Suicide Prevention Policy

Board Policy #: 2
Adopted/Ratified: July 21, 2020
Revision Date:

The Purpose—

The Board of Directors of The Cottonwood High School ("TCS," "School," or the "Charter School") recognizes that suicide is a major cause of death among youth and should be taken seriously. The purpose of this policy is to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide. TCS:

- Recognizes that physical and mental health are integral components of student outcomes, both educationally and beyond graduation
- Further recognizes that suicide is a leading cause of death among young people
- Has an ethical responsibility to take a proactive approach in preventing deaths by suicide
- Acknowledges the Charter School's role in providing an environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience
- Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components

In compliance with Education Code section 215, this policy has been developed in consultation with TCS and community stakeholders, TCS school-employed mental health professionals (e.g., school counselors, psychologists, social workers, nurses), administrators, other school staff members, parents/guardians/caregivers, students, local health agencies and professionals, the county mental health plan, law enforcement, and community organizations in planning, implementing, and evaluating TCS's strategies for suicide prevention and intervention. TCS must work in conjunction with local government agencies, community-based organizations, and other community supports to identify additional resources.

Scope—

This policy covers actions that take place in the Charter School, on Charter School property, at Charter School-sponsored functions and activities, on Charter School buses or vehicles and at bus stops, and at Charter School-sponsored out-of-school events where Charter School staff are present. This policy

applies to the entire School community, including educators, Charter School staff, students, parents/guardians, and volunteers.

Definitions—

- *At-Risk*: Suicide risk is not a dichotomous concern, but rather, exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention by the School. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset 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. This situation would necessitate a referral, as documented in the following procedures. The type of referral, and its level of urgency, shall be determined by the student's level of risk — according to the School policy.
- *Crisis Team*: A multidisciplinary team of administrative staff, mental health professionals, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention, response and recovery. Crisis Team members includes principal and teachers and support staff. These professionals have been specifically trained in areas of crisis preparedness and take a leadership role in developing crisis plans, ensuring School staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports. Crisis team members who are mental health professionals may provide crisis intervention and services.
- *Mental Health:* A state of mental, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder ("PTSD"), and substance use disorders. Mental health can be impacted by the home and social environment, early childhood adversity or trauma, physical health, and genes.
- *Risk Assessment:* An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated School staff. This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.
- *Risk Factors for Suicide:* Characteristics or conditions that increase the chance that a person may attempt to take their life. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. 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.

- *Self-Harm*: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury ("NSSI") lacks suicidal intent, youth who engage in any type of self-harm should receive mental health care. Treatment can improve coping strategies to lower the urge to self-harm, and reduce the long-term risk of a future suicide attempt.
- *Suicide*: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- *Suicide Attempt*: A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, ambivalence is not a reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.
- *Suicidal Behavior*: Suicide attempts, injury to oneself associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.
- *Suicidal Ideation*: Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one's life is still considered suicidal ideation and shall be taken seriously.
- *Suicide Contagion*: The process by which suicidal behavior or a suicide completion influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.
- *Postvention*: Suicide 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.

Intervention—

Assessment and Referral

When a student is identified by a peer, educator or other source as potentially suicidal — i.e., verbalizes thoughts about suicide, presents overt risk factors such as agitation or intoxication, an act of self-harm occurs, or expresses or otherwise shows signs of suicidal ideation — the student shall be seen by TCS's

trained administrator within the same school day to assess risk and facilitate referral if necessary. Educators shall also be aware of written threats and expressions about suicide and death in school assignments. Such incidences require immediate referral to the administrator. If there is no mental health professional available at that given time, a designated staff member shall address the situation according to Charter School protocol until a mental health professional is brought in.

Students shall be encouraged to notify a teacher, the Principal, another TCS administrator, psychologist, TCS counselor, suicide prevention liaisons, or other adult when they are experiencing thoughts of suicide or when they suspect or have knowledge of another student's suicidal intentions. TCS staff should treat each report seriously, calmly, and with active listening and support. Staff should be non-judgmental to students and discuss with the student, and parent/guardian, about additional resources to support the student.

