Assisting the School in Responding to a Suicide Death: What Every Psychiatrist Should Know

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KEYWORDS

• School-based mental health • Suicide • Postvention • Suicide contagion

KEY POINTS

- Suicide among school-age children has significant effects on the student population.
- Evidence-based suicide postvention guidelines are available to help guide schools following a student suicide.
- Child psychiatrists and mental health clinicians can play a variety of roles in the postvention process and can aid schools in a variety of ways through a well-thought-out response (ie, understanding grief reactions based on developmental levels, creating a crisis response team, advising schools on how to speak with the media).
- Providing suicide postvention following a student suicide is also a part of suicide prevention programming in schools.

Suicide is the second leading cause of death among young people between the ages of 15 and 19.[1] In 2016, 2439 children between the ages of 13 and 19 died by suicide,[2] and approximately 8% of high school students report making suicide attempts each year.[3] Additional concerns involve those students who are bereaved following a student suicide. Andriessen and colleagues[4] reported that past year prevalence of exposure to suicide among adolescents was approximately 4% and lifetime prevalence was approximately 21% (with suicide being more likely by a peer than a family member). The number of people impacted by each suicide ranges from 10 to 147, with 1 in 5 reporting devastating effects or major life disruption[5]; moreover, exposure to a

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suicide increases vulnerability to mental health issues, such as depression[6] and risk of suicide.[7]

A school is well positioned to provide support for students in the aftermath of a suicide. First, schools provide a familiar environment where students can continue to learn and thrive amid routines and people they know well. Second, school-based clinicians can provide mental health screening and targeted support to vulnerable youth to contain additional adverse outcomes, including the rare, but potentially lethal phenomenon of suicide contagion. Third, by promoting psychoeducation and open dialogues, schools can combat the stigma and shame that too often surround mental illness and suicide. Fourth, schools can offer frequent contact with individuals who are struggling with common trauma-related reactions (eg, ruminating on a "missed" opportunity to avert the suicide, feeling unsure how to respond, or feeling guilty for moving forward after a suicide). Finally, schools also have the unique opportunity to help scaffold the community (both school and town/city) to promote a wider healing after the tragedy of a school suicide.

Typically, a response to a student suicide is handled by the school mental health staff available in the local school district. However, the school may also consider reaching out to local child psychiatrists who can meaningfully and uniquely contribute to the healing process. Child psychiatrists may be contacted to assist with the initial crisis response, provide day-to-day guidance in the weeks after the death, and/or to gauge long-term progress. Having access to available resources and understanding the "dos and don'ts" of how to respond to a student suicide eases the navigation of an innately challenging situation. As champions of health and well-being for youth, child psychiatrists can serve as advocates for their communities to advance suicide prevention and promote healthier schools.

Having a coordinated plan to help students in the aftermath of suicide will lead to a faster recovery and return to precrisis academic and emotional functioning. When schools are not able to implement a postvention plan, there is risk for increase in psychological difficulties, disciplinary referrals, absences, and subsequently, a negative impact on the learning environment.[8] Emerging evidence provides clarity for specific steps to take during the immediate days, weeks, and months after a student suicide. There are a variety of online resources that schools might find helpful, including state-specific suicide prevention plans at the Suicide Prevention Resource Center (SPRC) Web site (http://www.sprc.org/states) and Substance Abuse and Mental Health Services Administration's Preventing Suicide: A Toolkit for High Schools, which provide an excellent starting place for developing a comprehensive approach to suicide prevention as well as response to a student suicide. Using these resources and examining the literature, what follows is a guide highlighting the elements of the school response to student suicide intersecting with the role of the child psychiatrist.

RESPONDING TO A SCHOOL SUICIDE: A TIMELINE

Postvention is the term used to describe the interventions implemented following a school crisis. More specifically, the term *suicide postvention* is defined as "activities developed by, with or for suicide survivors in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behavior."[9] Recommendations encompass both the procedures of responding to a suicide and the mental health interventions that are warranted and invaluable in the days to months that follow. Just as grief unfolds over time, it is natural for a school community to experience an evolving process after the tragic loss of a student. As such, conceptualizing a school response via a chronologic timeline is helpful in providing a roadmap and also detailing a staged

response that will parallel the grieving process of students and the larger school community.

