NASP
NATIONAL ASSOCIATION OF School Psychologists

COVID-19 Resources

Comprehensive School Suicide Prevention in a Time of Distance Learning

If you are currently dealing with a suicidal child or adolescent **consider contacting the National Suicide Prevention Lifeline at 1-800-273-TALK or the Crisis Text Line, which can be reached by texting "HOME" to 741741. If you think a youth is at immediate risk of suicide, call 911 immediately for help. Ensure the entire school community is aware of these suicide prevention resources.**

There are good reasons to believe that a global pandemic will influence suicide risk. Specifically, the need for physical distancing may increase a sense of social isolation. Uncertainty about the circumstances of the pandemic may generate fear and worry about the future. Further, its effects on the ability to work and bring home paychecks will likely increase economic distress within families. Lack of consistency in routines or structure in the day may heighten feelings of being out of control and unable to cope. Combined, these factors will likely affect the severity of pre-existing anxiety and depression, lead to more alcohol and substance abuse, and increase domestic violence. Given these observations, the need for school psychologists to continue to offer comprehensive suicide prevention is clear. However, doing so when youth are not attending brick and mortar schools requires knowledge of a range of telecommunication options, basic telehealth competence, and an appreciation of the unique challenges and opportunities of telehealth. This document begins to provide such guidance as well as recommended suicide prevention, intervention, and postvention strategies.

BASIC ASSUMPTIONS

Regardless of the delivery platform there are certain suicide prevention tenets, protocols, and procedures to which we must attend. As listed in Table 1, there are a variety of international, national, and federal agencies and associations that provide such guidance.

Table 1. Agencies and Associations Offering Suicide Prevention Guidance

- American Association of Suicidology
- American Foundation for Suicide Prevention
- American Psychiatric Association
- American Psychological Association
- Centers for Disease Control and Prevention
- National Association of School Psychologists
- World Health Organization
- Substance Abuse and Mental Health Services Administration
- Suicide Awareness Voices of Education
- Suicide Prevention Resource Center

Some of the more important principles of school suicide prevention (that must be attended to regardless of service delivery platform) are offered here. Specifically, school suicide prevention, intervention, and postvention efforts must:

1. Recognize that suicide can be a 24/7 challenge and that schools (and school-employed mental health professionals) do not operate around the clock. School suicide prevention must have clearly articulated connections to community resources. Schools cannot address the challenges of suicide prevention on their own. Collaboration is essential.
2. Be viewed through both developmental and cultural lenses.
3. Be shared with the school community (often via district and school webpages). School websites should include links to resources that promote mental wellness and support suicide prevention (e.g., National Suicide Prevention Lifeline, Crisis Text Line).

4. Make use of (or create) electronic access to established protocols (or work to refine and clarify existing procedures) that allow members of the school community to promptly bring youth at risk for suicide to the attention of school-employed mental health professionals.
5. Employ clear guidelines for how school-employed mental health professionals and their administrators, supervisors, and interns respond to the challenge of youth who are suicidal. These guidelines should include specific guidance on how to document and report suicide prevention activities.
6. Recognize that youth are more susceptible to suicide contagion than other age groups (and that social media can fuel contagion).
7. Appreciate that school staff members are subject to the same suicide risk factors as their students. Thus, there is a need to be attentive to suicide warning signs among school staff members.
8. Recognize that school psychology interns and fieldworkers require supervision and ready access to supervisors.

VIRTUAL SERVICE DELIVERY PLATFORMS

Even when not in a brick and mortar school, there are a number of different ways in which school-employed mental health professionals can connect with students and provide school psychological services. Key to ensuring as equal access to these services as possible is knowledge of a range of communication options, the most basic of which is the telephone. Other telecommunication options that might be employed to connect with students include Apple FaceTime, Facebook Messenger video chat, Duo Mobile, Google Hangouts Meet, Skype, and Zoom. Specific options that are HIPPA compliant include VSee and doxy.me. It is important to note the U.S. Department of Health and Human Services has offered that telehealth can be provided via these platforms "… without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency" (HHS.gov, para. 6).

