



Suicide Prevention Policy

Blue Ridge Academy is committed protecting the health and well-being of all Blue Ridge Academy students, including vulnerable youth populations, by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide and self-harming behavior. Vulnerable youth populations include LGBTQ (lesbian, gay, bisexual, transgender, questioning) youth, youth living with mental and/or substance use disorders, youth who engage in self-harm or have attempted suicide, youth in out-of-home settings, youth experiencing homelessness, American Indian/Alaska Native youth or youth that identify with other racial minority groups, youth bereaved by suicide and youth living with medical conditions and disabilities.

California *Education Code (EC)* Section 215, as added by Assembly Bill 2246, (Chapter 642, Statutes of 2016) mandates that the Governing Board of any local educational agency (LEA) that serves pupils in grades seven to twelve, inclusive, adopt a policy on pupil suicide prevention, intervention, and postvention. The policy shall specifically address the needs of high-risk groups, including suicide awareness and prevention training for teachers, and ensure that a school employee acts within the authorization and scope of the employee's credential or license.

The purpose of Blue Ridge Academy Governing Board approving this Suicide Prevention Policy is to accomplish the following:

1. Explain the Purpose for The Suicide Prevention Policy
 2. Identify Parental Involvement in Suicide Prevention
 3. Outline Key Terms and Definitions of Suicide Prevention
 4. Identify Risk Factors and Protective Factors
 5. Outline the Warning Signs of Suicide
 6. Outline How to Respond to the Warning Signs of Suicide
 7. Explain Suicide Discussion/Communication for Parents and Children.
 8. Outline the Process for Assessment and Referral
 9. Outline the Process for Implementing the Policy
 10. Provide Resources for Parents, Students, and Staff Members on Suicide Prevention
- 1. Purpose:** Blue Ridge Academy recognizes that:
- a) physical, behavioral, and emotional health is an integral component of a student's educational outcome,
 - b) further recognizes that suicide is a leading cause of death among young people,
 - c) the 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.

In recognition of the need to protect the health, safety and welfare of its students, to promote healthy development, to safeguard against the threat or attempt of suicide among school aged youth, and to address barriers to learning, Blue Ridge Academy hereby adopts a policy, which corresponds with and supports other federal, state and local efforts to provide youth with prevention education, early identification and intervention, and access to all local resources to promote health and prevent personal harm or injury.

With the intention of creating a safe and nurturing educational entity that minimizes suicidal ideation in students, we also recognize our duty to protect the health, safety, and welfare of our students, and aim to safeguard students and staff against suicide attempts, deaths and other trauma associated with suicide. These safeguards include ensuring adequate supports for students, staff, and families affected by suicide attempts and loss. Because the emotional wellness of students greatly impacts learning, motivation, and educational success, the current policy shall be paired with other policies that support the emotional and behavioral wellness of students. Our policy is based on research and best practices in suicide prevention, and has been adopted with the understanding that suicide prevention activities decrease suicide risk, increase help-seeking behavior, identify those at risk of suicide, and decrease suicidal behaviors. Empirical evidence refutes a common belief that talking about suicide can increase risk or "place the idea in someone's mind."

In an attempt to reduce suicidal behavior and its impact on students and families, the school has developed strategies for suicide prevention, intervention, and postvention, and the identification of the mental health challenges frequently associated with suicidal thinking and behavior. These strategies shall include professional development for parents/guardians, caregivers, students, and school personnel who regularly interact with students or serve in a position to recognize the risk factors and warning signs of suicide.

- 2. Parental/Guardian Involvement:** Parents and guardians play a key role in youth emotional and behavioral health, including suicide prevention. This policy is meant to be used as a tool for parents/guardians to be informed and actively involved in decisions regarding a child's welfare. Parents/guardians who learn the warning signs and risk factors for suicide are better equipped to connect with professional help when necessary. The school encourages and advises parents/guardians to take every statement regarding suicide or personal harm seriously and avoid assuming that a child is simply seeking attention.

Parents and guardians can also contribute to factors and conditions that reduce vulnerability to suicidal and self-harming behavior, for vulnerable youth populations. Feeling accepted by parents or guardians is a critical protective factor for vulnerable youth populations. As educators, Blue Ridge Academy faculty and staff can help protect vulnerable youth populations by ensuring that parents and guardians have adequate resources regarding family acceptance and the essential role it plays in students' behavioral and emotional health.

- 3. Student Participation and Education:** Blue Ridge Academy along with its partners has carefully reviewed available student curricula to ensure it promotes the mental health model of suicide prevention and does not encourage the use of the stress model to explain suicide.