For At-Risk Youth

- School staff shall continuously supervise the student to ensure their safety until the assessment process is complete
- The Principal shall be made aware of the situation as soon as reasonably possible
- The Principal shall contact the student's the parent/guardian and/or appropriate support agent or agency
- Urgent referral may include, but is not limited to, working with the parent or guardian to set up an outpatient mental health or primary care appointment and conveying the reason for referral to the healthcare provider; in some instances, particularly life-threatening situations, the school may be required to contact emergency services, or arrange for the student to be transported to the local Emergency Department, preferably by a parent or guardian
- If parental abuse or neglect is suspected or reported, the appropriate state protection officials (e.g., local Child Protection Services) shall be contacted in lieu of parents as per law

When School Personnel Need to Engage Law Enforcement

The Charter School's crisis response plan shall address situations when School personnel need to engage law enforcement. When a student is actively suicidal and the immediate safety of the student or others is at-risk (such as when a weapon is in the possession of the student), School staff shall call 911 immediately. The staff calling shall provide as much information about the situation as possible, including the name of the student, any weapons the student may have, and where the student is located. School staff may tell the dispatcher that the student is a suicidal emotionally disturbed person,

or “suicidal EDP,” to allow for the dispatcher to send officers with specific training in crisis de-escalation and mental illness.

Parental Notification

The Principal shall inform the student’s parent or guardian on the same school day, or as soon as possible, any time a student is identified as having any level of risk for suicide or if the student has made a suicide attempt (unless notifying the parent will put the student at increased risk of harm). Following parental notification and based on initial risk assessment, the Principal, designee, or school mental health professional may offer recommendations for next steps based on perceived student need. These can include but are not limited to, an additional, external mental health evaluation conducted by a qualified health professional or emergency service provider.

When there is an attempt on campus

When a student is in imminent danger (has access to a gun, is on a rooftop, or in other unsafe conditions), a call shall be made to 911.

When a suicide attempt or threat is reported on campus or at a school-related activity, the suicide prevention liaison shall, at a minimum:

1. Ensure the student’s physical safety by one or more of the following, as appropriate:

    a. Securing immediate medical treatment if a suicide attempt has occurred.
    b. Securing law enforcement and/or other emergency assistance if a suicidal act is being actively threatened.
    c. Keeping the student under continuous adult supervision until the parent/guardian and/or appropriate support agent or agency can be contacted and has the opportunity to intervene.
    d. Remaining calm, keeping in mind the student is overwhelmed, confused, and emotionally distressed.
    e. Moving all other students out of the immediate area.
    f. Not sending the student away or leaving him/her alone, even to go to the restroom.
    g. Providing comfort to the student, listening and allowing the student to talk and being comfortable with moments of silence.
    h. Promising privacy and help, but not promising confidentiality.

2. Document the incident in writing as soon as feasible.

Follow up with the parent/guardian and student in a timely manner to provide referrals to appropriate services as needed and coordinate and consult with the county mental health plan if a referral is made for mental health or related services on behalf of a student who is a Medi-Cal beneficiary.

Re-Entry Procedure—

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), whenever possible, the Principal, or designee shall meet with the student's parent or guardian, and if appropriate, include the student to discuss re-entry. This meeting shall address next steps needed to ensure the student's readiness for return to school and plan for the first day back. Following a student hospitalization, parents may be encouraged to inform the Principal of the student's hospitalization to ensure continuity of service provision and increase the likelihood of a successful re-entry.

1. The Principal shall be identified to coordinate with the student, their parent or guardian, and any outside health care providers. The Principal shall meet with the student and their parents or guardians to discuss and document a re-entry procedure and what would help to ease the transition back into the school environment (e.g., whether or not the student will be required to make up missed work, the nature of check-in/check-out visits, etc.). Any necessary accommodations shall also be discussed and documented.

2. The designated staff person shall periodically check-in with the student to help with readjustment to the school community and address any ongoing concerns, including social or academic concerns.

3. The Principal shall check-in with the student and the student's parents or guardians at an agreed upon interval depending on the student's needs either on the phone or in person for a mutually agreed upon time period (e.g. for a period of three months). These efforts are encouraged to ensure the student and their parents or guardians are supported in the transition, with more frequent check-ins initially, and then fading support.