TELEHEALTH CONSIDERATIONS

Among the first things school-employed mental health professionals should do as they consider service delivery via one or more of the telecommunication options is to acquire knowledge about this service delivery method. Table 2 provides a listing of resources available through NASP that promote such learning. Table 3 provides additional resources.

Table 2. NASP Guidance on Telehealth and Virtual Service Delivery

- When One Door Closes and Another Opens: School Psychologists Providing Telehealth Services
- Legal and Ethical Considerations for Remote School Psychological Services
- Sample Psych Services Log
- NASP Virtual Service Delivery in Response to COVID-19 Disruptions
- NASP Guidance for the Delivery of School Psychological Telehealth Services

Table 3. Telehealth and Virtual Service Delivery Resources

- Notification of Enforcement Discretion for Telehealth Remote Communications During COVID-19 …
- National Center for School Mental Health COVID-19 Resources
- Zero Suicide – Telehealth Tips: Managing Suicidal Clients During COVID-19 Pandemic
- COVID-19 Tips for Building Rapport With Youth via Telehealth
- A Practical Guide to Video Mental Health Consultation

Before initiating any form of telehealth, familiarity with state telehealth laws is important, and consultation with school district legal counsel is advised. At a minimum, when using telehealth it is important to obtain informed consent, and

when doing so to notify students and their primary caregivers of the privacy risks of virtual service delivery. Always strive to make use of available privacy and encryption tools and ensure the highest degree of confidentiality possible (e.g., avoid the use of public internet connections). In addition, school-employed mental health professionals should strive to ensure that not only is their physical service delivery space private, but they should also know the physical location of the student and work to ensure that they have privacy as well. Encouraging the use of headphones with a microphone will give more privacy (and will also cut down on background noise). Especially when delivering high stakes services, such as suicide prevention activities, account for the possibility of telecommunication failure and have back-up communication options (e.g., if using Zoom and your internet connection becomes unstable, then have a cell phone and/or land line that could be called). This should include how to contact any primary caregivers that might be in the home.

Finally, whenever making these services available, schools must work to ensure equal access for all students. Specifically, school-employed mental health professionals must ensure that students with disabilities are able to access these services (see the U.S. Department of Education for more information). In addition, service providers must work to identify and account for youth on the opposite side of the "digital divide," and use appropriate telecommunication options (e.g., telephones). An especially challenging group is homeless youth, and when meeting their needs collaboration with community mental health is essential.

SUICIDE PREVENTION

These include activities that promote mental wellness, and proactively provide guidance that mitigates danger associated with suicidal ideation. Examples of the opportunities and challenges of using telecommunications to provide suicide prevention are offered in Table 4. This is followed by a discussion of recommended practices.

Table 4. Suicide Prevention Telehealth Opportunities and Challenges

Opportunities	Challenges
• Promotes connectedness and reduces feelings of isolation • Efficiently shares suicide prevention messages with the entire school community (while maintaining physical distancing requirements) • Provides prevention documents and resources (e.g., hotlines, text lines, means restriction, mental health guidance) • Promotes collaboration with community service providers (geographic boundaries are minimized) • Effective platform for psychological education (e.g., social–emotional learning) that promotes mental wellness and builds resiliency • Empowers teachers and other caregivers with knowledge of risk factors and warning signs, and how to address suicidal thoughts and behavior • Reduced stigma associated with asking for mental health services	• Ensuring safe messaging; might be viewed as giving excessive attention to suicide and, in doing so, romanticizing/glorifying suicidal behavior • Knowing the exact location of youth and their caregivers when delivering lessons • Social media can: ▪ increase risk of exposure to a death by suicide ▪ give access to suicide images or methods that may normalize suicidal behavior and increase contagion ▪ give excessive attention to events that precipitate suicide death and increase contagion • Meeting the needs of youth who do not have internet connections ▪ Homeless youth, those in foster care, and those without access to the internet or computer will not benefit • Unreliable/unstable internet connections ▪ Requires backup communication plans (e.g., phone numbers) • Privacy may be difficult ▪ May be in living situation where space is an issue

Recommended virtual suicide prevention practices.[1] Just as would be done in a brick and mortar school, virtual suicide prevention service delivery should identify and assertively support vulnerable populations (e.g., those exposed to suicidal behavior; known to be challenged by mental illness, disabilities, and bullying/cyberbullying; with housing insecurity and who are homeless; with trauma histories; and with histories of nonsuicidal self-injury). LGBTQ+ students can be a high-risk group, especially if they view access to important social supports as no longer available, particularly if they are experiencing parental rejection or peer victimization. For this population, consider encouraging access to The Trevor Project. School-employed mental health professionals should work to identify and activate available protective factors that will serve to increase resiliency among these populations.

