NEW DESIGNS CHARTER SCHOOL (University Park).

Suicide Prevention, Intervention and Postvention Policy

Adapted from:

The Trevor Project: Model School District Policy on Suicide Prevention & LAUSD's Bulletin 2637.2

Publication and Distribution

This policy or information pertaining to parts/sections of the policy will be updated and distributed annually and included in all student and teacher handbooks and on the school website.

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Recognitions

The American Foundation for Suicide Prevention (AFSP) is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. To fully achieve its mission, AFSP engages in the following Five Core Strategies: 1) fund scientific research, 2) offer educational programs for professionals, 3) educate the public about mood disorders and suicide prevention, 4) promote policies and legislation that impact suicide and prevention, and 5) provide programs and resources for survivors of suicide loss and people at risk, and involve them in the work of the Foundation. Learn more at www.afsp.org.

The American School Counselor Association (ASCA) promotes student success by expanding the image and influence of professional school counseling through leadership, advocacy, collaboration and systemic change. ASCA helps school counselors guide their students toward academic achievement, personal and social development, and career planning to help today's students become tomorrow's productive, contributing members of society. Founded in 1952, ASCA currently has a network of 50 state associations and a membership of more than 33,000 school counseling professionals. Learn more at www.schoolcounselor.org.

The National Association of School Psychologists (NASP) represents more than 25,000 school psychologists who work with students, educators, and families to support the academic achievement, positive behavior, and mental wellness of all students. NASP promotes best practices and policies that allow school psychologists to work with parents and educators to help shape individual and system wide supports that provide the necessary prevention and intervention services to ensure that students have access to the mental health, social- emotional, behavioral, and academic supports they need to be successful at home, at school, and throughout life. Learn more at www.nasponline.org.

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24. Every day, The Trevor Project saves young lives through its accredited, free and confidential phone, text and instant message crisis intervention services. A leader and innovator in suicide prevention, The Trevor Project offers the largest safe social networking community for LGBTQ youth, best practice suicide prevention educational trainings, resources for youth and adults, and advocacy initiatives. Learn more at www.thetrevorproject.org.

INTRODUCTION

Suicide is the third leading cause of death among young people ages 10-19. In response, our school has developed policies and procedures to prevent, assess the risk of, intervene in, and respond to youth suicidal behavior.[1]

The Trevor Project and LAUSD Bulletin 2637.2, both of which are used in developing this policy were themselves developed by examining strong local policies, ensuring that they are in line with the latest research in the field of suicide prevention, and identifying best practices for a national and local framework. We have modified and incorporated these original documents to fit the unique needs of our school in developing our own policy.

Protecting the health and well-being of students is in line with school mandates and is an ethical imperative for all professionals working with youth. Because it is impossible to predict when a crisis will occur, preparedness is necessary. In a typical high school, it is estimated that three students will attempt suicide each year. On average, a young person dies by suicide every two hours in the US. For every young person who dies by suicide, an estimated 100-200 youth make suicide attempts.[2] Youth suicide is preventable, and educators and schools are key to prevention.

As emphasized in the National Strategy on Suicide Prevention, preventing suicide depends not only on suicide prevention policies, but also on a holistic approach that promotes healthy lifestyles, families, and communities. Thus our policy is intended to be paired with other policies and efforts that support the emotional and behavioral well-being of youth.

PURPOSE

The purpose of this policy is to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide. The school:

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

This policy will be applied in accordance with the school's Child Find obligations.

PARENTAL INVOLVEMENT

Parents and guardians play a key role in youth suicide prevention. Parents/ guardians need to be informed and actively involved in decisions regarding their child's welfare. Parents and guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with professional help when necessary. Parents/ guardians should take every statement regarding suicide and wish to die seriously and avoid assuming that a child is simply seeking attention.

Parents and guardians can also contribute to important protective factors – conditions that reduce vulnerability to suicidal behavior – for vulnerable youth populations such as LGBTQ youth. Research from the Family Acceptance Project found that gay and transgender youth who reported being rejected by their parents or guardians were more than eight times as likely to have attempted suicide. Conversely, feeling

accepted by parents or guardians is a critical protective factor for LGBTQ youth and other vulnerable youth populations. Educators can help to protect LGBTQ youth by ensuring that parents and guardians have resources about family acceptance and the essential role it plays in youth health.[3]

DEFINITIONS

1) **At risk:** A student who is defined as high risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures.
2) **Crisis team:** A multidisciplinary team of primarily administrative, mental health, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention/response and recovery. These professionals have been specifically trained in crisis preparedness through recovery and take the leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.
3) **Mental health:** A state of mental and emotional being that can impact choices and actions that affect wellness. Mental health problems include mental and substance use disorders.
4) **Postvention:** Suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.
5) **Risk assessment:** An evaluation of a student who may be at risk for suicide, conducted by the appropriate school staff (e.g., school psychologist, school counselor, or school social worker). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.
6) **Risk factors for suicide:** Characteristics or conditions that increase the chance that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and or social factors in the individual, family, and environment.
7) **Self-harm/injury:** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Can be categorized as either non-suicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.
8) **Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The

coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death.