Under the supervision of school-employed mental health professionals, and following consultation with county and community mental health agencies, students shall:

- Receive developmentally appropriate, student-centered education about the warning signs of mental health challenges and emotional distress;
- Receive developmentally appropriate guidance regarding the School's suicide prevention, intervention, and referral procedures.
- The content of the education shall include:
 - Coping strategies for dealing with stress and trauma;
 - How to recognize behaviors (warning signs) and life issues (risk factors) associated with suicide and mental health issues in oneself and others;
 - Emphasis on reducing the stigma associated with mental illness and the fact that early prevention and intervention can drastically reduce the risk of suicide.

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

Blue Ridge Academy will support the creation and implementation of programs and/or activities on campus that raise awareness about mental wellness and suicide prevent (e.g., Mental Health Awareness Weeks, Peer Counseling Programs, Freshman Success Programs).

4. Key Terms and Definitions:

- ***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.
- ***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.
- ***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.
- ***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.
- ***Risk Assessment*** An evaluation of a student^[SEP] who may be at risk for suicide, conducted by the appropriate school staff (e.g., school psychologist or school counselor). This

assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

- ***Risk Factors for Suicide*** Characteristics or conditions that increase the chance that a person may 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.
- ***Self-Harm*** 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.
- ***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.
- ***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.
- ***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.
- ***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.
- ***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.

5. Risk Factors and Protective Factors:

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

The most frequently cited risk factors for suicide are:

1. Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)
2. Problems with alcohol or drugs
3. Unusual thoughts and behavior or confusion about reality
4. Personality traits that create a pattern of intense, unstable relationships or trouble with the law
5. Impulsivity and aggression, especially along with a mental disorder

6. Previous suicide attempt or family history of a suicide attempt or mental disorder
7. Serious medical condition and /or pain

It is important to bear in mind that the large majority of people with mental disorders or other suicide risk factors do not engage in suicidal behavior.

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

The most frequently cited protective factors of suicide include:

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

It is important for school districts to be aware of student populations that are at elevated risk of suicidal or self-harming behavior based on various factors:

1. Youth living with mental and/or substance use disorders. While the large majority of people with mental disorders do not engage in suicidal behavior, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bipolar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are important risk factors for suicidal behavior among your people. The majority of people suffering from these mental disorders are not engaged in treatment, therefore school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk.
2. Youth who engage in self-harm or have attempted suicide. Suicide risk among those who engage in self-harm is significantly higher than the general population. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow up care.
3. Youth in out-of-home settings. Youth involved in the juvenile justice or child welfare systems have a high prevalence of many risk factors of suicide. Young people involved in the juvenile justice system die by suicide at a rate about four times greater than the rate among youth in the general population. Though comprehensive suicide data on youth in foster care does not exist, one research found that youth in foster care were more than twice as likely to have considered suicide and almost four times more likely to have attempted suicide than their peers not in foster care.
4. Youth experiencing homelessness. For youth experiencing homelessness, rates of suicide attempts are higher than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorders, and post-traumatic stress disorder.
5. American Indian/Alaska Native youth. In 2009, the rate of suicide among American Indian / Alaska Native youth ages 15-19 was more than twice that of the general youth population. Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma.

6. LGBTQ (lesbian, gay, bisexual, transgender, or questioning) youth. The CDC finds that LGBTQ youth are four times more likely, and questioning youth are three times more likely, to attempt suicide as their straight peers. The American Association of Suicidology reports that nearly half of young transgender people have seriously considered taking their lives and one quarter report having made suicide attempt. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejections, harassment, bullying, violence and victimization. For those youth with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ that will elevate the risk of suicidal behavior for LGBTQ youth.
7. Youth bereaved by suicide. Studies show that those who have experience suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.
8. Youth living with medical conditions and disabilities. A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of the conditions include chronic pain, loss of mobility, disfigurement, cognitive styles that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

6. Warning Signs of Suicide: It is vital to suicide prevention that individuals are equipped to recognize the warning signs of someone who is seriously contemplating suicide. Behaviors that may mean a person is at *immediate* risk for suicide and thus prompt you to take action right away include:

