



**American
Foundation
for Suicide
Prevention**

Policy Priority: Suicide Prevention in Schools (K-12)

According to the latest (2020) data from the Centers for Disease Control and Prevention (CDC, 2022), suicide is the third leading cause of death for young people ages 10-19. According to the 2021 Youth Risk Behavior Survey, in the 12 months preceding the survey, more than 1 in 5 high school students (22.2%) in the U.S. reported having seriously considered attempting suicide, 17.6% made a plan about how they would attempt suicide, and 10.2% of students (about 1 in 10) reported having attempted suicide (CDC, 2021).

These statistics point to a serious, yet preventable public health problem. Ninety percent of young people who died by suicide had a mental health condition at the time of their deaths, although often these conditions were untreated, under-treated, or undiagnosed. In fact, over half (54%) of people who died by suicide had not been identified as having had a mental health condition despite the co-occurrence of mental health conditions and suicide (CDC, 2018). This highlights the need for more education. While most people with mental health conditions do not engage in suicidal behavior, treating underlying mental health conditions is a key component of suicide prevention and can help people better manage suicidal ideation and behavior.

The first onset of mental illness typically occurs in childhood or adolescence. Children and teens spend a significant amount of their young lives in school; schools, administrators, and peers have an important role to play in identifying students who are showing signs of a mental health condition or suicide risk, intervening with students presenting acute risk or who attempt suicide, and responding to completed suicides within the school community. This includes school plans for prevention, intervention, and postvention as well as ensuring students have access to information, resources, and services related to suicide prevention.

School Policy & Personnel Training to Reduce Suicide

Prevention: There are 2 key tasks for schools in preventing youth suicide: (1) Schools can identify students at risk, and (2) Schools can work with parents and guardians to ensure students at risk are assessed and evaluated by a mental health professional (within or outside the school setting), according to school protocol or policy.

As children and teens spend a significant amount of their young lives in school, the personnel that interact with them daily are in a prime position to recognize the signs of mental health conditions and suicide risk and make the appropriate referrals for help. To be able to do this, personnel will need effective training to acquire the necessary skills and confidence to intervene with youth at risk; mandated training is one way to ensure that all school personnel have a baseline understanding of suicide risk and the referral process.

Suicide prevention training for school personnel is targeted within the updated [2012 National Strategy for Suicide Prevention](#) (NSSP), a report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. The NSSP includes 4 strategic directives and a set of 13 goals and corresponding 60 objectives that recommend a variety of organizations and individuals become involved in suicide prevention. Specifically, Goal 7 of the NSSP is to “Provide training to community and clinical service providers on the prevention of suicide and related behaviors.” These community-based and clinical prevention professionals include educators and school personnel, as their “work brings them into contact with persons with suicide risk,” and they should therefore be “trained on how to address suicidal thoughts and behaviors and on how to respond to those who have been affected by suicide.” Corresponding Objective 7.1 specifically indicates school counselors as persons “on the frontlines of suicide prevention” that should receive training, and recommends that schools, colleges, and universities “train relevant school staff to recognize students at potential risk of suicide and refer to appropriate services.” Several other objectives within the NSSP (Objectives 1.1, 3.1, and 5.2 specifically) also assert that suicide prevention should be integrated into the values, culture, leadership, and work of educational institutions, and that schools, colleges, and universities have a role to play in “training personnel who are in contact with individuals with suicide risk, and providing support to individuals in crisis,” (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention [U.S. Dept. of HHS & Action Alliance], 2012).

Prevention efforts cannot be done in isolation. Preventive approaches, like training school personnel to identify risk factors and warning signs, should be built on a foundation that also responds to two serious issues currently facing schools – students at high risk of suicide and a death by suicide in the school community. With intervention and postvention policies in place to ensure students at risk receive appropriate services and that suicides in the school community are addressed safely, preventive approaches such as staff training will be even more likely to prevent suicide. Therefore, it is imperative that schools adopt comprehensive policies and procedures on suicide prevention, intervention, and postvention to support personnel and to provide them with a clear roadmap, accessible year-round, for how to prevent, intervene in, and respond to student suicidal behavior.

