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South Dakota K-12 Schools Guide to Prevent Suicide Toolkit (GPS-T)

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About the Authors

Scott Poland, Ed.D.

I am currently a professor at Nova Southeastern University's College of Psychology in Fort Lauderdale, Florida and the director of NSU's Office of Suicide and Violence Prevention. I worked in schools as a psychologist and a director of psychological services for twenty-six years and am still very involved in school crisis response and consultation. I have recently provided on-site assistance after suicides in many school districts across the nation. As a survivor of my father's suicide, I am an example of those who never believed a suicide could happen in their own family.

After being promoted to Director of Psychological services in Cypress-Fairbanks ISD in Houston, Texas and facing the suicides of several students, I became dedicated to suicide prevention. In 1982, the district superintendent asked me what I was going to do about student suicides in our district. At the time, I answered that I did not know and quickly began my research and specialized training. I was figuring out how to prevent youth suicide which has been my highest professional priority ever since. I have presented more than 2,000 times on the topics of school crisis and suicide intervention.

I am a licensed psychologist and an internationally recognized expert on youth suicide and school crisis. I have authored or co-authored eight books on the subject. My first book, Suicide in Schools, published in 1989, was translated into several languages and has been cited as a pioneer work for suicide and schools. Additionally, my partner Donna, who is a former educator and school principal, and myself have authored the Suicide Safer Schools Plan for the state of Texas as well as the Montana Crisis Action School Toolkit on Suicide, the Maryland Plan for Suicide and the Florida STEPS (School Toolkit for K-12 Educators to Prevent Suicide).

I am a past president of the National Association of School Psychologists and a past director of the Prevention Division of the American Association of Suicidology. I testified about the mental health needs of children before the U.S. Congress on four occasions and have personally assisted school communities after seventeen school shootings and after acts of terrorism, natural disasters, and numerous suicide clusters. Most recently, I provided suicide prevention training that was attended by personnel representing every school district in Florida. Additionally, as a first responder in providing psychological strategic planning and training for impacted staff and parents immediately after the Parkland shootings, I received the "Helping Parkland Heal Award" from the city of Parkland. I also received the Houston Wage Peace Award, the American Psychological Association Jack Bardon Career Service Award in School Psychology and was previously named the most outstanding psychologist in Texas. I believe strongly that schools have a very important role in youth suicide prevention in partnership with parents, community, county, and state prevention resources.

Donna Poland, Ph.D.

I was a professional educator for 37 years of which 27 years were in public schools in the great state of Texas where everything is BIG! Imagine my surprise as a first-year teacher, when I discovered that my middle school classes averaged 30+ students and I had six classes each day! I very quickly discovered that I needed to get to know my students and build a respectful and nurturing environment before I could even consider teaching the curriculum. Having that vital connection with each student was the reason I walked joyfully into the building every day.

After 17 years in the classroom, I began my administrative journey as a director of instruction, an at-risk coordinator, an associate principal, and finally a principal. Immediately upon taking a leadership role, I was faced with the tragedy of a scholar athlete taking his life by suicide just days before he was due to enter 9th grade and at that time there was not a toolkit to follow. I felt a lot of responsibility to provide leadership and support to the affected school community and relied on the school mental health personnel to guide me, as the principal. I also encouraged and provided extensive support for the school crisis team members who were on the front-line for affected staff and students. I would like to say it was the only student suicide I experienced. Unfortunately, there were many situations that required working with parents, staff, and children in the aftermath of death by suicide, accidental death, and survivor impact on the death of a loved one or classmate.

The next ten years (at a small private college preparatory school in Florida) I continued to need the skills for developing programs, educating staff, and working with parents regarding the signs of depression and suicide. After experiencing a death by suicide, especially of a young person, one never forgets the details of a life ended too soon and the haunting questions of: what did we not see, what could we have done? Suicide prevention, intervention, and postvention in schools require planning and a team response. I found partnering with the school mental health professionals at my schools is essential.

Suicide prevention information, unfortunately, is not always a part of training to become a principal, but it is immensely essential training for administrators. Please know and follow the suicide prevention policies in your school district and review the South Dakota suicide prevention training requirements for districts. Work with your school mental health professionals (SMHPs) to ensure that training for staff takes place. It is also important to review the school suicide prevention policies with key staff members every year. School staff need to work as a team when a student is suspected of being at-risk for suicide.

I hope the information contained in this toolkit will help you in your work with all students and those at-risk for suicide.

Introduction

The South Dakota K-12 School Guide to Prevent Suicide Toolkit (GPS-T) was based on Dr. Scott Poland's pioneer work on suicide prevention over more than forty years and Dr. Donna Poland's many years as a teacher and school administrator. They are very grateful for all the input provided to them by South Dakota educators. The GPS-T has four main sections: prevention, intervention, postvention and the toolkit. The fourth section will provide many practical tools that will guide you through each process of assisting students, parents, staff, and the community in the event of a suicide crisis. Collaboration between school personnel, parents and community, and national suicide prevention resources is at the very foundation of suicide prevention in the schools.

This toolkit is designed to ***enhance***, **not to replace**, existing school procedures in SD and educators may modify the tools provided to best meet their school needs. In various places in the toolkit the term SMHP is used to designate school counselors, school psychologists and school social workers.

The term suicide screening will be used frequently, and the reader may wonder why the term suicide assessment is not used. Scott Poland used the term suicide assessment in his early writings but his career in schools has led him to believe a better term is suicide screening. SMHPs are spread thin in schools and rarely does the ratio of the SMHP approach the recommended level from their professional associations. Also, SMHPs have multiple non-mental health roles that take up much of their time. They have a very important role in identifying the suicide risk level of students which is primarily to determine the needed immediate supervision for student safety. ***The parents of a student suspected of being at-risk for suicide must be notified unless abuse of their child is suspected.*** If abuse is suspected, the South Dakota Social Services Division of Child Protective Services must be called.

The parents of a student suspected of being at-risk for suicide must be notified unless abuse of their child is suspected.

A current national issue of concern is the influence of social media on youth. The previous U.S. Surgeon General released an advisory titled, *Social Media and Youth Mental Health* that emphasized excessive screen time and social media usage is associated with numerous mental health issues for youth that includes loneliness, anxiety and depression (U.S. Department of Health and Human Services, Office of the Surgeon General 2023). Screen time is also associated with sleep deprivation. Proper rest is at the foundation of well-being for youth. **Tool 14** provides information about the relationship between social media and youth depression and suicide. Social media can be a source of prevention resources, connection, and support for suicidal students, but also can be a source of incorrect

information, and even encouragement to die by suicide. Also, unfortunately, many unsafe messages about suicide are often posted after a suicide.

Miller (2021) as well as many chapters and books that Scott Poland authored and co-authored made the additional following key points about youth depression and suicide prevention:

- Untreated or undertreated mental illness is at the foundation of many youth suicides often in combination with adverse childhood experiences.
- Depression is often a major factor in the suicide of a youth.
- Depression is among the most treatable of all mood disorders. More than three-fourths of people with depression respond positively to treatment.
- The best way to prevent suicide is through early detection, diagnosis, and treatment of depression and other mental disorders, including addictions.
- Suicide is preventable and there are evidenced-based treatment options for all forms of mental illness.
- Research has found that talking with youth about suicide does not cause them to think of suicide and in fact provides the opportunity for them to relieve anxiety and unburden themselves.
- Major protective factors against youth suicide identified by the World Health Organization are the following: stable families, positive connections at school, good connections with other youth, religious involvement, lack of access to lethal weapons, access to mental health care, problem solving skills and awareness of crisis hotline resources.
- It is recognized that many cultural issues may impact the implementation of this toolkit in SD especially in the areas of intervention and postvention.

GPS-T Sections:

Overview

All South Dakota K-12 educators are dedicated to preventing the suicide of a student. South Dakota K-12 public school districts and private schools may vary in their prevention resources and intervention plans. The larger school districts and larger private schools may already have many of the tools that can be found in this toolkit. However, many smaller school districts or smaller private schools may not have implemented detailed plans for suicide prevention. This toolkit is not intended to replace existing suicide prevention plans and efforts but only to enhance them. South Dakota schools are encouraged to utilize the tools in any way that will be helpful to them.

We are indebted to the South Dakota Department of Education who saw a need for this toolkit. South Dakota has a Helpline Center, and we believe it is essential that all youth be aware of the 988 number to call, text, or chat if they or a friend is thinking of suicide. The Helpline Center is a nonprofit organization serving the entire state of South Dakota. The Helpline Center can be reached by calling 988 or 211 and it supports schools across the state with a variety of services focusing on mental health and suicide prevention trainings. The 988 number is answered by the Helpline Center and available 24/7 for anyone to call, text or chat about mental health concerns. In addition, the Helpline Center supports schools by sponsoring Hope Squads, a peer-based model that connects students to help and hope. Schools that are interested in implementing a Hope Squad can reach out to the Helpline Center at hopesquad@helplinecenter.org. The Helpline Center works with schools to plan, implement, and support Hope Squads. If a child has attempted suicide by ingesting substances, then educators and parents need to know how to contact the Poison Control for South Dakota at 1-800-222-1222. Poison Control is available 24 hours a day.

We are also grateful to all the individuals who provided their time for interviews. The common theme for all interviews was the shortage of school mental health professionals (SMPHs) in the state primarily as a result of limited funding. Interviewees also shared the importance of all educators being on the same page and following best practices for suicide prevention, intervention and postvention. Interviewees also noted the importance of supporting those with higher risk and a high rate of suicidal behavior. There was also concern about the number of unsecured firearms in the homes of many students. The lack of available community-based mental health services and stigma about receiving those services were cited as barriers to at-risk students receiving needed community-based mental health services. It was noted that there are only eleven community mental health centers to serve the sixty-six counties in the state. It was also noted that students often must wait to receive community-based mental health treatment. Accomplishments for youth suicide prevention in SD cited during interviews were the legislative requirements for suicide prevention in schools, the implementation of the peer prevention programs Hope Squads and Natural Helpers, many school personnel received PREPaRE training from the National Association of School Psychologists (NASP), and a wealth of state resources and guides available to assist SD schools. Additionally, it was noted that suicide prevention professional development opportunities have increased. It was also suggested that those professional development opportunities provide time for

attendees to share information about their suicide prevention, intervention, postvention challenges, and their accomplishments. The NASP PREPaRE training in particular was cited as providing schools a framework to respond to a crisis. Numerous concerns were noted about the challenge of responding to a suicide and the need for a postvention checklist and a script for schools to follow to implement a best practices response. Interviewees also highlighted concerns about the suicide rate for two specific groups, Native Americans and farmers. A key recommendation stressed in all interviews was the importance of early detection of students at-risk for suicide and that all students need a go-to-trusted adult at school.

In 2024, suicide was the 2nd leading cause of death among youth ages 10-19 in South Dakota, according to SD Department of Health data, and we recommend that information about the warning signs of suicide and crisis resources be posted on the school district website. A template for the website page is provided in **Tool 21**. We know that responding to school tragedies takes its toll on educators and we have provided **Tool 22** to emphasize the importance of **Caring for the Educator Caregiver**.

Resources:

Goals of the South Dakota GPS Toolkit

Goal 1: The GPS Toolkit provides many tools for schools to utilize to enhance comprehensive suicide prevention, intervention, and postvention programs.

A best practices model for suicide prevention was released jointly by national professional associations with dedication to suicide prevention of which Scott Poland was a key advisor in the development of the model. Access the Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources on the High School Toolkit for Preventing Suicide webpage of the SD Suicide Prevention website. Additionally, according to the Substance Abuse and Mental Health Association (2012), the components of a comprehensive school suicide prevention program are prevention, intervention, and postvention. The South Dakota GPS Toolkit carefully follows these best practices and provides schools guidance on all components of suicide prevention, intervention, and postvention.

Postvention refers to the necessary steps after suicide to help all who have been affected emotionally. The postvention section also includes actions needed to prevent additional suicides. The GPS Toolkit provides many tools and forms for school personnel to screen for suicide risk, notify parents, make referrals to outside professionals who are competent in suicide risk assessment and management, and provides re-entry guidelines for any student who was hospitalized for suicidal behavior. It also provides a checklist and procedures for the postvention process.

Goal 2: The GPS Toolkit was developed to meet the unique needs of South Dakota schools.

Many South Dakota school districts already have extensive procedures, guidelines, and even toolkits in place for suicide prevention, intervention, and postvention. However, some school districts might be developing or refining suicide prevention procedures. The GPS Toolkit will not only provide a comprehensive model of suicide prevention, but also includes additional information on suicide related behaviors, important considerations for suicide prevention, postvention Q & A, and many tools that include risk screening, safety planning, and parent notification forms to assist schools in taking action to prevent youth suicide.

School administrators and mental health professionals are the key to increasing suicide prevention efforts in schools. School districts are encouraged to form a task force on suicide prevention while partnering with local community and state resources to promote collaboration for suicide prevention. The GPS Toolkit outlines key leadership steps for school administrators to implement a comprehensive suicide prevention, intervention, and postvention program in schools.

Goals of the GPS-T:

Goal 1: Provides many tools for schools to utilize to enhance comprehensive suicide prevention, intervention, and postvention programs.

Goal 2: Meets the unique needs of South Dakota schools.

Goal 3: Provides the most up to date information on South Dakota legislative requirements and statistics on youth suicidal behavior.

Goal 4: Promotes collaboration between schools and local and state prevention resources.

Positive results for prevention are founded on recognizing mental health issues for students, providing mental health services, and developing a sense of belonging within the school for each student (Erbacher et al., 2024). The GPS Toolkit provides strategies for dispelling myths about suicide, increasing knowledge about suicide warning signs, prevention resources, and empowering everyone to take action to prevent suicide.

Goal 3: The GPS Toolkit provides the most up to date information on South Dakota legislative requirements and statistics on youth suicidal behavior.