- Talking about wanting to die or to kill one's self
- Looking for a way to kill one's self, such as a new or sudden interest in buying a gun
- Talking about feeling hopeless or like there's no point in living or carrying on
- Unusual or unexpected visits or calls to family and friends to say "goodbye" as if they will not be seen again
- Sudden efforts to get one's affairs in order, e.g., making a will out of the blue or giving away prized possessions
- A sudden sense of calm and happiness; though this might sound contradictory, if an extremely depressed person suddenly seems calm or happy, this can mean the person has made a decision to commit suicide. *Do not assume a person expressing a desire to die is joking.* Ask if they are serious. And make sure to follow up. Someone might say they are only joking when in fact the "joke" is motivated by a sincere desire to die. Suicide is not a joking matter; do not treat it as such. Less immediate, but still concerning, warning signs of suicidal ideation include:
 - Feeling anxious or agitated
 - Sudden reckless behavior

- Significant changes in sleep behavior (hardly sleeping, sleeping too much)
- Withdrawing or isolating from others
- Talking about feeling trapped
- Talking about pain feeling unbearable
- Talking about being a burden to others
- Increased use/abuse of alcohol or drugs
- Extreme mood swings

The above behaviors do not necessarily indicate suicidal ideation in and of themselves. However, when combined with other factors (like a recent, painful loss or public moment of humiliation), they should take on a new sense of urgency to intervene with help.

7. Responding to the Warning Signs: The most important thing you can do is ***take the person seriously***. Do not judge them; do not make them feel bad; do not make a joke about it even if it makes you feel uncomfortable. Above all, do not assume the person is only seeking attention. That is not your judgment to make and you making it could be a life-threatening mistake. Be there, support them, and take immediate action. That immediate action should include, at the very minimum, the following:

- Talk to the person. Let them know you care about them.
- Listen without judging. This means you need to set aside whatever religious or theological beliefs you have about suicide in the abstract. This moment is about helping the human being in front of you who needs support.
- Try not to act/appear shocked. The person is already in distress; an overwhelming display of emotions on your part could only further distress them and make them feel they should not talk to you.
- Ask the person directly, “Are you thinking of ending your life?” or “Are you considering killing yourself?” Though it might make *you* uncomfortable, remember these four concrete questions: Suicidal? Method? Have what you need to follow through with plan? When?

The more information you know, the better you can help the suicidal person as well as the professionals that need to get involved. Also, asking these questions can help you determine how significant the risk. The more developed the person’s suicidal plan, the higher the risk. For example, if the person has a method and a time in mind, the risk is extremely high.

- If the person says, “No,” continue to be with the person and give support and stay in touch for the next few days, repeating the above process.
- If the person says, “Yes,” and has a plan and access to lethal means, do not leave the person alone. Get a professional involved. ***Immediately contact a local mental health***

professional, law enforcement, a local hospital emergency department, and/or the National Suicide Prevention Lifeline (1-800-273-8255).

- Provide any relevant information you may have about the person to those who are managing the crisis.
- Keep in contact with the person after the crisis and provide ongoing care and support.
- Draw on other leaders and volunteers in your home and school community to provide support
- If a person ever asks you to keep their suicidal feelings or thoughts secret, refuse. The most loving response to someone feeling suicidal is getting them the help they need. A life is at risk. *If the risk of chronic/not immediate:* ^[L]_[SEP] Sometimes people may display warning signs of suicide or *feel* suicidal but not have any plans to actually commit suicide. Their risk may be low, but their suicidal feelings or thoughts are still causing significant distress in their lives. Even though their risk of actually attempting suicide is low, you should still reach out and do your best to support them. Here are some ways you can do so:
 - Ask them directly about their feelings and thoughts. You'd be surprised how willing some people are to talk about their suicidal urges. It might even be a relief for them to have someone to talk to about those urges. The Help Guide gives the following suggestions for starting such a conversation:
 - Help Guide, "Suicide Prevention: How to Help Someone who is Suicidal," <http://www.helpguide.org/articles/suicide-prevention/suicide-prevention-helping-someone-who-is-suicidal>
 - *Ways to start a conversation about suicide:* I have been feeling concerned about you lately. Recently, I have noticed some differences in you and wondered how you are doing. I wanted to check in with you because you haven't seemed yourself lately.
 - *Questions you can ask:* When did you begin feeling like this? Did something happen that made you start feeling this way? How can I best support you right now? Have you thought about getting help?
 - *What you can say that helps:* You are not alone in this. I'm here for you. You may not believe it now, but the way you're feeling will change. I may not be able to understand exactly how you feel, but I care about you and want to help. When you want to give up, tell yourself you will hold off for just one more day, hour, minute—whatever you can manage.

Educate yourself about suicide. Study more about suicide, its causes, and how to show love to someone who struggles with it.

Do not talk about suicidal people as if they are "crazy" or "insane." Use words that will not make them feel like isolating themselves even more. Most suicidal people are not clinically

psychotic. They might be grief-stricken or depressed, but do not make them feel like they should be locked up in an asylum.

