strategies to address factors that may be contributing to the student's risk, such as bias, harassment, or bullying.

The Virginia Department of Education (VDOE) and the Virginia Center for School and Campus Safety (VCSCS) recognize the broad diversity across school divisions in terms of differing concerns, needs, staffing and resources to address these challenging issues. To that end, schools are encouraged to implement and utilize processes that minimize gaps in identification, assessment and intervention with students who may pose a risk of harm to self, and that build an effective nexus of communication, collaboration and coordination with existing threat assessment and management processes.

Localities may choose to create division wide or school-based suicide risk assessment teams or assign those duties to existing team(s). As all public schools in Virginia are mandated to have threat assessment teams, which already have some duties related to student self-harm and include similar school personnel, schools may use their threat assessment teams in this capacity.

COMPONENTS OF SUICIDE RISK ASSESSMENT

The following is a list of key components in the suicide risk assessment process. In some cases, not all components will be necessary, and the order in which each component 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 outline a systematic and comprehensive approach to the risk assessment process.

IDENTIFY STUDENT OF CONCERN

When a student is identified as at-risk, potentially suicidal, or engaging in an attempt or act of self-harm, the student shall be seen by a mental health professional as soon as possible. The mental health professional, such as a school psychologist, school counselor, school social worker, or community mental health provider should conduct a preliminary assessment within the same school day to

assess risk and facilitate referrals as necessary. The student should be continuously supervised to ensure their safety until the assessment process is complete.

A student may be referred to the suicide risk assessment team by any of (but not limited to) the following sources:

- Teacher or other staff member;
- Parent(s)/guardian(s) or other family members;
- Another student;
- School nurse;
- Administrator;
- Community member;
- Student self-referral; or
- Suicide screening process.

From the initial report or indication of concern, obtain as much detail as possible about the nature of the concern, and any information about any immediate risks to safety.

The student of concern should be escorted to a safe and private location where a trained mental-health professional can conduct a student interview. If a mental-health professional is not immediately available the student should remain supervised until the interview can be initiated. School administration should be notified that a suicide risk assessment has begun; however, they should not be directly involved in or present during the student interview.

Each school division should have a policy in place to address referrals received after school hours. If no such policy is in place, and a concern arises after school hours, school staff should contact the parent/guardian. If staff is concerned about the student's immediate safety and the parent/guardian cannot be reached, then local law enforcement should be notified.

STUDENT INTERVIEW

When conducting a student interview, school personnel with expertise in counseling (i.e., mental health professionals) have primary responsibility for the direct assessment of and intervention with the student of concern. This would be done in collaboration and consultation with team members. It is important to note that talking with a student about suicide does not increase the likelihood that they will commit the act.

When staffing allows, it is preferable for two mental health professionals to conduct the student interview. If two mental health professionals are not available, consultation by phone is an appropriate option. 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.

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 a collaborative conversation between the mental health professional and student. Part of the role of the mental health professional is to help the student participate in the conversation, better understand their own thoughts of suicide, and 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.

ASSURING STUDENT SAFETY AND PARENT/GUARDIAN CONTACT

The parent/guardian should be contacted and interviewed the day the student interview is conducted. Parent/guardian contact should be made regardless of the outcome of the suicide risk assessment. However, the parent/guardian should not be notified if the student has indicated that the reason for being at risk of suicide relates to parental abuse or neglect. Instead, the local department of social services should be notified (*Code of Virginia § 22.1-272.1*).

The parent/guardian should be interviewed to gather background information, observations, family history, and other pertinent information. Also, the interview should gauge the parent/guardian's ability and intent to follow recommendations necessary to keep the student safe.

Teams should always err on the side of caution when considering end-of-day transportation. If a student is at-risk for suicide, they should not be sent home until contact is made with a parent or guardian that can ensure they are supervised. It should also be considered if sending the student home via their normal transportation mode is a safe option or whether a parent/guardian needs to pick them up.

Parent/guardian notification should be documented. A sample parent notification form is provided on VDOE's Suicide Prevention webpage. A parent/guardian notification form should be used with every student that has been assessed to be at risk for suicide and should include:

- Student's name, date of birth, and grade;
- Parent(s)/guardian(s) name and phone number(s);
- Date of the student interview;
- Name(s) of the person(s) who conducted the student interview;
- Mental health referral information, if made;
- The steps that the parent/guardian is taking to keep the student safe;
- Emergency contacts outside of school, in case of a crisis;
- School and community resources; and
- Parent's/guardian's signature.

When families are notified of suicide risk, this is an opportunity to educate them about suicide risk factors, community resources, lethal means safety, and other relevant safety information that should be considered. A copy of the parent/guardian notification form should be given to the parent and the original should be maintained in a confidential location outside of the student's cumulative record.

GATHER INFORMATION AND TEAM CONSULTATION

Conducting a suicide risk assessment is a team process, which requires the expertise of many professionals. Suicide risk assessment team members can include:

- Mental health professionals, such as: school counselor(s), school psychologist(s), school social worker(s);
- Administrators;
- School nurse;

- School Resource Officer (SRO); and
- Other trained school-staff.

In addition to the student interview and parent/guardian interview, the team will determine the need for additional information to gather, which may include review of student records, school clinic records, attendance, staff interviews, and/or peer interviews, and others as warranted by the situation. Any additional gathering of information should be deemed essential to determining the risk level of the student and be balanced with maintaining privacy rights to the extent possible. This information can be compiled by any member of the suicide risk-assessment team.

