Department of Mental Health

Vermont Model School Protocol for Suicide Prevention

Published:
January 15, 2024

VERMONT

Contact Information

From:

Chris Allen, LICSW Director of Suicide Prevention
Agency of Human Services, Department of Mental Health
Christopher.M.Allen@vermont.gov, (802) 760-9208

To receive this information in an alternative format or for other accessibility requests, please contact:

Jennifer Rowell, Commissioner's Office, Executive Assistant
Agency of Human Services, Department of Mental Health
Jennifer.Rowell@vermont.gov , 802-241-0090

Contents

Executive Summary

The Department of Mental Health (DMH), Agency of Education (AOE), and the Center for Health and Learning (CHL) collaborated to develop a comprehensive model school protocol for suicide prevention and postvention. The "Umatter for Schools" training, conducted by CHL, facilitated the creation of suicide prevention protocols tailored to individual schools. Advisory Group meetings, involving diverse stakeholders, further refined the statewide model protocol. Challenges identified during this process include competing priorities, time constraints, staffing shortages, funding limitations, and the absence of a systemic approach.

Barriers to Implementation:

Local Education Agencies (LEA) and schools face overwhelming challenges, including academic, social-emotional, and safety expectations, compounded by workforce shortages. Key barriers to implementing the model school protocol include conflicting priorities, time constraints, staffing shortages, insufficient funding, lack of strategic coordination, and insufficient buy-in from administrators. Overcoming these challenges is crucial for intentional implementation, reducing suicide rates, and ensuring student well-being.

Recommendations for Successful Implementation:

To address the identified barriers, the report suggests several recommendations:

- **Awareness and Skills Training:** Provide comprehensive training for all staff to develop a basic understanding and common language related to suicide prevention.
- **Identify Target Groups for Training:** Identify specific groups within schools for more focused training on planning and implementation of suicide prevention measures.
- **Support for Health Standards:** Offer support to LEAs to meet health standards related to suicide prevention, especially in LEAs without full-time health educators.
- **Resource Allocation:** Provide resources for LEAs to contract with external organizations for suicide prevention education, ensuring access to quality training.

Components of the Model School Protocol for Suicide Prevention:

The model school protocol is outlined with the following core elements:

- **Relationship Mapping:** Establishing positive connections between students

and identified school adults to enhance protective factors and support.

- **Identification of At-Risk Students:** Educating school staff on recognizing warning signs and providing foundational knowledge for early identification.
- **Responding to Potential Suicidal Risks:** A protocol for responding to suicidal threats, whether in person, online, or on school grounds, ensuring immediate and appropriate support.
- **Student Attempts on Campus:** Guidelines for responding to life-threatening behaviors or suicide attempts on school premises, prioritizing safety and appropriate communication.
- **Student Attempts or Deaths off Campus:** Addressing the impact of suicide off-campus on the student body and outlining communication and support measures.
- **Student's Return to School:** Developing a supportive re-entry process for students who have attempted suicide, involving them in the planning to regain a sense of control.
- **Postvention:** Establishing protocols to address the needs of the family, students, staff, and the wider community after the death of a student, emphasizing advanced planning and staff support.

Eating Disorder Education Guidelines:
Recognizing the severity and prevalence of eating disorders, the report outlines education guidelines for school personnel. Topics include prevention, language, identification, and resources. Supervisory Unions/Supervisory Districts (SU/SDs) are tasked with determining how to meet minimum standards for education, ensuring quality professional development resources and materials, and providing ongoing training for school employees.

Competitive Grant Recipients:
A competitive grant program was initiated to support mental health and wellness services for children and youth. Recipients, including Boys and Girls Club of Brattleboro, Caledonia Central Supervisory Union, Champlain Valley School District, and others, aim to address mental health needs through various programs and services. Grants focus on expanding counseling services, providing online mental health counseling, incorporating after-school programs into restorative approaches, and enhancing physical education and counseling services.

In summary, the comprehensive model school protocol for suicide prevention, coupled with eating disorder education guidelines and competitive grants, represents a concerted effort to address mental health challenges in educational

settings. The report recognizes the complex landscape of priorities, challenges, and resource constraints, emphasizing the importance of intentional implementation to safeguard the well-being of students.

Legislative Language

From ACT 56:

(b) On or before January 15, 2024, the Director of Suicide Prevention, in collaboration with the Agency of Education and stakeholders, shall develop and submit a model protocol for all schools regarding suicide prevention, education, and postvention services to the House Committee on Health Care and to the Senate Committee on Health and Welfare. The model protocol shall:

> *(1) reflect preliminary data related to grants to expand mental health and well-being services to youth pursuant to 2022 Acts and Resolves No. 112, Sec.3; and*
>
> *(2) ensure that school employees receive education pertaining to the prevention of, use of language regarding, and identification of eating disorders in youth.*

Introduction

As evidenced by the 2021 results of the Youth Risk Behavior Survey, Vermont youth are experiencing an increasingly challenging time. Administered by the Vermont Department of Health in collaboration with the Agency of Education, the survey revealed that 35% of high school students experienced poor mental health most of the time or always during the past 30 days. Just over half of all high school students (52%) agree or strongly agree that they matter to people in their community. Female, BIPOC and LGBTQ+ students are significantly less likely to feel they matter to people in their community compared to their peers (47% female vs 57% male; 46% BIPOC vs 53% white, non-Hispanic; 36% LGBTQ+ vs 58% heterosexual, cisgender). Gender disparities were particularly concerning, with female students (41%) more than two times as likely as male students (19%) to report feeling so sad or hopeless during the past year that they stopped engaging in some activities. BIPOC students are significantly more likely than white, non-Hispanic students to have made a suicide plan during the past year. LGBTQ+ students are more than 3.5 times as likely as heterosexual, cisgender students to have made a suicide plan during the past year. Overall, 7% of students attempted suicide in the past year.

Though Vermont-specific data is limited, at least 9% of the United States population will suffer from an eating disorder at some point within their lifetime. Eating disorders disproportionally affect adolescents and females. Of note, suicide is a leading cause of death among those with eating disorders. Due to a combination of suicide and medical complications, eating disorders have the second highest mortality rate among mental health disorders, surpassed only by opiate addiction.

As we seek to provide early intervention and support for both suicidal ideation and disordered eating, schools play a pivotal role. By providing schools and school staff with the information and resources they need, in the form of comprehensive guidance and protocols, we can improve health outcomes and begin the work to reverse current trends.

Outline of Planning Process

The Department of Mental Health (DMH), Agency of Education (AOE), and the Center for Health and Learning (CHL) partnered in developing the model school protocol for suicide prevention and postvention. Umatter for Schools is a training developed and offered by CHL to school staff on ways to engage in suicide prevention in the school setting. This training has been made available for school staff to participate in. During the training, suicide prevention protocols are developed for each school with assistance provided by the CHL trainers. The protocol shared with participants formed the foundation of the statewide model school protocol. DMH and AOE led and facilitated efforts seeking input and feedback to further enhance the existing protocol through a series of Advisory Group meetings held in mid-October. Stakeholder participation was diverse, encompassing: UP for Learning, NAMI Vermont, CHL, Vermont Afterschool, Vermont Principals Association, Vermont Superintendents Association, school-based clinicians, community mental health agencies, and DMH, the Vermont Department of Health (VDH), and AOE. A planning committee was formed to incorporate feedback, further develop the protocol, and provide input from their expertise. Members included Meg Porcella (AOE), Marianna Donnelly (DMH), Kathleen Kilbourne (CHL), and led by Christopher Allen (DMH). Feedback was gathered in multiple ways, through meetings, via email, and using an electronic whiteboard with prompting questions. These opportunities allowed increased ability to engage with the material as the participant was able to process and spend time understanding the protocol, while providing an opportunity to share the feedback as they were able to.

The protocol outlines the foundational elements of a quality model school protocol for suicide prevention and postvention, while asking the Supervisory Unions/Supervisory Districts to align, meet, and exceed this standard. In accordance with Act 56, this protocol also includes guidelines for eating disorder education in schools, created in conjunction with many of the state partners and community stakeholders listed above. Both the model school protocol for suicide prevention and the eating disorder education guidelines are outlined below, with comprehensive versions included as appendices.