Help the person find professional assistance. Offer to help them find a counselor or therapist; offer to help fill out forms for applying to your county or state's mental health care system.

Encourage positive lifestyle changes, such as exercising more. Start small: for example, invite the person to going for a walk or hiking with you on the weekend.

Help the person make a safety plan. Help the person develop a set of concrete and specific-steps they promise to follow if they feel particularly suicidal. The plan should include things they promise to avoid (alcohol, drugs, etc.) and things they promise to do instead (call you, call another friend or therapist, etc.).

If necessary, have the person temporarily give you anything that they could use to commit suicide, such as unneeded, extra medications, razors, knives, etc.

Continue to stay in touch and support the person over the long-term. Repeat the above steps as needed.

8. For Parents- Suicide Discussion/Communication: Talking to your Children: *Here are some suggestions to help you with introducing the subject:*

- **Be courageous:** There is no shame in admitting that suicide is a scary issue. As parents, you probably want to protect your kids from all sorts of scary things. But you also have an obligation to teach them how to face reality and equip them to deal with all the scary things reality can bring. Here's the truth: your kids are going to learn about suicide one way or another. So would you rather that they learn about it from the media or a friend who suddenly kills himself, or would you rather that you have the opportunity to educate them in advance? So face those fears and dive right in.
- **Pick a time where you can have an uninterrupted conversation:** Start the conversation when you have the best chance of having your child's attention. A car ride, for example, ensures that your child will have fewer distractions than at home with the TV on. While you want to make sure your child gives you their attention, also make sure they don't feel trapped. Remember: if talking about suicide makes *you* uncomfortable, it can also make your child feel uncomfortable. So make sure you not only have their attention, but that you do so in an environment that feels non-threatening and open.
- **Plan in advance:** Think about what you want to say and make sure you have the right information to talk to your child accurately and helpfully about suicide. Make notes or plan a script if you want.
- **Tailor the conversation to your child's age:** When talking about suicide (or any big, serious topic, for that matter), make sure that you keep the conversation at a level that is appropriate for that child's developmental level. For younger children, your descriptions can be shorter and simpler. For older children, give longer and more detailed answers. Additionally, older children will likely have many questions. If you don't know the answer to a question, don't be afraid to say that. You can make it into

a learning experience and research the answer with your child together. That's much better than inaccurate or misleading information.

- **Explain suicide in a way that dispels common myths:** Let your children know not only the facts about suicide, but also what depression is and how it can make people feel suicide is their only escape. Let them know that suicide is never a necessity and that there is always hope. Let them know that they are not bad if they feel sad or upset and that it's ok to tell you if they do feel this way. Make sure they feel safe in your home and that they do not have to pretend to always be happy. Let them know you will not judge them if they are feeling down and that you love them no matter how happy or sad they are.
- **Encourage them to talk to trusted adults:** Let your kids know that they can talk to you if they are feeling depressed or suicidal. Or let them know that if they ever feel uncomfortable talking to you about depression or suicide, that they can always talk to another trusted family member or adult in your community. The important thing is that they do not hold their feelings inside until they become so unbearable they feel like they are going to explode.
- **Let your child speak:** Ask your child what *they* think about the topic. Just be direct, e.g., "Have you thought about suicide? What do you think about it? Do your friends think about it? Do you know who you can talk to if you're feeling these feelings?"
- **Listen to your child:** If you ask your child what they think, make sure to be silent and give them the space to talk. If they say something that is inaccurate or that worries you, definitely be honest but do not interrupt them. Wait until they are done, affirm that you heard what they said and appreciate that they shared their thoughts with you, and *then* address whatever issues you feel need to be corrected.
- **Seeking Assistance:** There are differing situations where your child's distress may become apparent. Your child may reveal their suicidal thoughts to you, a friend, or a trusted adult. Whoever becomes aware of your child's distress must immediately seek assistance. In seeking assistance, your child's safety is the first consideration. The child should **never** be left alone during this crisis. If your child has a physician or therapist, call to alert them of the situation.

For the Child/ Student: School can be an exciting time, filled with new experiences, but at times you might feel as though it is more of a struggle. This information is meant to help you as you work through a tough time.

Life can be stressful. Between the friend drama, packed schedules, classes, clubs, relationships, sports, jobs, parental expectations, figuring out who you are, uncertainty over things, and not getting enough sleep, life can occasionally get you down and feel overwhelming. That is normal.