Team consultation is necessary in order to review the information and data collected to make a determination of risk level. Some situations may require that the full team be convened to support a thorough review. It is best practice for the team to consult the same day as the student interview.

The team should determine which member will serve as the case manager. The case manager will ensure that all necessary assessment components are completed and 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; likely a school counselor, school psychologist, or school social worker.

DETERMINE RISK

Evaluate the information gathered to determine whether the student poses a risk of harm to themselves. The risk levels below are intended to assist with decision-making and are aligned with the Threat Assessment in Virginia's Public Schools: Model Policies, Procedures, and Guidelines. School divisions may choose to use a different suicide risk model when evaluating levels of risk. Whatever framework is used, staff should be well trained in its use and use the model consistently. Always err on the side of safety and prevention and when in doubt, choose the higher risk level.

OVERVIEW OF RISK LEVELS

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

NO RISK:
The student does not appear to pose a risk of harm to self. There are no significant risk factors or warning signs observed and protective factors are in place and stable.

This may be the outcome when a student is identified or referred regarding something the student says or writes that is construed as a threat to self. The assessment reasonably concludes that any such comment was taken out of context and there is no indication of ideation, intent, or suicidal behaviors. The student is connected socially, is well supported by family, and teachers report no concerns. The parent(s)/guardian(s) should be contacted. The parent(s)/guardian(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.

LOW RISK:
The student does not appear to pose a risk of harm to self and there are no warning signs or identified intent to act. Protective factors are in place and stable. Any needs for assistance or underlying issues are being addressed.

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." The assessment indicates that any comments regarding self-harm were made without thought, planning or intent. The student is connected socially, and has a good support system, but there may be mental health concerns. A support plan should be developed and the parent(s)/guardian(s) should be contacted. The parent(s)/guardian(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.

MEDIUM RISK:
The student does not appear to pose a risk of harm to self at this time, but exhibits behaviors that indicate a continuing intent and potential for future serious harm to self; 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 may be more specific planning but without preparation or observed intent to act on the ideation, or at least, not in the short term. 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)/guardian(s) engaged, and the student should be immediately referred for appropriate services. The parent(s)/guardian(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:
The student appears to pose a risk of harm to self, 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)/guardian(s) contacted, and the student should be referred to crisis counseling and/or for hospitalization for immediate help. The parent(s)/guardian(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.

IMMINENT RISK:
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 risk indicates that you believe serious violence will happen within the next 24-48 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)/guardian(s) contacted, and the student should be referred to crisis counseling and/or for hospitalization for immediate help. The parent(s)/guardian(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.

If at any time during the assessment process, any of the following concerns become apparent, in addition to, or in place of, the concerns of a potential threat to self, then the Threat Assessment Team shall conduct an assessment process that encompasses both threats:

- The student also appears to intend or pose a threat of harm to others.
- The student has engaged in behaviors (e.g., planning or preparation) that would place others at risk of harm, whether intended or not.

In situations where a student is simultaneously posing a threat to others as well as a threat to self, mental health staff as well as administrators and law enforcement must collaborate in the threat assessment team process.

SAFETY PLANNING, INTERVENTIONS, AND PROTECTIVE FACTORS

A safety plan is developed by the student and parent/guardian, if available, in collaboration with a mental health professional and other available suicide risk assessment team members. The case manager should ensure that a safety plan is developed immediately or when a student returns to the school setting after treatment. A sample safety planning form can be found on the VDOE's Suicide Prevention webpage. The safety plan outlines the steps necessary to keep the student safe from harming themselves and should include:

- Warning signs;
- Coping strategies that the student can use;
- Interventions, supports, or action steps to build protective factors;
- The people and places that improve the student's mood and make them feel safe;
- The trusted people the student can go to for help;
- Who to contact in an emergency, (The National Suicide Prevention Lifeline 1-800-273-TALK (8255) is available 24 hours a day, 7 days a week);
- The immediate steps the student can take during a suicidal crisis;
- Resources given to the family; and
- Name of the case manager.

After the team identifies needed supports, they are listed in the safety plan as actions to be taken by the school, parent/guardian, 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 appropriate school staff, monitoring the plan, and reconvening the team for any follow-up meetings. All participants in the safety planning sign the plan and a copy is given to the parent/guardian and student. The plan should be attached and stored with the suicide risk assessment, and the case manager may also keep a copy for student monitoring.

If the parent/guardian is unable to attend the safety plan meeting, the case manager should follow up with them to ensure that they are aware of the content, supportive measures, action steps, and what to do should they have concerns or there is an escalation in risk.

ACCESS TO EFFECTIVE TREATMENT, CARE, AND SUPPORT

A key element of suicide prevention for suicide risk assessment teams is ensuring that individuals with suicide risk have access to community mental health resources. Schools and divisions should work with community mental health providers to develop coordinated systems of care, which includes outlining a clear referral process allowing for timely access to these essential services.

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. During this meeting, the school should either revisit or create a safety plan.

The re-entry team meeting must include the assigned suicide risk assessment case manager and an administrator. Additional team members may include the student, appropriate family member(s), suicide risk assessment team members, as well as any out-of-school mental health care providers.