Recommendations and Barriers for Successful Implementation

Local Education Agencies (LEA) and schools report feeling overwhelmed with academic, social-emotional and safety expectations; meanwhile, student needs are increasing in each of these areas, and workforce challenges continue. A suicide prevention model school protocol is a critical step in supporting LEAs to provide the structure and support necessary. However, successful protocol and/or policy require accompanying training and support to have the impact needed. Therefore, before recommending requirements, it is important to understand the barriers that LEAs and schools experience in accessing and implementing key pieces of the model school protocol. The stakeholders consulted reported the following barriers:

- A competing set of priorities, that sometimes conflict
- A lack of time
- Widespread staffing shortages across multiple jobs (e.g., teachers, substitutes, administrators, cleaning staff, etc.)
- Insufficient funding to support quality, standardized training and protocol
- No strategic and systemic approach to utilize numerous protocols (ex. Behavioral Threat Assessment, School Crisis Planning, Education Support Teams, Bullying and Harassment, Suicide Prevention)
- Inadequate buy-in from training administrators to make the work a priority
- Inability to use the existing meeting times and spaces for training on this topic due to aforementioned reasons (ex. Annual conferences held for Vermont Superintendents Association, Vermont Principal Association, and Vermont School Board Association, BEST Summer Institute)

Stakeholders stress that intentional implementation is critical to reducing the number of deaths by suicide:

1. Develop awareness and skills training for all staff for basic understanding and common language
2. Identify groups to receive training for planning and implementation

3. Provide LEAs support to meet the health standards around suicide prevention, especially for LEAs without a full-time health educator
4. Provide resources to contract with outside organizations to provide suicide prevention education

Components of the Model School Protocol for Suicide Prevention

Suicide prevention, education, and postvention services are unique in each setting, although the utilization of a protocol is critical to creating a standard of guidelines and principles in emergency situations. Within a school setting, a protocol for suicide prevention will assist in providing a document to implement in their specific school, using language familiar to each one, and adapting it for relevancy and usefulness. Each protocol will be distinct as it is responsive to the cultural and environmental contexts of each school giving particular focus to ensuring equity for all no matter their sexual orientation, race, ethnicity, and gender. At its core all protocols will have the following elements or sections:

I. **Relationship mapping** to ensure each student has an identified school adult with which they have a positive connection. School staff can assist students with relationship mapping. School staff will be notified of the students who have identified them as a positive connection. Identifying this connection is an important protective factor for everyone. Students at increased risk of suicide or who need additional support will be reviewed on a weekly basis in the Multi-Tiered System of Support meetings.

II. **Students at Risk of Suicide** Having school staff aware and knowledgeable of the suicide warning signs is integral to identifying **the issue** when **behavior is described** directly or indirectly from students or other school staff. Education of school staff is a foundational step for staff to feel confident to identify when a warning sign is present.

III. **Responding to Potential Suicidal Risks** Each threat, whether it is in person, online, or on school grounds, is to be taken seriously. Suicidal risk is present when a school staff or student observes or is notified of warning signs associated with suicidal thoughts or intent. When notified, an immediate response to

support the student is appropriate and needed.

IV. **Student Attempts on Campus** Once a life-threatening behavior or suicide attempt has been made on campus, an immediate response is necessary. Safety is of paramount concern. School staff are to keep the student safe, under close supervision, and cannot leave the student alone. School administrators are to be notified who will then communicate with identified staff to address the emergency. Communication to the guardian of the circumstances and a plan to meet will transpire. Consultation with the Designated Mental Health Agency will occur as needed to assess the student's mental state and obtain a recommendation for treatment. Guidelines for assisting other students during an emergency are outlined.

V. **Student Attempts or Deaths off Campus** Death by suicide off campus can have a significant impact on the student body. Notification of the death needs to be communicated to the school administrator who will notify and alert principals at schools attended by siblings, who in turn will notify counselors, nurses, and others in a position to help siblings and other students who might be affected.

VI. **Student's Return to School** Students who have made a suicide attempt are at increased risk of attempting to harm themselves again. Appropriate handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school. This involvement helps the student to regain some sense of control. Confidentiality is extremely important in protecting the student and enabling school personnel to be helpful.

VII. **Postvention** Any death of a student is a tragic event and protocols should be in place to address the needs of the family, other students, staff, and the wider community. Each student and school staff will grieve differently. Managing the school environment after a suicide presents significant challenges to school personnel. Advanced planning, clear messages, self-care, and staff debriefing are essential components to effectively manage the school environment.

Eating Disorder Education Guidelines

Eating disorders (EDs) are serious, sometimes life-threatening illnesses, affecting at least 9% of the population. Recent data shows troubling increases in both prevalence and severity. While EDs may present throughout the lifespan, they often take hold during childhood and adolescence, and can greatly impact a youth's physical and psychological development.

As outlined by the American Academy of Pediatrics, schools play an integral role in improving outcomes for Vermont's youth through prevention, early detection, and awareness. Accordingly, ED-related education for school personnel was listed as a key strategy in a recent working group report to the Vermont legislature. The following education guidelines summarize relevant eating disorder-related topics and suggested resources, and task Supervisory Unions/Supervisory Districts (SU/SDs) with determining how they will meet minimum standards for the education of school personnel.

In establishing an ED education plan for school employees, school districts must take steps to ensure that quality professional development resources, materials, and/or trainings are offered (see Quality Training Standards provided by the Center for Disease Control). The education (which may include a range or compilation of a number of resources) as well as requirements on school employee accountability should be determined at the SU/SD level. Best practices and research in the space of ED prevention is continually developing, so initial (three hours upon employment) and ongoing education requirements at a minimum of one hour per year should also be established. School employees shall include teachers, school nurses, health educators, physical educators, athletic coaches, guidance counselors, support staff, food service staff, and administrators. It is essential that these trainings are coordinated (e.g. a common language) and that employees are also given opportunities to understand their role in prevention and identification of eating disorders within their specific SU/SD (e.g. trainings supplemented with SU/SD related processes, such as support plans for students experiencing disordered eating).

SU/SDs must ensure that ED education for staff addresses the following topic areas, at a minimum. The subtopics are elaborated in Appendix 2.

I. **Prevention.** Given their prominent role in the daily lives of children and youth, schools are well positioned to reduce modifiable risk factors,

enhance protective factors, and support prevention of EDs. Required subtopics:

a. Implicit bias and debunking myths
b. Weight-inclusive health education
c. Media literacy
d. Comorbidities of eating disorders

II. **Language.** School staff play a vital role in creating an educational environment - through supportive and body-affirming words and actions - that helps students to foster and develop healthy self-image and nourishing eating practices. Required subtopics:

a. Eating disorder literacy
b. Body neutrality
c. Weight inclusivity
d. Food culture and culture of food

III. **Identification.** Early identification of eating disorders, followed by strategic support of students and their families, can prevent severe illness and promote recovery. In addition to ensuring education, each SU/SD should establish a clear reporting/escalation protocol for staff to follow when they have concerns about a student. Required subtopics:

a. Warning signs
b. Strategies for assisting students
c. Strategies for supporting families

IV. **Resources.** In meeting minimum requirements for eating disorder-related professional development, SU/SDs are encouraged to utilize materials and programming that are right for their employees and students. Many vetted educational resources for schools are included in Appendix J.

2022 Acts and Resolves No. 112, Sec.3

This competitive grant sought a two-year program utilizing a tiered-support approach to ensure continuous support to children and youth in a variety of settings, including supervisory union and district-wide, in-school, community technical education centers, and afterschool, by providing grants to expand existing school-based counseling services in underserved districts of the State; or develop either school-based or community-based afterschool programs, operating in a variety of settings outside the school day and over the summer, including before and after school, in-service days, and school vacation week, that support the mental health and wellness needs of

students, families, and staff. The period of performance is through September 30, 2024. A status report will be submitted from each recipient on September 1, 2024, and data from the status report will be reported to the Legislature in January 2025.

Recipients

Boys and Girls Club of Brattleboro, Inc. - $200,000

The Boys and Girls Club of Brattleboro plans to use its grant to operate its Kids Club Program in partnership with Brattleboro's Retreat Farm, using their campus less than a mile west of Brattleboro's downtown district.

Caledonia Central Supervisory Union - $125,000

The Caledonia Central Supervisory Union plans to use its grant to provide online mental health counseling to its staff and students aged 13 or older.

Champlain Valley School District - $140,200

The Champlain Valley School District plans to use its grant to incorporate its after-school program into its restorative approaches processes.

Essex North Supervisory Union - $200,000

The Essex North Supervisory Union plans to use its grant to provide additional social- emotional clinician services to students and parents, create youth and teen extra-curricular activities, and train staff to provide additional mental health and trauma-based services to students and families.

Franklin West Supervisory Union - $200,000

The Franklin West Supervisory Union plans to use its grant to provide online mental health counseling as well as private practice support for students with significant needs.

Kingdom East Unified Union School District - $200,000

The Kingdom East Unified Union School District plans to use its grant to address students' social, emotional, mental health and wellness needs.

Lamoille South Unified Union School District - $200,000

The Lamoille South Unified Union School District plans to use its grant to

partner with Lamoille Health Partners to provide its middle and high school students with an innovative mental health wrap-around therapeutic model from 11 am-7 pm.

Orange Southwest Unified Union School District - $78,540

The Orange Southwest Unified Union School District plans to use its grant to hire an additional counselor to work with teachers, school guidance and other school counselors to meet the needs of the children and ensuring best practices are being used.

