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Responding to Suicide in School Communities: An Examination of Postvention Guidance from Expert Recommendations and Empirical Studies

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Abstract

Purpose of Review We review the published literature on a school's response after a student dies by suicide ("postvention"). We examine published recommendations based on expert guidance and empirical studies that have evaluated postvention measures.

Recent Findings Experts recommend careful communication with family, staff, and students that adheres to published suicide reporting guidelines. Experts also emphasize the importance of identifying and supporting high-risk students. Few robust, controlled studies have identified effective postvention measures. Effective measures tended to occur in group settings (e.g., group therapy), focus on improving grief symptoms, and involve mental health professionals.

Summary Postvention has not been robustly studied in the school context. Expert recommendations and a few evidence-backed studies provide the frame for a coherent, school-based postvention response. Further research is needed to strengthen and expand our collective understanding of effective postvention measures in the school context as youth suicide attempts continue to rise.

Keywords Student suicide · Youth mental health · College mental health · High school mental health · Suicide postvention · Suicide prevention

Introduction

Suicide is the second-leading cause of death for teens and young adults [1]. While the sources and methods for gathering data about suicide differ between age cohorts, all data show the same trend—suicidal thoughts and behaviors are increasing among young people. From 2007 to 2017, the suicide death rate among 10–24 years old increased by a startling 56% [2].

The majority in this age group is students, whose trends in suicide are equally alarming [3]. Between 2019 and 2021, the

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national survey data reported that 8–10% of high school students had attempted suicide in the past 12 months [4, 5]. Almost 19% of first-year college students in the USA reported suicidal ideation in the past year [6]. According to 2021 data from the American College Health Association, 3% of college students had attempted suicide in the past 12 months, a 53% increase from 2019 [7–9]. In both high school and college students, rates of suicidality are elevated in transfer students, racial minorities, and sexual minorities—especially transgender students [5, 10, 11].

Biological, relational, community, cultural, and societal factors influence a student's suicide risk [12]. Impulsivity is a key suicide risk factor in adolescent and young adults [13]. Neurodevelopmentally, the limbic system, which drives goal-directed and reward-seeking behavior ("accelerator"), develops years before the prefrontal cortex (think "steering wheel" and "brakes"), which manages executive function and impulse control. To use a simplistic metaphor, the adolescent brain's accelerator overpowers their steering and braking mechanisms. This contributes to a plethora of impulsive behaviors such as suicide attempts during adolescence and young adulthood [13].

The COVID-19 pandemic exacerbated many established suicide risk factors—including social isolation, loneliness, lack of belongingness, and barriers to accessing mental health treatment [14]. The pandemic also brought unique stressors including forced relocation, loss of independence, interruptions in education, missing social milestones, technological concerns about online learning, hindrance of physical activity and extracurricular activities, financial instability, employment uncertainty, the death of loved ones, and contraction of the COVID-19 virus [14, 15]. Many students' social, professional, and recreational engagements were restricted to online interaction. Although virtual connection may help improve sense of belongingness, dependency on the Internet and social media is associated with cyberbullying, lower self-esteem, and depression [16].

As contained communities, high schools and colleges are vulnerable to suicide contagion. Suicide contagion is the process by which knowledge of a suicide catalyzes subsequent suicide [17, 18]. While there is no consensus on how contagion occurs, one explanation is that an individual's emotional state can affect people around them through empathy (i.e., strongly feeling what another person has experienced) and identification (i.e., seeing oneself in another) [17]. Unfortunately, exposure to suicide is common. While data for exposure to suicide among students is scarce, one meta-analysis of eighteen studies across six countries found that 29.4% of individuals were exposed to death by suicide in one of their social relationships [19].

Suicide contagion can lead to clustering, in which multiple suicides occur in a timeframe or geographical area at a higher rate than expected in a community. Clustering is more common among adolescents and young persons than adults [20, 21]. Estimates for the proportion of youth and young adult suicides occurring in clusters varies from 1 to 10.3% in certain racial groups [18, 21, 22].

Beyond a student's school community, social, entertainment, and news media provide additional venues for exposure to suicide. Media reports of suicide have been associated with increased suicide rates—even when the deceased is a fictional character [18]. In March 2017, Netflix released the show *13 Reasons Why*, which describes the context and aftermath of the suicide of Hannah, a 17-year-old female high school student. Immediately after release of the show in the USA, web searches for suicide methods increased [23]. One month after its release, there was a 29% increase in suicide rates among young people aged 10–17 [24]. Many have criticized the show for glamorizing suicide and suggesting that suicide can immortalize a person's legacy.