The purpose of the meeting is to work toward identifying and addressing the issues that led to the crisis and build a strategy to prevent recurrence. The goals of the meeting are to update participants on progress and current student concerns, identify the needed supports for the student, and ensure safety for the student. If the team suspects a disability, the student should be referred for section 504 or special education consideration.

EXAMPLES OF POTENTIAL SUPPORTS MAY 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.

Schools should develop and maintain relationships with their local providers to assist in the transition of services between school and community. Schools can create an uninterrupted transition of care by facilitating the exchange of information among the various individuals and organizations involved in supporting the student. School staff should secure a release to exchange information with the student's out-of-school mental health provider so the school and the provider can coordinate efforts.-

DOCUMENTATION

School divisions should determine a way to consistently document all suicide risk assessments completed. Additionally, 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 suicide risk assessment documentation follows students through each educational level as appropriate. 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.

Documentation of each suicide risk assessment should include:

- Student's identifying information;
- Reason for referral and referral source;
- Date of the assessment;
- Team members who participated;
- Identified case manager;
- Assessed risk level/team determination;
- Person who notified the parent/guardian and when;
- Safety plan;
- Where the student was referred for crisis or mental health treatment; and
- Resources given to the family.

The flowchart on the following page provides an overview of this process.

SECTION III: POSTVENTION, AFTER A SUICIDE

The loss of a student or staff member to suicide can leave a school community struggling to understand what happened and why. In this situation, the school community needs reliable information, practical tools, and pragmatic guidance to support the school community, protect students, and communicate with the public. School crisis teams must be prepared to respond with empathy, carefully planned supports, and clear messaging.

A postvention plan is a set of protocols to help the school crisis team respond effectively and compassionately to a death by suicide. Postvention efforts should include immediate, intermediate, and long-term supports for people bereaved by suicide. Each school division's suicide prevention policy and/or crisis plan should include guidelines for postvention to address school and community needs when a member of the school community dies by suicide. These guidelines should include consistent practices when memorializing students, reducing the potential for suicide contagion, and how student needs will be monitored and addressed.

The American Foundation for Suicide Prevention (AFSP) 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.
- Children, especially adolescents are vulnerable to the risk of suicide contagion. Suicide contagion is the process by which one suicide death may contribute to another. Adolescents and teenagers appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. Therefore, it is important not to inadvertently simplify, glamorize, or romanticize the student or his or her death.
- Children are also resilient. With the proper information, guidance, 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.
- Help should be available for any student who may be struggling with mental health issues or suicidal feelings.
- Postvention efforts need to consider the cultural, religious, and spiritual diversity of those affected by a 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. Ideally the team will be a combination of administrators, counselors, social workers, psychologists, nurses, and school resource officers or local/state law enforcement. Due to their training, skills and ability to work compassionately and effectively under pressure, school mental health professionals should always be included on the crisis team; this is especially important when responding to 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.

SUICIDE INTERVENTION FLOWCHART

STUDENT OF CONCERN IS IDENTIFIED

A referral is made to school-based mental health personnel. Student remains supervised and administration is notified that a risk assessment for suicide has begun.

STUDENT INTERVIEW

The student interview is the most critical piece of information to be gathered a**nd should always be conducted by a mental health professional**. Consultation with another mental health professional is strongly recommended. When staffing allows, it is preferable for two mental health professionals to conduct the interview.

ASSURING STUDENT SAFETY AND PARENT/GUARDIAN CONTACT

The parent/guardian should be contacted and interviewed the day the student interview is conducted. Also, the interview should gauge the parent's/guardian's ability and intent to follow recommendations necessary to keep the student safe. **Notification should be documented.**

GATHER INFORMATION

In addition to the student and parent/guardian interview, additional information may include: student records, school clinic records, attendance, staff interviews, and/or peer interviews.

TEAM CONSULTATION

Team consultation happens the same day as the student interview. The team should **review information**, assign a **case manager** and **determine risk level**.

ASSURING STUDENT SAFETY AND PARENT/GUARDIAN CONTACT

The safety plan is developed in collaboration with the student, mental health professional and parent/guardian (if available). The plan should outline the steps necessary to keep the student safe and should include: warning signs, coping strategies, resources, steps to take in a crisis, interventions, supports, and/or action steps to build protective factors.

IMPORTANT CONSIDERATIONS

If the student has indicated that the reason for being at risk of suicide relates to parental abuse or neglect, this contact shall not be made with the parent but instead the local department of social services should be notified.

In situations where a student is simultaneously posing a threat to others, as well as, a threat to self, mental health staff as well as administrators and law enforcement must collaborate in the threat assessment team process.

- School crisis teams are encouraged to collaborate with their community partners, as community services boards (CSBs) often have staff trained for crisis debriefing and support that can be utilized following an attempt or death by suicide. CSBs often have staff trained for crisis debriefing and support that can be utilized following an attempt or death by suicide.

VERIFYING THE FACTS, CONFIRMING A DEATH

The team will attempt to confirm a reported death and ascertain the cause of death as determined by the medical examiner or as reported by the family of the deceased, local hospital, and/or law enforcement agency. 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.

COMMUNICATING WITH THE FAMILY

As soon as practicable, the school principal or designated member(s) of the crisis team should contact the family. That person should express sympathy as they would for any sudden death. The contact person should ask what the school can share about the student's death.