4. The administration shall disclose to the student's teachers and other relevant staff (without sharing specific details of mental health diagnoses) that the student is returning after a medically-related absence and may need adjusted deadlines for assignments. The Principal shall be available to teachers to discuss any concerns they may have regarding the student after re-entry.

After a Suicide Death

Development and Implementation of a Crisis Response Plan

The crisis response team, led the trained administrator, shall develop a crisis response plan to guide Charter School response following a death by suicide. This plan may be applicable to all school community related suicides whether it be student (past or present), staff, or other prominent school community member. Ideally, this plan shall be developed long before it is needed. A meeting of the crisis team to implement the plan shall take place immediately following word of the suicide death, even if the death has not yet been confirmed to be a suicide.

Action Plan Steps:
Step 1: Get the facts.
Step 2: Assess the situation
Step 3: Share the information with staff
Step 4: Avoid suicide contagion
Step 5: Initiate support services
Step 6: Develop memorial plans

Step 7: Prevention by reviewing/revising existing policiesA death by suicide in the school community (whether by a student or staff member) can have devastating consequences on the school community, including students and staff. The School shall follow the below action plan for responding to a suicide death, which incorporates both immediate and long-term steps and objectives:

The suicide prevention liaison shall:

1. Coordinate with the Principal to:

    a. Confirm death and cause.
    b. Identify a staff member to contact deceased's family (within 24 hours).
    c. Enact the Suicide Postvention Response.
    d. Notify all staff members (ideally in-person or via phone, not via e-mail or mass notification).

2. Coordinate an all-staff meeting, to include:

    a. Notification (if not already conducted) to staff about suicide death.
    b. Emotional support and resources available to staff.

   c. Notification to students about suicide death and the availability of support services (if this is the protocol that is decided by administration).
   d. Share information that is relevant and that which you have permission to disclose.

3. Prepare staff to respond to needs of students regarding the following:

   a. Review of protocols for referring students for support/assessment.
   b. Talking points for staff to notify students.
   c. Resources available to students (on and off campus).

4. Identify students significantly affected by suicide death and other students at risk of imitative behavior.

5. Identify students affected by suicide death but not at risk of imitative behavior.

6. Communicate with the larger school community about the suicide death.

7. Consider funeral arrangements for family and school community.

8. Respond to memorial requests in respectful and non-harmful manner; responses should be handled in a thoughtful way and their impact on other students should be considered.

9. Identify media spokesperson if needed.

10. Include long-term suicide postvention responses:

    a. Consider important dates (i.e., anniversary of death, deceased birthday, graduation, or other significant event) and how these will be addressed.
    b. Support siblings, close friends, teachers, and/or students of deceased.
    c. Consider long-term memorials and how they may impact students who are emotionally vulnerable and at risk of suicide.

Risk Factors and Preventive Factors

Risk Factors

Risk Factors are characteristics or conditions that increase the chance that a person may try to take her or his life or participate in self-harming behaviors. These risks tend to be highest when someone has several risk factors at the same time. The most frequently cited risk factors for suicide are:

1. Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)

2. Problems with alcohol or drugs

3. Unusual thoughts and behavior or confusion about reality

4. Personality traits that create a pattern of intense, unstable relationships or trouble with the law

5. Impulsivity and aggression, especially along with a mental disorder

6. Previous suicide attempt or family history of a suicide attempt or mental disorder

7. Serious medical condition and /or pain It is important to bear in mind that the large majority of people with mental disorders or other suicide risk factors do not engage in suicidal behavior.

Preventive Factors

Preventive Factors are characteristics or conditions that may help to decrease a person's risk of suicide or self-harming behaviors. While these factors do not eliminate the possibility of suicide, especially in someone with risk factors, they may help to reduce that risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them. The most frequently cited protective factors of suicide include:

1. Receiving effective mental health care

2. Positive connections to family, peers, community, and social institutions such as marriage and religion that foster resilience

3. The skills and ability to solve problems

At Risk Populations

TCS is aware of student populations that are at elevated risk of suicidal or self-harming behavior based on various factors:

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

2. Youth who engage in self-harm or have attempted suicide. Suicide risk among those who engage in self-harm is significantly higher than the general population. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow up care.

3. Youth in out-of-home settings. Youth involved in the juvenile justice or child welfare systems have a high prevalence of many risk factors of 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 research found that youth in foster care were more than twice as likely to have considered suicide and almost four times more likely to have attempted suicide than their peers not in foster care.