Virtual suicide prevention should involve promoting access to resources that support mental wellness, as well as those that address mental illness and give specific guidance on suicide prevention. Continue to provide social and emotional learning opportunities (and look to CASEL for guidance on such during the pandemic). Whenever providing direct instruction, always begin each lesson by identifying where students are located and the availability of parents and other caregivers, and ensure a back-up communication options are available if technology fails during sensitive conversations (e.g., a student has expressed behavior associated with any degree of lethality). It would be important to have the ability to subtly, but assuredly remove a student who is presenting with any degree of lethality from the lesson (and to provide them with the appropriate individual services). In addition, consider reposting NASP's guidance on addressing anxiety and anxiety disorders and Preventing Youth Suicide, and consider making use of the comprehensive collection of resources that can be found in *Helping Handouts: Supporting Students at School and Home*. For example, *Suicidal Thinking and Threats: Helping Handout for Home* is available from the NASP webpage.

Addressing stress and promoting mental wellness can be supported by the use of smartphone apps, and a resource for selecting mental health apps can be found at PsyberGuide. Similarly, telecommunication technology can be used to create a virtual circle of care for at-risk youth that includes trusted adults. In addition, telecommunication can be used to facilitate connections among students within prosocial peer groups.

Finally, it continues to be important (arguably more important) to educate students and their caregivers about the risks of social media (e.g., cyberbullying). In addition, to minimize risk of romanticizing and glorifying suicide, whenever presenting lessons specific to the topic of suicide do so with small and naturally occurring groups (e.g., established classroom groupings). In addition, encourage teachers to remain vigilant to the potential negative impact of lessons involving the topic of suicide on sensitive students.

SUICIDE INTERVENTION

These include activities that address the immediate risk associated with the student who has suicidal thoughts. Examples of the opportunities and challenges of using telecommunications to provide suicide intervention are offered in Table 5. This is followed by a discussion of recommended practices.

Recommended virtual suicide intervention practices. Virtual suicide intervention necessitates that youth who have suicidal thoughts are brought to the attention of school-employed mental health professionals. This requires implementation of many of the suicide prevention strategies identified above. In particular, students themselves, as well as teachers, need to know exactly what to do when a student is suspected of having suicidal thoughts.

Another prerequisite to virtual suicide intervention is for service providers to have a complete understanding of the 24/7 emergency services in their area, and who to contact should there be risk of suicidal behavior. In addition, before attempting to initiate any suicide intervention, service providers should document exactly when the intervention began and ended, the physical location of the student (i.e., street address, room wherein they are communicating from), as well as that of their primary caregivers. Ideally, primary caregivers have given at least verbal permission to offer this service, are readily physically available to their child, and can support the potential need to eliminate access to suicide methods

[1] When initiating virtual suicide prevention, it might be helpful to consider guidance offered by NASP specifically intended to support the school-employed mental health professional's response to the pandemic. These resources include Preparing for Infectious Disease Epidemics and The PREPaRE Model, Crisis Intervention, and Global Pandemic.

(e.g., removing firearms from the home). However, because suicide intervention is crisis intervention, parental consent is not required and the absence of parents should not prevent a suicide intervention. That said, school districts are encouraged to consult their legal counsel regarding how to manage these situations. Further, back-up modes of communication should always be established and employed in the event of virtual technology failures (e.g., a telephone number to call if an internet or cell phone connection is lost). The greater the number of alternative communication options available the better.