Typically, school responses to a suicide occur in 3 stages:

1. Immediately following a suicide: this interval usually consists of the immediate messaging to the school community, initial student/staff reactions, and funeral/service participation; usually, this phase lasts about 1 week after the school learns of the suicide;
2. Student reequilibration: this is the interval when most students return to regular functioning, while other students may struggle or even deteriorate, and thus require more intervention support. This is also the interval during which the school community begins moving forward with the legacy/memory of the student; this usually lasts for weeks to months;
3. School reequilibration: the long-term aftermath of the suicide includes integration of the suicide into school events, such as graduation or the anniversary of the event. Another important component of this period is the implementation of systematic changes, often with improved screening, new or altered service provisions, and sustainable program changes to address risk factors (eg, substance abuse, bullying).

Stage 1: Immediate Suicide Postvention (up to 1 Week After Suicide)

There are several resources that provide different steps that schools can take immediately following a student suicide death. The child psychiatrist can assist the school's crisis response team in implementing these steps. Each step encompasses a need for an in-depth understanding of the mental health needs of various groups (family of deceased, school staff, parents in the community, students).

The items listed are some of the key steps that schools should take. Each circumstance is unique, so it is best to address these items in an order that makes sense for the specific situation:

- Verify the student's death with the family when possible. Social media lends itself to the distribution of misinformation; therefore, verifying that information is accurate is necessary.
- Communicate condolences to the family and assist with a message to provide the school community that is consistent with the family's wishes.
- Have the school's crisis team meet (preferably before students arrive to school) to identify responsibilities:
  - Identify students likely to be impacted by this event and who will reach out to those students.
  - Determine who will provide information to parents/community, and the school's response, regarding this event.
- Notify and then assemble the school staff to share facts about the event and funeral details, and anticipate student questions. It is not necessary to go into detail about how the student died, but all staff and the crisis team should have a clear, factually correct narrative based on the events that occurred as well as what the family wants shared. School staff also benefits from crisis intervention themselves with ample opportunity to discuss reaction to the suicide death of a student.
- Clarify the process (the when and where information) to notify students.
- Prepare school staff with the following:
  - What to say to students about this event
  - How students can express condolences to the family (and "remember" the student)

- Provide information about depression, suicide, hotlines, availability of counselors, feelings that often emerge after a death, and so forth as is age appropriate for their students
- Provide ongoing Crisis Team Check-In throughout the day to clarify impacts and needs.
  - Are outside providers needed to speak with student/staff groups?
- School staff should debrief at the end of the day to discuss issues that emerged, students that might need additional support, and plan to address.

Notifying the staff and students

After working with the bereaved family to determine how and what information is to be shared, the focus then shifts to disseminating information to the school personnel and students. Staff should be notified about the death before students are formally told. Ideally, staff can be brought together to hear of the student's death and to ask any questions. At this time, a prepared statement to be read to students is shared with staff to allow for any modifications or revisions before the information is shared with students. It also provides an opportunity for school staff to get more information on what to share, how to respond to students' questions, where to direct them for help, how to recognize students who might need some additional support, and common student reactions to grief.

Initial information about the death is often shocking and can invoke intense feelings (from sadness to anger to shutting down) and thus should be addressed with students in small groups (eg, in their homeroom). It is important *not* to communicate the death through "public address system announcements" or large meetings. For students who are distraught, having an identified place (and counseling staff) to meet, in addition to the initial classroom announcement and discussion, can help students process their reactions.

Notification of the death to parents/community

Working with natural supports (ie, parents, coaches and other adults in the community who interact with students) can help foster an air of care and understanding. Parents also experience intense emotional reactions, and some will be at a loss of how to best help their children. The child psychiatrist can help schools prepare, if asked, a statement, but also help anticipate reactions of parents and how students may be affected by witnessing adults in distress. Schools can help shore up support for their students by reaching out to parents via letters and parent meetings about what occurred, how the school is managing it, and what resources exist. In-person meetings can both alleviate community concerns and enlist parental support in reaching vulnerable youth. A child psychiatrist or other mental health professional may be asked to be present at one of these meetings on topics, such as typical youth responses to a sudden death, symptoms of adolescent depression, risk factors and behaviors that indicate concern, and available resources. Because large meetings can be unwieldy and lead to scapegoating and blaming, it is recommended that the school divide the initial parent meeting into 2 parts. The first part reviews the facts related to the student death (respecting the family's wishes and preferably after reviewing the message with parents directly) and dissemination of general information about the school's response without opening the meeting up to discussion. The second part of the meeting should divide the parents into small group discussions with trained crisis counselors on site to answer questions and provide support. A sample agenda for a parent meeting is available in After a Suicide: A Toolkit for Schools.[10]

Interaction with local media

Designating an identified crisis team member (usually the Principal) to interact with the media and channeling all media personnel to that person is most helpful to provide consistent messages. Staff benefit from knowing to route all media contacts/requests to this person and media interviews of students on school grounds may make the school feel less safe; similarly, media participation at parent/student/staff meetings may allow sensitive information to be taken out of context and then broadcast repeatedly, often unhelpfully, which can impede community healing.

