The Center for Creativity, Innovation and Discovery

MENTAL HEALTH POLICY

I. Purpose

This policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles, and at school sponsored out-of-school events where school staff are present. This policy applies to the entire school community, including educators, school faculty and staff, students, parent/guardian, and volunteers. This policy will also cover appropriate school responses to suicidal or high-risk behaviors that take place outside of the school environment. The Utah Good Samaritan law provides protection to the school and staff if they attempt to administer aid to a student in crisis. “A person who provides emergency care at or near the scene of, or during, a [suicide] emergency, gratuitously and in good faith, is not liable for any civil damages or penalties as a result of any act or omission by the person providing the emergency care, unless the person is grossly negligent or caused the suicide emergency." (Utah Code § 78B-4-501)

Intentional violation of this policy is cause for disciplinary action consistent with local school board policy and under Section 53G-11-513.

II. Definitions

A. “At risk” means a student who is defined as high risk for suicide, who has made a suicide attempt, has acknowledged thoughts of suicide or intent to act on thoughts of suicide.

B. “Crisis Care Team” means a multidisciplinary team consisting of, administration, counselors, nurses, support staff, and mental health professionals whose primary focus is to address crisis preparedness, intervention/response and recovery. These professionals have been specifically trained in crisis preparedness through recovery, and take a leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.

C. “Means Restriction” means limiting the child’s access to mechanisms for carrying out a suicide attempt.

D. “Mental health” means a state of mental and emotional being that can impact choices and actions that affect wellness. Mental health problems include mental and substance use disorders.

E. “Postvention” means suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma

associated with suicide, disseminate factual information after the suicide death of a member of the school community, and finally to stabilize the school population to restore a sense of normalcy and readiness to learn.

F. “Suicide Risk Screening Tool” means a screening tool used for a student who may be at risk for suicide conducted by the appropriate school staff (e.g., school psychologist, school counselor, or school social worker). This tool is designed as a triage to elicit information regarding the student’s intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk and protective factors.

G. “Risk factors for suicide” means characteristics or conditions that increase the chance that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment.

H. “Self-harm” means behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Can be categorized as either nonsuicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

I. “Suicide” means a death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The coroner’s or medical examiner’s office must first confirm death by suicide before any school official may state this as the cause of death.

J. “Suicide attempt” means a self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

K. “Suicidal behavior” means suicide attempts, intentional injury to self associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other action indicating intent to end one’s life.

L. “Suicide contagion” means the process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides.

M. “Suicidal ideation” means thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one’s life is still considered suicidal ideation and should be taken seriously.

III. Prevention

A. Policy Implementation. The school principal shall have in place a crisis care team for issues relating to suicide (administrator, counselors, social worker, behavior specialist) prevention and policy implementation. All staff members shall report students they believe to be at risk for suicide to this team.

B. Recommended training. It is recommended that all crisis care team members be trained in the following:

1. Suicide Risk Screening Tool
2. Safety Planning
3. Counseling on Access to Lethal Means
4. Community Resource Planning
5. Postvention

CCID will provide these trainings and/or refer to other available resources for training on a regular basis.

C. Youth Suicide Prevention Programming. Developmentally appropriate, student-centered education materials will be integrated into the curriculum of all secondary health classes. In addition, schools must implement a youth suicide prevention program for grades 7 and 8. The content of these age-appropriate materials, resources and programs will focus on:

1. Bullying and cyberbullying (refer to: BOARD POLICY-9000 STUDENTS-CONDUCT: Bullying, Cyber-bullying, Hazing and Retaliation)
2. Prevention of youth suicide
3. How to recognize risk factors and warning signs of mental disorders and suicide in oneself and others,
4. Help-seeking strategies for oneself or others, including how to engage school resources and refer friends for help (e.g., SafeUT app). In addition, schools may provide supplemental small group suicide prevention programming for students.
5. Prevention and consequences of underage drinking of alcohol
6. Methods of strengthening the family
7. Methods of strengthening a youth's relationships in the school and community
8. The importance of safe and healthy choices and coping strategies, as well as examples of and opportunities to practice healthy coping strategies
9. A definition and examples of what it means to recover from mental health conditions in order to increase hope for recovery when these disorders are present