"Although the fact that a student has died may be disclosed immediately, official information about the cause of death should not be disclosed to students until the family has been consulted. The need to share information should be carefully balanced with honoring the family's request. Therefore, the school may choose to initially release a more general, factual statement without using the student's name if the family does not give permission" (e.g. "We have learned that a ninth-grade student died over the weekend." or "The family has requested that information about the cause of death not be shared at this time.") (After a Suicide: A Toolkit for Schools, AFSP, 2018)

Acknowledge that this is a great tragedy and that the school community shares their grief and wants to offer support, which may include:

- Asking what the school can do to support them;
- Asking what the school can do to support siblings;
- Discussing concerns they may have for siblings, friends, or acquaintances and following up accordingly; and
- Inquiring about funeral/memorial arrangements.

ASSESSING THE IMPACT AND RESPONSE PREPARATION

The crisis team will meet to prepare the postvention response, to consider how the death is likely to affect other students, and to determine which students are most likely to be affected. The crisis team should also consider the cumulative impact of other traumatic events that may have impacted the school community.

The team should consider and (as appropriate) act upon the following tasks.

- Establish a plan to immediately notify school staff of the death. If possible, this should be an in-person notification, especially for those who worked directly with the deceased student.
- Determine whether additional grief counselors, crisis responders, or other resources may be needed from outside the school.
- Schedule an initial all-staff meeting as soon as possible, ideally before the start of the next school day. Refer to the Sample Guidelines for Initial All-Staff Meeting in After a Suicide: A

Toolkit for Schools (Appendix A, page 45).

- When possible, arrange for students to be notified of the death in small groups, such as in homerooms. Do not notify students by public address system or in a large assembly.
- With family consent, disseminate a written statement for students to homeroom teachers. Refer to the tool Sample Death Notification Statement for Students in After a Suicide: A Toolkit for Schools (Appendix A, page 47).
- In the class or homeroom of the deceased student, it may be helpful to have a mental health professional (e.g., school psychologist, counselor, social worker) present as well as the teacher.
- Identify social media accounts that may need attention or monitoring and designate a member of the team to monitor them.
- With family consent, draft and disseminate a written statement to parent(s)/guardian(s) about the student's death. Refer to the tool Sample Death Notification Statements for Parents/Guardians in After a Suicide: A Toolkit for Schools (Appendix A, page 50).
- Disseminate the following handouts: Facts about Suicide in Adolescents, Tips for Talking about Suicide, Youth Warning Signs, and What to Do in a Crisis to school staff to give them more information about suicide and how to help their students. These can all be found in Appendix A of the After a Suicide: A Toolkit for Schools.

SUPPORTING AND MONITORING STUDENTS

Following a traumatic event, such as death by suicide, students may react with a variety of emotions. Adolescents are still learning 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 one suicide death may contribute to another. 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 Initial All-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

The crisis team should identify students likely to be most affected by the death and implement a strategy to engage with them to check on their well-being and determine needs for support. Where appropriate, the students may be assessed by a mental health professional to determine the level of support needed. Students likely to benefit from additional support may include (but are not be limited to):

- Close friends, siblings(s), relatives of the deceased;
- Those who had a conflicted or strained relationship with the deceased (e.g., ex-girl/boyfriends or someone who bullied the deceased); the close friends of these individuals may also benefit from support;
- Individuals with a history of depression or similar problems;
- Those who may have made a suicide attempt in the past;
- Those who have experienced a death by suicide or other loss in their lives in the past;
- Students who shared a class or extracurricular activity with the deceased;

- Teachers who had taught the student recently or in the past; and
- Vulnerable student populations (discussed in Section I: 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. 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.

ONGOING MONITORING

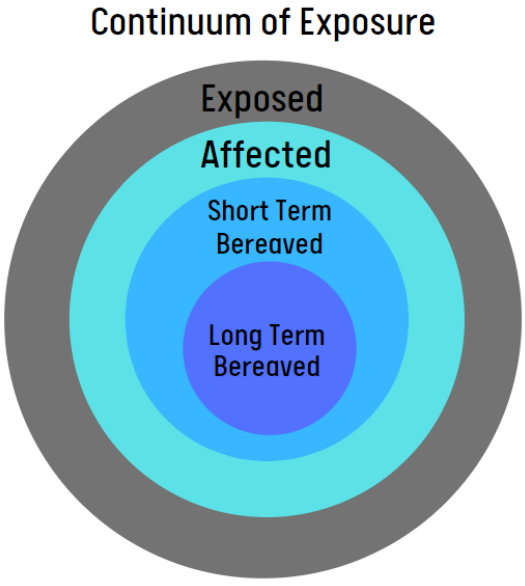
Response to a death by suicide should not only include the immediate response, but also ongoing monitoring of the emotional wellbeing of both students and staff. There may be events that trigger the return of intense emotions such as special school events (e.g., homecoming, holidays, or graduation) or special dates (e.g., birthday, death anniversary). Let students, families, and school personnel know that supportive services will be available as needed, especially at these times. After a death by suicide, school staff should be made aware of specific warning signs of emotional distress and any students that should be monitored.

Should risk factors be present, or if reactions to the death (e.g., continued decline in school performance, difficulty meeting demands at school, impaired functioning at home and with friends) persist without significant improvement, school mental health personnel should be made aware so that additional supports can be considered to meet student's 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.