Intervention: Comprehensive policies and procedures that incorporate methods of suicide intervention in addition to preventive measures will ensure that educators have guidance around and are supported in intervening with students at high risk for suicide or who attempt suicide at school. With a comprehensive intervention policy in place, educators will be empowered to intervene appropriately and confusion over educator roles and the referral process will be eliminated. Many schools cannot directly provide mental health services for students at risk, nor should teachers be taking on that role. Therefore, it is important that in-school and community mental health service providers to whom students can be referred are identified during the development of school policy and that these service providers and parents and guardians be involved while developing intervention protocols. It is also critical to ensure that the mental health service providers receiving said referrals have been [trained in suicide assessment, treatment, and management](#).

Postvention: The term “postvention” refers to the coordinated school response following a completed suicide in the school community. Suicide in a school community is tremendously sad, often unexpected, and can leave a school with many uncertainties about what to do next. Faced with students struggling to cope and a community struggling to respond, schools need concrete, pragmatic guidance on how to support both students and staff – *before* a crisis occurs. A comprehensive school policy that incorporates methods of postvention will ensure that educators know how to respond safely when a suicide occurs in the school community, avoiding suicide contagion or “copycat” suicides, and that educators are equipped to support affected students and their families as well as fellow school staff. Research shows that effective postvention support can contribute toward overall preventive efforts.

Student Education and Resources

Suicide Prevention and Mental Health Education: Identification of suicidal ideation and behaviors and access to assessment and intervention resources are key to preventing suicide in young people. Trained school personnel form an integral support system for students at risk for suicide, and students’ peers can work alongside school personnel to identify risk behaviors and provide connections to supportive adults. In addition, education about mental health conditions and suicide prevention can play a vital role in destigmatizing symptoms and treatment. Peer education models, such as the *Sources of Strength* program implemented in Georgia, New York, and North Dakota, have successfully changed student attitudes and behaviors around suicide and seeking help (Wyman, et. al, 2010). Educating students directly about suicide prevention can also positively impact student attitudes and behaviors; Objective 5.2 in the NSSP calls on schools to ensure “students at risk of suicide have access to mental health and counseling services and are encouraged to use those services” (U.S. Dept. of HHS & Action Alliance, 2012). Suicide prevention education curriculum is available from a variety of national programs, such as the National Council for Wellbeing’s *teen Mental Health First Aid* and the American Foundation for Suicide Prevention (AFSP)’s *More Than Sad: Teen Depression and Its Real: Teens and Mental Health* programs. For younger students, AFSP has partnered with the Connecticut Department of Mental Health and Addiction Services and the United Way of CT/ 2-1-1 on behalf of the CT Suicide Advisory Board to offer *Gizmo’s Pawesome Guide to Mental Health* through local AFSP chapters to promote positive mental health habits and trusted-adult connections for elementary-aged children.

Reducing Stigma and Increasing Knowledge of Services: While the reasons behind thoughts of suicide are complex, help and services are available, and students should be able to easily access them. However, stigma surrounding thoughts of suicide and mental health services can prevent youth from connecting with these vital resources. Recently, two approaches to reduce stigma and connect middle and high school students with resources have grown in popularity, including more widespread promotion of available crisis hotlines and allowing excused absences for mental health. These approaches align with the 2012 NSSP goals that encourage schools to make resources for suicide prevention known and easily accessible to students.

Providing students with the [988 Suicide and Crisis Lifeline](#) and other crisis line numbers serves to increase awareness and reduce stigma about seeking help. Through crisis lines, counselors can engage callers to deescalate a crisis (Gould et al., 2016). Crisis counselors may collaborate with emergency services, crisis centers, and other third parties to reduce access to lethal means, create a safety plan with the caller, and connect the caller to additional resources. In one study, crisis counselors were able to use these strategies to keep 76.4% of callers safe (Gould et al., 2016). By listing crisis line numbers like 988 in easy to see places, like a student identification card, schools can help increase the likelihood that those numbers are used during a suicidal or mental health crisis. Inclusion of crisis line numbers on student IDs, in student handbooks, and posted conspicuously in schools also helps to increase knowledge and acceptability of these resources.

Allowing students to be excused from school to attend to their mental health can increase transparency, reduce stigma, and encourage help-seeking behaviors. It also helps to create a school culture where mental health is seen as an important part of overall health and empowers students to prioritize mental wellness. Many schools still have policies that penalize students for “unexcused” absences, and not including mental health as an allowable absence leads to dishonesty about absences and increased stigma toward mental health symptoms. On the other hand, allowing for mental health absences can open conversations about mental health between students, parents and guardians, and administrators and empower students to recognize when they should take time to care for their mental health. This also better equips the entire school community to identify students at risk for suicide.