The state is to be complimented for mandating suicide prevention in schools. The requirements for South Dakota schools will be spelled out in the legislative section. South Dakota schools, at a minimum, must implement the suicide prevention legislative requirements. It is also very important for schools to continue to be updated on the most recent statistics about the incidence of youth suicide both nationally and in the state. South Dakota statistics can be found through the Youth Risk and Behavior Surveillance Survey (YRBSS), which comes out every other year. The most recent YRBSS data in the toolkit is from 2023, and school personnel are encouraged to be on the lookout for the 2025 YRBSS data that likely will be released by the CDC in late 2026.

Goal 4: The GSP Toolkit promotes collaboration between schools and local and state prevention resources.

Schools are strongly encouraged to communicate with each other and local and state prevention agencies and coalitions about their accomplishments and challenges. The GPS Toolkit provides **Tool 20**, for Data Collection for schools to document the suicidal behavior of students and actions for student safety taken by school personnel. Documentation is important to help local and state leaders understand the scope of the problem of youth suicide and to ensure there are follow-up services for students at risk of suicide. **Tool 20** provides a means for school districts to annually document the following:

- The number of students reporting suicidal ideation.
- The number of students who made a suicide attempt.
- The number of students who were referred to community mental health providers.
- The number of students whose family allowed record sharing between the school and community mental health providers.
- The number of students who were hospitalized for suicidal behavior.
- The number of re-entry meetings held at school for suicidal students who were hospitalized.
- The number of suicide safety plans developed jointly with suicidal students by school personnel.
- The number of parents notified of the suicidal behavior of their child.
- The number of student deaths by suicide.

Recognition
of the South Dakotans Interviewed

We are deeply appreciative of the insights from everyone that was interviewed and have included many of their thoughts and recommendations in this toolkit. We are especially thankful to many staff members from the South Dakota Departments of Education, Health, and Social Services, the South Dakota School Safety Center, and the Helpline Center who saw the need and worked tirelessly to develop this toolkit. We are very grateful to many individuals and especially the following individuals who were interviewed prior to developing the GPS-Toolkit.

- Brett Garland, Executive Director of the South Dakota School Safety Program
- Vanessa Barnes, Assistant Director, Office of Prevention and Crisis Services of the South Dakota Division of Behavioral Health within Department of Social Services
- Jordan Mounga, Program Manager, Suicide Prevention & Crisis Services of the South Dakota Division of Behavioral Health within Department of Social Services
- Tracy Naughton, Suicide Prevention Program Specialist of the South Dakota Division of Behavioral Health within Department of Social Services
- Ally Gross, Injury Prevention Coordinator for the South Dakota Office of Injury, Violence and Overdose Prevention within Department of Health
- Janet Kittams, Director and CEO of the South Dakota Helpline Center
- Andrea Effling, School Counseling & Student Support Administrator of the South Dakota Department of Education
- Kari Oyen, School Psychology Program Director of the University of South Dakota
- Kari Lena-Helling, Middle School and High School Counselor and South Dakota School Counselor Association Board Member

Key South Dakota Resources

The following resources are available to guide and assist South Dakota educators for suicide prevention, intervention and postvention:

South Dakota Helpline Center
helplinecenter.org

South Dakota School Crisis Prevention and Resource Hub
sites.google.com/usd.edu/south-dakota-school-crisis/home

South Dakota Behavioral Health School and Educator Toolkit
sdbehavioralhealth.gov/schooltoolkit

South Dakota Behavioral Health Youth and Parents Page on their Suicide Prevention
sdsuicideprevention.org/risks/populations/youth-and-parents

South Dakota High School Suicide Prevention Toolkit on Suicide Prevention Website
sdsuicideprevention.org/action/outreach-toolkits/high-school-toolkit

South Dakota Behavioral Health Free Materials and Suicide Prevention Trainings for schools
sdsuicideprevention.org/action/order-prevention-resources
sdsuicideprevention.org/action/training

South Dakota Behavioral Health Secure Storage
sdsuicideprevention.org/help/secure-storage

South Dakota School Safety Center
safe2say.sd.gov/schoolsafety.aspx

South Dakota Department of Education Mental Health
doe.sd.gov/mentalhealth

South Dakota Department of Education Youth Suicide Awareness & Prevention Training
doe.sd.gov/suicideprevention

The foundation of suicide is often untreated or an under-treated mental illness. Poland and Ferguson (2025) stressed that other major factors in youth suicide are adverse childhood experiences often referred to as ACES. The most significant ACES are the death of a parent, rejection from a parent, living in poverty, being the victim of bullying, being the victim of abuse, and living with a mentally ill or a substance abusing parent. There is considerable concern about the mental health of our youth. The previous U.S. Surgeon General released an advisory titled, Protecting the Mental Health of Our Youth which made recommendations for caregivers, communities, schools, and students (U.S. Department of Health and Human Services, Office of the Surgeon General 2021). The advisory emphasized that we must seize the moment to improve the mental health of our youth, and it was followed with an advisory titled, Social Media and Youth Mental Health (U.S. Department of Health and Human Services, Office of the Surgeon General 2023). **Tool 12** Social Media provides practical guidance for school personnel on social media with regards to suicide. Suicide rates have increased, and everyone needs to know how to get help for themselves or someone else who is suicidal. It is important to state that suicide is not inherited, nor is it anyone's fate or destiny. Suicide has been described as a wicked

problem and must be addressed from many avenues. Slight increases in protective factors and slight decreases in risk factors will save lives (Bryan, 2021). There are evidence-based treatments for all types of mental illness, but many barriers to obtaining the needed treatment for suicidal youth still exist including lack of insurance. Additionally, any cultural issues impact whether community-based treatments are received by a suicidal youth and unfortunately, there is still stigma attached to obtaining mental health treatment.

The K-12 Schools' South Dakota Guide to Prevent Suicide Toolkit (GPS-T) has been designed to assist schools with suicide prevention, intervention, and postvention. We recognize that many South Dakota schools, public or private, have highly developed procedures and this toolkit is provided to enhance the existing procedures. Our experience has been that schools appreciate being provided with practical tools that they can utilize. School personnel have our permission to utilize anything in the toolkit to aid their important work. It is anticipated that the toolkit will provide the most information for school administrators and school mental health professionals (SMHPs). We use the term SMHP to include school counselors, social workers, and school psychologists but school nurses also have a very important role in youth suicide prevention.

It is important to keep up to date with South Dakota legislative requirements for K-12 schools and the Youth Risk Behavior Surveillance Data for South Dakota. The most current information for both is provided in the toolkit. It is critical for schools to keep up with the most updated suicide incidence data, legislation initiatives, and trends for youth suicide. The state is to be commended for having legislative requirements in place for schools on suicide prevention. Additionally, social media is utilized by most youth, and because of this connection, social media provides an opportunity for safe messaging for suicide prevention.

Collaboration between schools, community, and state suicide prevention resources are at the very foundation of suicide prevention in the schools. The South Dakota GPS-Toolkit is intended to act as a step-by-step guide for all school personnel on suicide prevention, intervention, and postvention. It is important to remember that suicide prevention is an ongoing process that requires teamwork, and school partnership with local, county, and state prevention resources.

Incidence of Suicide Nationally and in South Dakota

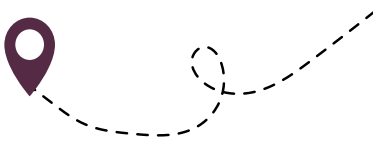
Suicides in the United States slightly declined for 2024, according to data from the CDC, with over 48,800 suicide deaths and a rate of 13.7 per 100,000 people. Suicide rates were the highest for white males and lowest for black females. In 2024, suicide was the 10th leading cause of death for all Americans (Centers for Disease Control and Prevention, CDC, 2025). For 2024, South Dakota was ranked 8th highest in the nation and had an age adjusted rate of 22 per 100,000 (CDC, 2025). Suicide is rare for elementary age children but SMHPs around the world have shared with Scott Poland that increasing numbers of elementary age children are threatening suicide and each threat must be taken seriously. Suicide is the second leading cause of death for the middle school age group and the third leading cause of death for the high school age group (CDC, 2025). According to the South Dakota Department of Health, suicide was the 2nd leading cause of death among South Dakota youth ages 10-19 in 2024.

National data on youth suicidal thoughts and actions has been gathered through the Youth Risk Behavior Surveillance Survey (YRBSS), for over thirty years by the Centers for Disease Control. The YRBSS gathers information about high school students regarding suicide behaviors. The latest YRBSS national survey is from 2023, which reported that nationwide 20.0 % of high school students seriously considered attempting suicide. 16.0% made a plan to die by suicide and 9.0% made one or more attempts in the past 12 months (Centers for Disease Control and Prevention, CDC, 2024). South Dakota participated in the YRBS survey. The data for high school students for 2023 found 17.1% of South Dakota high school students seriously considered attempting suicide, 15.2% made a plan to die by suicide, and 8.4% made one or more attempts in the past 12 months. South Dakota high school data from 2013 to 2023 found a slight decrease in attempts reported but a slight increase in the number of students who considered suicide and made a plan to die by suicide.

The YRBSS is the best state and national snapshot of high school students' at-risk behavior. The survey is inclusive of bullying, physical fights, school safety, alcohol, drug abuse, carrying a weapon to school, and many other at-risk behaviors. It is critical that South Dakota schools continue to participate in the Youth Risk Behavior Survey from the CDC. A few states also survey middle school students using the YRBSS and the data about suicide is equally concerning. However, middle school students are asked the questions over their lifetime rather than just the last twelve months.

All readers of this toolkit are encouraged to keep up with the latest YRBSS data which can be found at the website for the South Dakota Department of Health.

Data for youth can also be found on the South Dakota Suicide Prevention (SDSP) Prevention Data webpage.



South Dakota Legislation

South Dakota is to be complimented for being one of approximately 20 states that passed legislation addressing suicide prevention in schools. Legislative mandates and recommendations are essential in expanding suicide prevention in schools. School personnel need to implement legislative requirements and be proactive in informing legislators on the scope and trends for youth suicide. School personnel must also stay abreast of new legislative initiatives that address student mental health and suicide prevention.

The specific legislation in South Dakota at this time is **Codified Law 13-42-71 South Dakota Legislature Suicide Awareness and Prevention Training--Board approval--Requirements**. Prior to beginning employment at a school district or department-accredited school and every five years thereafter, an individual certified pursuant to this chapter and employed by a school district or department-accredited school must complete an approved youth suicide awareness and prevention training that is at least one hour in duration and the individual shall submit a certificate showing completion of the approved training to the school district or department-accredited school where the individual is employed. The school district or department-accredited school shall retain the certificates submitted as a part of the documentation necessary to earn or maintain state accreditation. Visit the South Dakota Department of Education's Youth Suicide Awareness and Prevention Training webpage to view trainings approved by the South Dakota Board of Education Standards to meet this training requirement.

The South Dakota State Department of Education at this time does not recommend a specific suicide screening instrument for schools to use. It is left up to the local education agency to determine which screening instruments to use. Scott Poland has been involved in numerous legal cases where schools were sued after a suicide and an issue in a few of those cases has been whether the SMHP utilized a standardized and/or a well- known screening instrument. This toolkit recommends the following screening instruments as they are well-known and researched: The Columbia Suicide Severity Rating Scale **Tool 2**, and the Suicide Assessment Five-Step Evaluation and Triage from SAMHSA **Tool 3**. South Dakota school staff members are encouraged to continually review their state recommendations for recommended screening instruments and suicide prevention programs.

Key Terms and Concepts

Died by Suicide: Many individuals know someone who died by suicide. The term "died by" is much more acceptable to survivors than the word "committed", as it takes the emphasis away from the suicide sounding like a criminal act. It is our hope that school personnel around the world will remember to use the term "died by suicide" and to also encourage others to avoid the term "committed".

Survivor of Suicide: This is a term referring to an individual who lost a loved one to suicide. The term does not refer to an individual who survived their suicide attempt. The grief of losing a loved one to suicide is very complicated. Becoming involved in suicide prevention efforts has provided meaning for many survivors. Many of the suicide prevention initiatives around the world are driven by suicide survivors as they do not want it to happen to anyone else's loved one.

Suicidal Ideation: This is referring to an individual who is having active thoughts of wanting to kill themselves without a plan.

Suicide Plan: This is referring to an individual who has planned how they will kill themselves.

Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with an intent to die. This means the suicide attempt may or may not have resulted in injury, but the attempt was intentional.

Suicide Postvention: The planned actions in the aftermath of a suicide. The purpose is to process feelings, concerns, and anticipated actions of those who have been impacted by the suicide. This is to prevent further suicides and to help all concerned with their emotions such as shock, grief, confusion and even guilt.

Suicide Contagion/Suicide Clusters: Adolescents are the most susceptible to imitating suicide. Contagion is a very real concern after a youth suicide and many schools in the U.S. have experienced suicide clusters. Suicide clusters are when multiple suicides have occurred in a short space of time in a confined geographic region.

SI: Self-injury is referred to when an individual is engaging in superficial and harmful behaviors such as cutting, burning, scratching, and not letting wounds heal, but without intent to die by suicide. SI is utilized by students to release endorphins and to regulate emotions. There is considerable evidence that some young people with a long history of engaging in SI who have used multiple methods of self-injury and experienced little pain with their SI are at high risk for attempting suicide. Joiner (2011) emphasized that individuals engaging in SI often become comfortable harming their body and used the term "habituating." SMHPs should not hesitate to ask those students known to be engaging in SI about suicidal thoughts and plans (Lieberman & Poland 2006; Erbacher et al., 2023).

Bullying and Suicide: A student known to be a victim of bullying should be asked about hopelessness and thoughts of suicide. There is a strong associative relationship between bullying and suicide (Poland & Lieberman 2018). In recent years there have been several lawsuits filed by parents against schools after the suicide of their child. Numerous lawsuits brought by parents of the suicide victim charged that bullying at school was a proximal cause of the suicide of their child. Poland and Hall (2023) discussed that many of these suits were settled out of court, and they were not aware of a bullying and suicide lawsuit where a jury awarded damages to the parents of the suicide victim. If a school district settles a legal case out of court, it is not an admission of wrongdoing. Scott Poland has been an expert witness many times when schools were sued after a suicide and recommends in his trainings that a student who is the victim of bullying be screened for suicide.

Top Things School Mental Health Personnel Can Do to Prevent Youth Suicide

It is important to be aware that **schools cannot provide all the needed treatment for suicidal students**.