Rising suicide attempts among college and high school students combined with an expansion of media portrayal of suicide make exposure to a suicide an increasingly common experience for students.

Postvention in the School Setting

Postvention, Institutional Responsibility, and Available Postvention Resources

A suicide in a school community necessitates a carefully planned response. This domain of suicide prevention is referred to as postvention, an organized institutional and community response to a suicide that includes two key aims. First, postvention aims to catalyze positive outcomes—facilitating the grieving process, supporting the community, returning to routine, and fostering posttraumatic growth in affected individuals [17]. Second, postvention aims to limit adverse outcomes. Traditionally, postvention has been targeted towards limiting suicide contagion. While this article focuses on suicide risk, we want to emphasize that postvention should also minimize adverse consequences beyond suicide [25]. In the school context, these non-suicide outcomes might include declining academic performance, depression, psychiatric hospitalization, or leaves of absence.

For ethical and legal reasons, educational institutions have developed a growing responsibility for suicide prevention over recent decades [26]. One court wrote in a 2005 Pennsylvania case that this responsibility derives from "humanistic and therapeutic" not just "liability" considerations" [27]. This legal domain is nuanced. The responsibility might differ for institutions of higher education compared to primary or secondary schools given the different ages of students [28••]. The responsibility is also bounded. The Massachusetts Supreme Judicial Court ruled in 2018 that universities do not have a "generalized duty to prevent suicide" [29•]. Nonetheless, Appelbaum writes that higher education institutions will "need to be more attentive to students who are potentially suicidal or aggressive and to be more assertive about intervening before harm occurs" [30•]. After a death by suicide, humanistic and liability considerations

suggest institutions should be vigilant to mitigate suicide contagion and clustering in the institutional community [31•].

Several organizations have developed toolkits and guides for implementing a postvention strategy in the educational setting. While some of these are titled as "guidelines," to avoid conflation with clinical practice guidelines that require a rigorous establishment process, we refer to these toolkits, guides, and guidelines, collectively as guides. Combining the results of a systematic review [32•] with an additional toolkit one of the authors helped develop, we identified eight postvention guides for educational institutions [33•, 34•, 35•, 36•, 37•, 38•, 39•, 40•].

Collectively, these school postvention guides are fairly recent, the earliest dates to 2010 and the latest to 2018 [33•, 39•]. Most guides are intended for the primary or secondary school context, but many principles could be applied to higher education settings. The Higher Education Mental Health Alliance developed a guide specific to postsecondary educational settings [37•]. Seven themes emerged from the recommendations contained in these guides (Table 1). Two primary themes are covered in subsequent sections.

Examining Expert Recommendations for Postvention: Communication

The first theme of the recommendations is communication which addresses notifying the family, staff, students, and the wider community [37•, 39•], working with the media [36•], and monitoring social media [33•].

Many recommendations describe communication principles that draw from the widely accepted World Health Organization (WHO) guidelines on reporting about suicide [41]. For example, leadership and media should use the phrases "died by suicide" instead of "committed suicide" or "killed themself" to avoid stigmatizing suicide [34•, 38•]. Details about the method and photographs of the death scene should not be featured in any communication [33•]. These details provide excessive attention to the suicide, which can reinforce further suicidal behavior in the community [42]. Messages to the community should also include information about where to receive help.

The TEMPOS tool was developed to evaluate adherence to media reporting guidelines with the aim to reduce suicide contagion [43•]. This tool—in addition to consultation with experts—could be used to help vet school statements prior to release and engage college newspaper writers and editors on journalistic best practices following the suicide of a campus community member. As demonstrated by a 2022 study, TEMPOS can be used by journalists (from college campuses to national media outlets), clinicians, and other professionals engaged in prevention programs to understand how media adherence to suicide reporting recommendations varies and to identify which recommendations are commonly violated and which are followed [43•].

Examining Expert Recommendations for Postvention: Identifying and Supporting Students at Risk

The second theme is that students at higher risk for suicide should be identified and connected to appropriate levels of care. Risk factors include pre-existing mental illness or suicide attempts, close relationships with the student who died by suicide, and new experiences of suicidal thoughts, feelings, or behaviors.