9) **Suicide attempt:** A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.
10) **Suicidal behavior:** Suicide attempts, intentional injury to self-associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.
11) **Suicide contagion:** The process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides.
12) **Suicidal ideation:** Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.
13) **Warning signs:** These are behaviors that signal the possible presence of suicidal thinking. They might be regarded as cries for help or invitations to intervene. Warning signs indicate the need for an adult to immediately ascertain whether the student has thoughts of suicide or self-injury. Warning signs include: suicide threat (direct or indirect); suicide notes and plans; prior suicidal behavior; making final arrangements; preoccupation with death; and changes in behavior, appearance thoughts and/or feelings.

SCOPE

This policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, and at school sponsored out-of-school events where school staff are present. This policy applies to the entire school community, including educators, school staff, students, parents/guardians, and volunteers. This policy will also cover appropriate school responses to suicidal or high risk behaviors that take place outside of the school environment.

IMPORTANCE OF SCHOOL-BASED MENTAL HEALTH SUPPORTS

Access to school-based mental health services and supports directly improves students' physical and psychological safety, academic performance, cognitive performance and learning, and social–emotional development. School employed mental health professionals (school counselors, school psychologists, school social workers, and in some cases, school nurses) ensure that services are high quality, effective, and appropriate to the school context.

School employed mental health professionals are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health services are properly and effectively infused into the learning environment. These professionals can support both instructional leaders' and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning.

Having these professionals as integrated members of the school staff empowers principals to more efficiently and effectively deploy resources, ensure coordination of services, evaluate their effectiveness, and adjust supports to meet the dynamic needs of their student populations. Improving access also allows for enhanced collaboration with community providers to meet the more intense or clinical needs of students.[4]

RISK FACTORS AND PROTECTIVE FACTORS

Risk Factors for Suicide

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

The most frequently cited risk factors for suicide are:

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

Protective Factors for Suicide

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

Protective factors for suicide include:

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

Protective factors do not entirely remove risk, especially when there is a personal or family history of depression or other mental disorders. There are certain student populations that are at elevated risk for suicidal behavior based on various factors:

1. **Youth living with mental and/or substance use disorders.**

While the large majority of people with mental disorders do not engage in suicidal behavior, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bi-polar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are important risk factors for suicidal behavior among young people.[5] The majority of people suffering from these mental disorders are not engaged in treatment, therefore school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk.

2. **Youth who engage in self-injury or have attempted suicide.**

Suicide risk among those who engage in self-harm is significantly higher than the general

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

3. **Youth in out-of-home settings.**

Youth involved in the juvenile justice or child welfare systems have a high prevalence of many risk factors for suicide. Young people involved in the juvenile justice system die by suicide at a rate about four times greater than the rate among youth in the general population. One researcher found that youth in foster care were more than twice as likely to have considered suicide and almost four times more likely to have attempted suicide than their peers not in foster care.[6]

4. **Youth experiencing homelessness.**

For youth experiencing homelessness, rates of suicide attempts are higher than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorders, and post-traumatic stress disorder. One study found that more than half of runaway and homeless youth have had some kind of suicidal ideation.[7]

5. **American/Indian/Alaska Native (AI/AN) youth.**

In 2009, the rate of suicide among AI/AN youth ages 15-19 was more than twice that of the general youth population.[8] Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see http://www.nctsnet.org/nctsn_ assets/pdfs/AI_Youth-CurrentandHistoricalTrauma.pdf.

6. **LGBTQ youth.**

The CDC finds that LGB youth are four times more likely, and questioning youth are three times more likely, to attempt suicide as their straight peers.[9] The American Association of Suicidology reports that nearly half of young transgender people have seriously considered taking their lives and one quarter report having made a suicide attempt.[10] Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ which elevate the risk of suicidal behavior for LGBTQ youth.

7. **Youth bereaved by suicide.**

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.[11]

8. **Youth living with medical conditions and disabilities.**

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive styles that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.[12]

PREVENTION

Suicide prevention involves school-wide activities and programs that enhance connectedness, contribute to a safe and nurturing environment, and strengthen protective factors that reduce risk for students. Suicide prevention includes:

(a) Promoting positive school climate by reinforcing the BUL-6231.0, *Discipline Foundation Policy: School-wide Positive Behavior Intervention Support.*

(b) Increasing staff, student and parent/guardian knowledge and awareness of risk factors and warning signs of youth suicide and self-injury.

(c) Monitoring students' emotional state and well-being, as well as engaging students by providing structure, guidance, and fair discipline.

(d) Modeling and teaching desirable skills and behavior.

(e) Promoting access to school and community resources.

RESPONSIBILITIES OF ADMINISTRATORS, DESIGNEES AND SCHOOL EMPLOYEES

A school-level suicide prevention coordinator shall be designated by the principal. This may already be a member of an existing crisis/emergency response team. The school suicide prevention coordinator will be responsible for planning and coordinating implementation of this policy for the school. The school suicide prevention coordinator will act as the point of contact for issues relating to suicide prevention and policy implementation. All staff members shall report students they believe to be at elevated risk for suicide to the school suicide prevention coordinator.

The school suicide prevention coordinator will work with an already existent Emergency Response Team to which one additional member with requisite qualifications or credentials in the mental health profession (e.g. licensed mental health professionals would include School Social Worker, School Psychologist, Licensed Professional Counselor or Marriage and Family Therapist) will be added.

All employees are expected to:

- Inform the school site administrator/designee immediately or as soon as possible of concerns, reports or behaviors relating to student suicide and self-injury.
- Adhere to the Suicide Prevention, Intervention and Postvention policy.