The following ten recommendations for school mental health professionals for suicide prevention were made by Poland, Lieberman and Niznik (2019).

1. Be the advocate for suicide prevention and help bring your district into compliance with any relevant laws.
2. Review model policies such as the Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources on the SD Suicide Prevention Resources for Educators webpage to reevaluate your school policies, procedures, and determine if additional strategies are necessary for suicide prevention, intervention, and postvention.
3. Provide suicide prevention training annually for all school staff who have direct contact with students.
4. Review all the high-quality suicide and crisis resources from your professional associations.
5. Make a commitment to staying current in the field of youth suicide prevention by attending professional conferences.
6. Seek input from the suicide prevention advocates in your country or state.
7. Review resources from the South Dakota Suicide Prevention website.
8. Subscribe to the South Dakota Suicide Prevention quarterly newsletter.
9. Prepare for suicide postvention by accessing resources found on the High School Toolkit for Preventing Suicide page on the SD Suicide Prevention website.
10. Advocate for increased suicide prevention efforts.

Best practices emphasize that a school's responsibility when a student is suspected of being a-risk for suicide is to:

- Screen the student for suicide risk.
- Develop a written safety plan jointly with the student.
- Notify their parents or caregiver and recognize that the single issue that has most often resulted in civil lawsuits finding schools responsible after a youth suicide was when school personnel had reason to believe that a student was suicidal but failed to notify the parent/caregiver of the student.
- Make recommendation for increased supervision and safety proofing the home.
- Recommend community-based treatment.
- Request a release to communicate with the community-based mental health professional.
- Provide follow-up support at school.

World Health Organization Recommendations

The World Health Organization (WHO) outlined strategies for preventing youth suicide.

1. **Remove or secure the lethal means,** which very often in the U.S. is a firearm. The Harvard's Means Matter website summarized the research from all around the world and found that removing or securing access to lethal means and increasing barriers on bridges reduced suicide rates. SMHPs are encouraged to have very direct conversations with parents/caregivers about an at-risk student's access to lethal means when there is any reason to suspect suicidal behavior of the student. In the U.S., guns are used in only approximately 5% of suicide attempts nationally, but account for approximately 50% of suicide deaths (Anestis 2018). It is important to know that rarely does anyone survive when they attempt with a gun.

2. **Reduce/eliminate adverse childhood experiences** such as rejection from a parent/caregiver, living in poverty, living with a mentally ill or a substance abusing family member, being physically, emotionally or sexually abused, being the victim of bullying and, experiencing the death of a parent.

3. **Increase education on the warning signs** for everyone and promote that suicide can be prevented. Prevention education was especially stressed for physicians. Estimates are that approximately 2/3 of suicide victims went to see their family doctor shortly before their suicide. It is noteworthy that Scott Poland's father visited with his physician just one week before his suicide. It is important for physicians to become more comfortable with asking their patients about suicidal behavior. Siu and the U.S. Prevention Task Force (2016) recommended that all teens seeing their physician for any reason be screened for depression. If a youth suicide has occurred in the community, no matter the original reason for the office visit, it is essential that physicians screen all teens who come into their office to prevent contagion.

SECTION 1

Suicide Awareness & Prevention

Section 1:
- **Guidelines for developing suicide prevention programs for K-12 schools**
- **Information on suicide awareness and strategies for the prevention of youth suicide**

Section 1 includes guidelines for developing suicide prevention programs for K-12 schools. In addition, it provides information on suicide awareness and strategies for the prevention of youth suicide. Staff development, student training, and information for parents are discussed with specific recommendations for creating awareness and prevention training. Erbacher et al., (2024) identified high-risk groups for youth suicide in the U.S. which include Native Americans, marginalized students, and homeless students, students living in foster care, students with mental illness, students engaging in self-injury, incarcerated youth, and those who lost a loved one by suicide.

The U.S. Substance Abuse and Mental Health Services Association (SAMHSA, 2012) recommended a four-step process for developing suicide prevention programs in schools:

Step 1- Engage administrators, school boards, and other key players who will endorse the programmatic changes in the school. Justify the time it takes to train school personnel and students on suicide prevention. Administrators need to understand the scope of the problem, believe that suicide among our youth is unacceptable, realize that schools are the most logical places for students to be identified, and know that talking about suicide with students will not increase the risk. In short, administrators need to seek training for themselves and provide the leadership necessary to create a culture of suicide awareness and prevention.

4-Step Process:
Developing suicide prevention programs

STEP 1: Engage key players

STEP 2: Start planning process

STEP 3: Provide information to key players

STEP 4: Develop strategy

Step 2- Bring personnel together to start the planning process and form a suicide prevention task force. Be sure to include the key players that will promote suicide awareness and intervention. In addition to school personnel, it is imperative that key community mental and medical health personnel, suicide prevention coalition members, local clergy, and parent groups be included.

Step 3- Provide all key players and task force members with basic information about youth suicide and suicide prevention. It can be prevented, and everyone plays a role!

Step 4- Develop your school and overall strategy for training staff/students and create a culture of suicide awareness and prevention.

Key Components of a Model Suicide Prevention and Response Policy

It is recommended that each school adopt a suicide prevention policy that addresses prevention, intervention, and postvention. The policy should outline the training that will be provided to staff and students and the programs that will be implemented. It is acknowledged that SD schools vary in their level of having policies and/or suicide prevention plans in place.

A model of suicide awareness, prevention, and response policy can best be developed by creating a suicide prevention task force that includes community members, reviewing local and national models, and being familiar with the best practices and evidenced-based practices for suicide protocols. Scott Poland was a contributor for the Model School District Policy on Suicide Prevention released in 2019, accessible on the SD Suicide Prevention High School Toolkit for Preventing Suicide page, that made the following recommendations:

- All staff should receive a minimum of one hour of training annually on suicide risk factors, warning signs, protective factors, response procedures, referrals and postvention.
- Training should include information on groups of students likely to be at elevated risk for suicide.
- Suicide screening training should be provided for all school mental health professionals (SMHPs).

Lieberman et al., (2014) emphasized that any suicide prevention information provided for staff and students should be selected very carefully and utilize best practices programs. Schools are strongly encouraged to ensure that any videos about suicide are approved by the administration or the curriculum director prior to being shown to staff or students. It is also strongly recommended that any speakers on the topic of suicide be researched carefully and ideally that they have a background in the mental health field. School assemblies on suicide are not recommended due to the dramatic nature of bringing all students together (Lieberman, et al., 2008). Additionally, in an assembly, students will be very unlikely to ask questions, and it will be difficult to monitor their reactions. Suicide prevention is best discussed with students in a classroom setting or even smaller groups with the session led by a SMHP with the teacher present and invested in prevention.

Key Components of a Model Suicide Prevention and Response Policy:

1. Develop the policy using a suicide prevention task force.
2. Task force reviews local and national suicide prevention and response models.
3. Address staff and SMHP training in your policy.
4. Address suicide prevention for students.
5. Address how suicide prevention information is shared out.
6. Address how suicide screening is employed.
7. Outline procedures for parent/caregiver notification if a student is at the slightest risk of suicide.
8. Outline the referral process to community-based mental health providers.
9. Outline re-entry procedures for students after being hospitalized.
10. Create a postvention checklist.

Training Staff on Suicide Awareness

All school staff need annual training on the warning signs of suicide and the process for immediately referring at risk students to the administration and SMHP staff for suicide risk screening. A student thought to be at-risk for suicide needs to be escorted by school staff to the office of the SMHP for a suicide screening. This step is the key for suicide prevention in schools and all school staff at every grade level need prevention and intervention training due to growing concern for suicide of elementary age students. All suicidal statements and behaviors must be taken seriously regardless of the student's age and school staff should never keep a secret about a student's suicidal behavior. Elementary students who make statements about suicide and are often expressing frustration and anger. Hopefully, we can help elementary students to be able to more clearly articulate what it is that is bothering them at the moment. However, if they've made statements about death, dying, and suicide then the school procedures for suicide prevention must be followed. It is also very important throughout the entire elementary school curriculum to reinforce the concept of always getting help from a trusted adult when you or a classmate is talking or thinking about threats of suicide or violence towards others. School personnel must follow through with the school plans and protocols even if the student in question is at the elementary level. Most importantly, notify the parents/caregivers of the student suspected of being suicidal. Ideally, every SD school annually asks every student to identify their go-to-trusted adults both at home and at school. It is vital that all students have a go-to trusted adult and know to go to that adult immediately if a classmate is threatening suicide or homicide. The South Dakota Suicide Prevention website highlights training opportunities for a wide variety of audiences. The Youth Suicide Awareness and Prevention Training webpage on the South Dakota Department of Education's website provides a list of approved trainings for educators to meet the training requirement per SDCL 13-42-71.

Important components of staff suicide prevention training

The recommended categories of training include understanding suicide is preventable, identifying students who are at-risk of suicide, following school procedures, and utilizing "best practice" interventions. Key steps are screening the student for suicide risk, developing a written safety plan jointly with the student, parent/caregiver notification, community referral, and follow-up support. If a student is hospitalized, or missed numerous days of school due to suicide risk, a student re-entry process must be utilized.

Training should be designed to achieve several specific goals related to suicide prevention:

- Convey current statistics, and trends for youth suicide.
- Dispel the myth that suicide is inherited or destiny.
- Emphasize that talking about suicide makes everyone safer and helps a suicidal individual realize they are not the first person to feel this way and that help is available.
- Review protective factors for youth
- Stress the importance of never keeping a secret about a student's suicidal behavior.
- Build a climate with connections between students and trusted adults.
    - Educate school staff about the warning signs of suicide risk.
    - Identify a suicide prevention expert for the school.
        - o Know the school referral procedures.
        - o Know who the suicide prevention expert for the school is.
        - o Know procedures to monitor students at risk of suicide.

- Provide information about suicide prevention resources in your school and community.
- Convey that suicide is almost always preventable and if a student died by suicide it was probably the result of untreated or undertreated mental illness. Emphasize that no one person nor one thing was to blame for a suicide.
- Document understanding suicide prevention and intervention with a pre and post training survey.
- Document staff attendance at suicide prevention and intervention training.
- SMHPs need additional training and should know:
    - o How to implement the suicide screening process.
    - o The importance of parent/caregiver notification of suicide risk.
    - o The importance of referral for community based mental health services.
    - o The community-based mental health personnel that are skilled in suicide risk and assessment.
    - o How to implement strategies for student re-entry to school.
    - o How to implement postvention strategies.
- Administrators serving in the leadership role at the school should also have additional training on communicating with staff in the aftermath of an attempted or completed suicide.

Suicide Prevention Student Training

It is our strong recommendation that all staff be trained in suicide prevention and intervention prior to any suicide prevention presentations to students. School procedures and plans for suicide prevention need to be understood by all school staff. Ideally, it is important to provide training for all secondary students, but **staff must be trained first**. This will ensure that school staff do not keep suicidal behavior a secret and that they follow the school protocols and involve the SMHP. Suicide prevention training helps students understand the warning signs of suicide and the importance of immediately seeking adult help. While there are numerous training modules for staff, there are only a few that are available for the students, especially at the elementary level. View school-based suicide prevention curriculum and programs, such as Signs of Suicide (for 6-12 grade students) on the SD Suicide Prevention Take Action-Professionals webpage.

We are only aware of one program at the elementary level in the U.S. with direct language about depression and suicide for upper elementary aged students and is the program Riding the Wave. Several school districts have shared with us that they were pleased with the Riding the Wave. Districts may utilize the Helpline Center or South Dakota Prevention Resource Centers to access this training. The South Dakota Prevention Resource Centers have Gizmo that can be checked out at no cost. South Dakota educators are encouraged to utilize prevention programs that are recommended by the state.

SECTION 2

Suicide Intervention

Section 2:

- **Screening suicidal students**
  - **Development of safety plans**
  - **Parent/caregiver emergency notifications**
  - **Identification of internal and external resources**
  - **Re-entry guidelines for students returning from a hospital**

Section 2 includes guidelines for screening suicidal students which includes the development of safety plans, parent/caregiver emergency notifications, the identification of internal and external resources, and re-entry guidelines for students returning from a hospital.

If you are looking at this toolkit for the very first time, it is likely that a student at your school is at-risk for suicide, and you are being asked to intervene with the at-risk student. The following Tools will guide you through best practices for suicide intervention in schools when a student is at-risk.

Tool 1: Suicide Risk Report
Tool 2: Brief Screener C-SSRS
Tool 3: SAFE-T
Tool 4: Parent Conference
Tool 5: Parent Notification Form
Tool 6: Suicide Proofing the Home
Tool 7: Safety Plan
Tool 9: Screening Community-based Mental Health Providers
Tool 10: Release of Information Form

Key school mental health professionals (SMHPs), which include school counselors, psychologists and social workers are the most trained and knowledgeable personnel to intervene with students at-risk for suicide. However, it is noted that in a very rural school in SD an administrator, a nurse, or a teacher may need to do the initial suicide screening for a student at-risk of suicide. It is essential that all school personnel believe that a student's suicide can be prevented and understand that everyone, staff, parents/caregivers, and students can play a role in preventing a suicide. Interacting with a student believed to be at-risk for suicide is anxiety provoking for the SMHP or any educator and they should utilize all their counseling and listening skills to support the at-risk student. The educator or SMHP is encouraged to seek collaboration and supervision about the screening while ensuring that the at-risk student is supervised by another school adult. Some school districts may require the suicide screening be done with two school adults in the room. Our experience is that most schools do not have two SMHPs available and that bringing a second school staff member in the room might result in the at-risk student feeling in trouble or reluctant to share their suicidal thoughts and plans. It is important for the student at risk for suicide not to feel that they are in trouble and to know they are not the first student to have suicidal thoughts and to know help is available.

Ideally all SMHPs will have observed a role-play of conducting a suicide screening with students utilizing direct language about suicide. Scott Poland likes to demonstrate in his trainings the process of screening a student for suicide risk, developing a written safety plan for the student, notification to parents/caregivers and referral for community-based mental health services. View Dr. Scott Poland Discusses Suicide Screening in Schools with Role Plays of a Suicide Screening and Parent Notification for a demonstration of screening for suicide risk and parent notification.