Current State Laws

State Mandated Annual Training for School Personnel (13 states)

Delaware, Georgia, Hawaii (charter schools only), Idaho, Iowa, Kansas, Louisiana, Maryland, Nebraska, New Hampshire, North Carolina, Rhode Island, and Tennessee currently mandate annual suicide prevention training for school personnel. In Georgia, Idaho, Kansas, Louisiana, Rhode Island, and Tennessee, this mandate is titled the *Jason Flatt Act*.

- **Delaware** requires public school employees to receive 90 minutes of training each year; training materials must be evidence based and developed/approved by the Departments of Health and Social Services, Services for Children Youth and their Families, and Education [adopted 2015]
- **Georgia** requires annual training for all certificated public-school personnel; the training must be provided within the framework of existing in-service training programs offered by the department of education or as part of required professional development offered by a local school system [adopted 2015]
- **Hawaii** requires annual youth suicide awareness and prevention training for charter school personnel who work directly with K-12 students [adopted 2019; separate section applies to public school personnel, and that requirement is not annual]

- **Idaho** requires the state board of education to adopt rules supporting annual suicide prevention and awareness training for public school personnel; training may be provided within existing in-service or professional development frameworks offered by the state board of education and state department of education [adopted 2018]
- **Iowa** requires annual, evidence-based training at least 1-hour in length for all school personnel who hold a license, certificate, authorization, or statement of recognition issued by the board of educational examiners and who have regular contact with students in kindergarten through grade 12 [adopted 2018]
- **Kansas** requires each school district board of education to provide suicide awareness and prevention programming to all school staff, including a minimum of 1 hour of training per calendar year [adopted 2016]
- **Louisiana** requires 2 hours of in-service training each year for public and approved nonpublic teachers, school counselors, principals, and other administrators “for whom such training is deemed beneficial” [originally adopted 2008, amended 2019]
- **Maryland** requires that all certificated school personnel who have direct contact with students on a regular basis complete a training each year in the skills required to understand and respond to youth suicide risk and to identify professional resources to help students in crisis [amended 2017; Maryland’s original Lauryn’s Law, adopted in 2015, only applied to school counselors and was not an annual requirement]
- **Nebraska** requires at least 1 hour of training each year for all public school nurses, teachers, counselors, school psychologists, administrators, school social workers, and other “appropriate personnel”; also requires the department of education to collaborate with others in the state to develop a list of approved training materials that identify available mental health services and instruct on when and how to refer youth and their families to those services [adopted 2014]
- **New Hampshire** requires at least 2 hours of training each year for all school district and chartered public school staff, including contracted personnel; training may be accomplished within the framework of existing in-service training programs or offered as part of ongoing professional development activities, and self-training materials may be used [adopted 2019]
- **North Carolina** requires employees to receive an initial mental health training of at least six hours within the first six months of employment and subsequent mental health trainings of at least two hours annually thereafter; said mental health training must include suicide prevention [adopted 2020]
- **Rhode Island** requires annual suicide awareness and prevention training for school personnel, including teachers, administration, custodians, lunch personnel, substitutes, nurses, coaches and coaching staff, and volunteers [adopted 2021]
- **Tennessee** requires 2 hours of in-service training each year for all school employees [amended 2016; original law adopted in 2007 only applied to teachers and principals]

State Mandated Training for School Personnel, Not Annual (24 states, plus DC)

Alaska, Arizona, Arkansas, Connecticut, DC, Hawaii, Illinois, Indiana, Kentucky, Maine, Minnesota, Mississippi, Nevada, New Jersey, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming currently mandate training in suicide prevention for school personnel but do not specify that the training must be annual. In Alaska, Arkansas, Mississippi, Ohio, South Carolina, South Dakota, Texas, West Virginia, and Wyoming, the law is titled the *Jason Flatt Act*.