Table 5. Suicide Intervention Telehealth Opportunities and Challenges

Opportunities	Challenges

• Potential for real-time connection with primary caregivers
• Hotlines and crisis text lines readily available (and have been shown to be helpful to those who choose to use them)
• Real-time collaboration with community service providers (geographic boundaries are minimized)
• Improved collaborative relationships with agencies that can respond directly to a student's home (e.g., law enforcement and social service agencies)
	• Many virtual platforms operate 24/7, and school is not a 24/7 resource
	• Knowing the exact location of youth and their caregivers
	• Responding when suicidal behavior is imminent
	• Responding when caregivers are not available
	• Addressing firearms in the home
	• Developing and monitoring safety plans
	• Teachers' ability to address lethality when it is identified during instruction
	• Obtaining consent to access confidential medical information
	  ▪ See FERPA, Disclosure of information in health and safety emergencies
	• Addressing student re-entry into the virtual classroom
	• Meeting the needs of youth who do not have internet connections
	  ▪ Homeless youth, those in foster care, and those without access to the internet or a computer will not benefit
	• Unreliable/unstable internet connections
	• Privacy may be difficult
	  ▪ May be in living situation where space is an issue

Whenever initiating a virtual suicide intervention, appreciate that safety planning is essential. Whenever suicidal thinking is identified, a safety plan should be among the most immediate topics discussed. The apps My3, Virtual Hope Box, and A Friend Asks might be useful when developing such a plan. And just as would be the case in a brick and mortar school, should there be any risk for suicidal behavior, strive to maintain constant visual (or at least verbal) contact with the student until the appropriate 24/7 resources (e.g., primary caregivers) are activated. Other electronically available resources that can support suicide risk assessment include the *Columbia Suicide Severity Rating Scale* (C-SSRS; particularly the short form) and SAMHSA's Suicide Safe Mobile App.

Whether provided in a school building or via telehealth connection, the school suicide intervention is necessarily a collaborative process, and school-employed mental health professionals should never be put in the position of going it alone. This is especially true for school psychology interns, practicum students, and fieldworkers. To the extent they are continuing to provide school psychological services, it is essential that they have immediate access to supervision.

It is important to consider how to interface with the treatment that is typically the result of a school suicide risk assessment. School-employed mental health professionals need to be able to obtain parental consent to monitor treatment and be able to facilitate school re-entry (even if the student is returning to a virtual classroom). Finally, as with any school psychological service, suicide intervention is a skill that requires ongoing professional development, and service providers should seek out such training (for example, the LivingWorks Start training).

SUICIDE POSTVENTION

As this special form of crisis intervention has the dual goals of intervening to help students cope with an extreme traumatic stressor and of minimizing suicide contagion (i.e., it is both prevention and intervention) many of the opportunities and challenges offered in Tables 4 and 5 are applicable. Examples of additional unique opportunities and challenges of using telecommunications to provide suicide postvention are offered in Table 6. This is followed by a discussion of recommended practices.

Table 6. Suicide Postvention Telehealth Opportunities and Challenges

Opportunities	Challenges
• Monitoring social media and virtual platforms helps to identify at-risk youth	• Social media fuels suicide contagion • Addressing memorials and memorial webpages • Family outreach • The ability to identify and connect with affected or traumatized students

Recommended virtual suicide postvention practices. As is the case for suicide intervention, suicide postvention is a skill that requires ongoing professional development, and service providers should seek out such training (for example, the American Foundation for Suicide Prevention and Suicide Prevention Resource Center's *After Suicide: A Toolkit for Schools* provides critical guidance for schools addressing the aftermath of a suicide death). This guidance is applicable regardless of the service delivery method. That said, special attention should be given to providing services to small groups of students who are judged to have significant coping difficulties and/or to be at risk for suicidal behavior. Large group virtual meetings or assemblies should be avoided. Social media should be monitored, not only to help identify individuals at-risk for suicide, but also for the presence of virtual memorials. As is the case for any memorial developed after a suicide death, strive to make sure that they focus on the promotion of mental wellness and the prevention of future suicides (and do not romanticize or glorify the suicide victim or suicide death). Finally, virtual connections to the family of a suicide victim are not preferred. After attending carefully to local physical distancing requirements, school suicide postvention should determine if a home visit is possible and appropriate.

For more information on suicide prevention and intervention for schools and on COVID-19, visit NASP's COVID-19 Resource Center at www.nasponline.org/COVID-19.

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