The parent or caregiver notification conference may be challenging for SMHPs. An effective parent notification conference that results in a partnership between the school and the parent or caregiver is essential for student safety. Ideally, all SMHPs will have observed a role-play of the parent or caregiver notification and have themselves practiced a role-play of a parent or caregiver notification. **Tool 4** provides guidance on conducting the parent conference.

Most importantly, safety for the student and decreased liability for the school's mental health professional is achieved through collaboration and supervision with other school crisis team members (Lieberman et al., 2008 & 2014). It is also especially important that the school administration be informed when there is a student at risk of suicide. The safety for the student is assured through supervising them through the screening, development of a safety plan, parent/caregiver notification, and referral for community-based mental health services (Erbacher, et al., 2015 & 2024). A student at-risk for suicide needs to be totally supervised by another school adult while the school mental health professional consults with colleagues and/or their direct supervisor. Every step taken for safety should be documented and **Tool 1** provides a suicide risk documentation form. **Tool 9** provides sample questions for the SMHP to ask community-based mental health professionals prior to making a referral for community-based mental health services for the at-risk student.

It is important to note that students are only in school for approximately seven hours a day and only one half the days of the year and school personnel cannot guarantee student safety. Ideally, SMHPs have previously identified community-based mental health professionals to refer a suicidal student to for a comprehensive suicide assessment and treatment in the community. It is acknowledged that community-based mental health resources vary greatly across South Dakota. Poland (1989) emphasized the importance of gathering extensive information from the student about the stress they are facing and asking students directly about suicidal plans with these two very important questions.

- Are you thinking of suicide now?
- If so, how would you end your life?

These questions have been expanded to six questions on the Columbia Suicide Severity Rating Scale. Schools are encouraged to utilize standardized screening and/or well-known instruments. The Columbia Suicide Severity Rating Scale as well as the SAFE-T are included in **Tool 2** and **Tool 3**. Both are free and standardized, and the Columbia has been translated into several languages and has several versions. The brief version of the Columbia, which is **Tool 2** has six questions to emphasize that the role of the school is an initial screening not a comprehensive suicide assessment. The SD Department of Education does not recommend a specific suicide screening instrument for utilization in schools as this is left to district determination. The screening instrument should be utilized primarily to determine the need for **immediate** and **constant supervision** from a school adult until there is a hand off for the at-risk student which transfers responsibility to parents/caregivers, law enforcement or a mobile crisis team.

The screening of a student for suicide risk **should never be rushed**, and the process involves more than the six questions from the Columbia. SMHPs are encouraged to use all of their skills to get as complete a picture possible of the stressors for the student, their suicidal plans, and their coping mechanisms. It is also important to discuss with students who they have turned to for help and some students in distress may have turned to artificial intelligence (AI) for help instead of confiding in peers or trusted adults. It is essential to ask directly about the method the student is thinking of using for a suicide attempt. SMHPs may be reluctant to ask direct questions about the method a student is thinking of using for suicide, but it is an essential component of the screening. The Suicide Prevention Resource Center has an online training module entitled, Counseling Access to Lethal Means available on the South Dakota Suicide Prevention Training webpage.

It is noted that increasing numbers of elementary age students are suicidal and it is especially challenging to screen a young child for suicide risk. The suicide of elementary students can happen, and Scott Poland has led the responses after the suicide of children as young as nine-years-old. SMHPs will need to utilize all their skills and understanding of child developmental levels in conducting a screening for suicide for young children. It is advised with a young child to ask questions like: "Have you thought of going away and never coming back or do you not want to be here anymore?" The challenge of screening students for suicide risk regardless of age is another reason why there should be a referral from the school to a community-based mental health professional for a comprehensive suicide assessment. SMHPs are strongly encouraged to seek supervision and collaboration when screening students for suicide risk. Joiner (2011) emphasized that suicide is the result of a psychological process that takes months but that a precipitating event may cause someone to act on their earlier thought-out suicidal plans. The most common precipitating events to a youth suicide outlined by (Erbacher & Poland 2023) are the following:

- a severe argument with parents.
- a break-up of a relationship.
- severe humiliation.
- severe discipline.

Parent/caregiver notification is not a discretionary duty; it is a mandatory duty with the only exception being if parent/caregiver abuse is suspected of which the proper authorities need to be notified.

Screening instruments provide a basis to classify suicide risk, and it is essential that a student thought to be at either a medium or high-risk level be constantly supervised by a school adult until a transfer of responsibility to parents/caregivers, law enforcement or a mobile crisis team can be made. It is also advisable to constantly supervise a student thought to be at low risk. One recommendation is to always classify the risk level one level higher than your initial determination. It is quite common for a student at risk for suicide to deny being suicidal during the screening process as they want to escape scrutiny from the SMHP. The student may want to avoid their parents being notified and they may be anxious to get out of the SMHPs' office. Scott Poland has discussed suicide screening in schools at length with Dr. Carolyn Stone the author of several books on counselor ethics and law as they have served as legal experts on the same side in several cases. Stone (2026) made the following key points in her most recent book on school counseling ethics and in conversations with Scott Poland:

- The school counselor cannot determine for sure if the student is safe.
- Peer reports must be taken seriously.
- The counselor cannot know if the student is telling them the truth.

- Parent/caregiver notification is not a discretionary duty; it is a **mandatory** duty with the only exception being if parent/caregiver abuse is suspected of which the proper authorities need to be notified.
- The parent/caregiver may deny the seriousness of the risk when they are notified their child is at-risk of suicide.
- Students at-risk for suicide should be referred for community-based mental health services.
- Counselors should seek collaboration and supervision and keep the administration informed when a student is at-risk even if the risk level is believed to be low.

The American School Counselor Association provides the Information-Gathering Tool: Suicide Concern found on the SD Suicide Prevention Resources for Educators webpage for school counselors to utilize for suicide risk screening. School counselors and other SMHPs need to follow best practices for suicide screening for student safety and are often concerned about liability. Poland and Hall (2023) provided an overview of the outcome of legal issues in many lawsuits filed against schools after a student suicide.

The following are recommendations made for SMHPs:

- Maintain individual liability insurance.
- Know and follow district policies and procedures for suicide prevention.
- Seek out supervision and/or consultation from colleagues when screening students for suicide risk.
- Recognize that it is common for a suicidal student to deny being suicidal.
- Take all peer reports of suicide concern for a friend very seriously.
- Always notify caregivers. Notification should be viewed as a mandatory duty, with the only exception being when parents are suspected of being abusive to their child, then the proper state protective services authorities should be notified, which is the SD Department of Social Services (DSS). DSS can be reached by calling 877-244-0864.
- Document notification to parents, regardless of the age of the student.
- Document all steps taken to keep the student safe from suicide, utilize written safety plans developed jointly with the student, insist that parents come to the school for a conference and transfer responsibility for student safety from the school to the parents.
- Make recommendations for increased parental supervision of the child and safety proofing their home as well as a community-based suicide assessment.
- Ensure that the building principal is informed of the suicide risk for a student. In the event the SMHP is absent and the principal is handling the situation, the SMHP should be informed about the student when they return.
- Note that an extreme discipline sequence (i.e., suspension or expulsion) could cause a student to act on suicidal plans and the student should be screened for suicide risk.

Poland and Hall (2023) also cited the case of Szostek versus the Cypress-Fairbanks Independent School District in Texas where a student recommended for expulsion died by suicide the same afternoon that she was removed from school. The school district prevailed in the lawsuit filed by her parents against the school district. However, SMHPs and administrators are encouraged to be alert for precipitating events for a suicide attempt, especially in severe discipline scenarios. It is recommended that a student faced with being expelled from school be immediately screened for suicide risk and provided counseling support.

Timely and Effective Notification for Parent/ Caregiver and Referral

An overview of suggestions for conducting the Parent or Caregiver Notification Conference is provided in **Tool 4**. Notification to the parent or caregiver regardless of the suicide risk level is essential and it is particularly important to consider cultural factors that may impact the reactions of the parent or the caregiver (Miller, 2021). The goal of the **face-to-face** notification conference is to receive a cooperative response and increase safety for the student who is at-risk of suicide. Stone (2017) emphasized that the parent or caregiver will look for reasons to deny the seriousness of the situation and that counselors cannot guarantee the safety of the student.

The school and parent or caregiver needs to partner for the safety of the student and obtain the needed community-based mental health services for the student. The parent or caregiver should be provided a copy of the written safety plan, **Tool 7**. Erbacher et al., (2024) emphasized that school districts have been found liable in civil court after a student suicide when the school had reason to believe the student was suicidal but failed to notify their parents or caregivers. Poland and Hall (2023) discussed the case of Gallagher versus Bader in Virginia where the SMHP was alerted by a peer that Jay Gallagher was suicidal. The SMHP thought that since Jay Gallagher denied being suicidal and he had just turned 18-years-old that his parents did not need to be notified of his possible risk of suicide. His parents filed a lawsuit against Bader the SMHP after the suicide of their son. The case was settled out of court for an undisclosed amount.

The school and parent or caregiver needs to partner for the safety of the student and obtain the needed community-based mental health services for the student.

There is only one exception to parents or caregivers notification and that is if school personnel have reason to believe that the child is being abused, then state protective services need to be notified immediately. The phone number for Child Protective Services in South Dakota is 1-877-244-0864. It is highly recommended that parent or caregiver notification be conducted face-to-face, and the notification documented regardless of the age of the student. Stone (2026), the previous ethics chair for the American School Counselor Association, emphasized that counselors have always known that notification to the parent or caregiver of a student at-risk for suicide is a ministerial and a required duty, not a discretionary duty.

A Parent Notification Form is provided in **Tool 5** that asks them to sign that they have been notified that their child is at-risk for suicide and they have been provided with community resources, suggestions to suicide proof their home and have been asked to increase the supervision of their child. **Tool 6** provides the parent or caregiver with very specific guidance for Suicide Proofing the Home. It is especially important to discuss with the parent or the caregiver the importance of removing or securing lethal means from the home but especially those means that their child plans to use to attempt suicide. The SMHP should discuss the availability of firearms and other lethal means in each home of suicidal students as some students may have divorced or separated parents resulting in the student traveling back and forth between homes. South Dakota is to be complimented for the statewide emphasis on safe storage of firearms. It is anticipated that a few parents or caregivers might refuse to sign **Tool 5**, the notification form, and if that occurs then the SMHP should ask another staff

member to witness their refusal to sign the form. If the parent or caregiver refuses to seek a community-based assessment for their child, then the principal should be informed, and it is also recommended that protective services be notified. Information sharing between the community-based mental health professional and the SMHP is very important for student safety and well-being, and **Tool 10** provides a Release of Information Form.

Certain cultural views may result in the parent or caregiver being resistant to seeking community-based mental health services for their child and they may view obtaining mental health services for a family member as a sign of weakness. It is strongly recommended that a student at-risk for suicide be referred to a community-based provider that is skilled in suicide risk assessment and management. A task force from the American Association of Suicidology (Schmitz et al. 2012) found that few mental health professionals were trained in suicide risk and management in their graduate program nor was a competency usually required for licensure.

Most suicide risk assessment and management skills are learned by professionals after graduation and licensure. This is why the U.S. Department of Substance Abuse and Mental Health Service Administration (SAMHSA) recommended contacting local mental health professionals and asking questions about their experience in suicide risk assessment and management prior to making a referral. Key questions recommended by SAMHSA to ask community-based mental health providers are summarized in **Tool 9**, Screening Community-Based Mental Health Providers. This tool will help SMHPs to identify those skilled in suicide risk and assessment and result in more effective treatment for the at-risk student. It is recommended skilled community-based providers be identified before making a referral and that schools refer to those not only skilled in suicide assessment and management but also those that know the value of sharing information with key school personnel such as SMHPs.

Some schools have told the parent/caregiver of an at-risk student that their child may not return to school until they have received community-based mental health treatment. Some schools may also require a statement that the student is safe to return to school from the community-based mental health professional. **Districts are encouraged to consult with their school district attorney on any policies related to student attendance after community-based mental health treatment**. Another important consideration for schools who use this approach is whether the student might be unsupervised at home and actually much safer when attending school.

Documentation

All steps taken, regardless of the level of parent or caregiver cooperation, should be documented on **Tool 1**, the Suicide Risk Report. **Tool 1** allows the SMHP to document all steps that have been followed to intervene with a student at-risk for suicide including ensuring that that school administration is informed and involved in the process. Erbacher et al., (2024) highlighted several lawsuits where the SMHP failed to document all the needed steps to safeguard a student at-risk for suicide.

Safety Planning

A written safety plan is provided in **Tool 7** and should be developed jointly with the at-risk student. It is an essential step and the current standard for suicide intervention in the schools. Historically many school personnel have used no-suicide contracts, but those have been criticized because they are all about what not to do (Lieberman et. al., 2008 & 2014).

The written safety plan is developed by the SMHP, in collaboration with the student as they sit side-by-side. It includes strategies for the student to utilize both internally and externally if they have suicidal thoughts. The SMHP and the at-risk student should both sign the safety plan, and the student should take a photo of it to store on their phone in addition to receiving a hard copy. The SMHP keeps a copy and provides copies to parents or caregivers and community-based mental health providers.

The safety plan includes both the 988 number, the local and national 24-hour crisis helpline numbers and the crisis text line number. The South Dakota Helpline Center offers a Safety Plan workbook available to utilize or order at no cost as part of its 988 promotional materials. The Suicide Prevention Resource Center offers a free one-hour course on Safety Planning for Youth, and the training can be accessed on the SD Suicide Prevention Safety Plan webpage.

Reentry Planning

A reentry meeting should be held at school for any student who has been hospitalized for suicidal behavior that includes the student, their parent or caregiver, a SMHP and an administrative representative. Ideally, a hospital staff member would also attend a transition meeting at school. **Tool 8** provides guidance for the reentry meeting. The parent or caregiver or the student themselves may be sensitive to or even opposed to the school personnel being aware of the hospitalization and the treatment. The SMHP should stress how the information shared will be confidential, but it is important for the school personnel to be alert for further warning signs of suicidal behavior and to determine how the school can support the community-based treatment the student is receiving. Hopefully, the school is referring at-risk students to community-based mental health professionals that know the value of sharing information with the school.