Orleans Central Supervisory Union - $151,638.62

The Orleans Central Supervisory Union plans to use its grant to enhance the services its school- based clinicians provide.

Rutland Northeast Supervisory Union - $125,100

The Rutland Northeast Supervisory Union plans to use its grant to provide wrap-around services for the grade 6 to grade 7 transition program.

St. Johnsbury School District - $200,000

The St. Johnsbury School District plans to use its grant to contract with an outside mental health and human services agency to bring qualified mental health clinicians into our school to provide one-on-one mental health counseling and support to our students most in need.

Washington County Mental Health Services - $200,000

The Washington County Mental Health Services plans to provide activities, training, and therapeutic during/ after-school resources for students, staff, and families throughout Vermont's Capital Region, the cities of Montpelier and Barre, and twenty-one rural townships, including three in the Orange County region of Vermont.

Windsor Southeast Supervisory Union - $155,900

The Windsor Southeast Supervisory Union plans to enhance physical education and counseling services to its students.

Appendix A: Suicide Prevention/Intervention Protocols for Schools

Suicide Prevention/Intervention Protocols for Schools

(8/16/2021, updated 12/1/2023)

PREFACE: The following protocols were compiled and adapted with the help of the Vermont Suicide Prevention Center - a public/private partnership with the Agency of Human Services. This protocol was developed as part of the *Umatter ® for Schools Suicide Prevention* program. It was updated in August 2021, which formed the foundation of this revised version. The Maine Youth Suicide Prevention Program with funding administered through the Substance Abuse and Mental Health Services Administration (SAMHSA), as part of the Garrett Lee Smith Memorial Act is credited with creating the Media Guidelines for School Administrators. The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA.

For more information about protocols for schools, contact the Center for Health and Learning info@healthandlearning.org

This document includes the following sections. Each section corresponds with a level of intervention:

I. Relationship Mapping

II. Students at Risk of Suicide

III. Responding to Potential Suicidal Risks

IV. Suicide Attempts on Campus

V. Suicide Attempts off Campus

VI. A Student's Return to School Following Suicidal Behavior

VII. Postvention

Appendices:

A. Suicide Prevention, Intervention, and Follow-Up Checklist

B. Student Safety Re-Entry Protocol

C. A Student's Return to School: Issues and Options

D. Media Guidelines for School Administrators

E. Crisis Response Agreement

F. Welcome Letter for New School Staff

G. Warning signs

H. Help resources

I. Glossary

J. Training and Screening options

Key Personnel involved in suicide prevention and intervention:

- Administrators: Principal, Assistant Principal
- School Counselors
- School Based Clinician/School Clinician
- School Nurse
- Home School Liaison/School Counselor

I. Relationship Mapping

Within the school setting there are many school staff representing various roles. Each of these staff members play an integral role in a student's experience in school. Students spend countless hours in the school setting developing bonds and ties to those around them, including school employees. These connections can form the foundation of a positive social relationship, one where safety, trust, and comfort are upheld professionally. Developing and maintaining social connections is a protective factor for each student, and especially for students struggling with their mental health. Relationship mapping is a tool to be implemented to ensure school employees are aware of each student having a positive connection to at least one school adult.
Here are a few steps to implement this strategy:

1. Students write down at least one school adult they have a positive connection with. Pay particular attention to students unable to think of one adult.
2. School employees are made aware of the students they identified as having the positive connection.
3. These connections are reviewed on a regular basis to incorporate any new positive connections or changes in the existing positive connection.

II. Students at Risk of Suicide

The risk of suicide is present when any student, teacher, or other school employee identifies a student as potentially suicidal because they have directly or indirectly expressed suicidal thoughts or demonstrated other clues or warning signs. The Umatter ® Suicide Prevention Handbook has a list of warning signs (see Appendix G). The school staff member who first hears of the suicide risk is to take the following steps after having talked with the student in a quiet, private setting to clarify the situation and provide appropriate support:

1. Take the threat of self-harm seriously.

2. Take immediate action. This should be addressed within the hour. Contact one of the Identified Staff (i.e., counselor, clinician, administrator, school social worker, family engagement coordinator, nurse) to inform them of the situation.

3. The staff member who first hears of the suicide risk will introduce the Identified Staff to the student. The Identified Staff close to the student speaks with them in a quiet, private setting to clarify the situation and provide appropriate support.

4. The Identified Staff trained in suicide prevention is contacted to meet with the student. The Identified Staff with a clinical background talks with the student and does an initial suicide risk screening, including specifically asking about a possible suicide plan. (see Appendix A: Suicide Prevention, Intervention, and Follow-Up Checklist)

5. Guardians must always be notified when there appears to be any risk of suicide. Be sensitive to circumstances where the Department of Children and Families (DCF) may need to be contacted first if there is suspected physical, sexual, or emotional abuse. The individual who notifies the guardian should be an Identified Staff who has experience and expertise in suicide prevention. Help resource information should be provided if needed. Sensitivity and awareness of the culture of the guardian and family is paramount when notifying the guardian. The same person should follow up with the guardians within a few days to determine what has been done and the next steps. (see Appendix A: Suicide Prevention, Intervention, and Follow-Up Checklist)

6. Teachers, school counselors, social workers and other school officials are all mandated reporters for suspected child abuse and neglect under Vermont Law. If a school staff member determines that a student under age 18 appears to be at risk of attempting suicide and the guardian refuses to obtain services for their child, a report should be made to DCF's Child Abuse Hotline for neglect or failure to seek necessary mental health treatment, which may place the student at risk of serious harm. DCF will conduct an assessment to determine if abuse or neglect does exist and to engage the family voluntarily in meeting the treatment needs of the student. If the guardian still will not seek treatment and DCF believes that this places the student at risk of serious harm, a Court Order may be sought ordering the required treatment services.

7. If deemed necessary, or if the student refuses to give any information to the school counselor or school-based clinician, they will contact the guardians to request that they seek crisis services at the Designated Agency. This call should result in obtaining consultation with a professional who has the skills, authority, and responsibility to formally assess the student for suicidal intention and determine the necessary level of care. **INSERT DESIGNATED AGENCY NAME AND PHONE NUMBER HERE**

8. Document actions and follow-up taken by completing the Suicide Prevention, Intervention, and Follow-Up Checklist (see Appendix A) with the student's school counselor.

III. Responding to Potential Suicide Risks

There is an assumption of suicidal risk when a staff person observes or is notified of warning signs inferring suicidal thoughts or intent. These can occur in person, on a remote platform or on social media.

All staff members understand that they are to take suicidal behavior seriously every time.

1. The staff person "on the scene" takes immediate action (within the hour) to inform the Identified Staff (i.e., counselor, clinician, administrator, school social worker, family engagement coordinator, nurse) to respond to such situations.

2. The staff person "on the scene" talks with the student, staying calm and listening attentively. It is crucial to keep the student under continuous adult supervision until the Identified Staff arrives. The Identified Staff conducts the school's identified evidence-based suicide risk screening with the student to determine the level of risk. (see Appendix J: Training and Screening options)

   a. This includes:
      i. Determining if the student has a plan for suicide.
      ii. Asking if the student has lethal means on their person or accessible elsewhere.
      iii. Consulting with **INSERT DESIGNATED MENTAL HEALTH AGENCY NAME HERE** if necessary to obtain an assessment of the student's mental status and a recommendation for treatment.

3. If the student is in possession of lethal means, secure the area and prevent other students from accessing this area. Lethal means must be removed without putting anyone in danger. It is best to call in a trained law enforcement officer to remove lethal means. Law enforcement officers have special training to de-escalate a situation that can become dangerous very quickly.

4. The Identified Staff contacts the guardians to:
    a. Notify them of the situation and request that they come to school, as soon as possible. Ask them about any potential barriers (transportation, financial, time off from employment etc.) to arriving promptly.
    b. Provide them with a verbal report upon arrival at school.

5. Discuss and advise them on steps to be taken.
    a. Release the student to the guardian with referrals and resources (names and phone numbers).
    b. Inform the guardian that the school will follow up with them on actions taken within three days.

6. The student, guardian, administrator, school counselor and other identified staff/necessary school personnel will engage in a reentry meeting before the student returns to school. (see Appendix B: Student Safety Re-Entry Protocol)

7. If a student up to the age of 18 is determined to be at risk of suicide and the guardian is notified and refuses to obtain services, a report should be made to the Division of Children and Families (DCF) for neglect, i.e., failure to seek necessary mental health treatment which may place the student at risk of serious harm. DCF will conduct an assessment to determine if abuse or neglect does exist and to engage the family voluntarily in meeting the treatment needs of the student. If the guardian still refuses to seek treatment and DCF believes that this places the student at risk of serious harm or at immediate risk of serious harm, a Court Order will be sought requiring the services.