Ideally, the school spokesperson should prepare a written statement for release to the media. The statement should not provide details of the death itself. Although it may include condolences to the survivors of the deceased, the focus should be on describing the positive postvention efforts designed to help student survivors as well as practical information about mental health and community resources available for struggling youth. The school should provide local media with Recommendations for Reporting on Suicide, available at http://reportingonsuicide.org/wp-content/themes/ros2015/assets/images/Recommendations-eng.pdf.[11]

School staff discussion with students

Staff will likely have several moments, both immediately and over subsequent weeks to months, when the topic of suicide will be brought up by students. **Table 1** provides ways that staff can talk about issues that may come up following a student suicide.

Student and staff reactions to the suicide

Each survivor experiences the loss differently, often with unanticipated emotions overwhelming their rational understanding of death. Moreover, although the suicide may involve a high school student, the siblings, classmates, friends, and community members impacted will cross all ages and developmental levels.

Although there is a common set of initial responses, including shock, sadness, anger, and disbelief, it is important to help the community understand that there is no correct way to grieve, and that each person may grieve on a different timeline (ie, the school will need to be flexible because various students and staff go through this initial grieving process at different paces). When feasible, it is preferable to continue school, classes, or scheduled activities, because the day-to-day structure of the regular school routine can provide comfort to the student community (extenuating circumstances do arise, however, such as a student athlete/musician committing suicide on the day of a game/concert, where the "team" is in too much shock to play a game that night, and so forth). That said, supporting teachers in providing flexibility can be helpful in minimizing additional stress and burden on students who are grieving.

Common grief reactions

Common adolescent grief reactions when a peer dies by suicide include the following:

- Guilt, blaming (others and self), shame, anger, rejection, and perceived stigma
- Risky coping behaviors, such as increased alcohol consumption
- A shift in perspectives on relationships and life
- A change in level of maturity
- A need to make meaning of the suicide, and to be able to talk about their experience
- Vacillating between help-seeking behaviors and isolation[6]

Understanding how developmental differences affect the grief process in students of different ages will help guide clinicians in deciding what strategies to use and to

Table 1
Tips for talking about suicide

Give Accurate Information About Suicide	**By Saying**…
Suicide is a complicated behavior. It is not caused by a single event. In many cases, mental health conditions, such as depression, bipolar disorder, PTSD, or psychosis, or a substance use disorder is present leading up to a suicide. Mental health conditions affect how people feel and prevent them from thinking clearly. Having a mental health problem is actually common and nothing to be ashamed of. Help is available. Talking about suicide in a calm, straightforward way does not put the idea into people's minds.	"The cause of *[NAME]*'s death was suicide. Suicide is not caused by a single event. In many cases, the person has a mental health or substance use disorder and then other life issues occur at the same time leading to overwhelming mental and/or physical pain, distress, and hopelessness." "There are effective treatments to help people with mental health or substance abuse problems or who are having suicidal thoughts." "Mental health problems are not something to be ashamed of. They are a type of health issue."
Address Blaming and Scapegoating	**By Saying**…
It is common to try to answer the question "why?" after a suicide death. Sometimes this turns into blaming others for the death.	"Blaming others or the person who died does not consider the fact that the person was experiencing a lot of distress and pain. Blaming is not fair and can hurt another person deeply."
Do Not Focus on the Method	**By Saying**…
Talking in detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable individuals. The focus should not be on how someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, and similar	"Let's talk about how *[NAME]'s* death has affected you and ways you can handle it." "How can you deal with your loss and grief?"
Address Anger	**By Saying**…
Accept expressions of anger at the deceased and explain that these feelings are normal.	"It is Okay to feel angry. These feelings are normal, and it doesn't mean that you didn't care about *[NAME]*. You can be angry at someone's behavior and still care deeply about that person."
Address Feelings of Responsibility	**By Saying**…
Help students understand that they are not responsible for the suicide of the deceased. Reassure those who feel responsible or think they could have done something to save the deceased.	"This death is not your fault. We cannot always see the signs because a suicidal person may hide them." "We cannot always predict someone else's behavior."
Promote Help-Seeking	**By Saying**…
Encourage students to seek help from a trusted adult if they or a friend are feeling depressed.	"Seeking help is a sign of strength, not weakness." "We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend

(*continued on next page*)

Table 1
(continued)

Promote Help-Seeking	By Saying…
	was feeling worried or depressed or had thoughts of suicide?"
	"If you are concerned about yourself or a friend, talk with a trusted adult."