It is important to ensure the sharing of information and treatment recommendations between the hospital and the school and to discuss how to help ease academic pressure for the student and increase the support needed for them at school. The reentry conference should include determining the frequency that a SMHP will be checking in with the student and reviewing their safety plan to see what needs to be added. If a written safety plan was not in place prior to hospital discharge then the SMHP and student need to develop one.

School Follow Up

It is essential that the SMHP follow up at school to remind at-risk students of their written safety plan **Tool 7**, and to determine if they are still receiving community-based treatment, re-assess the availability of lethal means in their home and to assess their overall stress and functioning level. If a student is believed to still be at-risk for suicide, then all previously identified steps for suicide screening and parent notification should be implemented and documented.

SECTION 3

Postvention after a Suicide

Section 3:

- **Guidelines for providing compassionate best practice responses in the event of a student suicide (support for the family, school staff, students, and community)**
- **Guidelines for appropriate media coverage**
- **Guidelines to help students and staff with their emotions and to prevent further suicides**

Section 3 recognizes postvention is a very challenging time for schools and includes guidelines for providing compassionate best practice responses in the event of a student suicide. Postvention includes the responses needed to provide support for the family of the suicide victim, school staff, students, and the community at-large. Additionally, it provides guidelines for appropriate media coverage of the suicide. This section provides step-by-step guidelines with the primary purpose to help students and staff with their emotions and to prevent further suicides. The South Dakota Helpline Center developed the Suicide Postvention Toolkit: Supporting K-12 Schools.

Adolescents are the most likely to imitate suicidal behavior, and suicide contagion is a process that can lead to suicide clusters. A suicide cluster is when more suicides occur than could possibly be expected in a short space of time and in a confined geographical area. Scott Poland has assisted many school communities after a youth suicide point cluster including a 2017 suicide cluster in Rapid City, SD.

If you are reading this toolkit because a student suicide has occurred, review **Tool 11**, the Postvention Checklist. The suicide of a student is a very challenging time for a school and the single greatest resources to guide schools is After a Suicide: A toolkit for Schools from the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center (2011 & 2018). Scott Poland helped develop both the initial toolkit in (2011) and the (2018) revision and all postvention recommendations in the GPS-T are based on these toolkits and his direct experience responding to numerous individual youth suicides and seventeen youth suicide point clusters.

It is very important to verify the cause of death of the student and to obtain permission from the family to disclose the cause of death. There is a great need to support affected students and to recognize that adolescents are the most susceptible to imitate suicidal behavior (Miller, 2021) and **Tool 19** addresses suicide contagion.

Postvention is a critical time not only to help students with reactions of shock, grief, and confusion but also to identify students that are now at increased risk for suicide (Erbacher, et al., 2015). There are many cultural issues that are extremely important for schools to recognize when responding to the aftermath of a suicide and it is important to always to use language that can be understood by the students and the families affected by suicide.

The South Dakota Helpline Center, which can be reached by calling 988 or dialing 211, supports schools who have experienced a suicide death of a student or a school staff member. They provide outreach grief support, policy guidance and connections to additional resources. The South Dakota Helpline Center also has the Suicide Postvention Toolkit: Supporting K-12 Schools available.

Tools:

Tools to guide you through best practices for suicide postvention in schools after a suicide in the school community.

- **Tool 11:** Postvention Checklist
- **Tool 12:** School Response Message and Safe Messaging and Media Guideline
- **Tool 13:** Sample Media Statement
- **Tool 15:** Identifying Students at Increased Risk after a Suicide
- **Tool 16:** Supporting Students after a Suicide
- **Tool 17:** Postvention Commonly Asked Questions and Appropriate Responses
- **Tool 18:** Memorials
- **Tool 19**: Understanding Suicide Contagion
- **Tool 22:** Caring for the Education/Caregiver

SECTION 4

The Tools

Section 4:

- **Sample forms that outline action steps**
- **Tools that can be easily adapted and personalized with minor revisions to meet your school's needs**

The Tools provided are what make the GPS-T a true toolkit. It provides many sample forms that outline action steps that can be easily adapted and personalized with minor revisions to meet your school needs. A number of tools summarize key points for suicide prevention, intervention and postvention. Various tools outline recommendations for responding to suicidal students, notifying their parents, documenting all actions, recommending needed supervision and community-based services for the suicidal students. South Dakota educators may use these tools in any way they wish to aid their suicide prevention efforts and there is no need to request permission to adapt them to meet their school needs. Many of these tools are available in Microsoft Word on the GPS-T webpage.

TOOL 1: Suicide Risk Report

Documentation of Suicide Screening and Steps for Student Safety

Student Suicide Risk Report

Screened level of risk: Low_____ Medium_____ High_____

Student Name:	Grade:
School-Based Mental Health Provider:	School:
Administrator:	
Risk Screen Completed by:	Date

Notification of Student's Counselor ❑ Yes ❑ No

Actions Taken

Date	Action	Members Present	Notes
	Student Conference		
	Notified Principal, Key Personnel		
	Parent Contacted		
	Parent Conference		
	Student Safety Plan Written		
	Parent Notification Form Signed		
	Release of Information Signed		
	Mental Health Referral for Community-Based Services made		

Follow-up documentation:

Student _____

_____

_____

_____

_____

_____

Parent / Caregiver _____

_____

_____

_____

_____

_____

Community Resource _____

_____

_____

_____

_____

_____

Copy for student's SMHP and designated administrator.

TOOL 2: Brief Screening CSSR-S

Columbia-Suicide Severity Rating Scale CSSR-S Brief

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past Month	
Ask questions that are **bolded** and **underlined**.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. **Have you wished you were dead or wished you could go to sleep and not wake up?**		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. **Have you actually had any thoughts of killing yourself?**		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* **Have you been thinking about how you might do this?**		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* **Have you had these thoughts and had some intention of acting on them?**		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. **Have you started to work out or worked out the details of how to kill yourself?** **Do you intend to carry out this plan?**		
6) Suicide Behavior Question: **Have you ever done anything, started to do anything, or prepared to do anything to end your life?** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: Were any of these in the past 3 months?**	**Past Month** **Lifetime**	

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

T3

TOOL 3: SAFE-T and Resource

SAFE-T
SUICIDE ASSESSMENT

Five-Step
EVALUATION AND TRIAGE

1. **IDENTIFY RISK FACTORS**
   Note those that can be modified to reduce risk
2. **IDENTIFY PROTECTIVE FACTORS**
   Note those that can be enhanced
3. **CONDUCT SUICIDE INQUIRY**
   Suicidal thoughts, plans, behavior, method, and intent
4. **DETERMINE RISK LEVEL & INTERVENTION**
   Determine risk. Choose appropriate intervention to address and reduce risk.
5. **DOCUMENT**
   Assessment of risk, rationale, intervention, and follow-up

Suicide assessments should be conducted (1) at first contact; (2) with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; (3) prior to changes in behavioral health treatment; and (4) at inpatient discharge.

SAMHSA
Substance Abuse and Mental Health Services Administration

1. RISK FACTORS[1]

- Prior suicide attempt(s)
- Alcohol or substance use
- History of mental health concerns, particularly depression and other mood disorders
- Access to lethal means, including firearms
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Chronic disease and/or disability
- Lack of access to behavioral health care
- Prolonged feelings of hopelessness

POPULATIONS AT INCREASED RISK FOR SUICIDE

- American Indian, Alaska Native, and Tribal communities
- Black youth
- Rural communities
- LGBTQI + youth and young adults
- Middle-aged men
- Older adults

2. PROTECTIVE FACTORS[1]

Note: Protective factors, even if present, may not counteract significant acute risk

- Connectedness to people, family, community, and social supports
- Effective behavioral health care
- Life skills (including problem-solving skills, coping skills, emotional regulation, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide
- No access to lethal means

[1] https://sprc.org/risk-and-protective-factors

3. SUICIDE INQUIRY

Specific questioning about thoughts, plans, behaviors, intent

- **Ideation:** Frequency, intensity, duration—in last 48 hours, past month, and worst ever
- **Plan:** Timing, location, lethality, availability, preparatory acts
- **Behaviors:** Past attempts, aborted attempts, rehearsals versus non-suicidal self-injurious actions
- **Intent:** Extent to which the patient (1) expects to carry out the suicide plan and (2) believes the plan/act to be lethal. Explore ambivalence: reasons to die versus reasons to live

For Youth: Ask parent/guardian about history of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition.

4. RISK LEVEL/INTERVENTION

- **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- **Reassess** as patient or environmental circumstances change
- **Develop** a safety plan for all individuals at low, moderate, and high risk levels

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
HIGH	Individuals experiencing severe behavioral health symptoms or acute precipitating event; protective factors not relevant	Suicidal ideation with plan (when and where), method (how), and intent to carry out the suicide plan	Emergency psychiatric treatment in a secure setting may be necessary unless a significant change reduces risk
MODERATE	Multiple risk factors, experiences some elevated behavioral health symptoms, and few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Give emergency/crisis numbers to include the 988 Lifeline
LOW	Manageable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral with a warm handoff, symptom reduction. Give emergency/crisis numbers, 988 Lifeline

Note: This chart is intended to serve as an example of a range of risk levels and interventions, not actual determinations.

5. DOCUMENT

Document: Risk level and rationale; treatment plan to address/reduce current risk (e.g., safety plan, medication, psychotherapy, contact with significant others, consultation, etc.); counseling on access to lethal means; follow-up plan. Patients/clients should receive a copy of their safety plan. For youth, the treatment plan should include roles for parent/guardian/supportive adult.

SUICIDE PREVENTION RESOURCES

988 Suicide & Crisis Lifeline, call or text 988 or chat at 988lifeline.org for 24/7 support
samhsa.gov/find-help/988

- Download this and additional resources at store.samhsa.gov
- SAMHSA's Suicide Prevention webpage: samhsa.gov/mental-health/suicide
- The 2024 National Strategy for Suicide Prevention and Federal Action Plan: hhs.gov/programs/prevention-and-wellness/mental-health-substance-abuse/national-strategy-suicide-prevention/index.html
- Suicide Prevention Resource Center: https://sprc.org
- National Action Alliance for Suicide Prevention: https://theactionalliance.org
- American Foundation for Suicide Prevention: https://afsp.org
- 988 End Cards for Media: samhsa.gov/find-help/988/partner-toolkit/end-cards-media

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TOOL 4: The Parent Conference

This conference is best held in person if at all possible and school procedures may require it to be in person.

1. Begin by asking the parent or caregiver how their child has been doing, and if they have noted any changes in their child's behavior.

2. There may be language barriers that may necessitate the SMHP utilizing an interpreter during the notification conference.

3. State what you have noticed in their child's behavior and ask how that fits with what they have seen in their child.

4. Provide an overview of your interaction with their child and the importance of safety planning and give the parent or caregiver a copy of the written safety plan **Tool 7**.

5. It may be difficult and even shocking for the parent to hear that their child is suicidal. It will be important to ensure the parent or caregiver understands the seriousness of the situation. It may be necessary to educate them on the scope of the problem of youth suicide and even to share a recent suicide of a student in the district or a nearby school.

6. Emphasize there are evidenced-based treatments for suicide and suicide can be prevented.

7. Advise parents to remove or secure lethal means from the home as their child is suicidal. You can equate this to how you would advise taking car keys from a youth who had been drinking. Key school personnel such as SMHPs are encouraged to ask the parent or caregiver directly about their child's access to a gun and to recommend strongly that guns and other lethal means be removed or safely stored. Go over **Tool 6**, Suicide Proofing the Home.

8. Acknowledge the emotional state of the parents. Provide empathy for the situation and comment on its likely scary nature for parents.

9. Acknowledge that it is essential for schools, parents, and community mental health and medical service personnel to collaborate to keep a suicidal child safe.

10. If the parent is uncooperative or unwilling to take certain actions, find out their beliefs about youth suicide risk/behavior and see if there are any myths they believe that are blocking them from taking the proper needed actions.

11. Acknowledge and explore any cultural, religious, or other concerns that might reduce their acceptance of the need for mental health treatment for their child.

12. When possible, align yourself with the parent or caregiver. It is important for them to understand the stress and depression their child is experiencing and to discuss ways to alleviate stress for their child and how to obtain the needed community-based mental health assistance for their child.

13. Refer the parent or caregiver to local community mental health providers that the school has previously worked well with and explain what parents can expect in the suicide assessment and the treatment of their child. If finances or insurance coverage are a family concern, then share information about either a sliding scale for services or any contractual community-based mental health services that the school has in place.

14. Assist the parent or caregiver in managing their own emotions and encourage them to truly listen to their child, increase supervision, and to avoid getting in an argument with their child.

15. Clarify the role of the school and the follow-up that will be done at school.

16. Utilize **Tool 5** and request the parent or caregiver sign the Parent Notification Form. If they refuse to sign the form then request another school staff member to witness their refusal to sign the form.

17. Utilize **Tool 10** and persuasively request that parent or caregiver sign the Release of Information Form so that designated school personnel can speak directly with community mental health professionals. State clearly that you will be checking with the student and their parents to verify that community-based mental health services were obtained.

18. Request that parent or caregiver take their child home and supervise them closely.

19. The SMHP should find the school administrator and provide them a summary of the parent or caregiver notification conference, and the steps taken for student safety.

20. If the parent or caregiver does not acknowledge the seriousness of the situation the SMHP should notify the administrator and discuss contacting South Dakota Child Protective Services at 1-877-244-0864.

21. The SMHP should fill out **Tool 1** for documentation which is the Suicide Risk Report.

TOOL 5: Parent Notification Form

School:

Date:

Student:

As the parent/caregiver of the student whose name is _____, I have authority to make decisions on behalf of my child and have the authority to sign this document. I acknowledge that I have been advised by school staff member _____ on _____ (date) that my child has expressed suicidal ideation and may be at risk of suicide.