8. If the situation requires transportation to a hospital emergency department, and the guardian is not available, emergency medical services should be contacted to assess the situation and expedite the transition to the hospital. School staff should never transport the student.

9. NO STUDENT IN THIS SITUATION SHOULD BE SENT HOME ALONE.

10. Any actions and follow-up taken should be documented by the student's school counselor.

11. Debrief with all staff members who assisted with the intervention.

12. Follow up with a guardian as arranged.

IV. **Suicide Attempts on Campus**

When a student exhibits life-threatening behavior or has attempted suicide on the school premises, an immediate response is necessary.

Procedures for a school employee assisting a student who has attempted suicide or engaged in life-threatening behavior:

1. Keep the student safe and under close supervision. Never leave the student alone. Designate one or more staff members to stay with the student and support them while help is being sought.

2. Notify a school administrator who will immediately communicate with designated individuals including Identified Staff. e.g., the school nurse, school-based clinician, school counselors, SAP counselor, Director of Facilities, Director of Transportation (if necessary), emergency medical professionals, community crisis service providers, and the Superintendent of schools.

3. Notify the student's guardian of what has occurred and arrange to meet them wherever appropriate, case by case. Ask them about any potential barriers (transportation, financial, time off from employment etc.) to arriving promptly.

4. Consult with crisis service agency staff at **INSERT DESIGNATED MENTAL HEALTH AGENCY NAME HERE**, as necessary, to assess the student's mental state and to obtain a recommendation for needed treatment.

5. If the youth does not require emergency treatment or hospitalization (as determined by crisis team) and the immediate crisis is under control, release the student to the guardian with arrangements for needed medical treatment and mental health counseling.

6. If the situation requires transportation to a hospital emergency department, and the guardian is not available, emergency medical services should be contacted to assess the situation and expedite the transition to the hospital. School staff should never transport the student.

7. Explain that a designated school staff member will follow up with the guardian and the student regarding arrangements for medical and mental health services.

8. Complete the necessary paperwork. (see Appendix A: Suicide Prevention, Intervention, and Follow-Up Checklist)

9. The school counselor, school-based clinician, or identified staff will plan for periodic contact with the student while they are away from school.

10. If the student is unable to attend school for an extended period, attention should be given to the student's academic needs and connection to the school should be maintained. (see Appendix D: A Student's Return to School: Issues and Options)

11. Other school policies that apply to a student's extended absence should be followed.

12. The student, guardian, administrator, school counselor and other necessary school personnel will engage in a reentry meeting before the student returns to school. (see Appendix B: Student Safety Re-Entry Protocol)

Procedures For Assisting Other Students During a Crisis:

- During the crisis, clear the area of other students immediately. It is best to keep students in current classrooms and provide a supportive presence until the emergency

is under control. If additional support is needed, school personnel should contact the school counselor or school-based clinician.

- If the student has siblings in the school or other schools, consult with the guardian to determine how best to inform the siblings and ask if the school can help. If the guardian is not available, refrain from notifying siblings until there is communication from the guardian.

- If the guardian wants the school to contact siblings, then communicate with the Administrator (and/or Superintendent) at schools attended by siblings of the affected student. Those administrators will notify counselors, nurses, and others in a position to help siblings and other students who might be affected in their school.

- Mobilize the school identified staff member, with support from **INSERT DESIGNATED MENTAL HEALTH AGENCY NAME HERE** or other community partner agencies, to help staff address the reactions of other students. When other students know about a suicide attempt, steps must be taken to avoid contagion responses among vulnerable at-risk students. (Note: At-risk students may be friends and relatives of the student and other students who may not know the individual, but who themselves are struggling.)

Suggested Responses:

- Provide support to students who have been directly impacted by the incident, i.e., In classrooms or other small groups. Keep the details of the attempt confidential.

- Describe and promote resources for where students can get help. (see Appendix H: Help resources)

- Monitor close friends and other students known to be vulnerable and offer support as needed. Staff should express any concern for students with a school counselor.

- Hold a mandatory debriefing for staff, administrators, and identified staff who directly dealt with the student in crisis. The facilitator of the debriefing should be identified and notified beforehand.

- Debrief with school staff not directly involved with the student in crisis to provide an opportunity to address feelings and concerns and conduct any necessary planning.

V. **Suicide Attempts or Deaths Off Campus**

A suicide attempt off school premises can have a significant impact on the student body. To prevent a crisis from escalating among students, it is important that school personnel follow these steps:

1. Notify a school administrator who will immediately communicate with designated individuals including Identified Staff. e.g., the school nurse, school-based clinician, school counselors, SAP counselor, Director of Facilities, Director of Transportation (if necessary), emergency medical professionals, community crisis service providers, and the Superintendent of schools.

2. The superintendent alerts principals at schools attended by siblings, who in turn will notify counselors, nurses, and others in a position to help siblings and other students who might be affected.

3. Mobilize the school-based crisis team, with support from **INSERT DESIGNATED MENTAL HEALTH AGENCY NAME HERE** or other community partner agencies, to help staff address the reactions of other students. When other students know about a suicide attempt, steps must be taken to avoid copy-cat behavior among vulnerable at-risk students. (Note: At- risk students may be friends and relatives of the student and other students who may not know the individual, but who themselves are struggling.)

4. Establish communication with the parent or guardian to determine intervention steps and how the school might be helpful and supportive to the student and family being aware and sensitive to the family culture and traditions. (see Appendix A: Suicide Prevention, Intervention, and Follow-Up Checklist)

5. Establish a plan for periodic contact with the student while away from school.

6. If the student is unable to attend school for an extended period, attention should be given to the student's academic needs and connection to the school shall be maintained. (see Appendix D: A Student's Return to School: Issues and Options)

7. Other school policies that support a student's extended absence should be followed.

8. The student, parent/guardian, administrator, school counselor and other necessary school personnel will engage in a reentry meeting before the student returns to school. (see Appendix B: Student Safety Re-Entry Protocol)

VI.A Student's Return to School following Suicidal Behavior

Students who have made a suicide attempt are at increased risk of attempting to harm themselves again. Appropriate handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school. This involvement helps the student to regain some sense of control.

Confidentiality is extremely important in protecting the student and enabling school personnel to be helpful. Although necessary for effective assistance, it is often difficult to get information on the student's condition. If possible, obtain a signed release from the guardian to communicate with the student's therapist. Meeting with guardian before their child returns to school is integral to making decisions about the support that the student will need.

Some suggestions to ease a student's return to school are as follows:

1. Prior to the student's return, a meeting between a designated liaison such as the school counselor, home-school liaison, school-based clinician, or an administrator who is trusted and chosen by the student and the guardian should be scheduled to discuss possible arrangements for services and to create an individualized re-entry plan. (see Appendix B: Student Safety Re-Entry Protocol)

2. Classroom teachers need to be informed of the student's re-entry plan.

3. Discussion of the case among school personnel directly involved in supporting the student should be specifically related to the student's treatment and support needs. Discussion of the student among other staff should be *strictly* on a "need to know" basis. *That is, information directly related to what staff must know to work with the student.*

4. Discussion of any specific case in classroom settings should be avoided entirely since such discussion would constitute a violation of the student's right to confidentiality and would serve no useful purpose to the student or their peers.

5. It is appropriate for school personnel to recommend to students that they discuss their concerns or reactions with the Identified Staff (i.e., counselor, clinician, administrator, school social worker, family engagement coordinator, nurse). The focus of these discussions should **not** be on the suicidal individual, but on developing help-seeking skills and resources for others who might be depressed or suicidal.

Any number of issues are likely to surface and will need to be considered on a case-by-case basis and addressed at the re-entry planning session. It is very likely that some of the school staff, the family, the mental health professional, and the student will express concerns regarding the transition process. For examples of specific issues, see Appendix D: A Student's Return to School: Issues and Options.

VII. **Postvention**

General Recommendations
Any death of a student is a tragic event and protocols should be in place to address the needs of the family, other students, staff, and the wider community. Responses to suicide should be treated in the same manner that any unexpected death of a student would be treated however, there are additional considerations. Effective planning for the aftermath of a death by suicide is a very important strategy which may help prevent another suicide. Managing the school environment after a suicide presents significant challenges to school personnel. These components of postvention following a death by suicide are recommended to help school personnel maintain control of the school environment and assist students who might be at risk.
Advanced planning of postvention activities following a suicide is best designed with input from school personnel, community crisis services staff, and students to meet the following goals:

- To support students, faculty, staff, and parents as they grieve.
- To provide a safe environment for students to express their feelings of grief, loss, anger, guilt, betrayal etc.
- To prevent contagion responses from other vulnerable students.
- To return the school environment to its normal routine as quickly as possible following crisis intervention and grief work. This is as important for after-school activities as it is during class time.