What is not normal is struggling through each day, feeling like things will only get worse. Maybe you feel like you have lost control, that nothing matters, or that you are alone. These feelings may indicate a condition that requires professional help, such as depression, anxiety or other mental health conditions.

Not everyone experiences mental health conditions in the same way, but **everyone struggling with their mental health deserves help**. Depression is among the most common conditions experienced. It is a complex medical illness that significantly interferes with an individual's ability to function, enjoy life, and feel like themselves.

A number of factors may contribute to a person becoming depressed; genetic predisposition and stressful life events can certainly play a role, but sometimes depression can occur without an obvious cause. This means that **anyone can become depressed**, even those who seemingly have every reason to be happy.

Depression commonly affects your thoughts, your emotions, your behaviors, and your overall physical health. Experiencing any one of these symptoms on its own does not constitute depression; a diagnosis of depression requires several of these symptoms to occur for at least two weeks. Here are some of the most common symptoms that point to the presence of depression:

- **Feelings:**

- Sadness
- Hopelessness
- Guilt
- Moodiness
- Angry outbursts
- Loss of interest in friends, family, and favorite activities

- **Thoughts:**

- Trouble concentrating
- Difficulty making decisions
- Trouble remembering
- Thoughts of harming oneself
- Delusions and/or hallucinations can also occur in cases of severe depression

- **Behaviors:**

- Withdrawing from people
- Substance abuse
- Missing work, school, or other commitments
- Attempts to harm oneself (e.g., cutting)

- **Physical/Somatic Problems:**

- Tiredness or lack of energy
- Unexplained aches and pains
- Changes in appetite
- Weight loss or gain
- Changes in sleep – sleeping too little or too much

If you are experiencing symptoms of depression, it is important to **talk to a trusted adult** (parent, teacher, counselor, coach, or clergy) or doctor so that you can get the help you need. **Depression does not go away on its own, but with the appropriate help it can be treated.** Studies show that more than 80% of people with depression can feel better with talk therapy (counseling) and/or medication. Maybe you have noticed that your friend has not been acting like themselves lately and you are worried about whether or not they are really “fine” after all. If you think a friend may be depressed, show them you care by reaching out. Give yourself time to talk in a private, comfortable place. Honestly share what you have noticed (changes in behavior, things they have said or done) and ask them how they are feeling. Let them know that you are asking them because you care, because you want them to feel better, and because there is help. Let them know that there is hope and help available, and support them to get the help they need. If you don’t feel comfortable asking your friend, share your concerns with a trusted adult who can. Talking about mental health can be difficult, but reaching out and getting help for depression is one of the most courageous, important things you can do for yourself or for a friend. **It might even save a life.**

- Resources at home or outside school:
 - Talk to a parent or older relative
 - Call your pediatrician or physician
 - Talk to a trusted adult, teacher, or guidance counselor
 - National Suicide Prevention Lifeline: 800-273-8255
 - If someone is in immediate danger, **call 911. *Getting help does not mean that you have failed, it demonstrates courage, hope, and means you’ve allowed others to show they care.***

9. Assessment and Referral: When a student is identified by a staff person as potentially suicidal, e.g., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm 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.

- School staff will continuously supervise the student to ensure their safety.
- The designated mental health and suicide prevention coordinator (s) will be made aware of the situation as soon as reasonably possible.

- The mental health professional/coordinator will contact the student's parent or guardian, and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local hospital 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.
- Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

Protecting the health and well-being of all students is of utmost importance. A suicide prevention policy serves to assist and protect all students through the following steps:

- Students should be made aware of and informed about recognizing and responding to warning signs of suicide in peers and friends, using coping skills, using support systems, and seeking help for themselves and friends.
- Blue Ridge Academy will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources.
- When a student is identified as being at risk, they will be assessed by a school employed mental health professional who will work with the parents, staff, and student, and help connect them to appropriate local resources.
- Students will have access to national resources which they can contact for additional support.
- All students will be expected to help create a school culture of respect and support in which students feel comfortable seeking help for themselves or friends. Students are encouraged to tell an adult (e.g., teacher, parent) if they, or someone they know, is feeling suicidal or in need of help.
- Students should also know that because of the life or death nature of these matters, confidentiality or privacy concerns are secondary to seeking help for students in crisis.
- If the student is in imminent danger (has access to a gun, is on a rooftop, or in other unsafe conditions), a call shall be made to 911.
- A referral process should be prominently disseminated to all staff members with access to students, so they know how to respond to a crisis and are knowledgeable about the school and community-based resources.
- The Superintendent shall establish crisis intervention procedures to ensure student safety and appropriate communications if a suicide occurs or an attempt is made by a student or adult on campus or at a school-sponsored activity.
- The referral process shall be prominently disseminated to all parents/guardians/caregivers so they know how to respond to a crises and are knowledgeable about the school and community-based resources.