The guides vary on how to identify at-risk students. Headspace Delphi recommends instructing students and staff to observe for students who need help, a passive surveillance approach (Table 1) [36•]. Other guides encourage structured, active approaches to screening such as a mental health screening tool [33•], monitoring student outcomes (such as attendance or student code violations) [38•], or contacting close social relationships of the deceased [39•].

Becoming aware of suicide risk (making a suicide "foreseeable" in legal terms) can incur responsibility to act preventatively [28••], which might make institutions hesitant to identify students at risk. Yet, given the well-documented phenomenon of suicide contagion, the recommendations—which are based on expert guidance—encourage surveillance (whether passive or active). A prudent approach might be to consult with a mental health expert on appropriate surveillance for a particular institutional setting.

According to the recommendations, students at high risk for suicide or other adverse outcomes should be connected to professional mental healthcare. Identifying emergency departments, hospitals, clinics, and clinicians (on campus, in local clinics, or affiliated with telehealth providers) in advance who can provide this care can help facilitate the connection-to-care process when a suicide does occur. This is not an easy task given the shortage of child and adolescent psychiatrists. Moreover, locations with the fewest mental health professionals also have the highest youth suicide rates; meaning regions needing the most postvention professional care will have the most difficulty obtaining it [44].

Strategizing the best course of action with students who have been identified as "at risk" raises numerous ethical and legal considerations. Confidentiality should be maintained wherever possible, though the Family Educational Rights and Privacy Act (FERPA) allows leeway to make disclosures in emergency situations [45]. Clinicians employed by educational institutions should be clear when they are acting as agents of the university rather than in a treatment relationship with the student [45]. Rigid university policies requiring suicidal students to take a leave of absence have been the targets of criticism and lawsuits [46••, 47••, 48]. A more robust, nuanced, and time-intensive approach would be to develop individualized plans with a

Table 1 Summary of published postvention recommendations for educational institutions

	Communication	Critical incident review	Identifying and supporting those at risk	Immediate crisis response	Memorials	Organizing a crisis team	Returning to routine	Grade focus
Active Minds	+ + +	+	+ +			+		K-13 +
AFSP & SPRC	+ +		+ + +	+ +	+ +	+ +		6–12
Headspace toolkit	+ + +	+	+ + +	+ +	+ +	+	+	9–12
Headspace Delphi	+ + +	+	+ +	+	+	+ +		9–12
HEARD	+ + +		+ + +	+	+	+	+	K-12
HEMHA	+ + +	+	+ + +		+	+ +	+	13 +
NCSCB	+ + +		+ + +	+	+			NA
South Australia	+ + +	+	+ +	+ + +	+	+	+	NA

This table describes the content covered by each set of recommendations as primarily derived from the table of contents for each set and a close review of the internal content. + indicates that a set of recommendations had one or two content headers dedicated to this category. + + indicates that three to four content headlines addressed this category. + + + indicates five or more content headlines addressed this category. If the recommendations stated they were intended for a specific school level, that was included in the final column, and otherwise, it was marked as "NA." For further details and to access the recommendations directly, please see Appendix. "AFSP & SPRC" represents the recommendations produced by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center. Headspace had two recommendations, one labelled as a suicide postvention toolkit (referred to as "Headspace toolkit" above) and a Delphi study on responding to suicide in secondary schools (referred to as "Headspace Delphi" above). HEARD stands for the Health Care Alliance for Response to Adolescent Depression. HEMHA stands for the Higher Education Mental Health Alliance. NCSCB stands for the National Center for School Crisis and Bereavement at Children's Hospital Los Angeles. "South Australia" refers to the recommendations published by the Government of South Australia in conjunction with the Catholic Education South Australia and the Association of Independent Schools of South Australia

student and their support system oriented around the goal of optimizing the student's mental and academic thriving [49]. Such an approach must balance short- and long-term considerations and be based on comprehensive psychiatric assessment.

Students at lower risk for suicide might not require individualized, professional mental healthcare services, but they might benefit from community-wide support. Cornell has developed a model for community support meetings in the postsuicide context [50]. Gatherings create space for students to reflect and process grief as a community [34•]. Leadership should also use these meetings to emphasize how to get help. These meetings should avoid unhealthy rumination over the method of suicide or glorification of suicide. Institutions should also support staff who can also be deeply affected by the loss of a student yet might be overlooked [35•, 36•, 38•].