From American Foundation for Suicide Prevention, Suicide Prevention Resource Center. After a suicide: a toolkit for schools. 2nd edition. Waltham (MA): Education Development Center; 2018; with permission.

know how the death might be conceptualized. Jellinek and Okoli[12] describe developmental differences important to recognize among students at different grade levels:

- Preschool: students display "magical thinking" with little understanding about the permanence of death, sometimes seeming "casual" or even excited about rituals surrounding death. They benefit from description of positive memories of the deceased and concrete pictures or mementos.
- Elementary: students of this age are developmentally self-focused, and so they may worry about how suicide may impact them or their family. Subsequently, reassurance that they are safe and their family will not substantially change can be helpful.
- Middle school: students of this age are beginning to individuate and thus are more peer-centric as they separate from parents. They may experience feelings of concern or guilt that they should have foreseen or even prevented this death. They may benefit from a discussion of the facts surrounding the death, information they may not have had, how each peer may feel something they did (or did not do) could have influenced the suicide ("I didn't say 'hi' in the hall the day before she died—I think that may have been what pushed her over the edge."); rarely, they may have had a significant fight, breakup, episode of bullying, or efforts to oust a student from their group immediately before the suicide, and thus, may require more intensive counseling.
- High school: students can recognize the finality of this person's death and that this will be the person's "identity" in this life, so they may benefit from a discussion of the meaning of the student's life and what will persist after the funeral beyond this "article" of the person's life. Given the complexity of peer relationships at this stage, it is important to consider the nature of interpersonal relationships between the deceased and his or her peers, and especially how these factors might contribute to others' vulnerabilities.

Research indicates that adolescents experience a range of negative cognitions and emotions following a peer suicide; however, these young survivors may not always have the ability to accurately articulate or identify their thoughts and feelings. For those adolescents who do present to staff, suggesting descriptive language beyond "mad, happy, or sad" and providing education about the physiologic symptoms of emotions (ie, butterflies in the stomach, sweaty palms, fatigue, poor concentration, numbness) may be helpful. Connecting with students and keeping them engaged in talking about their emotions can help further elucidate the impact of recent events on them. Asking open-ended questions, such as, "What is your biggest concern right now?" or "What would help to make you feel safer?," will help gauge the student's current specific needs.[13,14]

Box 1
Practical coping strategies

- Use simple relaxation and distraction skills, such as taking 3 deep slow breaths; counting to 10; or picturing themselves in a favorite calm and relaxing place
- Engage in favorite activities or hobbies, such as music, talking with a friend, reading, or going to a movie
- Exercise
- Think about how they have coped with difficulties in the past and remind them that they can use those same coping skills now
- Write a list of people they can turn to for support
- Write a list of things they are looking forward to
- Focus on individual goals, such as returning to a shared class or spending time with mutual friends

From American Foundation for Suicide Prevention, Suicide Prevention Resource Center. After a suicide: a toolkit for schools. 2nd edition. Waltham (MA): Education Development Center; 2018; with permission.

Practical coping strategies

Although the experience of adolescents who are grieving a peer who died by suicide is in many ways unique, counselors and mental health professionals are familiar with effective strategies. An understanding of relaxation techniques and cognitive exercises are all helpful in promoting resiliency and healing. After a Suicide: A Toolkit for Schools makes recommendations of strategies that can help adolescents cope (**Box 1**).[10]

Meeting with students in small groups or individually and having them practice these skills in vivo can help to reduce the stigma in using coping skills and can become an experience in itself that can promote positive feelings.

Students may ask difficult questions or ones that are beyond a staff's expertise. It is ok to say, "I don't know," or to reassure the student that they will help them find the answer. Students may also ask questions that need clarification. Staff needs to make sure they get back to students with a response. Rather than quickly responding, asking students to say more about a statement can provide additional information. Finally, these small groups also serve the purpose of protecting a time and place for meaningful connections with others, which can also be therapeutic.