Figure 2. Continuum of Exposure (Cerel, et al, 2014)



- The **Exposed** category includes absolutely anyone whose life or activities in any way intersect with a 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

It can be challenging for schools to strike a balance between compassionately meeting the needs of grieving students and staff and appropriately memorializing the life of someone who has died by suicide without risking suicide contagion. Schools should develop a policy on memorialization before a suicide death occurs and ensure that the policy is included in the school's crisis plan.

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 prejudice associated with suicide and may be deeply painful to the student's family and friends. Wherever possible, schools should meet with the deceased student's friends and coordinate memorialization with the family in the interest of identifying a meaningful, safe approach to acknowledging the loss. Make sure to be sensitive to the cultural and religious needs of all involved.

FUNERALS AND MEMORIAL SERVICES

Should a funeral or memorial service occur during school hours, the school should maintain its regular schedule. Regular school protocols should be followed for dismissing students to attend funerals. The school may consider coordinating with the family and funeral director to arrange for mental health professionals to attend the service. Best practice is for at least one school representative to be in attendance.

Schools should strongly encourage parent(s)/guardian(s) whose children express an interest in attending the funeral to attend with them. This provides not only emotional support but also an opportunity for parent(s)/guardian(s) to monitor their children's response, to open a discussion with their children, and to remind them that help is available if they or a friend are in need.

SPONTANEOUS MEMORIALS

It is common for students to create a spontaneous memorial by leaving flowers, cards, poems, pictures, stuffed animals, or other items in a place closely associated with the student, such as his or her locker or classroom seat, or at the site where the student died. Students may even come to school wearing T-shirts or buttons bearing photographs of the deceased student.

The school's goal should be to balance the students' need to grieve with that of limiting the risk of inadvertently glamorizing the death. If spontaneous memorials are created on school grounds, school staff should monitor them for messages that may be inappropriate (e.g., hostile or inflammatory) or that indicate students who may be at risk.

Although it may be necessary in some cases to set limits for students, it is important to do so with compassion and sensitivity, offering creative suggestions whenever possible. For example, schools may wish to make poster boards and markers available so that students can gather and write messages. It is advisable to set up the posters in an area that may be avoided by those who don't wish to participate (i.e., not in the cafeteria or at the front entrance) and, again, have them monitored by school staff.

Memorials may be left in place until after the funeral (or for up to approximately five days), after which the tribute objects may be offered to the family. Find a way to let the school community know that the posters are going to the family so that people do not think they were disrespectfully removed. For example, post a statement near the memorial on the before, and the day it will be taken down.

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 key students. 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 may be at risk. Students 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. (After a Suicide: A Toolkit for Schools, AFSP, 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. For additional information, please see the National Action Alliance for Suicide Prevention Framework for Successful Messaging, or the American Foundation for Suicide Prevention's Recommendations for Reporting on Suicide.

The school division communications office, 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 headline 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.

There is no single "best" suicide prevention message that will work for every messenger, goal, audience, and context. Thinking strategically helps you to create messages that fit your situation and use limited resources wisely. The National Action Alliance for Suicide Prevention offers a Framework

for Successful Messaging, which emphasizes strategy, safety, positive narrative and guidelines. Increased risk is associated with:

- Repeated, prominent, or sensational coverage;
- Details about suicide method or location;
- Portraying suicide as a common or acceptable response to adversity;
- Glamorizing or romanticizing suicide;
- Presenting simplistic explanations for suicide; and
- Including personal details that encourage identification with the person who died.

Messages should promote a positive narrative that focuses on safety by:

- Carefully reviewing content before sharing it;
- Being mindful of safety when sharing stories about individual suicide attempts or deaths with the public;
- If used, making sure data are strategic, safe, and prevention-focused;
- Conveying the complex causality of suicide;
- Highlighting solutions to stigma, and avoiding messages that reinforce stigma; and
- Conveying that prevention works and help is available.

APPENDIX I: GLOSSARY

At-Risk for suicide. A student identified 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 of potential mental health conditions or a deterioration of mental health. The student may have thoughts about suicide, including potential means of death, and may have a plan. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain.

Case Manager is identified through the suicide risk assessment process. The case manager will ensure that all necessary assessment components are completed and 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, likely a school counselor, school psychologist, or school social worker.

Community Services Board means the public body established pursuant to *§ 37.2-501*

that provides mental health, developmental, and substance abuse services within each city and county that established it; the term "community services board" shall include administrative policy community services boards, operating community services boards, and local government departments with policy-advisory community services boards.

Crisis Teams/Crisis Response Teams are structured based on the needs and resources of their community. Many school divisions have a division crisis team to handle larger crisis events, with each school having its own crisis team. This allows schools to pull from the division-wide team if they require additional support staff to meet the needs of their staff and students in the aftermath of a suicide. A division team is also beneficial if the school's crisis response team is emotionally impacted in a way that makes it difficult for school team members to engage in postvention activities effectively, or if they need extra support.

Mental Health Professionals may be school-employed mental health professions (i.e., school psychologists, school counselors, or school social workers) or community or private mental health providers.

Non-Suicidal Self-Injury (NSSI) is defined as directly and intentionally inflicting damage to one's own body without suicidal intent. The most common form of NSSI is self-cutting, but other forms include burning, scratching, hitting, intentionally preventing wounds from healing, and other similar behaviors.