Clear Messages offer stability in a difficult situation. Death by suicide has a profound impact on both the school staff and the student body. To help reduce the likelihood of sensationalizing or glorifying the person who died by suicide, key personnel need to step forward in a straightforward manner to let the school community know how this situation will be handled.
It is critical to give these messages:

- Expressing grief is important and appropriate.

- Feelings such as guilt, anger, and responsibility are normal.
- There must be no secrets when suicide is a possibility and if any student is worried about themselves or anyone else, tell an adult.
- Explain available crisis and grief services.
- Announce funeral arrangements as information becomes available.
- Thank the school community for being supportive of each other.
- Explain your wish to protect the family and the school from media attention and outline the school procedure for working with the media. (see Appendix D: Media Guidelines for School Administrators)

Suicide Prevention Education for staff and students is generally not appropriate in the immediate aftermath of a suicide. It is necessary for staff and students to have time to grieve before being asked to focus on prevention.
Self-care is especially important for staff that deal with a suicide crisis. Typically, school personnel concentrate on doing what is necessary for the student population, leaving little energy for themselves. Colleagues from neighboring districts, community crisis service agencies, and grief support agencies are often very helpful. Enlist trained, qualified outside help for debriefing and provide grief support to staff as well as students.
Staff Debriefing in the aftermath of a student suicide is essential. Every crisis presents unique circumstances, and the school must adapt as necessary. It is likely to involve three to five days of intense work before there is any semblance of "normalcy." Each crisis also presents an opportunity to be better prepared for the next crisis. It is important for the crisis response team to debrief about the management of the event.

- Take the time to recognize what went well.
- Identify what challenged the team.
- Plan any modifications needed to improve the response in the future.

Guidelines For Postvention Procedures

Responsibilities of the School Principal or Administrators

- Convene the school-based crisis response team.
- Contact law enforcement to verify the facts of the case.
- Inform faculty/staff of death. If school is not in session, contact school staff via the phone tree.
- Contact the family of the deceased to express condolences.
- Inform the school superintendent and administrators of schools where siblings are enrolled.
- Schedule the time and place for after school debriefing sessions for school personnel to provide emotional support and to review next steps.
- Provide information about the death and funeral arrangements to parents of other students. They should also be provided with information about warning signs of suicide, supportive services available to students at school, other community resources, crisis line telephone numbers and helpful responses to students' questions about suicide.

- For safety purposes, permit students to leave school premises only with parental permission and documentation. Implement an enhanced system to carefully track student attendance.
- Act as spokesperson to the media. Direct the entire staff to refer all media requests to this individual. When speaking to the media focus on the positive steps of the school's postvention plan to help students through the immediate crisis period. Offer the warning signs of suicide and several resources where parents and students can turn for help. Provide a written copy of all statements made to the media. (see Appendix D: Media Guidelines for School Administrators)

Responsibilities of the School Based Suicide Crisis Response Team

Once activated by the school administrator, the crisis team begins to manage the emotional aftermath within the school community and to decrease the potential for a contagion response. Tasks include:

- Meet with school staff as soon as possible to communicate next steps (be sure to share information with staff who may not be in the building, i.e., paraprofessionals, secretaries, bus drivers, coaches, etc.).
- Mobilize the plan for communicating the news to students and parents.
- Prepare school personnel for student body reactions.
- Allow time for staff to ask questions and express feelings.
- Clarify the pre-arranged steps that will be taken to support school personnel, students, and parents (grief counseling, debriefing etc.)
- Review the process for students leaving school grounds and tracking student attendance.
- Consider the possibility of a contagion response and ask staff to identify concerns they may have about individual students, clarify how to monitor at-risk students.
- Announce how the school will interact with media representatives. Remind staff not to talk with the press or spread rumors and that all inquiries must be directed to a designated media spokesperson. (see Appendix D: Media Guidelines for School Administrators)
- Consider the feelings that may be brought on by a suicide death such as guilt, anger, responsibility, fear for personal safety and well-being. Remind staff of available resources for help in dealing with these feelings.
- Call **INSERT DESIGNATED MENTAL HEALTH AGENCY NAME HERE**, other school counselors, and faith leaders to arrange for crisis intervention and debriefing assistance as outlined in postvention planning.
- Announce the death to students through a prearranged system. The announcement should be as honest and direct as possible and include the facts as they have been officially communicated to the school. Do not overstate or assume facts for which there is not yet evidence. Death by suicide should NOT be announced in a large assembly or over a loudspeaker. It is best if there is a system of Advisory or Home Room announcements in which all students are given the same information at the same time by teachers they know and trust, allowing time for initial reactions and discussion.
- Parents or guardians should also be notified as soon as possible so that they will be prepared and available to provide support to each student. Resources and information on youth suicide prevention should be provided at the same time.
- Relay information about visiting hours and funeral arrangements to students, faculty, staff, and community members in a sensitive manner. Announce arrangements for support resources at the same time.
- Mobilize the postvention strategy to monitor and assist other students who are considered at risk of suicide. Follow-up should be conducted with individual students, especially those who were close to the student who died, and those who may not have known that person, but who may be described as vulnerable. Follow-up with these

individuals and their families should be maintained for as long as necessary, remembering that special events, transitions, and anniversaries are particularly difficult times. School staff should be especially sensitive to students who are particularly affected by the death. Peer groups, teams, and clubs of which the student was a part, will need to talk about their issues. Attention to these students during the postvention period may help prevent future suicidal behavior.

- Conduct daily debriefings with faculty and staff during the crisis and postvention periods.
- Document activities as dictated by school protocols. Each crisis presents an opportunity to improve the process for handling the next crisis, so documentation is important.

How Suicide Postvention Activities Help Prevent a Contagion Response

Grief counseling: This may be the first experience with death for some students. Students and staff need opportunities to express their grief within safe, comfortable settings individually or in small groups, in classroom discussions with their teacher, counselor, crisis facilitator, and grief worker. Strong feelings will be expressed and will need to be validated. Grieving is an important part of healing and provides an opportunity to learn how to cope with loss. However, when suicide is the cause of death, there is a fine line between encouraging students to express their feelings and giving the death so much attention that it may make the idea of suicide attractive to other vulnerable students. It is a delicate balance that requires a thoughtful approach.

Grief process after suicide: Individuals who lose a family member or close friend to suicide face some unique challenges that may complicate their grieving process. An intense search for the reasons for the death is normal but may lead to scapegoating or blaming others for the death. This may put the person being blamed at risk of suicide. It is important to remind people that there is never one reason for someone to choose suicide nor is there ever only one opportunity to intervene to stop someone from killing themselves. Holding oneself responsible for the whole of the person's decision is unreasonable. Feelings of personal guilt, rejection, and desertion is also common in the aftermath of a traumatic death. Effective handling of the grief process is directly related to the ability of the school community to return to normalcy. Special events and anniversaries of the death may be especially significant and difficult for those close to the person who died by suicide.

Memorial Arrangements: Schools that have had experience with suicide report that often the day/s of the memorial is critical in terms of crisis management. Ask the family, when possible, to hold the memorial after school hours to allow those attending in the evening to be supported by their families and each other. If that is not possible, students should be allowed to attend the memorial during school hours, with parental permission. Announce arrangements regarding the absence from school for attending memorials. If possible, avoid use of the school as the memorial site because some youth will associate the room in which the service is held with the death forever.

Keep the School Open: Follow regular school routines to the extent it is possible. While the school must be sensitive to the students affected by the death, they must also consider the needs of those not closely affected. The way to avoid undue anxiety is to undertake all activity in a straightforward manner, letting students, parents, and faculty know that this situation is being handled.

Inappropriate Memorial Activities: Avoid memorial services being held within the school building, flying the flag at half-staff, large student assemblies, dedications of sports or other events, permanent memorial markers, or anything that glamorizes or glorifies suicide. Such activities provide an invitation to other vulnerable youth to consider suicide. Grieving families and students may insist that their deceased loved one be honored. These energies are best channeled into constructive projects that help the living. Advance planning for responding to any student death will help school personnel stay with school procedure rather than being driven by intense

emotion in a time of crisis. Only the President or Governor has the legal authority to mandate flying a flag at half-staff.

Appropriate Memorial Activities: Encourage donations to the bereaved family, favorite charities, suicide prevention efforts, youth support programs at school, or the support of community-based (as opposed to school-based) efforts by the family to commemorate their loved one. It is strongly recommended that all schools, rather than give students who die by suicide less attention (or more attention) than other deaths, provide guidelines for appropriate commemorative activities designed to honor any member of the school community who dies for any reason in a fair and equitable way. This eliminates the possibility that popular people or certain types of death will garner far more attention than others.

Yearbooks and Graduation Ceremonies: The death of a student who has died by suicide should be handled the same as any student death is handled. Refer to Inappropriate Memorial Activities above.