I have been asked to remove or secure all lethal means of suicide in my home to ensure they are not accessible to my child. I understand that removal or securing all lethal means is an essential suicide prevention strategy. I acknowledge that the Suicide Proofing the Home Form has been shared with me.

I understand that I have been advised to take my child to an appropriate medical and/or mental health providers for evaluation and treatment. I understand that the school would like to be able to communicate with the medical and/or mental health providers for the safety of my child.

_____(name of school staff member) will follow up with me and my child within one week from the date of this letter as well as other times that the staff member determines a need.

I understand that any referral information provided to me that identifies medical, mental health, or related health providers is meant for my consideration only and not a requirement that I use these providers. I am free to select other providers of my choice.

The school is not responsible for evaluation expenses for any service providers.

Parent/Caregiver Signature:_____ Date _____

Print Name: _____

Parent/Caregiver current address and phone contact information _____

_____

_____

Staff member signature: _____ Date _____

Witness if parent/caregiver refuses to sign the form. Date: _____

**Copies provided for parent or caregiver, SMHP, and administrator*

TOOL 6: Suicide Proofing the Home

School personnel have notified you that your child is at risk of suicide, and they recognize this is very difficult information for you to hear. Please supervise your child closely and find opportunities for your child to truly talk to you about their suicidal thoughts. One important thing you can do is remove or secure lethal means available in your home and especially those means that your child has already mentioned they would use in a suicide attempt. Removing or securing lethal means for suicide in your home is an essential and a very effective strategy to prevent suicide. Gun locks and medication lock boxes are provided free by the state and information to obtain them can be accessed on the SD Suicide Prevention Request Materials webpage.

The following are recommendations for suicide proofing your home.

- It is very desirable that all knives, firearms, and ammunition be removed from the home. If that is not possible, lock these items securely away to deny your child access. If these items are locked in a safe, ensure that your child does not have the key or knows the safe combination. Store ammunition in a separate place from the firearm.
- Search your house and your child's room. Look for any items that could be used for suicide. These items include weapons, sharp objects, over-the-counter and prescription medicines, belts, ropes, and cords. Learn more on suffocation and strangulation by accessing the SD Suicide Prevention Ligature Safety Infographic.
- Lock up or remove all prescription and over-the-counter medicines. Safe medication storage and disposal tips are available on the SD Suicide Prevention Safe Medication Storage & Disposal Infographic.
- Your child should not have access to alcohol, cleaning supplies, pesticides, poisons, and power tools. View more information on How to Safeguard Your Home: A Guide to Crisis Prevention in the Home.
- There are other items in your home that may be difficult to remove that also could be used in a suicide attempt and those include: plastic bags, belts, and cords of any kind.
- If your child is old enough to drive, deny them access to a car until your child has received a suicide assessment done by a community-based mental health professional.

TOOL 7: Safety Plan

Student Name: _____ School Staff: _____ Date: _____

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a suicidal crisis may be developing:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Step 2: How can I keep myself safe? How can I keep my environment safe?

1. _____
   _____
2. _____
   _____
3. _____
   _____

3. Thankfully, something has kept you alive thus far and what is that? _____
   _____

Step 3: Trusted adults at school, home, or in my community whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 4: Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____

   _____

2. _____

   _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name: _____ Phone: _____

   Clinician Pager or Emergency Contact#: _____

2. Local Urgent Care Services:_____

   Address: _____ Phone: _____

Suicide Prevention Lifeline 24 hour phone Number is 988
CrisisTextLine.org 24 hour text help to 741 741
Have an iPhone? Talk to Siri and ask for help.

Student Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Note: Emphasis is on the safety plan being developed jointly with the student. If the plan is for an older student, they fill it out with the help of the SMHP. The SMHP and the student should sit side by side to fill it out. If a student refuses to sign the safety plan, then hospitalization may be warranted. The parent or caregiver should be given a copy of the signed safety plan. For follow-up at school, students should be continually asked if they still have their written copy and is the safety plan stored on their phone, and do they have anything to add to it to increase their safety? If the safety plan has been lost by the student, another one should be developed. It is noted that it is not uncommon for a suicidal student receiving community-based treatment or even who has received hospitalization services not to have a written safety plan. If that is the case, then the SMHP should immediately develop a safety plan jointly with the student, give them a copy and have the student store a picture of their safety plan on their phone and provide the parent or caregiver a copy.

TOOL 8: School Re-entry After Hospitalization of Suicidal Student

- The principal and SMHP meet with student, their parent/caregiver and ideally the hospital representative to discuss re-entry and steps needed to ensure the student has a successful and safe return to school.
- Review student's progress with the hospital and any other mental health provider outside of school. Hopefully, a release of information form has been signed, and if not, then discuss the necessity of sharing information for the safety and well-being of the student.
- Review all information from the mental health provider especially with regards to safety planning and support services needed at school.
- Plan the follow-up services within the school community that will be available to the parent/caregiver and the student.
- Discuss any foreseeable social and/or academic challenges the student will experience and plan for easing those challenges.
- The SMHP should meet with the student on the first day of the student's return from the hospital and before the student attends any classes.
- The SMHP should schedule regular check-ins with the student to assess the student's adjustment to the academic and social environment.
- It is recommended the SMHP follow up with the student **weekly for a minimum of two months** and if suicidal thoughts and behaviors are noted then conduct a suicide screening using procedures outlined in **Tool 2** or **Tool 3**, document all steps taken in Tool 1 and conduct another parent conference **Tool 4**.
- Ensure that a written safety plan is in place for the student. If one was not developed while the student was hospitalized it will be necessary for the SMHP to jointly develop one with the student and provide a copy for the student and their parent or caregiver.
- Discuss with student the progress they have made while under mental health care. Do they feel hopeful for the future? Are they looking forward to getting back to classes? Are they looking forward to meeting up with friends? Who are their friends?
- Help the student identify and know how to find the SMHP (or another school adult they express trust in) if they are distressed or have a question.
- Review the plan for the SMHP staying in touch with the student to make sure they are adjusting to the academic and social requirements.
- If the student has been out for an extended time, missed assignments may have to be prioritized by importance and coordination with teachers is advised to set up a manageable schedule for the student. Also, consider postponing interim or final course grades until the student has had time to catch up.
- Provide appropriate information for the student's teachers and any other staff on a need-to-know basis so they can be alert to any further suicide warning signs.

TOOL 9: Screening Community-Based Mental Health Providers

The following questions can be asked of mental health service providers to help you get an idea of whether they meet the needs of students at risk for suicide. These questions were drawn from the authors' professional experiences and adapted from the SAMHSA Toolkit (2012).

Professional Qualifications

1. Are you able to provide services to children and adolescents?
2. Are there ages that you work more frequently with or have more expertise and training with?
3. What types of services do you provide?
4. Do you do individual, family, couples, or group therapy?
5. Do you have experience working with marginalized students and other groups that are disproportionately at risk for suicide?
6. Do you have experience working with varied cultural, ethnic and religious groups found within our community?
7. Do you have experience assessing suicide risk in youth? If yes, where did you get your training?
8. Do you have experience managing and treating suicide risk in youth? If yes, what treatment approach do you use? Do you have training in any empirically supported treatments for suicidal youth (e.g. cognitive behavioral therapy, dialectical behavior therapy, interpersonal psychotherapy, attachment-based family therapy)?
9. Do you have experience working with people who have lost a loved one to suicide?
10. What process do you follow in the event of a suicide crisis?
11. Do you see the value of sharing your treatment recommendations with parental permission with a SMHP? Under what circumstances would you come to the school or do a home visit to see a student or parent?
12. Do you work with a psychiatrist?

Business Issues

1. Where are you located?
2. Are you accessible via public transportation?
3. What is your typical wait-time to see a new client?
4. What insurance do you accept?
5. Do you have a sliding fee scale for people who pay out-of-pocket? What is the range of the fee scale?
6. Do you have the necessary clearances to work in schools if you were to come here: child abuse, police and clearances?

Substance Abuse and Mental Health Services Administration (2012). Preventing suicide: A toolkit for high schools. HHS Publication No.SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

TOOL 10: Release of Information Form

Student Information		
Student Full Name	Student ID#	Date of Report
Name of School	Student Grade	Student Sex
Student Birth Date		
Staff Full Name	Staff Job Title	
Parent/Caregiver Full Name	Phone Number	Email Address

Release of Records
Information sharing between schools, parents, caregivers, and community-based providers can make services faster and easier to access. Student records will only be shared to the extent that the information is helpful for service providers, and with the consent of the caregiver or parent(s).

Information Request #1	
Organization/Provider Name	Organization/Provider Type
Organization/Provider Address	Organization/Provider Contact
Information to Share	Information to Receive

Information Request #1	
Organization/Provider Name	Organization/Provider Type
Organization/Provider Address	Organization/Provider Contact
Information to Share	Information to Receive

I consent to the exchange of confidential information (written and verbal) described above.

Caregiver/Parent Signature_____ Date Signed_____

Staff Signature_____ Date Signed_____

TOOL 11: Postvention Checklist

- ☐ Verify the death has occurred and confirm the cause.
- ☐ Mobilize the school crisis team.
- ☐ Assess the impact on the school community and estimate the level of postvention response needed. There may be a need to utilize outside mental health support from other schools or the community.
- ☐ Contact the family of the suicide victim, preferably in person as soon as possible. It is recommended that the school administrator and a school mental health professional (SMHP) contact the family together to express sympathy and offer support.
- ☐ Ask the family to allow the school to share the facts about the cause of death as that will help prevent future suicides and provide an opportunity to teach the warning signs of suicide. Assure the family that there will be no discussion of why the suicide occurred as the emphasis will be on preventing further suicides and that can best be accomplished by sharing the cause of the death. Respect the family's wishes if they don't want the cause of death of their child disclosed.
- ☐ Identify and support any siblings of the victim that attend school in the district.
- ☐ Discuss with the family the funeral arrangements and request the funeral be held after school or on the weekend so that parents can accompany their children to the funeral. The location of the funeral should be in the community, not at school.
- ☐ Ask the family for the name of the clergy member who will be conducting the funeral and ask permission to speak with them.
- ☐ Encourage the family to allow school staff to attend the funeral to support grieving students.
- ☐ Notify other school personnel and provide support to the school staff. School staff need to be made aware of employee assistance and support.
- ☐ Determine what information can be shared with staff and students about the death.
- ☐ Determine how to share the information with staff and students about the death. It is especially important that students be notified in a group size no larger than a classroom and not be notified via the Public Announcement system. Students should be given permission for a range of emotions and provided opportunities to express their emotions. Graphic details about the suicide method should be avoided. Students and even staff may look for a simplistic explanation for the suicide, and it should be emphsized that no one thing and no one person is to blame, and that the victim traveled a long road and may have suffered from mental illness that was untreated or undertreated.

- [ ] Conduct a faculty planning session as soon as possible and focus first on supporting staff. Staff members who have lost loved ones to suicide will need extra care. Discuss with faculty how to best support students and acceptable ways for memorialization of the victim at school. **Tool 18** provides extensive guidance for school memorials. The emphasis should be on dispelling rumors by providing facts. Faculty should have an opportunity to express emotions and to ask questions. Procedures for students who are emotionally upset and ask to leave campus should be outlined. Teachers need to be encouraged to allow students to express their emotions in class. The emphasis must be on helping students with their emotions and should avoid speculation about the reasons behind the suicide. Teachers need to know how to access classroom assistance from SMHPs. School staff should refrain from talking to the media and direct all media requests to the principal. Key questions to ask students are, "How can the adults at school and at home help you at this time?" "What can you do for your self-care at this difficult time?"
- [ ] Determine what information can be shared with the parents of the other school students about the death.
- [ ] The SMHP should identify students most affected by the death, provide support, and screen them for suicide risk. This should include at a minimum the close friends of the victim, and all students at the school at any grade level known to be previously suicidal.
- [ ] If other students are believed to be at-risk for suicide then all intervention steps outlined in the Suicide Intervention Section of this toolkit should be followed.
- [ ] The SMHP should meet with the Communications Director or Public Relations Officer for the school district to discuss safe messages after suicide and the recommended media reporting guidelines. The term *died by suicide* is preferred to the term *committed suicide*. Safe messages that need to repeated by all school staff are the following: most suicides can be prevented, no one thing—no one person is ever to blame for a suicide, the victim of suicide traveled a long road and mental illness is often at the foundation of a youth suicide, all available 24 hour crisis lines should be shared and that evidenced-based treatments exist for all forms of mental illness, the answers to why the suicide happened were lost with the victim and it is important for all students to know how to get help for themselves or a suicidal friend. Information on reporting guidelines through the Suicide Awareness Voices of Education (SAVE) are accessible on the SD Suicide Prevention Resources for Educators webpage.
- [ ] SMHPs are encouraged to meet with students to gain insight into what is being posted on social media about the death and to encourage students to post safe messages about suicide prevention and the importance of getting adult help for themselves or a friend and utilizing available crisis resources.
- [ ] Students may have immediate thoughts on memorializing the suicide victim and their ideas should be heard by the administration and given careful consideration with no immediate decision made. The administration should review the recommendations in **Tool 18**.
- [ ] Spontaneous memorials have become common place and if students create one at school it should be allowed at school until after the funeral. Digital pictures of the spontaneous memorial should be taken before it is removed.

- [ ] The administration should review the policies for memorialization of a student and best practices after a suicide which emphasize striving to treat all deaths the same regardless of the cause of death, the popularity, or the socio-economic level of the victim's family.
- [ ] The school crisis team should debrief at the end of the school day and identify the students that are the most affected by the suicide and make plans for continuing support for staff and students.
- [ ] The school administrator should recognize how stressful the day has been for the school crisis team members and thank them for their support and encourage them to engage in self-care.
- [ ] Review the Social Media **Tool 14** to gain insight into the importance of posting safe messages on social media and that suicide can be prevented and the importance of students seeking adult help for themselves or their friends,
- [ ] The school crisis team is encouraged to meet daily until the mood of the school returns to normal.
- [ ] Students considered at be at-risk for suicide need to be monitored closely and hopefully they are receiving community-based mental health services, and a release of information has been signed so that the SMHP can communicate with the community-based mental health provider.
- [ ] Students often want to increase awareness of suicide and become more involved in suicide prevention after losing a friend or a classmate to suicide. Students can make a difference by creating a Hope Squad. Schools that are interested in implementing a Hope Squad can reach out to the Helpline Center at hopesquad@helplinecenter.org. The Helpline Center works with schools to plan, implement, and support Hope Squads.
- [ ] Schools are encouraged to share any local suicide survivor group support available with the family of the victim. If no local support is available for survivors then share the information about online suicide survivor support groups.