- **Alaska** requires an unspecified duration of training each year for teachers, administrators, counselors, and specialists who provide services to public school students, provided according to the schedule adopted by the governing body of a school district [originally adopted 2012, amended 2015 (removed annual requirement) and 2016 (expanded to all grades)]
- **Arizona** requires all school guidance counselors, teachers, principals, and other school personnel who work with students in grades 6-12 to receive training in suicide prevention at least once every three years [adopted 2019]; requires each teacher, school counselor, or school social worker training program to develop or adopt evidence-based instruction on suicide awareness and prevention and provide that instruction to all candidates [originally adopted 2019, amended 2020]
- **Arkansas** requires 2 hours of professional development for licensed personnel [originally adopted 2011, amended 2013]
- **Connecticut** requires (an unspecified duration of) training once, as a condition of initial certification for beginning teachers; local boards of education must also provide an in-service training program for teachers, administrators, and pupil personnel that includes information on youth suicide prevention and response [adopted 2011]
- **District of Columbia** requires all teachers and principals in public schools and public charter schools and staff employed by child development facilities to complete the DC Youth Behavioral Health Program (includes recognizing warning signs and risk factors for youth suicide and best practices for suicide prevention, intervention, and postvention) once every two years [adopted 2016]
- **Hawaii** requires that a mandatory youth suicide awareness and prevention training program be provided to teachers, teacher assistants, administrators, and counselors; said training may be provided to contract workers [adopted 2019]
- **Illinois** requires licensed school personnel and administrators who work with pupils in grades K-12, at least every 2 years, to be trained and taught appropriate intervention and referral techniques; the training must be provided within the framework of existing in-service training programs or required professional development activities [originally adopted 2009, amended 2018]
- **Indiana** requires that each school corporation, charter school, and state accredited nonpublic school require all principals, teachers, librarians, school counselors, school psychologists, school nurses, and school social workers employed at schools providing instruction to students in grades 5-12 participate in research based in service youth suicide awareness and prevention training in a manner prescribed by the State Board of

Education [amended 2017, 2018, and 2020; originally adopted 2011 to require unspecified duration of training for initial teaching licensure at any grade level; amended 2017 to require at least 2 hours of training every 3 years for all school personnel listed above in current statute; amended 2020 to eliminate length and frequency requirements and allow for State Board to make such determinations]

- **Kentucky** requires at least 1 hour of in-person, live streaming, or video suicide prevention professional development training every other school year for all school employees who have direct contact with 6th-12th grade students; also requires newly hired staff members to receive materials on suicide prevention when hired in a year training is not provided [amended 2018 and 2019; original law adopted in 2010 required 2 hours of “self-study review of suicide prevention materials” each year for high school and middle school principals, guidance counselors, and teachers]
- **Maine** requires all elementary, middle, and high school personnel to receive a 1-2 hour in service training module in suicide prevention awareness every 5 years, and at least two personnel in each school to take a more intensive one-day course in suicide prevention and intervention training every 5 years [adopted 2013]
- **Minnesota** requires all licensed teachers to obtain at least one hour of suicide prevention best practices training in each licensure renewal period based on nationally recognized evidence-based programs and practices; initial training must include understanding the warning signs of early-onset mental illness in youth, and subsequent training must include more in-depth understanding of students’ mental illness trauma, related accommodations, parents’ roles, and de-escalation methods, among others [originally adopted 2016, amended 2017]
- **Mississippi** requires (an unspecified duration of) training for all newly employed school district employees [originally adopted 2009, when training requirement only applied to licensed teachers and principals; amended in 2017 to include all district personnel]
- **Nevada** requires training for teachers, pupils, and school resource officers concerning the prevention of suicide; training must include information on mental health services available in the community and individuals/organizations available to assist in responding to a suicide [adopted 2019]
- **New Jersey** requires 2 hours of training to be completed in each professional development period for public school teaching staff members; New Jersey is unique in that it specifies that a qualified trainer in the mental health community must administer the training [adopted 2006]
- **Ohio** requires that training in youth suicide, awareness, and prevention be incorporated into existing in-service training required for nurses, teachers, counselors, school psychologists, administrators, and any other “appropriate” personnel every 5 years [adopted 2012]
- **Oklahoma** requires all school staff district-wide receive training on suicide awareness and prevention once every 2 years [adopted 2021]
- **Pennsylvania** requires at least 4 hours of training every 5 years for professional educators in school buildings serving students in grades 6-12 [adopted 2014]
- **South Carolina** requires 2 hours of training every 5 years (consistent with the state’s existing licensure cycle) [adopted 2012]