Examining Expert Recommendations for Postvention: Other Themes

In this section, we briefly review the themes beyond communication and identifying students at risk. A more comprehensive summary is provided in Appendix.

Many guides address the initial crisis response, which involves ensuring immediate safety of others (e.g., do not leave affected individuals alone), fact-checking, and collecting the deceased's belongings [35•].

Almost all guides emphasize the importance of having a crisis team with delegated roles, emergency response plans, and a mobilization protocol [36•]. Several guides encourage a critical incident review months after the suicide to gather feedback and review the postvention response [36•]. Other recommendations include addressing cultural diversity and maintaining good documentation of the institutional response [33•, 39•]. Good documentation is encouraged to assist with critical incident reviews or external inquiries [39•]. Half the guidelines discuss the importance of returning to routine [38•].

Finally, all but one guide address messaging around memorials and funerals. Participants and speakers at these events should be informed about and adhere to guidelines for reporting suicide [37•]. Institutions should memorialize deaths by suicide in a way that is consistent with how they memorialize deaths from other causes (e.g., cancer) [35•]. Differential handling can stigmatize or glorify suicide. Many guides discuss logistic considerations, such as where to hold the service (not on school grounds) or when (not during school hours) [33•]. A chief goal is to minimize disruption to routine.

Beyond these themes, the guides discuss the importance of planning in advance for a death by suicide and provide useful documents including flowcharts, templates for media statements, and sample letters of notification.

A Critical Review of the Evidence Base for Postvention Measures

Available Studies and Their Limitations

We identified four published reviews on postvention measures. Two were systematic reviews [32•, 51••]. One included a defined search strategy, but did not search multiple databases [52••]. The fourth did not include a defined search strategy

[53•]. One of the systematic reviews included a search of the gray literature [32•]. Compiling the studies cited by these three reviews, we counted twenty-five unique studies examining effectiveness of postvention measures.

Several studies had non-statistically significant impacts of the studied intervention [54–57]. In studies that did find positive impacts, the most frequently improved symptoms were depressive and grief symptoms [58–68]. A key limitation was that many of the studies finding a positive impact did not compare their intervention against a control group. Grief and depressive symptoms are expected to be high immediately after a loss and to dissipate over time. Studies that found a positive impact over time without a control group might be simply documenting the natural course of grief, rather than the effect of an intervention. Other limitations were variability in outcomes measured and length of follow-up among the studies (from a few days to 13 months).

The interventions in the six studies that showed improvement over a control group included:

- An 8-week support group focused on grief and facilitated by a mental health professional [58]
- Four 2-h home visits by psychologists to deliver psychoeducation on suicide, bereavement, and coping [59]
- Ten weekly 1.5-h group sessions for children and parents (in separate groups) facilitated by psychologists and focusing on psychoeducation, coping, and support [61]
- Three community focused supportive interventions for youth in a church context including an open meeting, a psychoeducation session, and a memorial service [69]
- Fourteen 1.5-h support group sessions facilitated by clinicians [70]
- A crisis intervention team providing outreach, support, and referrals to services [71]

The short list of studies that show improvement over control group invites the question: why are there so few studies on postvention measures?

Barriers to Research

Institutional Review Board (IRB) approval, study recruitment, control group monitoring, and the low prevalence of the critical outcome—suicide—can each give rise to barriers when evaluating postvention measures. First, ethical concerns about studying suicidal patients can result in a lengthy, complex process for IRB approval. Specific processes are advised for research that involves participants at risk of suicidal thoughts or behaviors [72, 73]. Delays in the IRB process can prevent timely implementation of an intervention in the aftermath of a suicide.

Second, recruitment can hinder study feasibility. While the prevalence of lifetime exposure to suicide is high, past-year prevalence is 4.3% [19]. Geographic limitations and bounded enrollment time windows narrow the pool of eligible participants. Including a control group is a key element in robust study designs but increases the required number of participants.