Postvention is a crisis intervention strategy designed to assist with the grief process following suicide loss. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school's healthy postvention effort can lead to readiness to engage further with suicide prevention efforts and save lives.

Protective Factors are characteristics or conditions that may help to decrease a person's suicide risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them. These factors do not eliminate the possibility of suicide, especially in someone with risk factors. Protective factors help to create resiliency, or an ability to "bounce back" from setbacks encountered throughout life. School divisions should consider practices and programming that foster the development of protective factors as part of a larger suicide prevention plan.

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.

Risk factors can exist at any, some, or all 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.

Safety Plan is developed by the student and parent/guardian, if available, in collaboration with a mental health professional and other available suicide risk assessment team members. The case manager should ensure that a safety plan is developed immediately following a suicide risk assessment or when a student returns to the school setting after treatment. A sample safety planning form can be found on the VDOE's Suicide Prevention webpage. The safety plan outlines the steps necessary to keep the student safe from harming themselves and should include:

- Warning signs;
- Coping strategies that the student can use;
- Interventions, supports, or action steps to build protective factors;
- The people and places that improve the student's mood and make them feel safe;
- The trusted people the student can go to for help;
- Who to contact in an emergency, (The National Suicide Prevention Lifeline 1-800-273-TALK (8255) is available 24 hours a day, 7 days a week);
- The immediate steps the student can take during a suicidal crisis;
- Resources given to the family; and
- Name of the case manager.

School-Based Mental Health Personnel/Professionals/Staff are employed by the school division and have extensive backgrounds and training in counseling, providing interventions, and responding to crises. These typically include school psychologists, school counselors, and school social workers.

Suicide Contagion is the process by which one suicide death may contribute to another. Adolescents and teenagers appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. Therefore, it is important not to inadvertently simplify, glamorize, or romanticize the student or his or her death.

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 themselves. 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 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.

Suicide Risk Assessment Team conducts suicide risk assessments to determine if a student poses a risk for harming themselves and is in need of additional intervention or support. The assessment should be comprehensive and include the student's risk factors, behaviors, protective factors, and circumstances within the school or community that may be contributing to the risk, as well as input from parent(s)/guardian(s) and other relevant adults/peers. The suicide risk assessment team may be created, or the duties assigned to an existing multi-disciplinary team. School mental health professionals, in conjunction with community-based professionals, as appropriate, have primary responsibility for the direct assessment and crisis intervention with the student. Other team members can provide additional assistance and guidance as needed and may include school administrators, other school mental health professionals (i.e., school counselor, school psychologist, school social worker), and school nurse, school resource officer, and other trained school personnel.

Threat Assessment Teams respond to students whose behavior may pose a threat to the safety of school staff or students. Threat assessment teams, which are mandated by Virginia Code, also provide guidance to students, faculty and staff regarding recognition of threatening or aberrant behavior that may represent a threat to the community, school, or self.

Warning signs are signs and indicators that someone may be in danger of harming themselves and requires an immediate referral for a suicide risk assessment and appropriate intervention. Warning signs can include but are not 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;
- Attempting 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.

APPENDIX II: REFERENCES

1. Alavi, N., Reshetukha., Prost, E., Antoniak, K., Patel, C., Sajid, s., & Groll, d. (2017). Relationship between bullying and suicidal behaviour in youth presenting to the emergency department. Journal of the Canadian Academy of Child and Adolescent Psychiatry, 26(2), 70–77.
2. American Foundation for Suicide Prevention. (2019). Model School District Policy on Suicide Prevention: Model Language, Policy, and Resources. American Foundation for Suicide Prevention, American School Counselor Association, National Association of School Psychologists and The Trevor Project.
3. American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a Suicide: A Toolkit for Schools (2nd ed.). Waltham, MA: Education Development Center.
4. American School Counselor Association (2014). Mindsets and Behaviors for Student Success: K-12 College- and Career-Readiness Standards for Every Student. Alexandria, VA: Author.
5. Baiden, P. Tadeo, S. K., Graaf, G., & Respress, B. N. (2019). Examining the association between weapon carrying on school property and suicide attempt among adolescents in the United States. Social Work in Public Health, 34(7), 570–582.
6. Brown G, Stanley B, Department of Veterans Affairs. (2008). Patient Safety Plan Template. Retrieved from Patient Safety Plan Template.
7. Cederbaum, J.A., Gilreath, T.D., Benbenishty, R., Astor, R.A., Pineda, D., DePedro, K.T., & Atuel, H. (2014). Well-being and suicidal ideation of secondary school students from military families. Journal of Adolescent Health 54(6), 672-677.
8. Centers for Disease Control and Prevention. (2009). School Connectedness: Strategies for Increasing Protective Factors Among Youth. Atlanta, GA: U.S. Department of Health and Human Services.
9. Centers for Disease Control and Prevention. (2014). The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools. Chamblee, GA: CDC.
10. Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of survivorship: Definitional issues in the aftermath of suicide. Suicide and Life-Threatening Behavior, 44, 591–600. doi: 10.1111/sltb.12093.
11. Cerel, J., Maple, M., Van De Venne, J., Brown, M., Moore, M., & Flaherty, C. (2017). Suicide exposure in the population: Perceptions of impact and closeness. Suicide and Life-Threatening Behavior, 47 (6), 696–708.
12. Education Development Center. (2002-2019). Suicide Prevention Resource Center: Virginia. Retrieved from Virginia Suicide Prevention Resources.
13. Goldblum, P., Espelage, D.L., Chu, J., & Bongar, B. (2015). Youth Suicide and Bullying: Challenges and Strategies for Prevention and Intervention. New York: NY: Oxford University Press.
14. Hargus E, Hawton K, Rodham K (2009). Suicide Life Threat Behavior. 2009 Oct; 39(5):518-37.
15. HEARD Alliance. (2016). K-12 Comprehensive Suicide Prevention Toolkit for Schools. Retrieved from HEARD Alliance Toolkit.
16. The National Action Alliance for Suicide Prevention. (2015). Responding to Grief, Trauma, and Distress after a Suicide: National Guidelines. National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force. Retrieved from Responding to Grief, Trauma, and Distress after a Suicide.
17. The National Action Alliance for Suicide Prevention. (2018). Action Alliance Framework for Successful Messaging. Retrieved from Action Alliance Framework for Successful Messaging.