Appendix B: Suicide Prevention, Intervention, and Follow-Up Checklist

Confidential

SUICIDE PREVENTION, INTERVENTION, AND FOLLOW-UP CHECKLIST

Student: Date:

Person Completing Form: Role:

Guardian:

Home Phone #: Work Phone #:

Concerns/Observations: check all that apply.

Has a plan for suicide_____	Has access to lethal means_____
Previous attempt or threat_____	History of antisocial behavior_____
Giving away personal possessions_____	History of impulsiveness_____
Family crisis_____	Has a close friend or family member who attempted or died by suicide_____
History of depression/mental illness___	Cutting, scratching, other self-destructive behaviors_____
Sense of hopelessness_____	Anniversary of a significant loss_____
Death themes throughout spoken, written, and artwork_____	Recent loss through death or suicide___
Sudden positive behavior change following a period of depression_____	Other (explain)_____
Recent loss through death or suicide___	

Support System (list individuals & phone numbers, if appropriate):

Consultation/Notification (consider contacts given level of risk):

Guardian notification

Consultation with another crisis team member or colleague: _____
Consultation with other school personnel (list below):_____
Designated Agency contacted: _____
Referral to other outside services:

Follow-Up Considerations: Date:

Is the student receiving counseling?

What support services are in place?

Summarize student's progress since last meeting:

Next Steps:

Appendix C: Student Safety Re-Entry Protocol

Student Safety Re-entry Protocol

Completed By (Staff): **Today's Date:** **Student Name:**
Warning Signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

Internal coping strategies: things that I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity, etc.):

If you notice warning signs, please follow these steps:

While at school, the adults I can contact for support are:
Name: Location:

Name: Location:

Name: Location:

While at home or away from home, the adults I can contact for support are:

Name: Phone Number:

Professionals or agencies I can contact during a crisis:

Name: Phone:

DA Emergency Services Phone:

Parent(s)/guardian(s):

Name: Phone:

Name: Phone:

Medications:

Name: Dosage:

Name: Dosage:

** Obtain consent (Release of Information) for the exchange of information for all outpatient providers. **

Supportive contact: Maintain supportive contact with the student's family.

Appendix D: A Student's Return to School: Issues and Options

Challenge: Social and Peer Relations
Options:

1. Place the student in a school-based support group, peer helpers' program, or buddy system.
2. Be sensitive to the need for confidentiality and how to restrict gossip.

Challenge: Transition from the hospital setting
Options:

1. If possible, arrange contact with the student in the hospital or home to begin the re-entry process with permission from the guardian.
2. Request permission to attend the treatment planning meetings and the hospital discharge conference.
3. Attend to the student's academic needs and connection to the shall be maintained while the student is in the hospital and prior to returning to school.
4. Include the therapist in the school re-entry planning meeting.

Challenge: Academic concerns upon return to school
Options:

1. Arrange appropriate academic **support.**
2. Modify the schedule and adjust the course load and to relieve stress, if necessary.
3. Allow make-up work to be adjusted/extended without penalty.
4. Monitor the student's progress.

Challenge: Family concerns (denial, guilt, lack of support, social embarrassment, anxiety, etc.)
Options:

1. Schedule a family conference with designated school personnel to address their concerns.
2. Include guardians in the re-entry planning meeting.
3. Refer the family to an outside community agency for family counseling

services.

Challenge: Student's social/emotional needs
Options:

1. Stay aware of student's attendance and tardiness. Provide additional support, when possible, to maintain regular school attendance.
2. Provide referrals to the guardian for outside counseling.

Issue: Medication
Options:

1. Alert the school nurse to obtain information regarding prescribed medication and possible side effects.
2. Notify teachers if significant side effects are anticipated.
3. Follow the policy of having the school nurse monitor and dispense all medication taken by the student at school.

Issue: On-going support
Options:

1. Maintain contact with the therapist (obtain a signed release of information) and guardians.
2. Ask the student to check in with the school counselor daily or weekly.
3. Utilize established support systems, Student Assistance Teams, support groups, friends, clubs, and organizations.
4. Schedule follow-up sessions with the home-school liaison, when appropriate.
5. Provide information to families on community resources that are available when school is not in session (988, crisis hotline, local emergency room).

Appendix E: Media Guidelines for School Administrators

Media Guidelines for School Administrators

There is Scientific Basis for Concern

Research has demonstrated potentially harmful effects of some types of news coverage about suicide on vulnerable individuals in the community. There is evidence of an increase in suicidal behavior, especially among youth, following prominent news coverage of suicide. This behavior may result in multiple suicide attempts or deaths. This is referred to as a contagion response. It is very important to address this concern with representatives of the media and to describe how responsible reporting can help reduce the risk of contagion.

Media reports should neither sensationalize nor normalize suicide. Reporting should be concise and factual to minimize the likelihood of a contagion response. Details of the suicide method and location are to be avoided in news coverage. Never use the phrase "a successful suicide" which links death and being successful. Conversely, to say someone "committed suicide" implies criminality or wrongdoing. Use the term "suicide death" or "death by suicide" instead. Media accounts can serve as a preventative tool if the reporting ends with the 988 Suicide & Crisis Lifeline phone number and nearby counseling resources. Exploration of these themes is given below.

Suicide is a Tragedy, it might be Reported

The mission of a news organization is to report information on events in the community. If a suicide is considered newsworthy, it will probably be reported. Efforts to prevent news coverage may not be effective. The goal should be to assist news professionals to report responsibly and accurately.

"No comment" is Not Productive

Refusing to speak with the media will not prevent coverage of a suicide. Use a media request for information as an opportunity to influence the contents of the story. Always provide information on state and local resources for suicide prevention and crisis intervention and other available services.

Responsible News Coverage May Help Prevent Suicide

Certain types of news coverage can produce a contagion effect further impacting the community. Explain the potential for a contagion response associated with certain types of reports and suggest ways to minimize this risk. Encourage news reporters to provide information that increases public awareness of risk factors, warning signs, and possible actions to help a person experiencing suicidality ideation. Emphasize the importance of listing available community resources for individuals at-risk and describing what is being done to promote safety for vulnerable individuals in the aftermath of a suicide. Provide relevant Lifeline and crisis services phone numbers and ask that they be published. Encourage news stories that portray individuals who have found positive ways of coping with their difficult situations.

Aspects of News Coverage that May Promote a Contagion Response

Although scientific research in this area is not complete, preliminary findings indicate that the likelihood of a contagion response may be increased by the following actions:

Presenting Simplistic Explanations for Suicide

Suicide is never the result of a single factor or event; it usually results from the complex interaction of many factors. Although a final precipitating event may have occurred, it is unlikely that it was the sole cause of the suicide. Most persons who died by suicide have had a history of problems that may not have been reported during the aftermath of the suicide. A detailed description is not necessary, but acknowledgment of the complexity of suicidal behavior is recommended.

Engaging in Repetitive, Prominent or Excessive Reporting of Suicide

Repetitive or prominent coverage of suicide tends to promote and maintain a preoccupation with suicide among at-risk persons. This preoccupation has been linked to a contagion response.

Providing Sensational Coverage of Suicide

Sensational news coverage of suicide also heightens the general public's' preoccupation with suicide. This reaction is associated with the development of a contagion response. Providing the morbid details of suicide increases sensationalism. Reporting the story prominently and using dramatic photographs related to the suicide (e.g., photographs of the funeral, the deceased person's bedroom, or the site of the suicide) also increases the risk of a contagion response.

Reporting "How-To" Descriptions of Suicide

Describing technical details about the method of suicide is not recommended. For example, reporting that a person died from carbon monoxide poisoning may not be harmful; however, providing graphic details of the mechanism and procedures used during the suicide may promote imitation of the suicidal behavior by other at-risk persons.

Presenting Suicide as a Tool for Accomplishing Certain Ends

Suicide is usually the rare act of a struggling person. Presenting suicide as a way of coping with personal problems (e.g., the break-up of a relationship or retaliation against discipline) may suggest to at-risk people that suicide is a reasonable solution.

Glorifying Suicide or Persons Who Kill Themselves

Reports of community expressions of grief (e.g., public eulogies, flying flags at half-staff, and erecting permanent public memorials) should not be overemphasized. Such actions may contribute to a contagion response by suggesting to susceptible persons that society is honoring the suicidal behavior of the deceased person, rather than mourning the person's death.

Appendix F: Crisis Response Agreement

Crisis Response Agreement

In the event of a crisis or critical incident impacting the students or staff of _____ (insert school name), a member of the School Crisis Team or other authorized school personnel will contact DA _____(insert DA name). _____(insert DA name) is the designated crisis response agency in _____County. The nature of the crisis will be explained, and the name and number of a contact person will be given. DA will respond with crisis intervention and assessment services, crisis stabilization, and other services based on each incident through collaboration between the School Crisis Team and DA.