4. Youth experiencing homelessness. For youth experiencing homelessness, rates of suicide attempts are higher than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorders, and posttraumatic stress disorder.

5. American Indian/Alaska Native youth. In 2009, the rate of suicide among American Indian / Alaska Native 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.

6. LGBTQ (lesbian, gay, bisexual, transgender, 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 suicide attempt.

Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejections, harassment, bullying, violence and victimization. For those youth with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ that will elevate the risk of suicidal behavior for LGBTQ youth.

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

8. Youth living with medical conditions and disabilities. A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of the 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.

Prevention Policies Implementation

TCS designates the following administrators to act as the primary and secondary suicide prevention coordinators:

1. Principal
2. Trained Certificated Staff Member

The suicide prevention coordinator will be responsible for planning and coordinating implementation of suicide prevention for the School.

The TCS suicide prevention coordinator will act as a point of contact in the school for issues relating to suicide prevention and policy implementation. All staff members shall report students they believe to be at elevated risk for suicide to the School's primary suicide prevention coordinator. If this primary suicide prevention coordinator is unavailable, the staff shall promptly notify the secondary suicide prevention coordinator.

Providing a safe, positive, and welcoming school climate; and ensuring that students have trusting relationships with adults serves as the foundation for effective suicide prevention efforts. Bullying and suicide-related behaviors have a number of shared risk factors including mental health challenges (e.g., depression, hopelessness, and substance use/abuse). Youth who report frequently bullying others and those who report being frequently bullied are at increased risk for suicidal thoughts and behavior. Bully-victims (those who report both bullying others and being bullied) are at the highest risk for suicidal thoughts and behaviors. Keep in mind the relationship between bullying and suicide is more complex

and less direct than it might appear. While bullying may be a precipitating event, there are often many other contributing factors, including underlying mental illness.

Prevention efforts should also address non-suicidal self-injury (NSSI or "cutting"). While the behavior is typically not associated with suicidal thinking, it is a red flag that someone is distressed and does increase the risk for suicidal thinking and behaviors. It is important that school staff learn to recognize the signs of NSSI, including cuts, burns, scratches, scabs, and scrapes, especially those that are recurrent and if explanations for the injuries are not credible. Suicide risk assessment should always be a part of intervention with the student who displays NSSI.

Staff Professional Development

All suicide prevention trainings shall be offered under the direction of mental health professionals (e.g., school counselors, school psychologists, other public entity professionals, such as psychologists or social workers) who have received advanced training specific to suicide. Staff training may be adjusted year-to-year based on previous professional development activities and emerging best practices.

In addition to initial orientations to the core components of suicide prevention, ongoing annual staff professional development for all staff may include the following components:

a. The impact of traumatic stress on emotional and mental health.
b. Common misconceptions about suicide.
c. Charter School and community suicide prevention resources.
d. Appropriate messaging about suicide (correct terminology, safe messaging guidelines).
e. The factors associated with suicide (risk factors, warning signs, protective factors).
f. How to identify youth who may be at risk of suicide.
g. Appropriate ways to interact with a youth who is demonstrating emotional distress or is suicidal. Specifically, how to talk with a student about their thoughts of suicide and (based on the School guidelines) how to respond to such thinking; how to talk with a student about thoughts of suicide and appropriately respond and provide support based on the School guidelines.
h. Charter School-approved procedures for responding to suicide risk (including multi-tiered systems of support and referrals). Such procedures should emphasize that the suicidal student should be constantly supervised until a suicide risk assessment is completed.
i. Charter School-approved procedures for responding to the aftermath of suicidal behavior (suicidal behavior postvention).
j. Responding after a suicide occurs (suicide postvention).
k. Resources regarding youth suicide prevention.
l. Emphasis on stigma reduction and the fact that early prevention and intervention can drastically reduce the risk of suicide.

m. Emphasis that any student who is identified to be at risk of suicide is to be immediately referred (same day) for assessment while being constantly monitored by a staff member.