IV. Assessment and Referral

A. When a student is identified by a staff person as potentially suicidal, i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, parent/guardian will be notified. In addition, the student should be seen by a member/s of the crisis care team, within the same school day to screen for risk and facilitate referral. School staff may ask a student questions related to youth suicide prevention, intervention, or postvention.(Refer to Suicide Risk Screening Tool)

For youth at risk:

1. School staff will supervise the student until he or she is released to parent/guardian or appropriate emergency personnel.
2. The principal and or member of the crisis care team should be made aware of the situation as soon as reasonably possible.
3. The school principal, or member of the crisis care team will contact the student's parent/guardian and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local Emergency Department, but in most cases will involve encouraging parent/guardian and students to set up an outpatient mental health or primary care appointment.
4. Staff should ask the student's parent/guardian for written permission to discuss the student's health with outside care.
5. School Counselor/Social Workers/Nurses should have a current list of community-based mental health resources that is updated at least annually.
6. A member of the crisis care team should schedule a time to follow up with the student at risk and their parent/guardian.
7. All actions and assessments must be documented and kept secure and confidential. (Refer to Suicide Risk Screening Tool).

V. In-school Suicide Attempts

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

1. Call the police and/or emergency medical services, such as 911
2. The school counselor or mental health care team member or principal will contact the student's parent/guardian, as described in the Parental Notification and Involvement section.
3. First aid will be rendered until professional medical treatment and/or transportation can be received, following CCID emergency medical procedures.
4. School staff will supervise the student's safety.
5. Staff will move all other students out of the immediate area as soon as possible.

6. Staff will immediately notify the principal regarding in-school suicide attempts.

7. The school should engage the crisis care team as needed to assess whether additional steps should be taken to support the student's safety and well-being. They will also follow up with the parent/guardian as soon as possible to offer additional referrals/support as needed and to request they check in with a member/s of the crisis care team to establish a Return to Learn plan.

VI. Out-of-School Suicide Attempts

A. If a staff member becomes aware of a imminent suicide attempt out-of-school, the staff member will:

1. Call the police and/or emergency medical services, such as 911.
2. Inform the student's parent/guardian as soon as possible.
3. Inform the member/s of crisis care team and principal as soon as possible.
4. A member/s of the crisis care team will follow up with the parent/guardian as soon as possible to offer additional referrals/support as needed, and to ask to check in with the student before he or she returns to class to collaborate on a Return to Learn Safety Plan.

VII. Return to Learn

A. For students returning to school after a mental health crisis, it is recommended that a member/s of the crisis care team meet with the student's parent/guardian, and the student. This meeting shall address next steps needed to assess the student's readiness for returning to school and plan for the first day back. (Refer to Student Return to Learn Plan). Parent/guardian should be encouraged to inform the school of the nature of the student's mental health-related crisis to support continuity of service provision and increase the likelihood of a successful return to learning.

B. While not a requirement for returning to school, the school-employed mental health professional may, if possible, coordinate with the hospital and any external mental health providers to support the student in transitioning back to school following a mental health crisis. (Refer to Authorization for Release of Information Form).

1. To address ongoing concerns, including social or academic, it is recommended that the student will check in with the school counselor(s). The duration and procedure will be identified through the Student Return to Learn Safety Plan.
2. A member of the crisis care team should check in with the student and the student's parent/guardian at a mutually agreed upon interval and duration and may decrease in frequency over time.

3. A member of the crisis care team should work with the administration to disclose to the student's teachers and other relevant staff that the student is returning to school after a medical absence and any suggested accommodations.

VIII. Parental Notification and Involvement

A. In situations where a student is assessed at risk for suicide or has made a suicide attempt, the student's parent/guardian will be informed as soon as possible by a member/s of the crisis care team. If reasonable attempts to reach the parent/guardian or adult in whose custody the student may be released are not successful, the case will be treated as a medical emergency, and arrangements will be made to contact appropriate medical services or local law enforcement. Documentation of all parties attempted to be reached will be made. Failure on the part of the family to take seriously and provide for the safety of the student may be considered emotional neglect and reported to Utah Division of Child and Family Services.