Coping Skills/Healthy Behaviors: These are positive actions and behaviors that a student engages in to help them through their struggles on a daily basis. Some coping strategies include

activities that students can do in order to regulate his/her emotions; ask the student for input, and teach him/her additional strategies if necessary. Strategies may include: *slow breathing, yoga, play basketball, draw, write in journal, take a break from school activities to drink water, listen to music.*

Places I Feel Safe: These are places that the student feels most comfortable. It should be a safe, healthy, and generally supportive environment. This can be a physical location, an imaginary happy place, or in the presence of safe people. Help students identify a physical and/or emotional state of being. Places may include: *my being with my friends, youth group at church, imagining I am on a beach watching the waves.*

School Support: Any school staff member or administrator can check in with a student regularly (regardless of whether or not the student seeks out help). Notify student's teacher(s) and request monitoring and supervision of the student (keeping in mind not to share confidential information).

Adult Support: It is important that a student also feel connected with healthy adults at home or in their community. The student should trust these adults and feel comfortable asking for help during a crisis. Identify how student will communicate with these individuals and include a phone number. Some adults may include: *family (e.g., grandparent, aunt, uncle, adult sister); clergy (e.g. youth pastor); or neighbor.*

- 10. Prevention: School Policy Implementation:** A suicide prevention coordinator shall be designated by Blue Ridge Academy Administration. This may be an existing staff person, such as a School Counselor or School Psychologist. The suicide prevention coordinator will be responsible for planning and coordinating implementation of suicide prevention for the school.

The school suicide prevention coordinator will act as a point of contact in the school for issues relating to suicide prevention and policy implementation. All staff members shall report students they believe to be at elevated risk for suicide to the school mental health/suicide prevention coordinator.

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

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

Staff Professional Development: All staff will receive annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention. The professional development will include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native student, LGBTQ 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 and school nurses.

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

Designated members of the school crisis team should conduct a suicide risk assessment. The purpose of the assessment is to determine the level of risk and to identify the most appropriate actions to ensure the immediate and long-term safety and well-being of the student. This should be done by a team that includes a school-employed mental health professional.

Caregiver notification is a vital part of suicide prevention. The appropriate caregiver(s) must always be contacted when signs of suicidal thinking and behavior are observed. Typically, this is the student's parent(s); however, when child abuse is suspected protective services should be contacted. Even if a child is judged to be at low risk for suicidal behavior, schools may ask caregivers to sign a form to indicate that relevant information has been provided. Regardless, all caregiver notifications must be documented. Caregivers also provide critical information in determining level of risk. Whether a student is in imminent danger or not, it is strongly recommended that lethal means are (e.g., guns, poisons, medications, and sharp objects) are removed or made inaccessible.

Refer to community services if warranted. Referral options to 24-hour community-based services should be identified in advance. It is best to obtain a release from the primary caregiver to facilitate the sharing of information between the school and community agency.

Help the parent/caregiver and/or school staff to develop with the student a safety plan. Helping the student to develop a written list of coping strategies and sources of support that can be of assistance when he or she is having thoughts of suicide (e.g., a safety plan) is recommended. Suicide prevention hotlines (e.g., 800-273-TALK) and the app MY3 (my3app.org) can be helpful elements of such a plan.

Schools are legally responsible for documenting every step in the assessment and intervention process. A documentation form for support personnel and crisis response team members should be developed to record all suicide intervention actions and caregiver communication. Student information must be kept confidential but there are exceptions to FERPA when safety is of concern. Staff responsible for the safety and welfare of the student should be provided with the information necessary to work with the student and preserve the

safety. School staff members do not need clinical information about the student or a detailed history of his or her suicidal risk or behavior. Discussion among staff should be restricted to the student's treatment and support needs.

Keep tabs on the rumor mill (including social media). If you hear or see something credible, refer the student to a school-employed mental health professional or crisis response team member. At the same time, gossip about particular incidents and students should also be discouraged.

Please Remember:

If it seems that an individual is in immediate danger of hurting himself or herself: Take the person to a hospital Emergency Room to be evaluated by a health professional.

If the person refuses help: Call 9-1-1 for police evaluation of the individual. If the person is a danger to self or others, the officer can transport the person to a hospital where he or she may be held.

Postvention. Following a suicide, school communities must strike a delicate balance. Students should have an opportunity to grieve, but in a way that does not glorify, romanticize or sensationalize suicide, which may increase suicide risk for other students.