School routine

Students (and staff) will react differently to the suicide, such that the first week requires allowances for students to endure the natural process of grief as they contend with this event and its impact on them, their friends, and the community. Having counseling staff available throughout each day for the first week is helpful because students may appear to do well initially and then struggle over time. In addition, staff similarly needs opportunities for clinical support this first week, because they often feel exhausted at various points trying to "hold it together" for students. Pertinently, the week surrounding a student suicide is likely to be erratic, and attempting to implement the "normal routine" is often difficult for students and staff; thus, it is advised to dissuade high-stakes events (testing, sporting events, and so forth) during this interval.

Stage 2: Student Reequilibration (Weeks to Months After Suicide)

Although some students may return to baseline after the first week, other students may need several additional weeks to adjust. Flexibility may be needed both for school

schedules and for individual students to resume a routine similar to the time before the suicide. Additional staff check-ins and booster support sessions may be warranted. Opportunities that will allow for students to contact school counselors/mental health staff if events rekindle painful recollections or distress that interfere with classroom functioning will still be necessary in the months following the suicide.

Some students may continue to struggle and have more impairment. Typically, 2 (often overlapping) groups of students may deteriorate or have elevated risks:

1. Students who knew the student who died by suicide
2. Students experiencing distress or psychiatric symptoms now exacerbated by this difficult event.

The interventions for each group may similarly overlap, although there are differences in response to each group.

Identifying students at risk

Students who knew the deceased student may feel inadequate, guilty, or even responsible for the suicide.[15,16] Students often perceive that they "should" have noticed some behavior or made some comment that could have prevented the suicide. Continuing to offer support at the school in the months following the event offers providers an opportunity to support these students in small groups or individual meetings. Staff and clinician efforts to listen and "hear out" the student can be particularly helpful. Clinicians or staff can then bring up other variables for consideration that may have contributed to the death. Although a suicide note might ascribe blame to another student, rarely is that the only variable contributing to a suicide.

The most common psychopathologies following a peer suicide are depression, anxiety, and posttraumatic stress disorder (PTSD), as well as an increase in suicidal behavior.[5,17–19] By understanding specific presentations of adolescent depression, anxiety, and trauma-related disorders, schools can more easily identify students who may need more support. Schools can provide screening for higher-risk individuals or for those who continue to present for help. Students who experience the suicide as traumatic and demonstrate symptoms of (1) avoidance of reminders, (2) negative cognitions (eg, the world is unsafe, it is all my fault), (3) reexperiencing of the event, and (4) difficulties with increased arousal, poor concentration, or sleep disruption a month after the event are likely struggling with PTSD and should be referred for individualized treatment. Students who are more irritable or down, suddenly doing worse in academics, and exhibiting signs of being withdrawn should be identified and screened for depression. For those who screen positive, referrals to the community are warranted, and school counselors must follow up to ensure the student was actually able to connect with the outside provider.

In addition to helping schools be on alert for psychiatric signs and symptoms, an understanding of characteristics beyond *Diagnostic and Statistical Manual of Mental Disorders* diagnoses can further identify vulnerable students. One model useful for identifying at-risk students is the "Circles of Vulnerability."[20] This trauma-derived model describes the degree of emotional impact on members of a community following the occurrence of a critical incident or disaster and can assess how suicide may impact students.[21] The 3 circles that intersect with one another are the following:

1. Psychosocial proximity,
2. Geographic proximity,
3. Populations at risk.

Understanding how students may fit in to these circles and which ones have an accumulation of risks helps to identify students who need more intensive surveillance and support.

Stage 3: School Reequilibration (Months After Suicide)

Months following the suicide, students and staff may find ways to integrate the suicide event and perhaps even be able to learn from it. The child psychiatrist can help the school recognize suicide risk factors (eg, substance use, bullying) as they consider prevention strategies. Similarly, protective factors (eg, cohesion provided by extracurricular activities, partner community groups including youth organizations, sports organizations, religious organizations) can be identified and enhanced through collaboration between the school and community leaders and organizations.

The school will typically resume the regular schedule within 1 to 2 weeks of the suicide. However, events significant to the deceased, such as roles in sporting activities, extracurricular activities, or even "anniversaries" of events or birthdays, serve as ongoing reminders and may trigger student and staff emotions. When events warrant inclusion of the student who died by suicide, early recognition and positive contributions appear most helpful. As the shock of the suicide wanes, both staff and students are positioned to think about the legacy or positive lessons this student will leave, and what viable school changes might reduce subsequent suicides in this school community.