Administrator or Designee should:

- Respond to reports of students at risk for suicide or exhibiting self-injurious behaviors immediately or as soon as possible.
- Monitor and follow-up to ensure that the risk has been mitigated through support and resources.
- Ensure that the Suicide Prevention, Intervention and Postvention policy is implemented.
- Provide follow-up to relevant staff as needed.
- Create reports and update any records as needed.
- Be responsible for providing training and adherence to the Suicide Prevention, Intervention and Postvention policy.

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

The professional development will include information regarding groups of students at elevated risk for suicide, including those living

with mental and/or substance use disorders, those who engage in self-injury or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities.

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

Youth Suicide Prevention Programming
Developmentally-appropriate, student-centered education materials will be integrated into the curriculum of all K-12 health classes. The content of these age-appropriate materials will include:

1) The importance of safe and healthy choices and coping strategies,
2) How to recognize risk factors and warning signs of mental disorders and suicide in oneself and others,
3) Help-seeking strategies for oneself or others, including how to engage school resources and refer friends for help.

In addition, the school will engage outside professional organization that deal with suicidal youth to provide whole school or small-group suicide prevention programming for students.

SUICIDE PREVENTION TASK FORCE

The school will also establish a suicide prevention task force which will consist of administrators, parents, teachers, school employed mental health professionals, representatives from community suicide prevention services, and other individuals with expertise in youth mental health. This task force will be administered by the suicide prevention coordinator. The purpose of such a task force will be to provide advice to the school and the school board regarding suicide prevention activities and policy implementation.

The task force will help identify and compile a list of community resources to assist with suicide prevention activities and referrals to community mental health providers. The task force shall be in force for a period not exceeding two years, or sustained as needed at the discretion of the school suicide prevention coordinator with the assent of the principal. At the expiration of the task force, the school suicide prevention coordinator will assume the role of maintaining the list of community suicide prevention resources.

ASSESSMENT AND REFERRAL

When a student is identified by a staff person as potentially suicidal, i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-injury occurs, or a student self-refers, the student will be seen by a school employed mental health professional within the same school day to assess risk and facilitate referral. If there is no mental health professional available, a school nurse or administrator will fill this role until a mental health professional can be brought in.

For youth at risk:

a) School staff will continuously supervise the student to ensure their safety.
b) The principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.
c) The school employed mental health professional or principal will contact the student's parent or guardian, as

described in the Parental Notification and Involvement section, and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local Emergency Department, but in most cases will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider.

d) Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

IN-SCHOOL SUICIDE ATTEMPTS

In the case of an in-school suicide attempt, the health and safety of the student is paramount. In these situations:

1. First aid will be rendered until professional medical treatment and/or transportation can be received, following the school's emergency medical procedures.
2. School staff will supervise the student to ensure their safety.
3. Staff will move all other students out of the immediate area as soon as possible.
4. If appropriate, staff will immediately request a mental health assessment for the youth.
5. The school employed mental health professional, the principal or suicide prevention coordinator will contact the student's parent or guardian, as described in the Parental Notification and Involvement section.
6. Staff will immediately notify the principal or school suicide prevention coordinator regarding in-school suicide attempts.
7. The school will engage as necessary the crisis team to assess whether additional steps should be taken to ensure student safety and well-being.

OUT –OF –SCHOOL SUICIDE ATTEMPTS

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member will:

1. Call the police and/or emergency medical services, such as 911.
2. Inform the school suicide prevention coordinator and principal.

If the student contacts the staff member and expresses suicidal ideation, the staff member should maintain contact with the student (either in person, online, or on the phone). The staff member should then enlist the assistance of another person to contact the police while maintaining verbal engagement with the student.

RE-ENTRY PROCEDURE

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), a school employed mental health professional, the principal, suicide prevention coordinator or designee will meet with the student's parent or guardian, and if appropriate, meet with the student to discuss re-entry and appropriate next steps to ensure the student's readiness for return to school.

1. A school employed mental health professional or other designee will be identified to coordinate with the student, their parent or guardian, and any outside mental health care providers.

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

PARENTAL NOTIFICATION AND INVOLVEMENT

In situations where a student is assessed at risk for suicide or has made a suicide attempt, the student's parent or guardian will be informed as soon as practicable by the principal, designee, or mental health professional. If the student has exhibited any kind of suicidal behavior, the parent or guardian should be counseled on "means restriction," limiting the child's access to mechanisms for carrying out a suicide attempt. Staff will also seek parental permission to communicate with outside mental health care providers regarding their child.

Through discussion with the student, the principal or school employed mental health professional will assess whether there is further risk of harm due to parent or guardian notification. If the principal, designee, or mental health professional believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate. If contact is delayed, the reasons for the delay should be documented.