B. If the student has exhibited any kind of suicidal behavior, the parent/guardian should be counseled on "means restriction," limiting the child's access to mechanisms for carrying out a suicide attempt. Staff will also seek parental permission to communicate with outside mental health care providers regarding their child. Through discussion with the student, the principal, and/or a member of the crisis care team will assess whether there is further risk of harm due to parent/guardian notification. If it is determined that contacting the parent/guardian would endanger the health or well-being of the student, then the Division of Child and Family Services (DCFS) must be contacted immediately.

IX. Postvention

A. Development and Implementation of an Action Plan. The crisis team will develop an action plan to guide school response following a death by suicide. A meeting of the crisis team to implement the action plan should take place immediately following news of the suicide death. For a more detailed description of the recommended postvention response, see the Crisis Response Plan. The action plan may include the following steps:

1. Verify the death. Staff will confirm the death and when possible the cause of death. Even when a case is perceived as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent/guardian will not permit the cause of death to be disclosed, the school will not share the cause of death but will use the opportunity to discuss suicide prevention with students. The school principal and the school employed mental health professional or counselor should visit with the family as soon as possible to offer condolences, ask if the family would like students or school staff to be

informed of the funeral services, ask which students may be most in need of support who were close to the deceased, etc.

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

3. Share information. Before the death is officially classified as a suicide, the death can and should be reported to staff, students, and parent/guardian with an acknowledgement that its cause is unknown. Inform the faculty that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Public address system announcements should be avoided. The crisis team may prepare a letter (with the input and permission from the student's parent/guardian) to send home with students that includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available. Examples of written statements and letters after a suicide death can be found at https://chapterland.org/wp-content/flipbooks/afterasuicide/index.html?page=58

4. Avoid suicide contagion. Students at increased risk of contagion may or may not include those who were closest to the student who died. The suicide death of a peer may increase risk for youth who did not personally know the youth who died but who were already at heightened risk for suicide. Alert staff to be aware of this possibility and be aware of all youth, including but not limited to friends of the deceased. It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high-risk students is to prevent another death. The crisis team will work with teachers to identify students who are most likely to be significantly affected by the death. In the staff meeting, the crisis team will review suicide warning signs and procedures for rapidly referring students who generate concern. Ask teachers to refer students who seem distressed or show suicide warning signs to the crisis teams, and encourage students to self refer and seek out the crisis team themselves if they recognize thoughts of suicide in themselves. Follow protocol IV and VII for any students who disclose thoughts of suicide during postvention. Schedule follow up with any highly distressed students or students who disclose

their own suicide ideation. Remember that anniversaries of the death, holidays, or rites of passage like graduation are also difficult times for survivors of suicide loss that could increase risk for suicidal thoughts. Postvention supports and/or referrals to services should continue as long as needed for students at high risk.

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

6. Memorials.

a. Permanent memorials are not a recommended practice. They increase potential for traumatization and may glamorize and romanticize suicide.

b. The school should not create on-campus physical memorials (e.g., photos, flowers) or fly the flag at half-staff.

c. Schools should not be canceled for the funeral.

d. Any school-based memorials (e.g., small gatherings, school newspapers, online memorial pages) will include a focus on how to prevent future suicides and prevention resources available and will be closely monitored by school staff.

e. Schools should also keep any spontaneous memorials monitored and time limited.

f. Memorials by school-sponsored groups, during school-sponsored activities or during a school day, are not appropriate.

g. Memorial plaques, mock headstones, etc. are inappropriate and are not to be placed on school property.

h. All plants, trees, shrubbery, etc., are placed on school property by CCID and should not be associated directly with any individual.

i. Family and friends wishing to recognize an individual are encouraged to establish scholarships or make other donations that benefit the education of students. Donations should be free of any expectation of plaques or other memorials.

j. Yearbooks-Dedication pages in yearbooks are strongly discouraged for any deaths among students and staff, including death by suicide as they are considered a ‘permanent’ memorial.

B. External Communication. The school principal or designee will work directly to provide external communication as needed. Staff will refer all inquiries from the media directly to the spokesperson. The spokesperson will:

1. Keep the director informed of school actions relating to the death.
2. Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation, means of suicide, or personal family information.
3. Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide, and not to use the phrase “suicide epidemic” – as this may elevate the risk of suicide contagion. They should also be encouraged not to assign a single cause to the suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available. It is also important to give hope for recovery and publicly acknowledge that most youth who experience thoughts of suicide go on to lead long meaningful lives, especially when they receive appropriate treatment and support.