School suicide prevention programming

Staff training to recognize and respond to student comments about suicide, death, or depression can be helpful for the "school community" to better recognize early warning signs.

Trainings useful for school staff can be found by searching in the Resources and Programs section of the SPRC Web site.

Remembrance

Anniversaries are times when students may be triggered to remember prior events and have been known to see an increase in suicidal behavior in students. Providing a positive outlet 1 year after a student suicide can help create a focus for the school community and raise awareness that help for mental health issues is available. Fund-raisers that (1) donate to a suicide prevention organization, (2) create a memory quilt in honor of the deceased, (3) organize a walk/run in the person's memory with a mental health focus, or (4) distribute materials related to mental health and suicide prevention are all ways that provide effective solutions going forward. Additional anniversaries that may trigger intense feelings include birthdays, graduation, prom, or opening day for athletic or theatrical events in which the student participated. The 2-year anniversary is also notable to students, and schools can also provide similar activities.

SUICIDE CONTAGION

Although relatively rare, suicide contagion can occur following the suicide of a peer and is often on the mind of parents and administrators in the days and weeks following. Suicide contagion can account for 1% to 5% of teenage suicides[22] or 100 to 200 deaths annually. Contagion in this context can have various meanings[21]; however, for purposes of exploring a school's response, it is defined as the process of one suicide death leading to another.[23–26] Adolescents are more susceptible to the phenomenon,[5,7,17] leading caregivers and school personnel to understandably be concerned following a student suicide. Fortunately, there are now helpful

Box 2
The role of the child psychiatrist

- Provide schools administrators with available resources for suicide postvention
- Review procedures for conducting classroom or small group presentations on responses to sudden loss
- Familiarize staff with the developmental tasks associated with recovery from loss, and the dynamic nature of trauma and loss
- Screen students and provide appropriate referrals when warranted
- Colead support groups
- Assist school staff in conducting parent meetings
- Advise staff on how to respond to media representatives
- Provide clinical consultation to school counselors and the postvention team
- Provide support services or referrals
- Meet with the postvention team to review their process
- Assist the team in evaluating their efforts
- Make suggestions for improving the postvention policy and procedures
- Identify new community resources for future situations
- Present information on prevention to community members

Adapted from Kerr MM, Brent DA, McKain B, et al. Postvention standards manual: a guide for a school's response in the aftermath of a sudden death. 4th edition. Pittsburgh (PA): University of Pittsburgh, Services for Teens at Risk (STAR-Center); 2003; with permission.

guidelines that schools can follow to help reduce the risk of suicide contagion. Well-implemented postvention can reduce further loss and trauma and lead to prevention and improved mental health among a student body. In fact, one of the goals of implementing a stronger suicide postvention response in schools is to prevent further self-harm or suicidal behavior among students in addition to supporting the student body through the experience of grief and loss.[8]

The Role of the Child Psychiatrist

Each school will adapt postvention efforts in ways that best fit their culture and climate and meet the needs of their staff and students. Child psychiatrists may serve a role in these efforts in a variety of ways. Examples of the various tasks of the child psychiatrist are described in **Box 2**.

Ultimately, incorporating mental health programming "upstream" of more well-defined problems and targeting at-risk individuals can help strengthen the emotional well-being of students. There is now ample evidence for programming to support schools in this endeavor. Schools are where children and adolescents spend most of their waking hours, and providing mental health programming, particularly in the wake of suicide and loss, can only help strengthen schools and the students within them. Although a school community that has experienced a student suicide is forever changed, in the midst of the tragedy, there is also opportunity to build resilience and maximize the potential of students, staff, administrators, and the community.

SUMMARY

When suicide occurs among school-age students, the tragedy profoundly impacts the community. The school itself is in a position to address and decrease the impact of such

tragic circumstances. However, the school also benefits from community support in such an event, because this type of death requires a specialized response. High-quality, evidence-based guidelines freely available to schools can be very helpful during a devastating time for other students and staff. If called upon, child psychiatrists can provide their unique skills set and understanding of child development, psychopathology, risk assessment, as well as consultation skills to support schools throughout the crisis. Using these resources provides an effective roadmap to guide their support with a bereaved school.

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