POSTVENTION

1. **Development and Implementation of an Action Plan**: The crisis team will develop an action plan to guide school response following a death by suicide. A meeting of the crisis team to implement the action plan should take place immediately following news of the suicide death. The action plan may include the following steps:

    a. **Verify the death:** Staff will confirm the death and determine the cause of death through communication with a coroner's office, local hospital, the student's parent or guardian, or police department. Even when a case is perceived as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian will not permit the cause of death to be disclosed, the school will not share the cause of death but will use the opportunity to discuss suicide prevention with students.

    b. **Assess the situation:** The crisis team will meet to prepare the postvention response, to consider how severely the death is likely to affect other students, and to determine which students are most likely to be affected. The crisis team will also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. If the death occurred during a school vacation, the need for or scale of postvention activities may be reduced.

    c. **Share information:** Before the death is officially classified as a suicide by the coroner's office, the death can and should be reported to staff, students, and parents/guardians with an acknowledgement that its

cause is unknown. Inform the faculty that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Public address system announcements and school-wide assemblies should be avoided. The crisis team may prepare a letter (with the input and permission from the student's parent or guardian) to send home with students that includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available.

d. **Avoid suicide contagion:** It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high risk students is to prevent another death. The crisis team will work with teachers to identify students who are most likely to be significantly affected by the death. In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting students who generate concern.

e. **Initiate support services:** Students identified as being more likely to be affected by the death will be assessed by a school employed mental health professional to determine the level of support needed. The crisis team will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, crisis team members will refer to community mental healthcare providers to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs.

f. **Develop memorial plans:** The school should not create on-campus physical memorials (e.g. photos, flowers), funeral services, or fly the flag at half-mast because it may sensationalize the death and encourage suicide contagion. School should not be canceled for the funeral. Any school-based memorials (e.g., small gatherings) will include a focus on how to prevent future suicides and prevention resources available.

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

    a) Keep the school suicide prevention coordinator and superintendent informed of school actions relating to the death.

    b) Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation,

means of suicide, or personal family information.

c) Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide, and not to use the phrase "suicide epidemic" – as this may elevate the risk of suicide contagion. They should also be encouraged not to link bullying to suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available.

MESSAGING AND SUICIDE CONTAGION

Research has shown a link between certain kinds of suicide-related media coverage and increases in suicide deaths. Suicide contagion has been observed when:

- the number of stories about individual suicides increases,
- a particular death is reported in great detail,
- the coverage of a suicide death is prominently featured in a media outlet, or
- when the headlines about specific deaths are framed dramatically (e.g., "Bullied GayTeen Commits Suicide By Jumping From Bridge").

Research also shows that suicide contagion can be avoided when the media report on suicide responsibly, such as by following the steps outlined in "Recommendations for Reporting on Suicide" at www.reportingonsuicide.org.

Contagion can also play a role in cases of self-harm behavior. These behaviors may originate with one student and can spread to other students through imitation. Because adolescents are especially vulnerable to the risk of contagion, in the case of a suicide death, it is important to memorialize the student in a way that does not inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicides and underlying mental health issues such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

However, schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student's family and friends. Refer to the American Foundation for Suicide Prevention's "After a Suicide" resource listed in the Resources section for sample notification statements for students and parents/guardians, sample media statements, and other model language.

Finally, after a death by suicide it is important for schools to encourage parents/guardians to monitor their child's social networking pages. Students often turn to social networking websites as an outlet for communicating information and for expressing their thoughts and feelings about the death. Parents/ guardians should be advised to monitor the websites for warning signs of suicidal behavior.

LEGAL OBLIGATIONS AND LIABILITY

Schools have been sued and found liable for failing to take proper action, particularly for failing to notify parents/guardians, when a student was thought to be suicidal. The key issues in court cases have been foreseeability and negligence and have included cases in which schools did not warn parents/guardians about both verbal and written statements about suicide as well as cases in which the school failed to provide supervision and counseling for suicidal students.

Schools have also been sued over more complex issues, such as school climate and failure to reduce bullying, that were claimed to contribute to the suicide of a student. As the U.S. Department of Education Office for Civil Rights has emphasized, schools have legal obligations under anti-discrimination laws. Once a school knows or reasonably should know of possible student harassment, it must take immediate action to investigate, take steps to end the harassment, eliminate a hostile environment, and prevent its recurrence.

These duties are a school's responsibility even if the misconduct also is covered by an anti-bullying policy and regardless of whether the student makes a complaint (more information, including example cases, at: http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.pdf.). New Designs will develop plans and protocols to comply with state and other relevant laws while at the same time instituting best practices to protect and serve students and staff.

INTERVENTION PROTOCOL FOR RESPONDING TO STUDENTS AT RISK FOR SUICIDE.

The following are general procedures for the administrator/designee to respond to reports of students at risk for suicide or exhibiting self-injurious behaviors. These procedures are only a guide and can be modified and improved to enhance response effectiveness. **The urgency of the situation will dictate the order and applicability in which the subsequent steps are followed**.

A. Respond Immediately

1. Report concerns or incidents to the administrator/designee immediately or as soon as possible. Make direct contact with the administrator/designee. For example, do not wait until the end of the day or leave a note, send an e-mail, or leave a voicemail without ensuring that the message was received.

2. Supervise the student at all times. Ensure that any student sent to the office for assessment is accompanied by a staff member, not a student.

B. Secure the Safety of the Student

1. For immediate, emergency life threatening situations call 911.

2. Supervise the student at all times.

3. If appropriate, conduct an administrative search of the student to ensure there is no access to means, such as razor blades or pills.

4. If a student is agitated, unable to be contained or there is a need for immediate assistance, contact the local law enforcement agency (phone number here).

5. School employees should not transport students unless authorized to do so.

6. If the school receives information that the student may pose a danger to self and/or others but is not in attendance, contact local law enforcement to conduct a welfare check to determine the safety and well-being of the student.

C. Assess for Suicide Risk

1. The administrator/designee or designated school site crisis team member should gather essential background information that will help with assessing the student's risk for suicide (e.g., what the student said or did, information that prompted concern or suspicion, copies of any concerning writings, drawings, text messages, social media, or previous injury history).