- **South Dakota** requires a minimum of 1 hour of training for initial certificate and renewal certificate as a teacher, administrator, or other educational professional [adopted 2016]
- **Texas:**
 - Requires staff development for educators in suicide prevention; training must be based on best practice recommended by the Department of State Health Services in coordination with the Texas Education Agency and may be completed via independent online review [originally adopted 2015, amended in 2021 to remove annual frequency]
 - Requires that minimum academic qualifications for certified educators also require instruction regarding mental health, substance abuse, and youth suicide, provided through a program selected from the list of recommended best practice-based programs established under Texas Education Code §38.351, and including effective strategies for teaching and intervening with students with mental or emotional disorders, including de-escalation techniques and positive behavioral interventions and supports [originally adopted 2013, amended 2015]
- **Utah** requires 2 hours of training consistent with the state’s licensure cycle [adopted 2012]
- **Virginia** requires school counselors to complete training in the recognition of mental health disorders and behavioral distress, including depression, trauma, violence, youth suicide, and substance abuse, for initial licensure and license renewal [adopted 2017]
- In **Washington**, school social workers, school nurses, school psychologists, and school counselors are required to receive at least 3 hours of training as a condition of professional certification [adopted 2013]
- **West Virginia** requires “routine education” for professional educators, including principals, administrators, and those service personnel having direct contact with students, under guidelines established by the State Board of Education [originally adopted 2012, repealed 2018, reenacted 2020]
- **Wyoming** requires at least 8 hours of suicide prevention education every 4 school years for all teachers and administrators using “suitable materials reviewed and recommended” by the state superintendent and the director of the department of education [adopted 2014]

State Encourages Training for School Personnel (12 states)

Alabama, California, Colorado, Florida, Massachusetts, Michigan, Missouri, Montana, New York, North Dakota, Oregon, and Wisconsin currently have laws in place that encourage suicide prevention training for school personnel. In some states, this means the provision of access to training as an option for professional development. In others, structures are put in place by the legislature to provide for the training, but school personnel are not required to make use of those training options. The state may allow grant funding to be used for suicide prevention training, but not require it, or the state may require training “subject to appropriation” without continually appropriating those funds.

**School Policies & Programs on Suicide Prevention, Intervention, and Postvention
(required in 25 states, plus DC)**

Alabama, California, Connecticut, Delaware, DC, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, and Washington currently require school suicide prevention, intervention, and postvention policies and/or suicide prevention programming statewide; six other states (Louisiana, Maryland, New Jersey, Texas, Virginia, and Wisconsin) encourage such policies and or programming.

Reporting Suicide Risk to Parents/Guardians and/or Administrators (required in 6 states)

Kansas, New Jersey, Oklahoma, Texas, Utah, and Virginia require school personnel and/or other professionals to report to school administration and/or parents or guardians when they believe a student may be at risk for suicide.

- **Kansas** requires that parents or guardians be notified verbally and give consent before their child is screened or assessed for suicide risk; said screening or assessment may occur after any school district employee becomes aware that a student may be at risk of suicide by a credible report from the student, the student's peers, or another school district employee.
- **New Jersey** requires teachers and licensed psychologists, social workers, marriage and family therapists, professional counselors, physicians, physician assistants, alcohol and drug counselors, registered nurses, and licensed practical nurses, as well as public health officials to report information obtained in the course of their employment about the attempted or completed suicide of a student.
- **Oklahoma** requires teachers, counselors, principals, administrators, and other school personnel to immediately notify the parents or legal guardians of students determined to be at risk for attempting suicide.
- **Texas** requires district improvement plans to include provisions for suicide prevention programs, which includes a parental or guardian notification procedure; school districts must develop procedures for providing notice of a student identified as at risk of attempting suicide to a parent or guardian of the student within a reasonable amount of time after the identification of early warning signs.
- **Utah** requires schools to notify a parent or guardian if their student threatens to complete suicide or is involved in a bullying incident and maintain a record of that notification; school boards are required to adopt a policy regarding the process for parent/guardian notification.
- **Virginia** requires all licensed administrative or instructional personnel to contact a student's parent "as soon as practicable" should they have reason to believe, as a result of direct communication from a student, that such student is at imminent risk of suicide.