18. National Association of School Psychologists. (2015). Preventing Suicide: Guidelines for Administrators and Crisis Response Teams. Retrieved from Prevention Suicide: Guidelines for Administrators and Crisis Teams. Accessed May 8, 2019.

19. National Council for Behavioral Health & Missouri Department of Mental Health. (2019). Youth Mental Health First Aid Training. Retrieved from Youth Mental Health First Aid Training.

20. Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2014). Attorney General's Advisory Committee on American Indian and Alaska Native Children Exposed to Violence: Ending Violence So Children Can Thrive. Washington, DC: Author.

21. Office of the U.S. Surgeon General. (2012). National Action Alliance for Suicide Prevention. (2012). National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US). Available from: Office of the U.S. Surgeon General.

22. World Health Organization (2018). Preventing suicide: a community engagement toolkit. Retrieved from Preventing Suicide: a community engagement toolkit.

23. Rudd, M. D., Berman, A. L., Joiner, T. E. Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. Suicide and Life--Threatening Behavior, 36(3), 255--262.

24. Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

25. Substance Abuse and Mental Health Services Administration. (2012). Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012.

26. Substance Abuse and Mental Health Services Administration. (2019). Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration.

27. Substance Abuse and Mental Health Services Administration. (August 6, 2019). Resources for Suicide Prevention. Retrieved from Resources for Suicide Prevention.

28. Subs Lifeline. Retrieved from National Suicide Prevention Hotline Substance Abuse and Mental Health Services Administration. National Suicide Prevention.

29. Suicide Awareness Voices of Education, et al. (2015). Recommendations for Reporting on Suicide. Retrieved from Recommendations for Reporting on Suicide.

30. The Trevor Project. (2019). Resources: Preventing Suicide. Retrieved from Resources: Preventing Suicide.

31. Virginia Department of Criminal Justice Services. (2020). Threat Assessment & Management in Virginia Public Schools: Model Policies, Procedures, and Guidelines (3nd ed.). Richmond, Virginia.

32. Virginia Department of Health. (2019). Recognize. Talk. Act. Retrieved from Recognize Talk Act (http://www.vdh.virginia.gov/suicide-prevention/).

33. Wyman, P.A., Pickering, T.A., Pisani, A.R., Rulison, K. Schmeelk-Cone, K., et al. (2019). Peer-adult network structure and suicide attempts in 38 high schools: implications for network-informed suicide prevention. Journal of Child Psychology and Psychiatry, 60:10, 1065-1075.

34. Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Hoschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J.P., Saiz, P.A., Lipsicas, C.B., & Bobas, J., Cozman, D., Hegerl, U., Zohar, J. (2016). Suicide Prevention Strategies Revisited: 10-year Systematic Review. The Lancet Psychiatry, 3(7), 646–659. Retrieved from Suicide Prevention Strategies.

APPENDIX III: LAWS RELEVANT TO SUICIDE PREVENTION IN SCHOOLS

§ 22.1-272.1. Responsibility to contact parent of a student at imminent risk of suicide.

Notice to be given to social services if parental abuse or neglect; Board of Education, in cooperation with the Department of Behavioral Health and Developmental Services and the Department of Health, to develop guidelines for parental contact.

A. 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. Such contact shall be made in accordance with the provisions of the guidelines required by subsection C.

B. 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*. 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.

C. The Board of Education, in cooperation with the Department of Behavioral Health and Developmental Services and the Department of Health, shall develop guidelines for making the contact required by subsection A. These guidelines shall include, but need not be limited to, (i) criteria to assess the suicide risks of students, (ii) characteristics to identify potentially suicidal students, (iii) appropriate responses to students expressing suicidal intentions, (iv) available and appropriate community services for students expressing suicidal intentions, (v) suicide prevention strategies which may be implemented by local schools for students expressing suicidal intentions, (vi) criteria for notification of and discussions with parents of students expressing suicidal intentions, (vii) criteria for as-soon-as-practicable contact with the parents, (viii) appropriate sensitivity to religious beliefs, and (ix) legal requirements and criteria for notification of public service agencies, including, but not limited to, the local or state social services and mental health agencies. These guidelines may include case studies and problem-solving exercises and may be designed as materials for in-service training programs for licensed administrative and instructional personnel.