2. The administrator/designee or the designated school site crisis team member should meet with the student to complete a risk assessment. Based on the information gathered and assessment of the student, the assessing party should collaborate with at least one other designated school site crisis team member to determine the level of risk (use Suicide Risk Assessment Tool for questions to ask, levels of risk, definitions, and warning signs).

3. If the assessing party makes phone calls for consultation, these should be made in a confidential setting and not in the presence of the student of concern. The student should be supervised at all times by another designated staff member. ***(NOTE: The privacy of all students should be protected at ALL times. Disclose information only on right to know and need to know basis).***

D. Communicate with Parent/Guardian

The administrator/designee or designated school site crisis team member should contact the parent/guardian or consult the emergency card for an appropriate third party. When communicating with parent/guardian:

1. Share concerns and provide recommendations for safety in the home (e.g., securing/removing firearms, medications, cleaning supplies, cutlery, and razor blades).

2. If the student is transported to the hospital, communicate a plan for re-entry pursuant to Student Re-Entry Guidelines. Complete and provide parent/guardian Return to School Information for Parent/Guardian which outlines steps to facilitate a positive transition back to school.

3. Provide school and/or local community mental health resources. Students with private health insurance should be referred to their provider.

4. Facilitate contact with community agencies and follow-up to ensure access to services.

5. Provide a copy of Suicide Prevention Awareness for Parents/Caregivers; Self-Injury Awareness for Parents/Caregivers and Resource Guide.

6. Obtain parent/guardian permission to release and exchange information with community agency staff using Parent/Guardian Authorization for Release/Exchange of Information.

E. Determine Appropriate Action Plan

The assessing party should collaborate with at least one other designated school site crisis team member to determine appropriate action(s) based on the level of risk. Refer to Suicide Risk Assessment Levels, Warning Signs & Action Plan Options. Action items should be based upon the severity and risk of suicide. There are circumstances that might increase a student's suicide risk. Examples may include bullying, suspension, expulsion, relationship problems, significant loss, interpersonal conflict, or sexual orientation/gender bias. The action plan determined should be documented and managed by the school site administrator/designee. Actions may include:

1. Develop a safety plan. A safety plan is a prioritized list of coping strategies and resources that a student may use before, during, or after a suicidal crisis. See Recommendations

for Developing a Student Safety Plan and Student Safety Plan template.

a. Throughout the safety planning process, the likelihood of the student implementing the steps should be assessed and potential obstacles should be identified. A collaborative problem solving approach should be used to address any potential barriers to the student utilizing the safety plan.

b. If the student enrolls in a new school, the safety plan should be reviewed with the new school site crisis team to ensure continuum of care and revised as needed.

2. Follow student re-entry guidelines. See Student Re-entry Guidelines for a checklist of action items to consider and Sign-in Sheet Template for Meeting to document participation in any re-entry or safety planning meeting.

a. A student returning to school following psychiatric evaluation or hospitalization, including psychiatric and drug/alcohol inpatient treatment, must have written permission by a licensed California health care provider to attend school (see Medical Clearance for Return to School).

b. If the student has been out of school for any length of time, including mental health hospitalization, the school site administrator/designee may consider holding a re-entry meeting with key support staff, parents, and student to facilitate a successful transition.

c. As appropriate, consider an assessment for special education for a student whose behavioral and emotional needs affect their ability to benefit from their educational program.

3. Mobilize a support system and provide resources (see Resource Guide).

a. Connect student and family with social, school and community supports.

b. For mental/physical health services, refer the student to a community resource provider, or their health care provider.

4. Monitor and manage.

a. The administrator/designee should monitor and manage the case as it develops and until it has been determined that the student no longer poses an immediate threat to self.

b. Maintain consistent communication with appropriate parties on a need to know basis.

c. If the parent/guardian is not following the safety recommendations, a suspected child abuse report may be filed (see BUL-1347.3 - Child Abuse and Neglect Reporting Requirements).

F. Important Considerations

The following are clarifications of some of the action plan options noted above:

1. When Certificated Staff Accompany a Student to the Hospital

If Psychiatric Mobile Response Team (PMRT) or law enforcement determines that the student will be transported to an emergency hospital/medical facility, the school site administrator should designate a certificated staff member to accompany the student if:

a. The student requests the presence of a staff member.

b. The school is unable to make contact with the parent/guardian.

c. Parent/guardian is unavailable to meet the student at the hospital.

d. Deemed appropriate pursuant to circumstances, such as age, developmental level, or pertinent historical student information.

2. Providing Information for a Psychiatric Evaluation

If the student will be transported, the assessing party should complete Summary of Relevant Student Information, indicating summary of incident and pertinent historical information. This document should be provided to PMRT or law enforcement prior to transporting to an emergency hospital. For information on how to complete the summary report refer to Completion of the Summary of Relevant Student Information.

G. Document All Actions

The administrator/designee shall maintain records and documentation of actions taken at the school for each case by completing an incident report. Notes, documents and records related to the incident are considered confidential information and remain privileged to authorized personnel. These notes should be kept in a confidential file separate and apart from the student's cumulative records.

INTERVENTION PROTOCOL FOR RESPONDING TO STUDENTS WHO SELF-INJURE.