Confirm facts. Confirm the facts related to the death with the family and/or police. Inform other schools in the district with students related or close to the deceased. Contact the family to offer condolences, ask what the school can do to help, offer resources, and to discuss communication with the school community. Protect and gather the personal effects of the deceased for the family and/or the police. Pay close attention to other students (and staff) who may also be at risk of suicidal behavior.

Resources needed. In some situations, schools may have adequate resources to handle the aftermath of a suicide. However, it is critical that schools assess the impact of the suicide on the school community to determine the level of postvention support needed. Factors to consider include how well known the student was, if the suicide was public (e.g., occurred at a school event), and/or if the deceased had shared his/her suicidal intentions with others (particularly to large numbers of other students via social media). These factors generally increase the impact and thus the potential postvention needs of members of the school community.

Contagion. Suicide contagion occurs when suicidal behavior is imitated. The effect is strongest among adolescents: they appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. Guilt, identification, and modeling are each thought to play a role in contagion. Sometimes suicide contagion can result in a cluster of suicides. Studies indicate that 1-5% of all suicides within this age group are due to contagion (100-200 teenage cluster suicides per year).

Suicide postvention strategies designed to minimize contagion include avoiding sensationalism or giving unnecessary attention to the suicide, avoiding glorifying or vilifying of suicide victims, and minimizing the amount of detail about the suicide shared with students.

If there appears to be contagion, school administrators should consider taking additional steps beyond the basic crisis response, including stepping up efforts to identify other students who may be at heightened risk of suicide, collaborating with community partners in a coordinated suicide prevention effort, and possibly bringing in outside experts.

Memorials. Memorials in particular run the risk of glamorizing suicide and should thus be implemented with great care. Living memorials are recommended such as making donations to a local crisis center, participating in an event that raises awareness about suicide prevention, or providing opportunities for service activities in the school that emphasize the importance of student's taking care of each other.

Care for the caregiver. It is important that administrators and crisis team members not underestimate the potential impact that a suicide can have on school staff members. School leaders should promote a culture in which both the students and the adults in the building feel comfortable asking for help and/or to take a break. Providing contact information and encouraging staff to meet their own mental health needs is an important first step in ensuring that staff are adequately supported.

Grief. Understanding the nature of grief can help us better cope with loss. Grief is a natural, healthy process that enables us to recover from terrible emotional wounds. Grief can affect our thinking, behavior, emotions, relationships, and health. People may experience sleeplessness, exhaustion, indigestion, lack of appetite, or memory lapses. Recognizing that these are common reactions to grief can help us minimize them by reaching out to friends, or joining a community support group.

The journey through grief has four phases:

- Shock – In the days and weeks immediately following a devastating loss, common feelings include numbness and unreality, like being trapped in a bad dream.
- Reality – As the fact of the loss takes hold, deep sorrow sets in, accompanied by weeping and other forms of emotional release. Loneliness and depression may also occur.
- Reaction – Anger, brought on by feelings of abandonment and helplessness, may be directed toward family, friends, doctors, and the one who died or deserted us. Other typical feelings include listlessness, apathy, and guilt over perceived failures or unresolved personal issues.
- Recovery – Finally, there is a gradual, almost imperceptible return to normalcy. This is a time of adjustment to the new circumstances in life.

These phases vary in duration for each person, so the school should not impose a timetable upon anyone. Some people need a year or two, while others may take less time. Holidays, anniversaries, and birthdays can trigger intense grief, especially the first year. Everyone grieves differently – depending on personality, religious beliefs, maturity, emotional stability, and cultural traditions.

The following steps should be implemented after a **mental health crisis** has happened:

- Treat every threat with seriousness and approach with a calm manner, make the student a priority;
- Listen actively and non-judgmental to the student. Let the student express his or her feelings;

- Acknowledge the feelings and do not argue with the student;
- Offer hope and let the student know they are safe and that help is provided. Do not promise confidentiality or cause stress;
- Keep close contact with the parents/guardians/caregivers and mental health professionals working with the student.

The following steps shall be implemented upon **re-entry to school after a suicide attempt**:

- Obtain a written release of information signed by parents/guardians/caregivers and providers;
- Confer with student and parents/guardians/caregivers about any specific requests on how to handle the situation;
- Inform the student's teachers about possible days of absences;
- Allow accommodations for student to make up work (be understanding that missed assignments may add stress to student);
- Mental health professionals or trusted staff members should maintain ongoing contact to monitor student's actions and mood;
- Work with parents/guardians/caregivers to involve the student in an aftercare plan.