Student Education on Suicide Prevention and/or Mental Health (required in 22 states)

Suicide Awareness and Prevention Education (required in 15 states): Connecticut, Illinois, Kentucky, Louisiana, Maine, Nevada, New Hampshire, New Jersey, Pennsylvania, Rhode Island, Texas, Vermont, Washington, West Virginia, and Wisconsin currently require that students receive education on suicide awareness and prevention. Many require that this occur as part of the health curriculum. Six states (Connecticut, Maine, New Hampshire, Texas, Vermont, and Washington) also include mental health in these requirements.

- **Connecticut** requires the program of instruction offered in public schools to include health and safety, including community and consumer health; physical, mental and emotional health, including youth suicide prevention; and substance abuse prevention, including opioid use and related disorders [adopted 1989]
- **Illinois** requires that (mandatory) school suicide awareness and prevention policies include protocols on how to administer age-appropriate youth suicide awareness and prevention education to all students; the State Board of Education model policy must include recommended resources and age-appropriate educational materials on youth suicide awareness and prevention [adopted 2015]
- **Kentucky** requires that public schools provide suicide prevention awareness information to all 6th-12th grade students in person, by live streaming, or via a video recording; the information may be obtained from the Cabinet for Health and Family Services or from a commercially developed suicide prevention training program [adopted 2010]
- **Louisiana** requires public schools to offer age- and grade-appropriate evidence-based training on suicide prevention and student safety and violence and social isolation prevention to students in grades 6-12; each student must receive not less than one hour or one standard class period, whichever is shorter, of training in suicide prevention per year [adopted 2022, effective 7/1/23]
- **Maine** requires that the Department of Health and Human Services, in cooperation with the Department of Education, develop a teenage suicide prevention strategy and model suicide prevention program to be presented in secondary schools; development of said program must include preparation of relevant educational materials that must be distributed in the schools [adopted 1987]; instruction in health education must also recognize the multiple dimensions of health by including instruction in mental health and the relationship between physical and mental health [adopted 2019]
- **Nevada** requires the State Board of Education to adopt regulations establishing a course of study for the prevention of suicide and the grade levels for which the course applies for [adopted 1999]
- **New Hampshire** requires that (mandatory) school district and chartered public school policies include educating students on risk factors and warning signs of mental health conditions and suicide, help seeking strategies, and identifying within the school the person(s) who serve as the point of contact when a student is believed to be at an elevated risk for suicide [adopted 2019, effective 2020]; requires the state board of education to provide information about youth suicide prevention to all public and private schools to facilitate the delivery of appropriate courses and programs [adopted 2008]

- **New Jersey's** core curriculum content standards in comprehensive health and physical education must provide for instruction in suicide prevention in an appropriate place in the curriculum of elementary, middle, and high school pupils [adopted 2006]
- **Pennsylvania** requires that (mandatory) school suicide awareness and prevention policies include protocols for administering youth suicide awareness and prevention education to students; requires the department of education to develop a model youth suicide awareness and prevention curriculum and make such curriculum available to all school entities and, upon request, to nonpublic schools, and to post online recommended resources and age-appropriate educational materials on youth suicide awareness and prevention [adopted 2014, effective 2015]
- **Rhode Island** requires annual suicide awareness and prevention training for students in grades 6-12 [adopted 2021]
- **Texas** requires K-12 school districts to offer, as a required curriculum, an enrichment curriculum that includes suicide prevention, including recognizing suicide-related risk factors and warning signs, and mental health, including instruction about mental health conditions, substance abuse, skills to manage emotions, establishing and maintaining positive relationships, and responsible decision-making [adopted 2019]
- **Vermont** requires comprehensive health education in elementary and secondary schools to include the study of family health and mental health, including instruction that promotes an understanding of depression and the signs of suicide risk in a family member or fellow student that includes how to respond appropriately and seek help, and provides an awareness of available school and community resources and crisis hotlines [adopted 2005]
- **Washington** requires school districts to have in place in elementary, middle, and high schools assessments or other strategies chosen by the district to assure that students have an opportunity to learn the essential academic learning requirements in health and fitness, which includes mental health and suicide prevention education [adopted 2011]; requires the office of the superintendent of public instruction to work with state agency and community partners to assist schools in implementing youth suicide prevention activities, which may include training for students in recognizing and responding to suicide warning signs [adopted 2011]
- **West Virginia** requires that public middle school and high school administrators disseminate and provide opportunities to discuss suicide prevention awareness information with all students; this information may be obtained from the Bureau for Behavioral Health and Health Facilities or from a commercially developed suicide prevention training program approved by the State Board of Education [adopted 2020; similar language was originally adopted in 2015]
- **Wisconsin** school boards must provide instructional programs that include information on the risk factors and warning signs of suicide, the relationship between suicide and the use of alcohol and controlled substances, and available community youth suicide prevention and intervention services [adopted 1997]