Self-injury is the deliberate act of harming one's own body, through means such as cutting or burning. Although self-injury often lacks suicidal intent, youth who self-injure are more likely to attempt suicide. Therefore, it is important to assess students who cut or exhibit any self-injurious behaviors for suicidal ideation. For an abbreviated version of the protocol outlined below, see **Protocol for Responding to Students Who Self-Injure**.

A. Warning Signs of Self-Injury

- Frequent or unexplained bruises, scars, cuts or burns
- Consistent, inappropriate use of clothing to conceal wounds (e.g., long sleeves or turtlenecks, especially in hot weather; bracelets to cover the wrists; not wanting to change clothing for Physical Education).
- Possession of sharp implements (e.g., razor blades, shards of glass, thumb tacks)
- Evidence of self-injury (e.g., journals, drawings, social networking sites)

B. Protocol for Responding to a Student who Self-Injures

1. Respond immediately or as soon as possible.

2. Supervise the student.

3. Conduct an administrative search of student for access to means.

4. Assess for suicide risk using the Suicide Risk Assessment Tool.

5. Communicate with and involve the parent/guardian, even if the student is not suicidal, so the behavior may be addressed as soon as possible. Provide handout on Self-Injury Awareness for Parents/Caregivers.

6. Encourage appropriate coping and problem-solving skills; do not shame the student about engaging in self-injury.

7. Listen calmly and with empathy; reacting in an angry, shocked or shaming manner may increase self-injurious behaviors.

8. Develop a safety plan with the student. See Recommendations for Developing a Student Safety Plan and Student Safety Plan template.

9. Provide resources. See Resource Guide.

10. Document all actions.

C. Self-Injury and Contagion

Self-injurious behaviors may be imitated by other students and can spread across grade levels, peer groups and schools. The following are guidelines for addressing self-injurious behaviors among a group of students:

1. Respond immediately or as soon as possible.
2. Respond individually to students, but try to identify peers and friends who may also be engaging in self-injurious behaviors.
3. As students are identified, they should be supervised in separate locations.
4. Each student should be assessed for suicide risk individually using Suicide Risk Assessment Tool.
5. If the self-injurious behavior involves a group of students, the assessment of each student individually will often identify a student whose behaviors have encouraged the behaviors of others. This behavior may be indicative of more complex mental health issues for this particular student.

D. Other Considerations for Responding to Self-Injury and Contagion

The following are guidelines for how to respond as a school community when addressing self-injurious behaviors among a group of students:

1. Self-injury should be addressed with students individually and never in group settings, such as student assemblies, public announcements, school newspapers, or the classroom.
2. When self-injurious behaviors are impacting the larger school community, schools may respond by inviting parent(s)/guardian(s) to an informational parent meeting at the school. Considerations should be made for supervising students and children during this time. The meeting should be reserved for parent(s)/guardian(s) only (see Sample Letter to Parent/Guardian RE: Self-Injury).

VI. SUSPECTED CHILD ABUSE OR NEGLECT

If child abuse or neglect by a parent/guardian is suspected or there is reasonable suspicion that contacting the parent/guardian may escalate the student's current level of risk, or the parent/guardian is contacted and unwilling to respond, report the incident to the appropriate child protective services agency following the District's Child Abuse and Neglect Reporting Requirements, BUL-1347.3. This report should include information about the student's suicide risk level and any concerning ideations or behaviors. The reporting party must follow directives provided by the child protective services agency personnel.

VII. RESPONDING TO STUDENTS WITH DISABILITIES

For students with disabilities whose behavioral and emotional needs are: documented to be more intense in frequency, duration, or intensity; affect their ability to benefit from their special education program; and are manifested at the school, at home, and in the community, follow guidelines as indicated in BUL-5577.1 Counseling and Educationally Related Intensive Counseling Services (ERICS) for Students with Disabilities and contact the Division of Special Education ERICS Department at (213) 241-8303 for assistance.

Self-injurious behaviors may be exhibited by students with profound disabilities without being indicative of suicide or suicidal ideation. Please follow District guidelines as indicated in BUL-6269.0, Multi-Tiered System of Behavior Support for Students with Disabilities and contact the designated contacts in the Charter

Operated Programs office of the Charter Schools Division for assistance.

VIII. RESPONDING TO STUDENTS WHO MAY BE LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING (LGBTQ)

LGBTQ youth who are targets of bias, bullying or rejection at home or at school have elevated rates of suicidality, compared to non-LGBTQ youth. LGBTQ students with rejecting families have an eight-fold increased risk for suicidal ideation than do LGBTQ students with accepting families.

When working with LGBTQ youth, the following should be considered:

1. Assess the student for suicide risk using the Suicide Risk Assessment Tool.
2. Do not make assumptions about a student's sexual orientation or gender identity. The risk for suicidal ideation is greatest among students who are struggling to hide or suppress their identity.
3. Be affirming. Students who are struggling with their identity are on alert for negative or rejecting messages about sexual orientation and gender identity.
4. Do not "out" students to anyone, including parent(s)/guardian(s). Students have the right to privacy about their sexual orientation or gender identity.
5. Provide LGBTQ-affirming resources (see Resource Guide).
6. Ensure safe campuses (see BUL-6224.1 Transgender Students - Ensuring Equity and Nondiscrimination).

IX. OTHER RELATED MATTERS

A. Responding to Threats and School Violence

For matters related to students exhibiting suicidal ideation and threatening or violent behaviors towards others, follow guidelines as indicated in BUL-5799.0 Threat Assessment and Management (Student-to-Student, Student-to-Adult).