11. Resources for Parents, Students and Staff Members on Suicide Prevention:

- **Parents as Partners: A Suicide Prevention Guide for Parents** is a booklet that contains useful information for parents/guardians/caregivers who are concerned that their children may be at risk for suicide. It is available from Suicide Awareness Voices of Education (SAVE). See the SAVE Web page at <https://www.save.org/product/parents-as-partners/>
- **Sources of Strength:** <https://sourcesofstrength.org>
- **Know the Signs:** <http://www.suicideispreventable.org>
- **National Mental Health and Suicide Support Services:** The following are just a few places you can access listings for local mental health services in your area. Please call or visit their websites for details.
- **National Suicide Prevention Lifeline:** 1 (800) 273-TALK (800-273-8255)
- **Mental Health America (MHA):** www.mentalhealthamerica.net 1-800-969-6642
- **Mental Health Services Locator:** www.mentalhealth.samhsa.gov/databases
- **American Foundation for Suicide Prevention** www.afsp.org
- **American Association for Suicide Prevention** www.suicidology.org

- **Center for Disease Control & Prevention** www.cdc.gov/ViolencePrevention/suicide
- **Healthy Place** - www.healthyplace.com
- **Jed Foundation** - www.jedfoundation.org
- **National Federation of Families for Children's Mental Health** www.ffcmh.org
- **National Alliance on Mental Illness (NAMI)** www.nami.org 1-800-950-NAMI (6264)
- **The Trevor Lifeline** - www.thetrevorproject.org 1-866-488-7386
- **National Institute of Mental Health (NIMH)** - www.nimh.nih.gov
- **Strength of US-** www.strengthofus.org
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** www.samhsa.gov/prevention/suicide.aspx
- **Suicide Awareness Voices of Education (SAVE)** www.save.org
- **Suicide Prevention Action Network USA** - www.spanusa.org
- **Suicide Prevention Resource Center (SPRC)** - www.sprc.org

Book Resources for Parents: Mental Health and Resilience

- Beardslee, William. *Out of the Darkened Room: When a Parent is Depressed: Protecting the Children and Strengthening the Family.* 2002.
- Rapee, Ronald et al. *Helping your anxious child: A step by step guide.* 2000.
- Manassis, Katharina & Levac, Anne Marie. *Helping your teenager beat depression: A problem-solving approach for families.* 2004.
- Lezine, DeQuincy and Brent, David. *Eight Stories Up: An Adolescent Chooses Hope over Suicide.* 2008.
- Bourne, Edward. *The Anxiety & Phobia Workbook.* 2005.
- Riera, Michael. *Uncommon Sense for Parents with Teenagers.* 2004.
- Phelan, Thomas. *Surviving Your Adolescents: How to Manage and Let Go of Your 13-18 year olds.* 1998.
- Sachs, Brad. *The Good Enough Child: How to Have an Imperfect Family and Be Totally Satisfied.* 2001.
- Apter, Terri. *The Confident Child: Raising Children to Believe in Themselves.* 1997.
- **Book Resources for Teens: Mental Health and Resilience**

- Hipp, Earl. *Fighting Invisible Tigers: A Stress Management Guide for Teens*. 2008.
- Fox, Annie. *Too Stressed to Think? A Teen Guide to Staying Sane When Life Makes You Crazy*. 2005
- Seaward, Brian. *Hot Stones and Funny Bones: Teens Helping Teens Cope with Stress and Anger*. 2002.
- Espeland, Pamela. *Life Lists for Teens: Tips, Steps, Hints, and How-To's for Growing Up, Getting Along, Learning, and Having Fun*. 2003.
- Covey, Sean. *The 7 Habits of Highly Effective Teens*. 1998.
- Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide*
- Andrew Slaby and Lili Frank Garfinkle, *No One Saw My Pain: Why Teens Kill Themselves*
- Beverly Cobain and Jean Larch, *Dying to Be Free: A Healing Guide for Families after a Suicide*
- Linda H. Kilburn, *Reaching Out After Suicide: What's Helpful and What's Not*
- Judith Herman, *Trauma and Recovery: The Aftermath of Violence—from Domestic Abuse to Political Terror*
- Laura Van Dernoot Lipsky and Connie Burk, *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*
- Pema Chodron, *The Places that Scare You: A Guide to Fearlessness in Difficult Times*
- Pete Walker, *The Tao of fully feeling: Harvesting forgiveness out of blame.*
- Peter A. Levine, *Waking the Tiger: Healing Trauma*