Third, the control group receiving "usual care" might limit the ability to detect beneficial findings from an intervention. A research protocol would not mandate termination of existing mental health treatment. Diversity of participants' treatment engagement outside the study introduces variability into the study's findings. Further, regular staff interaction with participants in the control group can have therapeutic effects [74–76], particularly for participants who are suffering from social isolation and lack of emotional support. The more improvement the control group receives from interaction with healthcare professionals both inside and outside of the study, the harder it is to detect comparative improvement in the intervention group.

Finally, one of the most important outcomes for postvention research is suicide contagion. Capturing and measuring the impact of interventions on rare phenomena like contagion require large, costly studies that are difficult to execute.

Overall, the small number of studies showing meaningful differences in the postvention setting should be acknowledged as a result of the difficulty conducting this kind of research, rather than the impossibility of effective postvention measures. The dearth of studies invites more investigation.

Other Strategies to Consider

Given the limitations of the evidence base for postvention measures, we encourage educational leadership to look for strategies beyond controlled studies of postvention measures. One approach is to simply ask those who have lost someone to suicide (sometimes referred to as "suicide loss survivors") "What was most helpful to you?" One such study found that suicide loss survivors identified as helpful both professional treatment and one-to-one contact with other survivors [77]. The American Foundation for Suicide Prevention has developed the Healing Conversations program for the latter purpose [78].

Another fruitful tactic would be to cull from the broader literature on bereavement. Bereavement camps have been developed to help children and adolescents process loss [79, 80]. These camps could be a resource for grieving students. There are therapies for grief that have a robust evidence base, including complicated grief treatment (CGT) pioneered by Katherine Shear. CGT—grounded in attachment theory and utilizing techniques from interpersonal psychotherapy, cognitive behavioral treatment for PTSD, and motivational interviewing [81]—has been supported by at least three randomized-controlled trials [82–84] and shows promise in individuals bereaved by suicide [60].

While the number of robust postvention studies are limited, they are not entirely absent. Supplementing several guides

Table 2 Synthesis of key take-aways from expert recommendations and available studies

Theme	Recommendations	Evidence from reviewed studies
Identifying and supporting those at risk	(1a) Provide opportunities for staff and students to receive support and process grief	- Suicide loss survivors endorse support from other survivors - Group therapy was the most common effective postvention measure - Robust studies show benefit of complicated grief treatment
	(1b) Connect the community to mental health services as appropriate	- Several studies show efficacy of group therapy, grief therapy, and psychoeducation - Suicide loss survivors state importance of professional care
	(1c) Monitor student and staff wellbeing	—
Communication	(2a) Liaise with family, and keep staff and students informed	—
	(2b) Work with the media to follow suicide reporting recommendations	—
Memorials	(3) Memorials should avoid stigmatizing or glorifying suicide	—

This table synthesizes some of the key themes from the recommendations and organizes them by sub-themes in the middle column. We included lessons from the literature as reviewed in the prior section in the far-right column to show where there was alignment in the sub-themes. We did not fill rows in the evidence column when we were unable to identify studies focused on that specific postvention aspect

published over the last decade with feedback from suicide loss survivors and evidence-based strategies from the broader bereavement literature, institutional leaders have the signposts they need to set forth a coherent postvention response.

Synthesizing Expert Recommendations and Available Studies: Key Takeaways

In this section, we synthesize our review of the expert recommendations and the available studies, outlining the frame of a coherent postvention response. We focus on the three primary themes of (1) identifying and supporting those at risk, (2) communication, and (3) memorials (Table 2). In reviewing key areas of emphasis, we point out where the recommendations and studies agree and where the evidence is lacking.

With regard to identifying and supporting those at risk, the recommendations and research agree on (1a) the importance of providing opportunities for staff and students to receive support and process grief. Most of the effective postvention measures in controlled studies occurred in group settings, and grief symptoms were improved more commonly than other symptoms. As described above, CGT is a therapy modality that has a robust evidence base for improving grief and could be adapted for the postvention context.

The recommendations and research support (1b) connecting the community to mental health professionals. Most of the effective controlled studies reviewed above involved mental health professionals in the intervention. Moreover, suicide loss survivors emphasize the importance of professional care in their bereavement. Given the difficulties with finding psychiatric care, becoming familiar with local and quality telehealth resources in advance can help reduce this burden when needing to point the community to resources. The recommendations also consistently emphasize the importance of (1c) monitoring student and staff wellbeing, but this has not been studied in the postvention context as far as we are aware.