B. Responding to Bullying and Hazing

For matters related to students expressing suicidal ideation in conjunction with reports of bullying or hazing, additional guidelines indicated in BUL-5212.2 Bullying and Hazing Policy (Student-to-Student and Student-to-Adult) should be followed.

C. Responding to Hate Violence

For matter related to students expressing suicidal ideation in conjunction with reports of hate-motivated violence, additional guidelines indicated in BUL-2047.1 Hate-Motivated Incidents and Crimes – Response and Reporting should be followed.

POSTVENTION: PROTOCOL FOR RESPONDING TO A STUDENT DEATH BY SUICIDE.

The following are general procedures for the administrator/designee in the event of a death by suicide. See Postvention: Protocol for Responding to a Student Death by Suicide for an abbreviated version of the protocol indicated below.

A. Gather Pertinent Information

1. Confirm cause of death is the result of suicide, if this information is available.
2. The administrator/designee should designate a certificated staff member to be the point of contact with the family of the deceased. Information about the cause of death should not be disclosed to the school community until the family has consented to disclosure.

B. Notify on a Need to Know Basis

1. School site staff that need to know
2. Other offices, as appropriate (see - Resource Guide).

C. Mobilize the School Site Crisis Team

Concerns and wishes of family members regarding disclosure of the death and cause of death should be taken into consideration when providing facts to students, staff and parents/guardians.

1. Assess the extent and degree of psychological trauma and impact to the school community (see BUL-5800.0 Crisis Preparedness, Response and Recovery for protocol on responding to school-wide crisis).

2. Develop an action plan and assign responsibilities.

3. Establish a plan to notify staff of the death, once consent is obtained by the family of the deceased.

   a. Notification of staff is recommended as soon as possible (e.g., optional emergency meeting before or after school).

   b. To dispel rumors, share accurate information and all known facts about the death that the family has approved to be shared.

   c. Emphasize that no one person or event is to blame for suicide. Suicide is complex and cannot be simplified by blaming individuals, drugs, music, school or bullying.

   d. Allow staff to express their own reactions and grief; identify anyone who may need additional support and provide resources.

4. Establish a plan to notify students of the death, once consent is obtained from the family of the deceased.

   a. Discuss plan for notification of students in small group settings, such as the classroom. Do not notify students using a public announcement system.

   b. Provide staff with a script of information to be shared with the students, recommendations for responding to possible student reactions and questions, and activities to help students process the information (e.g., writing, drawing, or referral to crisis counselor).

   c. Review student support plan, making sure to clarify procedures and locations for crisis counseling.

5. Establish a plan to notify other parents/guardians of the death, once consent is obtained from the family of the deceased.

6. Define triage procedures for students and staff who may need additional support in coping with the death. Refer to BUL-5800.0 Crisis Preparedness, Response and Recovery for actions to consider, including:

   a. Identify a lead school site crisis response staff member to assist with coordination of crisis counseling and support services.

   b. Identify locations on campus to provide crisis counseling to students, staff and parents/guardians.

   c. Request substitute teachers.

   d. Maintain sign-in sheets and documentation on individuals

serviced for follow-up (refer to BUL-5800.0 Crisis Preparedness, Response and Recovery, for crisis response forms).

e. Provide students, staff or parents/guardians with after-hours resource numbers such as the 24/7 Suicide Prevention Crisis Line (877) 727-4747 (see - Resource Guide).

7. Refer students or staff who require a higher level of care for additional services such as a community mental health provider, or their health care provider. Indicators of students and staff in need of additional support or referral may include the following:

a. Persons with close connections to the deceased (e.g., close friends, siblings, relatives, and teacher).

b. Persons who experienced a loss over the past six months to a year, experienced a traumatic event, witnessed acts of violence, or have a loved one who has died by suicide.

c. Persons who appear emotionally over-controlled (e.g., a student who was very close to the deceased but who is exhibiting no emotional reaction to the loss) or those who are angry when majority are expressing sadness.

d. Persons unable to control crying.

e. Persons with multiple traumatic experiences. These individuals may have strong reactions that require additional assistance.

D. Document

The administrator/designee shall maintain records and documentation of actions taken at the school by completing an incident report.

E. Monitor and Manage

1. The administrator/designee, with support from the school crisis team, should monitor and manage the situation as it develops to determine follow up actions.

2. Maintain consistent communication with appropriate parties.

3. Update all actions taken at the school in appropriate records.

F. Important Considerations

1. Memorials

Memorials or dedications to a student who has died by suicide should not glamorize or romanticize the student or the death. If students initiate a memorial, the administrator/designee should offer guidelines for a meaningful, safe approach to acknowledge the loss. Some considerations for memorials include:

a. Memorials should not be disruptive to the daily school routine.

b. Monitor memorials for content.

c. Placement of memorials should be time limited. For example, they may be kept in place until the funeral services, after which the memorial items may be offered to the family upon review of appropriateness of items by administrator/designee.

2. Social Networking

Students may often turn to social networking as a way to communicate information about the death; this information may be accurate or rumored. Many also use social networking as an opportunity to express their thoughts about the death and about their own feelings regarding suicide. Some considerations in regard to social networking include:

a. Encourage parents/guardians to monitor internet postings regarding the death, including the deceased's personal profile or social media.

b. Social networking sites may contain rumors, derogatory messages about the deceased or other students. Such messages may need to be addressed. In some situations, postings may warrant notification to parents/guardians or law enforcement (see BUL-5688.1 Social Media Policy for Employees and Associated Persons).