The SMHP needs to be aware of future dates that will be difficult for the friends and family of the suicide victim such as the birthday of the victim, anniversary of their death and graduation time. Just prior to those dates is an important time for the SMHP to reach out and provide support to surviving siblings and close friends of the suicide victim.

TOOL 12: School Response Message and Safe Messaging and Media Guidelines

- We are heartbroken over the death of one of our students. Our hearts, thoughts, and prayers go out to [his/her] family and friends, and the entire community.
- We recognize the problem of youth suicide and want to work with parents and the community to prevent further deaths.
- We recognize that removing or securing lethal means available to a suicidal youth is a powerful tool for the prevention of suicide.
- We will be offering grief counseling for students, faculty and staff starting on [date] through [date].
- We will be hosting an informational meeting for parents and the community regarding suicide prevention on [date/time/location]. Experts will be on hand to answer questions.
- No TV cameras or reporters will be allowed in the school or on school grounds.
- Media are strongly encouraged to follow media guidelines that are available through the Suicide Awareness Voices of Education and accessible on the SD Suicide Prevention Resources for Educators webpage.
- Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion ("copycat" suicides), particularly among youth.
- Media coverage that details the location and manner of suicide with photos or video increases the risk of contagion.
- Media is encouraged to avoid printing or showing a picture of the suicide victim or making the suicide front page news in the local newspaper or a leading news story on local television.
- The media is encouraged to avoid repetitive coverage of suicide.
- Safe messaging matters and the media is encouraged to provide messages about suicide that support safety and help-seeking.
- The term "died by suicide" is strongly preferred over the term, "committed suicide." No one thing and no one person is ever to blame for a suicide. Even a youth traveled a very long road, and their suicide is no one's fault.
- Media should also avoid oversimplifying the cause of suicide (e.g., "student took his own life after breakup with girlfriend"). This gives the audience a simplistic understanding of a very complicated issue. The answers to why the suicide occurred were lost with the victim.
- Media should include links to information about helpful resources such as warning signs of suicide and available crisis hotlines.
- Media should promote awareness of the 988, 24-hour crisis line.

TOOL 13:Sample Media Statement

School personnel were informed by the coroner's office or from the parents that their [__]-year-old student at [_____] school has died. The cause of death was suicide.

Our thoughts and support go out to [his/her] family and friends at this difficult time. Key school personnel have reached out to the family in person to provide support.

Several postvention activities will be conducted in the school and these activities will help our staff and students manage the complex emotions they may be experiencing such as shock, confusion, and grief because of the suicide. Postvention activities are very important to prevent further suicides. The school will be hosting a meeting for parents and others in the community at [date/time/location]. Members of the School's Crisis Response Team will be present to provide information about common reactions following a suicide and how parents can assist their children at this difficult time. Information will be provided about suicide prevention and mental illness in adolescents, including risk factors and warning signs of suicide. The meeting will address attendees' questions and concerns. A meeting announcement has been sent to parents, who can contact school administrators or counselors at [number] or [e-mail address] for more information.

School mental health professionals (SMHPs) will be available to meet with students and staff starting tomorrow and continuing over the next few weeks as needed. Please contact the school counseling office if you have concerns about your child being at-risk of suicide. Do not hesitate to get help for your child. It is very important that all parents know the warning signs of youth suicide. This is a time when all lethal means available in your home such as firearms and medication should be secured from your children. Please share with the SMHP for your child if your child has a previous history of suicidal thoughts and/or actions. Please also be alert for precipitating events for your children such as a severe argument with parents, the break-up of a relationship, severe discipline problem, severe disappointment, or extreme humiliation in addition to the warning signs listed below.

- Talking about wanting to die or kill oneself
- Looking for ways to kill oneself, such as obtaining access lethal means such as a gun or medications
- Talking about feeling hopeless or having no reason to live and/or researching suicide online
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated, or behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing hostility, rage or talking about seeking revenge
- Displaying extreme mood swings and/or being overwhelmed by their life

Local Community Mental Health Resources [To be inserted by school]
National Suicide Prevention Crisis Lifeline 24 Hour Number 988
Crisis Text line 24 Hour text Hello to 741741
Local hotline numbers if available [To be inserted by school]

TOOL 14: Social Media

There are many concerns about the role of social media and youth suicide. Excessive social media time is linked with depression for youth (Niznik, et al., 2019, Part 1). Social media is always changing, and it is important for school personnel and parents/caregivers to do their best to keep up with the latest trends, applications, and social networking platforms. The previous U.S. Surgeon General's Advisory Report recommended that adults model appropriate use of technology and families were encouraged to have blackout evening times when no one in the family uses technology and instead interacted with each other. The recommendations below were drawn from articles in the NASP Communique by Niznik, et al., 2019, Part 1 and Part 2.

Benefits of Social Media

- Vulnerable and marginalized youth find each other through social media, which allows them to connect and to have the benefit of sharing experiences and emotions, as well as, to receive and provide support to each other, and to understand the necessity of obtaining adult help if they or a friend is suicidal.
- Social media provides a place to reduce the stigma about seeking mental health services.
- Social media can play a very important role in prevention, as many platforms provide suicide prevention resources and screen for suicidal terms posted by content users.

Risks of Social Media

- Many youths are exposed to suicide related content through Internet sources.
- Unfortunately, digital media, such as the news, television, and movies may encourage suicide when the suicide of the victim is glamorized, and details of the suicide method are provided, and suicide is presented as a way to solve a problem.
- Social media gives voice to pro-suicide groups that portray suicide as a solution and an acceptable option, which may normalize and encourage suicide for a troubled individual.
- The impact of a suicide is greater than ever before and is not confined to a specific geographical area largely as the result of social media.
- Emotional negativity can be spread much more quickly and to more recipients on social media than through interactions in person. Other negative effects may include access to suicidal images or methods that may normalize suicidal behavior and increase contagion.

Social media platforms commonly used by teens involve the sharing of content that is created by the users (in this case, adolescents) rather than media professionals. This highlights the need to expand safe messaging guidelines to incorporate creators of content (adolescents) on social media. It is important for school personnel to not only model responsible social media usage, but to educate our youth on how to communicate information via social media about suicide that emphasizes that suicide is preventable and the intervention of any one young person knowing the importance of seeking adult help can make all the difference to save a life.

Best Practices for Social Media

- **Educate users on creating content**
  In the creation of any content, we need to teach our youth how to relay effective and safe messages to their audience. As a natural extension, safe messaging guidelines regarding reporting content relating to suicide via digital media (news, blogs, and networks over the Internet) have also been recommended.

  They include:
  - o Avoid hyperlinking of suicidal material, such as video or audio footage (e.g., emergency calls) or links to the scene of a suicide, especially if the location or method is clearly presented.
  - o Avoid using pictures of a person who has died by suicide.
  - o Avoid harmful wording in headlines.
  - o Avoid data visualizations or sensationalizing statistics about suicide.
  - o Don't use language that normalizes suicide or implies that it solves problems.
  - o Do not provide details about the site/location of the suicide.
  - o Do include information about the warning signs of suicide and where to seek help.
- **Teach teens how to help other teens.**
  Many of the existing gatekeeper programs provide important information to students about safe messaging through social media and teach suicide warning signs and the importance of seeking adult help. Research shows that stigmatizing attitudes about suicide can be replaced with empathy, understanding, and the ability to reach out to those in need to let them know they are not alone and there is help available.
- **Proactively provide resources.**
  In the future, we expect social media to have an even greater impact than it currently has. We all need to be aware of the influence that social media has on our youth. SMHPs must keep up with the research on the impact of social media and to be aware of harmful information and messages that are posted.

Schools are encouraged to do the following:

- Utilize students as "brokers" to help faculty and staff understand the social media that currently is most used by students.
- Train students in gatekeeper roles and specifically identify what suicide risk looks like when communicated via social media.
- Utilize students to help school staff monitor social networks and help students post safe messages that suicide is preventable and largely the result of mental illness, and that evidence-based treatments exist for mental illness.
- Encourage students to make use of social media to post messages about prevention resources and available crisis support lines, and school and community mental health resources.
- Give students specific helpful language to include when making use of social media.
- Encourage families to delay giving children a smartphone until at least the end of 8th grade. Wait Until 8th, a parent led movement, explains more and is accessible on the SD Suicide Prevention Suicide Among Youth and Parents webpage.
- Encourage parents to follow the age limits recommended for children to be on social platforms.
- Encourage parents when their child is old enough to be on social media to closely monitor their child's social media.
- Dr. Scott Poland provides frequent parenting sessions on Raising Children in Challenging Times that provide many parenting recommendations for safeguarding their children including technology recommendations. Contact him at spoland@nova.edu for more information.
- Dr. Scott Poland recently did a podcast on social media for Safe and Sound Schools and the podcast can be viewed at The Sound Off On School Safety: The Social Media Health Crisis in Schools with Dr. Scott Poland.

TOOL 15: Identifying Students at Increased Risk After a Suicide

There is evidence that exposure to suicide is a significant risk factor for future suicidal behaviors with estimates that if a suicide of a student occurred the chances of another suicide increase significantly (Poland and Ferguson 2025). Postvention recommendations from Erbacher, et al., (2024) recommend that after a student suicide SMHPs and administrators ask the following questions to help identify those most likely at-risk.

- Did another student back out of a suicide pact?
- Did any student have a last very negative interaction with the suicide victim?
- Did any student encourage suicide?
- Does any student feel like they missed obvious warning signs of suicide?
- What other students at the school have been previously known to be suicidal?
- What other students have their own adverse childhood experiences, and or struggles with mental illness?

Is very important that schools recognize that after suicide, those now more at risk may not have even known the suicide victim well. They may view their life as parallel to the victim and as having as many or even more problems than they believe the suicide victim had. Barriers, and the inhibitions are down, and suicide seems a more viable option.

There is great need for more postvention research, but research has found that postvention efforts at school are often too short in duration and focus on too few students. Schools need to cast a broader net to identify students now more at risk. Losing a classmate to suicide may affect students for many years. Research also found that a single exposure to a suicide may not result in imitating suicidal behaviors in the absence of other vulnerability factors (Gould et al., 1990; Niznik et al., 2019). The vulnerability factors in addition to the recent exposure to a suicide that have been identified are the following:

- current or past psychiatric conditions
- history of previous suicide attempts
- substance abuse history
- recent stressful life events
- having access to lethal means

TOOL 16: Supporting Students after a Suicide

The aftermath of a youth suicide is a sad and challenging time for a school. Poland (1989) cited the work of Dr. Ed Shneidman who coined the term "postvention" to describe appropriate acts after a dire event designed to help everyone with their emotions. The term has become synonymous with the challenging aftermath of suicide, and few events are scarier for a school and community than the suicide of a K-12 student. The major tasks for suicide postvention are to help students and staff to manage their understandable feelings of shock, grief, and confusion. The major focus after a suicide should be grief resolution and the prevention of further suicides.

Adolescents are the age group most likely to imitate suicidal behavior and numerous schools have experienced suicide contagion and clusters. Once a student suicide happens then barriers and inhibitions against suicide are reduced. The following suggestions are intended to guide staff in postvention were provided by Lieberman & Poland (2017).

- It is important to be honest with students about the scope of the problem of youth suicide and the key role that everyone (including students) play in prevention.
- It is important to balance being truthful and honest about suicide without violating the privacy of the suicide victim and their family and to take great care not to glorify their actions.
- It is important to have the facts of the incident, be alert to speculation and erroneous information that may be circulating in the school and assertively, yet kindly, redirect students toward productive, healthy conversation about their own coping and the prevention of further suicides.
- It is important that students do not feel that the suicide victim has been erased and that students be provided an opportunity to talk about and memorialize the deceased.
- There has been debate about how to appropriately memorialize a suicide victim at school. The debate has unfortunately resulted in some schools concluding that nothing should be done after a student suicide. No one ever said do nothing after a suicide as the focus after a suicide must be on grief resolution and the prevention of further suicides. **Tool 18** provided many recommendations for schools on memorials.
- School personnel are encouraged to monitor student social media after suicide occurs as vulnerable youth often connect with each other online. Unfortunately, is not unusual for messages to be posted encouraging suicide, and that suicide is someone's destiny and emphasizing suicide solves problems. Safe messaging is always important about suicide but is critically important after a suicide.
- School personnel should review curriculum content that focuses on death and suicide in literature readings such as Romeo and Juliette. Tragic readings of this type should be postponed after a suicide and when the reading is resumed there should always be a discussion of prevention and crisis resources that are available today.

- School personnel often consider postponing previously scheduled suicide prevention programs if a suicide has occurred, but prevention information is needed more than ever as suicide postvention focuses on prevention of further suicides.
- Schools are often reluctant to implement depression screening programs that are available for middle and high school students like Signs of Suicide (SOS). SOS has considerable data about the program increasing students in their understanding of the warning signs of suicide and the importance of seeking help from adults. The SOS Signs of Suicide program specifically includes empowering videos where students learn how to help themselves or their friends through the motto, ACT Acknowledge, Care and Tell an adult. Often the reluctance for schools to utilize depression screening is only overcome after a school has experienced multiple suicides. Schools are strongly encouraged to research SOS. Learn more about SOS on the SD Suicide Prevention Resources for Educators webpage.

TOOL 17: Postvention- Commonly Asked Questions and Appropriate Responses

Why did he /she die by suicide?
We are never going to know the answer to that question as the answer has died with him/her. The focus needs to be on helping students with their thoughts and feelings and everyone in the school community working together to prevent future suicides.

What method did they use to end their life?
It is generally best not to state the method, but it is especially important not to go into explicit details about the type of gun or rope used or the condition of the body etc.