While unable to identify studies that support the remaining highlights, we note their emphasis across the expert recommendations. These recommendations are grounded in expert understanding of suicide and seem sensible to implement given the tragic nature of negative outcomes they are trying to avert. With regard to communication, the guides consistently emphasize (2a) the importance of liaising with the family and updating staff and students and (2b) that schools and the media should follow suicide reporting guidelines. Finally, (3) memorials require careful planning to avoid stigmatizing or glorifying suicide. While memorial messaging has not been closely studied, lessons from poor media treatments of suicide (even fictional suicide, such as in *13 Reasons Why*) show the negative impacts of careless portrayal of suicide.

Conclusion

Student suicides are becoming more common and pose a risk of sparking suicide clusters. A coherent postvention strategy—an organized institutional and community response to a suicide—aims to mitigate suicide contagion but is fraught with ethical, legal, and logistical complexities. Fortunately, recommendations based on expert guidance outline key aspects of postvention responses at educational institutions. Robust studies on postvention measures are few but support the recommendations on the importance of supporting students and staff as they process grief and involving mental health professionals, especially for those who are at higher risk. Identifying effective postvention measures and optimizing their implementation in the educational institution context will only become more important as suicidal ideation and attempts among youth and young adults continue to rise.

Appendix

The original table in this appendix was divided into two parts to maintain readability. Each part covers the content of recommendations for four of the eight guides reviewed in this paper.

Part 1: The four columns in this half of the table describe the recommendations for the guides published by Active Minds, AFSP & SPRC, Headspace, and Headspace Delphi

Category	Active Minds	AFSP & SPRC	Headspace	Headspace Delphi
Communication	- Talking about the suicide	- Inform the school community	- Keep staff well-informed, ensure regular staff meetings	- Liaising with the deceased student's family
	- Promote Mental Health Resources	- Reach out to parents	- Inform students	- Informing staff of the suicide
	- Psychoeducation about suicide and mental illness	- Work with the media	- Inform parents, keep parents informed	- Informing students of the suicide
	- De-stigmatize mental health	- Social media	- Inform wider community	- Informing parents of the suicide
	- Mental health promotion and education		- Help the media report on the incident in an appropriate manner	- Informing the wider community of the suicide
			- Liaise with family	- Dealing with media
			- Mental health information sessions	- Internet and social media
			- Managing social media	
Critical incident review	- Review existing policies		- Conduct a critical incident review	- Conduct a critical incident review
Identifying and supporting those at risk	- Provide opportunities for reflection and healing	- Helping students cope	- Monitor students and begin assessments of those identified as being at risk	- Identifying and supporting high-risk students
	- Create a culture of healing and support	- Schedule meetings with students in small groups	- Set up a support room for students	- Ongoing support of students
	- Support each other	- Help students identify and express their emotions	- Contact relevant mental health services	- Ongoing support of staff
		- Identify and monitor at-risk students	- Monitor student wellbeing	- Continued monitoring of students and staff
		- Connecting the community to mental health resources	- Monitor staff wellbeing	
		- Suicide clusters		
Immediate crisis response		- Get the facts	- Ensure immediate safety for others	- Managing a suspected suicide that occurs on school grounds
		- Activities for responding to a crisis	- Find out the facts	- The deceased student's belongings
		- Tools for crisis response	- Ensure that affected individuals are not alone	
			- Protect the student's belongings for the police and family	
Memorials		- Anniversaries and special events	- Plan the school's involvement with funeral	- Funeral and memorial
		- Funerals and memorial services	- Memorials	- Yearbook and newsletter
		- Other situations (e.g., online memorials, yearbooks, graduation)	- Plan for anniversaries, birthdays, other school events of relevance	
Organizing a team	- Organize mental health and suicide prevention task forces	- Mobilize a crisis response team	- Convene emergency response team	- Developing an emergency response plan
		- Working with the community (review multiple community roles)		- Annual review of the emergency response plan

Part 1: The four columns in this half of the table describe the recommendations for the guides published by Active Minds, AFSP & SPRC, Headspace, and Headspace Delphi

Category	Active Minds	AFSP & SPRC	Headspace	Headspace Delphi
		- Bringing in outside help		- Forming an emergency response team
				- Activating the emergency response team
Other		- Address cultural diversity	- Ensure good documentation	- Documentation
Returning to Routine			- Ensure regular school routine	
Includes checklist			+	
Includes template documents (e.g., letters, media statements)		+	+	
Year	2017	2018	2012	2015