When any school personnel have cause to suspect that a student is at risk of harm to themselves or others, an administrator, school counselor, school-based clinician, or school nurse will be informed, a risk screening will be completed, and the appropriate referral will be made. If it is determined that the student is in imminent danger of self-harm, the DA will be contacted to discuss the situation as will the student's guardians. Access to the DA services will consist of the following options:

- Guardian transports their child to the DA.
- The DA worker meets the student at the respective school for assessment and intervention services.
- Individual needing services is transported by guardian or local ambulance services to a local hospital, where they will meet with a DA worker and other appropriate health care providers.

Following the assessment, the DA will develop a plan based on the student's and family's needs or situation. The DA and the school will make efforts to obtain a release of information from guardians so that appropriate school personnel will be informed of the outcome of the crisis contract and share other pertinent information as necessary.

Signatures:

_____ _____

Area Manager of DA Superintendent of Schools Emergency Services

Date: Date:

Appendix G: Letter for School Staff

Dear Staff:

Welcome to the _____ school year! We have written a suicide prevention protocol and are in the process of getting it approved by the _____administration. In the meantime, we would like to give you some information that may prove to be invaluable to you in your role here. Suicide is a sensitive topic, yet as educators, we need to know the basics of suicide intervention: recognizing the warning signs, showing we care, getting help, and reinforcing the message that everyone is important. Each of us has a place in the big picture and yours may be in helping one of our students in a time of crisis. You will find detailed procedures for how to handle suicidal behavior in our Emergency Operations Plan.

Additionally, you will be asked to participate in some basic suicide prevention training. Please see me at your earliest convenience for information about the next available training session. Thank you and welcome aboard!

Sincerely,

(Personalize according to school)

Appendix H: Suicide Warning Signs and Protective Factors

Suicide Warning Signs

Cause for Immediate Concern

The following behaviors are cause for immediate concern:

- Threatening suicide or expressing a strong wish to die
- Making a plan-how, when, where
- Seeking access to lethal means-guns, medications, poisons, rope, alcohol, cars
- Talking, writing, drawing or texting about death, dying or suicide
- Displaying severe/overwhelming emotional pain or distress
- Giving away prized possessions, putting life in order
- Showing abrupt improvement after a period of sadness or withdrawal
- Feeling "beyond help", expressing hopelessness about the future

Indications of Serious Depression that Could Lead to Suicide

- Unrelenting low mood
- Pessimism or hopelessness
- No sense of purpose in life
- Desperation or feeling trapped
- Anxiety, agitation, irritability, or psychic pain
- Withdrawal from family and friends
- Changes in sleep (increased or decreased)

Other Warning Signs

The following behaviors are indications that the person is in severe psychological pain. They may not signal an immediate emergency, but the person does need help:

- Increased or any alcohol or other drug use
- Abandonment of activities or relationships once considered enjoyable
- Impulsiveness and unnecessary risk-taking
- Anger or hostility that seems out of character or out of context
- Persistent feelings of failure
- Persistent physical complaints
- Neglect or personal appearance
- Preoccupation with death (through music, poetry, drawings, video games, movies)
- Difficulty concentrating
- Severe mood swings

Protective Factors[1]

- Support from partners, friends, and family
- Feeling connected to others
- Feeling connected to school, community, and other social institutions

- Availability of consistent and high quality physical and behavioral healthcare
- Reduced access to lethal means of suicide
- Cultural, religious, or moral objections to suicide
- Effective coping and problem-solving skills
- Reasons for living (ex: family, friends, pets, relationships, etc.)
- Strong sense of cultural identity

Appendix I: Help Resources

Help Resources

Local Resources
988: https://988lifeline.org/
Pathways Warm Line: https://www.pathwaysvermont.org/what-we-do/our-programs/vermont-support-line/
Center for Health and Learning (CHL): https://healthandlearning.org/
Training Calendar: https://healthandlearning.org/trainings/
Department of Child and Families Child Abuse & Neglect Helpline: (800) 649-5285
http://dcf.vermont.gov/contacts/helplines
Facing Suicide VT: https://facingsuicidevt.com/
Vermont Community Mental Health Agency List: https://ddsd.vermont.gov/designated-agencies-da
Vermont Suicide Prevention Center (VTSPC): https://vtspc.org/
Help Card: https://vtspc.org/resource/vt-help-card/
Vermont Suicide Prevention Platform: https://vtspc.org/wp-content/uploads/2023/08/Vermont-Suicide-Prevention-Platform-2023.pdf

National Resources
Action Alliance Framework Successful Messaging:
https://www.suicidepreventionmessaging.org/action-alliance-framework-successful-messaging
American Foundation for Suicide Prevention: https://afsp.org/
After a Suicide Toolkit: https://aws--fetch.s3.amazonaws.com/flipbooks/afterasuicide/index.html?page=1
The Jed Foundation: https://jedfoundation.org/
Mental Health First Aid for Youth: https://www.mentalhealthfirstaid.org/population-focused-modules/youth/
Mental Health First Aid (Teen): https://www.mentalhealthfirstaid.org/population-focused-modules/teens/
Suicide Prevention Resource Center: https://sprc.org/
The Trevor Project: https://www.thetrevorproject.org/
Zero Suicide: https://zerosuicide.edc.org/

Appendix J: Glossary

Contagion: "A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts"[2]

Postvention: "Refers to programs and interventions for survivors following a death by suicide. These activities help alleviate the suffering and emotional distress of suicide survivors and help prevent suicide contagion."[3]

Protective Factors: "Personal or environmental characteristics that reduce the probability of suicide. Protective factors can buffer the effects of risk factors. The capacity to resist the effects of risk factors is known as resilience." (see footnote #3)

Self-Injury: "Self-injury (also known as self-mutilation or deliberate self-harm) is known as intentionally and often repetitively inflicting socially unacceptable bodily harm to oneself without the intent to die." (see footnote #3)

Suicidal Behavior: "A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and death by suicide." (see footnote #2)

Suicidal Ideation: "Self-reported thoughts of engaging in suicide-related behavior." (see footnote #2)

Suicide: "Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death." (see footnote #2)

Suicide Attempt (or Suicidal Act): "A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that a person intended to kill themselves. A suicide attempt may or may not result in injuries." (see footnote #2)

Suicide Survivor: "Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide." (see footnote #2)

Appendix K: Trainings and Screening Options

Each school employee, including school administrators, is recommended to participate and complete suicide prevention awareness foundational training. There are options listed below and above on the Center for Health and Learning Training Calendar (see Appendix H: Help Resources). Clinicians, school counselors, and school nurses are recommended to have advanced training in screening tools, assessments, and safety planning. Training should be provided at the beginning of each school year, along with reminders in school communications especially during the changing of seasons, holiday breaks,

upcoming academic testing and moments of vulnerability and isolation. In cases when a new employee is hired during the school year, trainings should be completed within 6 months of onboarding.

Training

SAMSHA Evidence Based Practice Resource Center: https://www.samhsa.gov/resource-search/ebp
Suicide Care Training Options: https://zerosuicide.edc.org/sites/default/files/2020-11/2020.11.18%20Suicide%20Care%20Training%20Options_0.pdf
Center for Health Learning Training: https://healthandlearning.org/

Screening information

List of evidence-based screening options: https://zerosuicide.edc.org/toolkit/identify-screening-and-assessment/screenassess

References:

[1] Center for Disease Control and Prevention. Risk and Protective Factors [Webpage]. Retrieved from https://www.cdc.gov/suicide/factors/index.html.

[2] Suicide Prevention Lifeline. (n.d.). Mental health & suicide prevention glossary [Webpage]. Retrieved from https://suicidepreventionlifeline.org/ mental-health-suicide-prevention-glossary/.

[3] Substance Abuse and Mental Health Services Administration. 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. Retrieved from https://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669.

Appendix L: Eating Disorder Education Guidelines for School Employees

Act 56 requires the Department of Mental Health (DMH), specifically the Director of Suicide Prevention, in association with the Agency of Education (AOE) and other stakeholders, to develop and submit a model protocol for suicide prevention and postvention in schools. The model protocol must also *"ensure that school employees receive education pertaining to the prevention of, use of language regarding, and identification of eating disorders in youth."* The following education guidelines summarize relevant eating disorder-related topics and suggested resources, and task Supervisory Unions/Supervisory Districts (SU/SDs) with determining how they will meet minimum standards for the education of school personnel. In the creation of these guidelines, the DMH has consulted with the AOE, Vermont Department of Health, the Vermont Principals' Association, the Vermont Superintendents' Association, Vermont Association of School Psychologists, eating disorder education content experts, parents with lived experience, and other stakeholders within the greater education community; we gratefully acknowledge their assistance.