All staff will receive annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention. The professional development will include additional information regarding core components of suicide prevention, including:

- How to talk with a student about thoughts of suicide.
- How to respond appropriately to the youth who has suicidal thoughts. Such responses shall include constant supervision of any student judged to be at risk for suicide and an immediate referral for a suicide risk assessment.
- Emphasis on immediately referring (same day) any student who is identified to be at risk of suicide for assessment while staying under constant monitoring by staff member.
- Emphasis on reducing stigma associated with mental illness and that early prevention and intervention can drastically reduce the risk of suicide.
- Reviewing the data annually to look for any patterns or trends of the prevalence or occurrence of suicide ideation, attempts, or death. Data from the California School Climate, Health, and Learning Survey (Cal-SCHLS) should also be analyzed to identify school climate deficits and drive program development. See the Cal-SCHLS Web site at http://cal-schls.wested.org/.
- Information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in suicidal ideation, self-harm or have attempted suicide, those in out-of-home settings (such as foster care), those experiencing homelessness, American Indian/Alaska Native student, LGBTQ students, students bereaved by suicide, and those with medical conditions or certain types of disabilities.

Materials approved by the Charter School for training shall include how to identify appropriate mental health services, both at the school site and within the larger community, and when and how to refer youth and their families to those services. Materials approved for training may also include programs that can be completed through self-review of suitable suicide prevention materials.

Employees of TCS must act only within the authorization and scope of their credential or license. While it is expected that school professionals are able to identify suicide risk factors and warning signs, and to prevent the immediate risk of a suicidal behavior, treatment of suicidal ideation is typically beyond the scope of services offered in the school setting. In addition, treatment of the mental health challenges often associated with suicidal thinking typically requires mental health resources beyond what schools are able to provide.

Student Participation and Education

Messaging about suicide has an effect on suicidal thinking and behaviors. Consequently, TCS along with its partners has carefully reviewed and will continue to review all materials and resources used in awareness efforts to ensure they align with best practices for safe messaging about suicide. Suicide prevention strategies may include, but not be limited to, efforts to promote a positive school climate that enhances students' feelings of connectedness with TCS and is characterized by caring staff and harmonious interrelationships among students.

The School's instructional and student support program shall promote the healthy mental, emotional, and social development of students including, but not limited to, the development of problem-solving skills, coping skills, and resilience. The instruction shall not use the stress model to explain suicide.

The School's instructional curriculum may include information about suicide prevention, as appropriate or needed. If suicide prevention is included in the Charter School's instructional curriculum, it shall consider the grade level and age of the students and be delivered and discussed in a manner that is sensitive to the needs of young students. Under the supervision of an appropriately trained individual acting within the scope of her/his credential or license, students shall:

1. Receive developmentally appropriate, student-centered education about the warning signs of mental health challenges and emotional distress. The content of the education may include:

    a. Coping strategies for dealing with stress and trauma.
    b. How to recognize behaviors (warning signs) and life issues (risk factors) associated with suicide and mental health issues in oneself and others.
    c. Help-seeking strategies for oneself and others, including how to engage school-based and community resources and refer peers for help.
    d. Emphasis on reducing the stigma associated with mental illness and the fact that early prevention and intervention can drastically reduce the risk of suicide.

2. Receive developmentally appropriate guidance regarding TCS's suicide prevention, intervention, and referral procedures.

Student-focused suicide prevention education can be incorporated into classroom curricula (e.g., health classes, orientation classes, science, and physical education).

The School will support the creation and implementation of programs and/or activities on campus that raise awareness about mental wellness and suicide prevention (e.g., Mental Health Awareness Week,

Peer Counseling, Freshman Success, and National Alliance on Mental Illness on Campus High School Clubs).

Identification and Intervention

Early identification and intervention are critical to preventing suicidal behavior. When a member of school staff becomes aware of a student exhibiting potential suicidal behavior, they should immediately and contact a member of the school's crisis response team for a suicide risk assessment and support. If the appropriate staff is not available, 911 should be called. Typically, it is best to inform the student what you are going to do every step of the way. Under no circumstances should the student be left alone (even in a bathroom/ restroom). Reassure and supervise the student until a 24/7 caregiving can assume responsibility.

References

American Foundation for Suicide Prevention, American School Counselor Association, National Association of School Psychologists & The Trevor Project (2019). Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources (2nd ed.). New York: American Foundation for Suicide Prevention