3. Suicide Contagion

Suicide contagion is a process by which the exposure to suicide or suicidal behaviors of one or more may influence others to attempt or die by suicide. Some considerations for preventing suicide contagion are:

a. Identify students who may be at an increased risk for suicide, including those who have a reported history of attempts, are dealing with known stressful life events, witnessed the death, are friends with or related to the deceased.

b. Refer student for mental health services (see Resource Guide).

c. Monitor media coverage.

4. School Culture and Events

It is important to acknowledge that the school community may experience a heightened sense of loss in the aftermath of a death by suicide when significant events transpire that the deceased student would have been a part of, such as culmination, prom or graduation. Depending on the impact, such triggering events may require planning for additional considerations and resources.

GUIDEBOOKS AND TOOLKITS

"Preventing Suicide: A Toolkit for High Schools" – U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services
http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/ SMA12-4669

"After a Suicide: A Toolkit for Schools" – American Foundation for Suicide Prevention and Suicide Prevention Resource Center
www.afsp.org/schools

"Guidelines for School-Based Suicide Prevention Programs" – American Association of Suicidology
http://www.sprc.org/sites/sprc.org/files/library/ aasguide_school.pdf

"Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel" – Maine Youth Suicide Prevention Program
http://www.maine.gov/suicide/docs/Guideline.pdf

"Trevor Resource Kit" – The Trevor Project
thetrevorproject.org/resourcekit

"Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender (LGBT) Children" – Family Acceptance Project
http://familyproject.sfsu.edu/publications

National Center for School Crisis and Bereavement
http://www.stchristophershospital.com/pediatric-specialties-programs/specialties/690

Adolescent and School Health Resources –

Centers for Disease Control and Prevention, contains an assortment of resources and tools relating to coordinated school health, school connectedness, and health and academics http://www.cdc.gov/healthyyouth/schoolhealth/index.htm

SCHOOL PROGRAMS

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

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

"Lifeguard Workshop Program" – The Trevor Project thetrevorproject.org/adulteducation

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

CRISIS SERVICES FOR STUDENTS

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

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

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

RELEVANT RESEARCH

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

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

WORKING WITH THE MEDIA

"Talking About Suicide & LGBT Populations" –

Gay & Lesbian Alliance Against Defamation, Movement Advancement Project, American Foundation for Suicide Prevention, The Trevor Project, et al. http://www.afsp.org/understanding-suicide/for-the-media/reporting-on-suicide/talking-about-lgbt-suicide

"Recommendations for Reporting on Suicide" – American Foundation for Suicide Prevention, et al. http://reportingonsuicide.org/

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RESOURCES:

1. Protocol for Responding to Students at Risk for Suicide
2. Protocol for Responding to Students Who Self-Injure
3. Suicide Risk Assessment Tool
4. Suicide Risk Assessment Levels, Warning Signs & Action Plan
5. Recommendations for Developing a Student Safety Plan
6. Student Safety Plan template
7. Student Re-Entry Guidelines
8. Parent/Guardian Authorization for Release/Exchange of Information
9. Completion of the Summary of Relevant Student Information
10. Summary of Relevant Student Information template
11. Return to School Information for Parent/Guardian
12. Medical Clearance for Return to School
13. Sign-in Sheet Template for Meeting
14. Postvention: Protocol for Responding to a Student Death by Suicide
15. Suicide Prevention Awareness for Parents/Caregivers
16. Self-Injury Awareness for Parents/Caregivers
17. Sample Letter to Parent/Guardian RE: Self-Injury
18. Resource Guide

AUTHORITY:

California Civil Code sections 56-56.10, 1798;
California Constitution Article 1, §28(c);
California Education Code §32210 et seq.;
California Education Code §35160;
California Education Code §44808 ;
California Education Code §48900 et seq.;
California Education Code §48950 ;
California Education Code sections 49060 et seq.;
California Health & Safety Code sectiom123100-123149.5, 124260;
California Penal Code §626 et seq.;
California Code of Civil Procedure §527.6;
Family Educational Rights and Privacy Act;
Health Insurance Portability and Accountability Act; and
Los Angeles Municipal Code §63.94.

LAUSD BULLETINS:

BUL-5212.2, Bullying and Hazing Policy (Student-to-Student and Student-to-Adult), November 26, 2014.
BUL-1347.3, Child Abuse and Neglect Reporting Requirements, August 19, 2016.
BUL-5577.1, Counseling and Educationally Related Intensive Counseling Services (ERICS) for Students with Disabilities, July 21, 2014.
BUL-5800.0, Crisis Preparedness, Response and Recovery, October 12, 2015

BUL-6231.0, Discipline Foundation School-Wide Positive Behavior Intervention Support (SWPBIS), February 14, 2014.
BUL-5269.2, Incident System Tracking Accountability Report, July 10, 2013
BUL-2047.1, Hate-Motivated Incidents and Crimes – Response and Reporting, June 15, 2015.
BUL-6269.0, Multi-Tiered System of Behavior Support for Students with Disabilities, April 7, 2014.
BUL-5688.1, Social Media Policy for Employees and Associated Persons, January 29, 2015.
BUL-5799.0, Threat Assessment and Management, July 12, 2012.
BUL-6224.1, Transgender Students - Ensuring Equity and Nondiscrimination, September 15, 2014.