Table of Contents:

---

1. **Introduction.** Eating disorders (EDs) are serious, sometimes life-threatening illnesses, affecting at least 9% of the population. Disordered eating behaviors are even more widespread and describe a range of disordered eating, including presentations that do not yet meet criteria for clinical diagnosis. Eating disorders, anorexia nervosa in particular, have the highest mortality rate among mental health disorders outside of opiate addiction. Recent data shows troubling increases in both prevalence and severity. While EDs may present throughout the lifespan, they often take hold during childhood and adolescence, and can greatly impact a youth's physical and psychological development. As outlined by the American Academy of Pediatrics, schools play an integral role in improving outcomes for Vermont's youth through prevention, early detection, and awareness. Accordingly, ED-related education for school personnel was listed as a key strategy in a recent working group report to the Vermont legislature.

2. The selection and provision of education for school employees on "prevention of, language regarding, and identification of eating disorders" by SU/SDs, as outlined in Act 56, serves to meet requirements found in local wellness policies (see Vermont Local Wellness Policy Guide), 16 VSA 131, 16 VSA 165, and 16 VSA 261a. Vermont schools are required to implement a comprehensive health education

(CHE) program (16 VSA 131; 16 VSA 906) and, are required to have a Local Wellness Policy (LWP) that include goals for CHE implementation, as per 16 V.S.A. 136 and Act 66 of 2021. SU/SDs are at the same time required to maintain and monitor needs-based professional learning (Series 2000-Education Quality Standards; 2121.3) that serves district goals/policies, such as those specific to CHE. As outlined in Rules Governing the Licensing of Educators and the Preparation of Educational Professionals Series 5100, licensed health educators must show evidence of knowledge in, "Nutrition (basic nutrition concepts, nutrient needs, dietary guidelines for Americans, and common nutritional problems of children and adults, *including disordered eating*)" (5440-31 Health Education, p. 125). However, this same requirement is not held for other school employees who are often engaged in the implementation of comprehensive health education (e.g., elementary educators, physical educators, consumer science, etc.). Inclusion of this needs-based professional learning as a component of a LWP, in service to compliance with Educational Quality Standards and state law, would also meet goals as outlined in Act 56. Furthermore, SU/SDs may choose to build in specific policies related to ED prevention within their LWPs (under "Other-School Based Activities to Support Student Wellness) – with ED education being again a component/evidence of policy compliance if the SU/SD so chooses.

3. **Review.** The content and quality of education pertaining to the prevention of, language regarding, and identification of EDs should be vetted prior to establishing requirements for education for school employees (including mode and method of training). The education (which may include a range or compilation of a number of resources) as well as requirements on school employee accountability should be determined at the SU/SD level. Best practices and research in the space of ED prevention are continually developing, so initial (three hours upon employment) and ongoing education requirements at a minimum of one hour per year should also be established. School employees shall include teachers, school nurses, health educators, physical educators, athletic coaches, guidance counselors, support staff, food service staff, and administrators. SU/SDs may consider linking ED education to other regular professional development requirements or activities underway. Furthermore, different populations may have different needs in terms of trainings, as school nurses, guidance counselors, and health educators often have some pre-training in this area, and therefore, specific role-based trainings should also be considered. Act 56 requires ED education across the age/school level continuum. Given differences in school settings and developmental levels (e.g. elementary school vs. high school), education resources and professional development opportunities may vary but should meet the needs of the context in which they are offered.

   The following guidelines describe the characteristics of comprehensive eating disorder education/training, and outline quality resources in this space.

   a. **Standards for Professional Development Materials.** In establishing an ED education plan for school employees, school districts must take steps to ensure that quality professional development resources, materials, and/or trainings are offered (see Quality Training Standards provided by the Center for Disease Control).

   b. **Coordination.** SU/SDs may select different trainings for different school employees to fulfill a district wide requirement. However, it is essential that these trainings are coordinated (e.g. a common language) and that employees are also given opportunities to understand their role in prevention and identification of eating disorders within their specific SU/SD (e.g. trainings supplemented with SU/SD related processes, such as support plans to students experiencing disordered eating).

   c. **Topics.** SU/SDs must ensure that ED education for staff addresses the following topic areas, at a minimum:

i. **Prevention.** Given their prominent role in the daily lives of children and youth, schools are well positioned to reduce modifiable risk factors, enhance protective factors, and support prevention of EDs.
   1. **Implicit bias and debunking myths**. Implicit biases - attitudes towards food and body shape that may contribute to weight-based stigmatization - are common among the general public. Furthermore, EDs are not well understood, which causes the perpetuation of myths that can negatively impact affected individuals. Education on the facts around these biases and misconceptions can improve recognition and help individuals feel supported.
   2. **Weight-inclusive health education.** A weight-inclusive approach to health shifts away from a weight-centric understanding of wellbeing to one that supports individuals' health behaviors across the weight spectrum in order to promote self-care behaviors rather than body size.
   3. **Media literacy.** Various studies have illustrated the negative impacts that social media, and media in general, can have on an individual's relationship to their body and food, as well as general wellness. Media literacy is a preventative tool that allows individuals to think critically about how society and the media communicate unrealistic and harmful body ideals, as well as risky disordered eating practices.
   4. **Comorbidities of eating disorders**. EDs often co-occur with other mental health conditions, including depression, anxiety, and/or obsessive compulsive disorder (OCD) and may contribute to greater symptom severity and poorer prognosis. Awareness of overlapping symptoms can support screening and help school staff to recognize warning signs.

ii. **Language.** School staff play a vital role in creating an educational environment - through supportive and body-affirming words and actions - that helps students to foster and develop healthy self-image and nourishing eating practices.
   1. **Eating disorder literacy.** Establishing basic knowledge of eating disorders (e.g. anorexia nervosa, bulimia nervosa, binge eating disorder) ensures these are discussed in an informed and non-stigmatizing way.
   2. **Body neutrality.** Relationship to body is a multifaceted construct that is used to describe one's perception, cognition, affection and behavioral relationship towards one's body. Fostering body neutrality encourages appreciation of one's body for what it can do rather than how it appears.
   3. **Weight inclusivity.** Everyone is capable of achieving health and wellbeing, and deserves access to non-stigmatizing health care. Weight measurements (such as BMI) do not reflect health behaviors, health status or moral character.
   4. **Food culture and culture of food.** Relationships with food and eating are often embedded in cultural contexts. A health-centered but inclusive understanding of eating behaviors, language and cultures should be honored (e.g. fasting for Ramadan).

iii. **Identification.** Early identification of eating disorders, followed by strategic support of students and their families, can prevent severe illness and promote recovery. In addition to ensuring education, each SU/SD should establish a clear reporting/escalation protocol for staff to follow when they have concerns about a student.

1. **Warning signs.** EDs are mental and physical illnesses that impact individuals across the spectrum of gender, race, ethnicity, body size and socioeconomic class. As such, warning signs vary across categories and settings. For example, whereas food service staff may notice a student's concerning eating habits, coaches may notice excessive exercise. Recognizing early signs of all EDs can prevent life-long illness or death.
2. **Strategies for assisting students.** Understanding the social and cognitive impacts of EDs, as well as the often disruptive nature of intensive treatment, schools can collaborate with pediatricians, nutritionists, and families to establish support plans offering students flexible accommodations and educational assistance.
3. **Strategies for supporting families.** A well-informed workforce serves as the foundation for trusting relationships and open communication with students, parents/caregivers and families affected by EDs. School staff are well-positioned both for early identification of disordered eating and promoting recovery through school-based support and monitoring.

d. **Resources.** In meeting minimum requirements for professional development related to EDs, SU/SDs are encouraged to utilize materials and programming that are right for their employees and students. The following resource compilation includes toolkits, guidebooks, videos, virtual trainings, health curricula, and awareness materials (brochures, flyers, posters).

i. Be Real USA
   1. BE REAL's BodyKind High School Curriculum - BE REAL USA
   2. Body Confident Schools Workshops - BE REAL USA

ii. Strategic Training Initiative for Prevention of Eating Disorders (STRIPED)
   1. Body Confident Schools Training | STRIPED | Harvard T.H. Chan School of Public Health
   2. Webinar with CME for school RNs and others: Screening, Symptom Recognition & Referral to Treatment for Eating Disorders in Pediatric Primary Care

iii. Emily Program
   1. Recorded Presentations (e.g. ED 101)
   2. School and Community Resources

iv. National Eating Disorder Association (NEDA)
   1. Educator Toolkit
   2. Coach and Athletic Trainer Toolkit
   3. Back to School Flyers and Graphics

v. National Alliance for Eating Disorders
   1. Trainings available for school personnel: Bring The Alliance To You | National Alliance for Eating Disorders

vi. The Body Positive
   1. Be Body Positive Training for Educators and Student Leaders

vii. With All: Helping Young People Feel Good in their Bodies and with Food

viii. Weight-Inclusive Nutrition (WIN) research group at UVM