Mental Health Education (required in 7 states): Arizona, California, Florida, Missouri, New York, South Carolina, and Virginia currently require that student health curricula include

information about mental health. These states do not mandate inclusion of specific information on suicide prevention, warning signs, or resources.

- **Arizona** requires the State Board of Education to require all health education instruction to include mental health instruction and to consult with the Departments of Health Services and Education and mental health experts in adopting said requirement [adopted 2021]
- **California**, subject to appropriation, provides for youth behavioral health training for school employees and related curriculum for pupils in grades 10-12 [adopted 2021]; also requires each school district, county office of education, state special school, and charter school that offers one or more courses in health education to pupils in middle school or high school to include mental health instruction in those courses [adopted 2021]
- **Florida** requires district school boards to provide comprehensive age-appropriate and developmentally-appropriate K-12 health education that addresses mental and emotional health [adopted 2002]; the State Board of Education approved a mandate in 2019 requiring public schools to provide students at least 5 hours of mental health instruction starting in 6th grade
- **Missouri** requires that students in public schools and charter schools receive mental health awareness training anytime during their four years of high school, prior to graduation; instruction must be included in the district's existing health or physical education curriculum and be based on a model program established by the department of elementary and secondary education [adopted 2022]
- **New York** requires that school health education programs recognize the multiple dimensions of health by including mental health and the relation of physical and mental health [adopted 2018]
- **South Carolina** requires that instruction in comprehensive health education for grades K-8 include the topics of substance use and abuse and mental and emotional health [adopted 1988]
- **Virginia** requires that school health instruction for pupils in public elementary, middle, and high schools incorporates standards that recognize the multiple dimensions of health by including mental health and the relationship of physical and mental health; allows said health instruction to include an age-appropriate program of instruction on the safe use of and risk of abuse of prescription drugs [adopted 2018]

Five additional states (Alabama, Maryland, Michigan, Minnesota, and Oklahoma) encourage school districts to include suicide prevention and/or mental health in student curriculum.

Student IDs include 988 Suicide and Crisis Lifeline/Other Crisis Lines (22 states)

Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, Nevada, New Hampshire, Oklahoma, South Carolina, Tennessee, Texas, Washington, and Wisconsin require that the 988 Suicide and Crisis Lifeline (formerly the National Suicide Prevention Lifeline), the Crisis Text Line (text

TALK to 741-741), or other local suicide prevention crisis line numbers be visible on student identification cards for middle schoolers and/or high schoolers.

Allowance for Excused Mental Health Absences (7 states)

Arizona, California, Maine, Nebraska, Nevada, Oregon, and Utah currently require schools to excuse absences specifically related to a student's mental health; Kentucky allows school boards to excuse student absences for mental or behavioral health reasons. (In other states, schools may choose to accept notes from mental health providers or excuse absences due to a student's mental health, but there is no law protecting the ability for a student to use ongoing mental health struggles as a reason for missed school.)

Other School Suicide Prevention Statutes

- **Florida** and **Louisiana** designate schools that offer suicide prevention training/programming per statute as "Suicide Prevention Certified Schools."
- **Louisiana** randomly surveys school employees to ascertain their compliance with state-mandated suicide prevention training and reports survey findings to the legislature.
- **Utah** requires school districts to offer evening parent seminars at no cost that cover a variety of topics, to include substance use and prevention, bullying, mental health, depression, suicide awareness, suicide prevention, and internet safety.