§ 22.1-207.2:1. Anti-bullying or suicide prevention materials; parental right to review.

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. 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.

The provisions of this section shall not limit the powers and duties of other state agencies.

§ 54.1-2969. 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 substance abuse (as defined in *§ 37.2-100*), mental illness or emotional disturbance.

A minor shall also be deemed an adult for the purpose of accessing or authorizing the disclosure of medical records related to those services.

§ 8.01-220.1:2. Civil immunity for teachers under certain circumstances.

A. Any teacher employed by a local school board in the Commonwealth shall not be liable for any civil damages for any acts or omissions resulting from the supervision, care or discipline of students when such acts or omissions are within such teacher's scope of employment and are taken in good faith in the course of supervision, care or discipline of students, unless such acts or omissions were the result of gross negligence or willful misconduct.

B. No school employee or school volunteer shall be liable for any civil damages arising from the prompt good faith reporting of alleged acts of bullying or crimes against others to the appropriate school official in compliance with *§§ 22.1-279.6* and *22.1-291.4* and specified procedures.

C. This section shall not be construed to limit, withdraw, or overturn any defense or immunity already existing in statutory or common law, to affect any claim occurring prior to the effective date of this law, or to prohibit any person subject to bullying or a criminal act from seeking redress under any other provision of law.

§ 9.1-184. Virginia Center for School and Campus Safety created; duties.

A. From such funds as may be appropriated, the Virginia Center for School and Campus Safety (the Center) is hereby established within the Department. The Center shall:

1. Provide training for Virginia public school personnel in school safety, on evidence-based anti-bullying tactics based on the definition of bullying in *§ 22.1-276.01*, and in the effective identification of students who may be at risk for violent behavior and in need of special services or assistance;
2. Serve as a resource and referral center for Virginia school divisions by conducting research, sponsoring workshops, and providing information regarding current school safety concerns, such as conflict management and peer mediation, bullying as defined in *§ 22.1-276.01*, school facility design and technology, current state and federal statutory

and regulatory school safety requirements, and legal and constitutional issues regarding school safety and individual rights;

3. Maintain and disseminate information to local school divisions on effective school safety initiatives in Virginia and across the nation;
4. Develop a case management tool for the collection and reporting of data by threat assessment teams pursuant to *§ 22.1-79.4*;
5. Collect, analyze, and disseminate various Virginia school safety data, including school safety audit information submitted to it pursuant to *§ 22.1-279.8*, collected by the Department;
6. Encourage the development of partnerships between the public and private sectors to promote school safety in Virginia;
7. Provide technical assistance to Virginia school divisions in the development and implementation of initiatives promoting school safety, including threat assessment-based protocols with such funds as may be available for such purpose;
8. Develop a memorandum of understanding between the Director of the Department of Criminal Justice Services and the Superintendent of Public Instruction to ensure collaboration and coordination of roles and responsibilities in areas of mutual concern, such as school safety audits and crime prevention;
9. Provide training for and certification of school security officers, as defined in *§ 9.1-101* and consistent with *§ 9.1-110*;
10. Develop, in conjunction with the Department of State Police, the Department of Behavioral Health and Developmental Services, and the Department of Education, a model critical incident response training program for public school personnel and others providing services to schools that shall also be made available to private schools in the Commonwealth;
11. 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; and
12. Develop a model memorandum of understanding setting forth the respective roles and responsibilities of local school boards and local law-enforcement agencies regarding the use of school resource officers. Such model memorandum of understanding may be used by local school boards and local law-enforcement agencies to satisfy the requirements of *§ 22.1-280.2:3*.

B. All agencies of the Commonwealth shall cooperate with the Center and, upon request, assist the Center in the performance of its duties and responsibilities.

§ 22.1-79.4 Threat assessment teams and oversight committees.

A. 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*. Such policies shall include procedures for referrals to community services boards or health care providers for evaluation or treatment, when appropriate.

B. 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.

C. Each division superintendent shall establish, for each school, a threat assessment team that shall include persons with expertise in counseling, instruction, school administration, and law enforcement. Threat assessment teams may be established to serve one or more schools as determined by the division superintendent. Each team shall (i) provide guidance to students, faculty, and staff regarding recognition of threatening or aberrant behavior that may represent a threat to the community, school, or self; (ii) identify members of the school community to whom threatening behavior should be reported; and (iii) implement policies adopted by the local school board pursuant to subsection A.

D. Upon a preliminary determination that a student poses a threat of violence or physical harm to self or others, a threat assessment team shall immediately report its determination to the division superintendent or his designee. The division superintendent or his designee shall immediately attempt to notify the student's parent or legal guardian. Nothing in this subsection shall preclude school division personnel from acting immediately to address an imminent threat.

E. Each threat assessment team established pursuant to this section shall collect and report to the Center quantitative data on its activities using the case management tool developed by the Center.

F. Upon a preliminary determination by the threat assessment team that an individual poses a threat of violence to self or others or exhibits significantly disruptive behavior or need for assistance, a threat assessment team may obtain criminal history record information, as provided in *§§ 19.2-389 and 19.2-389.1*, and health records, as provided in *§ 32.1-127.1:03*. No member of a threat assessment team shall re-disclose any criminal history record information or health information obtained pursuant to this section or otherwise use any record of an individual beyond the purpose for which such disclosure was made to the threat assessment team.