What should I say about him/her now that they have made the choice to die by suicide?
It is important that we remember the positive things about them and respect their privacy and that of their family. Please be sensitive to the needs of their close friends and family members.

Didn't he/she make a poor choice and is it okay to be angry with them?
They did make a very poor choice, and research has found that many young people who survived a suicide attempt are very glad to be alive and never attempted suicide again. You have permission for all your feelings in the aftermath of suicide, and it is okay to be angry with them.

After a suicide what is important to know?
The suicide of a young person has been compared to throwing a rock into a pond with ripple effects in the school, church, and the community and there is often a search for a simple explanation. These ripple effects have never been greater with the existence of social networks. It is recommended that school staff and parents monitor what is being posted on social networks sites in the aftermath of a suicide. Poland (1989) pointed out that suicide is a multifaceted event, and sociological, psychological, biological, and physiological elements were all likely present to some degree. Many individuals who died by suicide had untreated mental illnesses or under treated mental illness. The most likely illness was depression, and it is important that everyone is aware of resources that are available in their school and community so that needed treatment can be obtained. It is always important that everyone knows the warning signs of youth suicide.

Isn't someone or something to blame for this suicide?
The suicide victim made a very poor choice and there is no one to blame. The decision to die by suicide involved every interaction and experience throughout the young person's entire life up until the moment they died and yet it did not have to happen. It is the fault of no one. No one person, no one thing is ever to blame.

How can I cope with this suicide?
It is important to remember what or who has helped you cope when you have had to deal with sad things in your life before. Please turn to the important adults in your life for help and share your feelings with them. It is important to maintain normal routines, proper sleeping and eating habits, and to engage in regular exercise. Please avoid drugs and alcohol. Resiliency, which is the ability to bounce back from adversity, is a learned behavior. Everyone does their best in recovery when surrounded by friends and family who care about them and by viewing the future in a positive manner.

What are the warning signs of suicide?
Suicide Awareness Voices in Education emphasized that the most common signs are the following: making a suicide attempt, verbal and written statements about death and suicide, fascination and preoccupation with death, giving away of prized possessions, saying goodbye to friends and family, making out wills, being overwhelmed, withdrawal or hostility towards others, irritability, exhibiting other dramatic changes in behavior and personality. Sleep deprivation is also strongly associated with youth suicide.

What should I do if I believe someone is suicidal?
Listen to them, support them, and let them know that they are not the first person to feel this way. There is help available and mental health professionals such as counselors and psychologists have special training to help young people who are suicidal. Do not keep suicidal behavior a secret, save a life by getting adult help as that is what a good friend does. If you cannot immediately reach a trusted adult, then call or text 988 and get connected with the National Crisis Line or text Hello to 741 741 to reach the National Crisis Text Line. Someday your friend will thank you for getting their help.

How can I make a difference in suicide prevention?
Know the warnings signs, listen to your friends carefully, do not hesitate to get adult help and remember that most youth suicides can be prevented and become aware of ways to get involved with suicide prevention. You can start a Hope Squad at your school which can meet as a club or a class. Schools that are interested in implementing a Hope Squad can reach out to the Helpline Center at hopesquad@helplinecenter.org. The Helpline Center works with schools to plan, implement, and support Hope Squads. Remember one person can make the difference and prevent a suicide!

Where can I go for more information about preventing suicide?
Visit the SD Suicide Prevention Resources for Educators webpage for access to suicide prevention resources.

TOOL 18: Memorials

Many schools have struggled with requests made by the parents or close friends of the suicide victim to create a memorial in memory of a student who died by suicide. **The goal should be as much as possible to treat all student deaths the same way.** It's strongly recommended that the school district create a memorialization procedure so that all student deaths are treated the same, regardless of cause of death or factors such as socioeconomics or popularity

- Encourage and allow students, with parental permission, to attend the funeral.
- Encourage staff attendance at the funeral to support the family and monitor reactions of students.
- Contribute to suicide prevention efforts in the community.
- Develop living memorials, such as student assistance programs, that address risk factors in local youth.
- Implement a Hope Squad in memory of the suicide victim. More information on this peer-to-peer prevention program is available at hopesquad.com. Schools that are interested in implementing a Hope Squad can reach out to the Helpline Center at hopesquad@helplinecenter.org. The Helpline Center works with schools to plan, implement, and support Hope Squads.

Prohibiting all memorials has been problematic for schools resulting in students and parents becoming upset that the memorialization of a student who died from other causes such as an accident or an illness was managed very differently from that for the suicide victim

- Recognize the challenge to strike a balance between the needs of distraught students and fulfilling the primary purpose of learning in education.
- Meet with students and be creative and compassionate.
- Spontaneous memorials at school should be left in place until after the funeral.
- Photos should be taken as a digital way to preserve the memorial.
- Avoid holding funeral services on school grounds and suggest the funeral be held after school so parents can accompany their children.
- Schools may hold supervised gatherings such as candlelight memorials.
- Monitor student gatherings off campus.
- Yearbook and graduation dedication or tributes should all be treated the same regardless of the cause of death of the student.
- Grieving friends and family should be discouraged from dedicating a school event in memory of the suicide victim and guided instead towards promoting suicide prevention.

- Permanent memorials on campus are discouraged but schools are encouraged to memorialize all students the same way regardless of the cause of death. If a precedent has already been set for example such as planting a tree on campus or establishing a bench on campus in memory of a student who died in an accident or from an illness for example, then it can also be done in memory of the suicide victim.
- Previously, it was estimated that a death by suicide profoundly affected six people, but that estimate has been raised to eighteen people (Erbacher, et al., 2024). Our experience is that suicide prevention is often driven by survivors, as many of them choose to get involved in suicide prevention efforts. Fifty years ago, before becoming a psychologist, Scott Poland lost his father to suicide and now realizes he missed the warning signs and Scott does his best through countless trainings around the world to educate others on the warning signs of suicide and how to intervene to save a life. It is our hope that this toolkit results in improved suicide prevention efforts in South Dakota.

TOOL 19: Understanding Suicide Contagion and Clusters

A single adolescent death by suicide could increase the risk of additional suicides.

Erbacher et al., (2024) emphasized that the suicide of a student has a rippling effect in the school and community. The process by which a suicide increases the suicidal behavior of others and results in additional deaths is called contagion.

Adolescents are the most susceptible age group for imitating suicidal behavior, and schools play a central role in preventing contagion (Poland, et al, 2019). Schools cannot stop suicide contagion alone and the response to suicide contagion must involve the entire community (Poland & Ferguson 2025). A single exposure to the suicide of another student is unlikely to result in imitative behavior in the absence of adolescent vulnerability factors such as, current or past psychiatric conditions, family history of suicide or past suicide attempts, substance abuse, stressful life events, access to lethal methods, and lack of protective factors.

Cluster Types

There are two main types of suicide clusters. *Mass clusters* are characterized by a temporary increase in suicides nationally and are associated with the media coverage of celebrity suicides. For example, there was an increase in suicide rates in the U.S. after the highly publicized suicide of Robin Williams in 2014. *Point clusters* are characterized by an increase in suicides that are close in time and/or space and occur in the school community (Gould et al., 1990). Numerous point clusters have occurred in the U.S. and Scott Poland has led school and community intervention efforts numerous times after point clusters including one in Rapid City, South Dakota. Factors in the clusters identified were the following: male gender, mental health issues, history of suicidal ideation or suicide attempts, substance abuse issues, relationship problems, a recent crisis, parents not recognizing the severity of the mental health needs of their child, sleep deprivation; academic pressure, sexual orientation, and intimate partner violence Poland et al., 2019).

Key Points in Postvention to Prevent a Point Cluster

It is important for schools to recognize the possibility of contagion after a student suicide and to implement best practices in postvention in a timely manner. Schools are strongly encouraged to seek consultation immediately from mental health professionals who are experienced in responding to a point cluster. Postvention assistance in schools after a suicide is often too short in duration and focuses on too few students. The impact is much wider than the suicide victim's closest friends and many students will need support. The national YRBS data for 2023 well documents that twenty percent of high school students considered suicide in the last 12 months and when it actually happens in the school community it becomes a more viable option for those who have previously considered suicide. Poland et al., (2019) called for more research on suicide postvention and for postvention efforts to be longer in duration and focus on more students and they used the phrase "casting a broad net." Scott Poland has been asked by SMHPs many times if since a suicide has happened does the SMHP need to check in with all students previously known to be suicidal even if they did not know the victim

and the answer is yes! It is also likely that the suicide victim sent a final message to a few students and if those students failed to take immediate action involving calling police or crisis lines and /or notification to adults they may become suicidal themselves and will need intervention and support.

It takes a community to respond and stop a point cluster and a collaborative effort between schools, community agencies, mental health practitioners, medical personnel, law enforcement, clergy, parents, survivor groups, and students. Community members and especially medical and mental health professionals can assist school personnel in screening exposed teens who are now at greatest risk of suicide imitation. It is essential that physicians screen all the teens they see for depression and suicide after a youth suicide has occurred in the community. There is a great need for more research on responding to point clusters and understanding the factors that make our youth susceptible to suicide imitation.

TOOL 20: Data Collection

School: _____ Date: _____ School Year: _____

Data Recorder: _____

The number of students reporting suicide ideation _____

The number of students who made a suicide attempt _____

The number of students who were referred to community mental health providers_____

The number of students who received services from community mental health providers_____

The number of students whose family allowed record sharing between the school and community mental health providers _____

The number of students who were hospitalized for suicidal behavior _____

The number of re-entry meetings held at school for suicidal students who were hospitalized_____

The number of suicide safety plans developed jointly with a suicidal student by school personnel_____

The number of parents notified of the suicidal behavior of their child_____

The number of students who died by suicide_____

TOOL 21: Suicide Prevention Information for Posting on School District Website

The_____ School District recognizes that suicide is a leading cause of death for school age students and we are dedicated to working with parents, community and state agencies to prevent youth suicide. The suicide of a youth is often the result of untreated or undertreated metal illness and we as a district have developed plans for suicide prevention and intervention. If you are a student and concerned about your friend or are a parent concerned about your child, then the key person to contact in our district for assistance is_____ who can be reached at _____. If they cannot be reached immediately then call or text 988 and you will be connected with the South Dakota Helpline Center and you can also reach the National Suicide Prevention Lifeline at 1-800- SUICIDE or 1-800-273 TALK or 1-800-273 TALK as trained crisis responders are available 24 hours a day. The National Crisis Text Line can be reached by texting HELLO to 741741 and it is available twenty fours a day. Do not leave a suicidal individual alone. If a suicide attempt has actually been made, then immediately contact 911.

If you believe your child or your friend is suicidal please take every precaution and get immediate help. If you are a student concerned about a friend, it is very important to get a trusted adult involved immediately. If you are a parent concerned about your child, then obtain professional help for your child and increase your supervision and secure or remove any lethal means from their ready access. Many people are hesitant to ask directly about suicide for fear that they will be planting the idea in the mind of the person. Asking them directly about thoughts of suicide **does not plant the idea of suicide**. In fact, it provides them an opportunity to unburden themselves, know they are not alone and they not the first person to think of suicide and help is available.

TOOL 22: Caring for the Education/Caregiver

School personnel such as administrators, teachers, nurses, counselors, school psychologists, and social workers respond to many tragic situations. One of the most difficult is responding to a student suicide. These school professionals have their own issues with regard to tragedy and loss and when they respond to yet another school tragedy, it is common to think about their own losses. A school tragedy takes a little piece of our heart each time. The authors as a principal and director of psychological services have responded to many school tragedies in our careers and have seen many educators step forward and provide extensive support for students and parents after a tragedy. A phrase they have used often with school staff after a tragedy is "let your heart be your guide, as in your heart you have good ideas about how to help students after a tragedy." Education caregivers know the importance of staying calm, being collaborative and focusing on the needs of other people but crisis response is intense and takes its toll on the caregiver. It's important to state that there may be a time when the individual or family circumstances for an individual caregiver make it difficult or even impossible for them to focus on the needs of others. If this is the case then they need to speak up and hopefully can take a supportive role in the background instead of being face-to-face with grieving staff and students.

Caregivers who serve on school crisis team are often relied on if a school district has experienced multiple crises and burnout for them can possibly develop. **It is a sign of maturity and courage for a caregiver to speak up when they know that they are being overwhelmed by the stress of crisis intervention.** Caregivers are encouraged to be assertive in stating what they need in the way of support from school administration, friends, and family. The wise school administrator would meet with caregivers at the end of the day and check in with them to see how they are doing in the aftermath of a tragedy. Caregivers need to feel appreciated by the administration and to know they did the best they could in a tragic situation. **There is no such thing as a perfect crisis response; it is about showing up and caring.** There are no magic words, but it is important to state, "I am sorry about the loss and here to listen anytime you want to talk." Caregivers know that is important to help those affected by the tragedy to identify previous sources of support and this is important for the caregiver as well.

Caregivers are encouraged to do the following:

- Utilize healthy stress management behaviors that help them on a normal school day such as the following: eating well, getting enough sleep, utilizing relaxation, positive imagery and meditation, ensuring that they put some fun and relaxation into their day, spend time outside, exercise, reach out to the significant positive others in their life, build a professional network and avoid isolation. Think of self-care like car maintenance.
- Short term-- if HALT Hunger, Anger, Loneliness or Exhaustion are developing. Get boost and utilize the strategies outlined above.
- Long term—get professional help, seek formal support and get a health inventory.

Resources

Final Thoughts & Additional Free Online Resources Developed by Scott and Donna Poland

The authors hope this toolkit results in improved suicide prevention, intervention, and postvention in South Dakota schools and all educators are encouraged to use this toolkit in any way to assist their important suicide prevention work. Please review the previous work of Dr. Donna Poland, a veteran school principal in both public and private schools, and Dr. Scott Poland in developing toolkits for several U.S. states.

- Texas Suicide Safer School Roadmap (2021)
- Montana CAST-S Crisis Action School Toolkit-Suicide (2017) revised (2022)
- Florida STEPS School Toolkit for Educators to Prevent Suicide (2021)
- Maryland Action Plan to Prevent Suicide in K-12 Schools (2024)

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