Part 2: The four columns in this half of the table describe the recommendations for the guides published by HEARD, HEMHA, NCSCB, and South Australia

Category	HEARD	HEMHA	NCSCB	South Australia
Communication	- Notify school community	- General communication considerations	- Inform staff	- Inform staff, keep them informed
	- Organize staff meeting	- Communicating with friends of the deceased	- Involve the public information officer for the school district	- Inform students via a prepared script in small groups
	- Minimize risk of suicide contagion by working with the media	- Communicating with staff	- Inform students	- Keep parents informed
	- Communicate with and support broader school community	- Communicating with family of the deceased	- Inform family, prepare a statement	- Inform wider community with a prepared letter
	- Designate someone to remain in contact with the family in weeks following the death	- Working with campus media	- Explaining mental health problems and suicide	- Work with media liaison
		- Monitoring social media	- Talking about the suicide	- Liaise with family
			- How to address unknown cause	- Mental health information sessions
Critical incident review		- Debriefing		- Conduct a critical incident review
Identifying and supporting those at risk	- Enhance identification and support of vulnerable students	- Clinical services	- Crisis and grief counseling and related support services	- Identify and plan support for students at risk
	- Low risk level of suicide	- Group discussion and support sessions	- Identifying students who would benefit from additional emotional support	- Set up a support room in the school
	- Moderate—to high risk level of suicide	- Individual clinical support	- Ongoing monitoring	- Monitor student wellbeing
	- Extremely high risk level of suicide	- Self-care for responders	- Identify and monitor at-risk students	- Monitor staff wellbeing
	- Support staff	- Challenge of dealing with contagion and suicide clusters	- Risk factors after a suicide	
	- Support students during the school day			
	- Provide support as needed for siblings of the deceased enrolled in the district			

Part 2: The four columns in this half of the table describe the recommendations for the guides published by HEARD, HEMHA, NCSCB, and South Australia

Category	HEARD	HEMHA	NCSCB	South Australia
	- Identify and support vulnerable students			
Immediate crisis response	- Contact key individuals		- Notify and activate the school crisis team	- Ensure that affected individuals are not left alone
			- Handling the student's belongings	- Find out the facts / circumstances as far as possible
				- Ensure immediate safety of community members
				- Inform relevant authorities
				- Collect all deceased student belongings
Memorials	- Key considerations for appropriate memorialization	- Memorials and related events	- Memorials: participation of students, spontaneous memorials	- Plan school involvement with funeral
	- Prepare for anniversaries and special events			- Plan for anniversaries, birthdays, significant events
Organizing a team	- Crisis response team members and roles	- Planning in advance		- Convene emergency response team
		- Forming a postvention committee		
		- Implementing the postvention plan		
Other		- Considerations when the student who died by suicide was a counseling center client		- Continue documentation of all actions
		- Campus murder-suicides		
Returning to Routine	- Process for re-entry to school after extended absence or hospitalization	- Getting back to routine		- Restore regular routine
	- Coordinate implementation of long-term response protocol			
Includes checklist				+
Includes template documents (e.g., letters, media statements)	+	+		+
Year	2013	2014	2017	2010

This Appendix provides a synthesis of the content covered by each of the guidelines as primarily derived from the table of contents for each guidelines, but also from a close review of the internal content. Content headers were taken verbatim from the guidelines wherever possible, with only occasional editing for clarity, concision, and relevance. "AFSP & SPRC" represents the guidelines produced by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center. Headspace had two guidelines, one labelled as a suicide postvention toolkit (referred to as "Headspace toolkit" above) and a Delphi study on responding to suicide in secsondary schools (referred to as "Headspace Delphi" above). HEARD stands for the Health Care Alliance for Response to Adolescent Depression. HEMHA stands for the Higher Education Mental Health Alliance. NCSCB stands for the National Center for School Crisis and Bereavement at Children's Hospital Los Angeles. "South Australia" refers to the guidelines published by the Government of South Australia in conjunction with the Catholic Education South Australia and the Association of Independent Schools of South Australia.

Declarations

Conflict of Interest The authors declare no competing interests.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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