Current Advocacy Efforts

AFSP recognizes that adoption of comprehensive school suicide prevention, intervention, and postvention policies and mandating related student education and school personnel training are crucial steps toward reducing youth suicide attempts and deaths. Other legislative approaches as discussed in this brief are also showing promise, including more widespread promotion of the 988 Suicide and Crisis Lifeline and other crisis hotlines and allowing for excused mental health absences. Promoting adoption of these laws across the U.S. is therefore a top public policy priority for AFSP.

Many states that currently mandate suicide prevention training for school personnel achieved this through adopting a bill titled *The Jason Flatt Act*, the hallmark piece of legislation for the not-for-profit organization, the Jason Foundation, Inc. (JFI). In most states, the *Jason Flatt Act* mandates 2 hours of suicide prevention training for school personnel, although in each state the requirements vary slightly. Recognizing this accomplishment, and to better address this public policy priority, AFSP joined efforts with JFI in 2011 to actively support passage of the *Jason Flatt Act* in several states. AFSP continues to work with JFI and other partners, like the Trevor Project, to support related legislation nationwide.

AFSP Model Legislation on Suicide Prevention in Schools: After working with JFI on several states in 2011-2012, AFSP wanted to promote this type of advocacy work in additional states where JFI did not plan to introduce the *Jason Flatt Act*. For these

states, AFSP developed model legislation for use by advocates who would like to propose this type of legislation to their own state lawmakers. In development of the model, AFSP public policy staff consulted with members of AFSP's National Public Policy Council, referenced current empirical research and existing state laws, and incorporated feedback from stakeholders who were involved in the passage of K-12 suicide prevention laws in their state. The resulting model legislation is intended to serve as an ideal starting point with elected officials who are considering sponsoring a suicide prevention in schools bill. **See page 16 of this document for the full model.**

Training Resources

Every state has some form of suicide prevention training or awareness program available. However, the availability and accessibility of these programs vary. **The appeal of AFSP's Model Legislation on Suicide Prevention in Schools, and of the *Jason Flatt Act*, is that their language is worded to allow flexibility within states to choose the training programs that will best fit the educational environment(s) within their state.**

AFSP offers several resources for schools that may be used to implement existing laws or to offset the cost of proposed legislation, or "fiscal note." This includes, but is not limited to, AFSP's *More than Sad, It's Real: Teens and Mental Health*, and *Signs Matter* programs, and the jointly released *Model School District Policy on Suicide Prevention*. Details can be found online at afsp.org/education. All resources are offered either as a free download online or through local AFSP chapters, which currently serve all 50 states and DC. Find your local chapter online at afsp.org/chapters.

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AFSP Model Legislation: Suicide Prevention in Schools

(1) Beginning in the 2023-2024 school year, the State *Board/Department* of Education shall adopt rules to require that all public-school personnel receive at least 2 hours of suicide awareness and prevention training each year*. This training shall be provided within the framework of existing in-service training programs offered by the State *Board/Department* of Education or as part of required professional development activities.

(2) The State *Board/Department* of Education shall, in consultation with *state agency/coalition charged with coordinating state suicide prevention activities, other stakeholders, and suicide prevention experts*, develop a list of approved training materials to fulfill the requirements of this Section.

(a) Approved materials shall include training on how to identify appropriate mental health services both within the school and also within the larger community, and when and how to refer youth and their families to those services.

(b) Approved materials may include programs that can be completed through self-review of suitable suicide prevention materials.

(3)

(a) Each public-school district shall adopt a policy on student suicide prevention. Such policies shall be developed in consultation with school and community stakeholders, school employed mental health professionals, and suicide prevention experts, and shall, at a minimum, address procedures relating to suicide prevention, intervention, and postvention.

(b) To assist school districts in developing policies for student suicide prevention, the Department of Education shall develop and maintain a model policy to serve as a guide for school districts in accordance with this section.

(4)

(a) No person shall have a cause of action for any loss or damage caused by any act or omission resulting from the implementation of the provisions of this Section or resulting from any training, or lack thereof, required by this Section.

(b) The training, or lack thereof, required by the provisions of this Section shall not be construed to impose any specific duty of care.

*NOTE: In those states where the legislature must amend section (1) to require training less often, for example, once every 5 years, or that remove a frequency requirement entirely, a new section will be added that states:

The State *Board/Department* of Education shall adopt rules to require that all newly employed public school personnel receive at least 2 hours of suicide awareness and prevention training within 12 months of their date of hire.