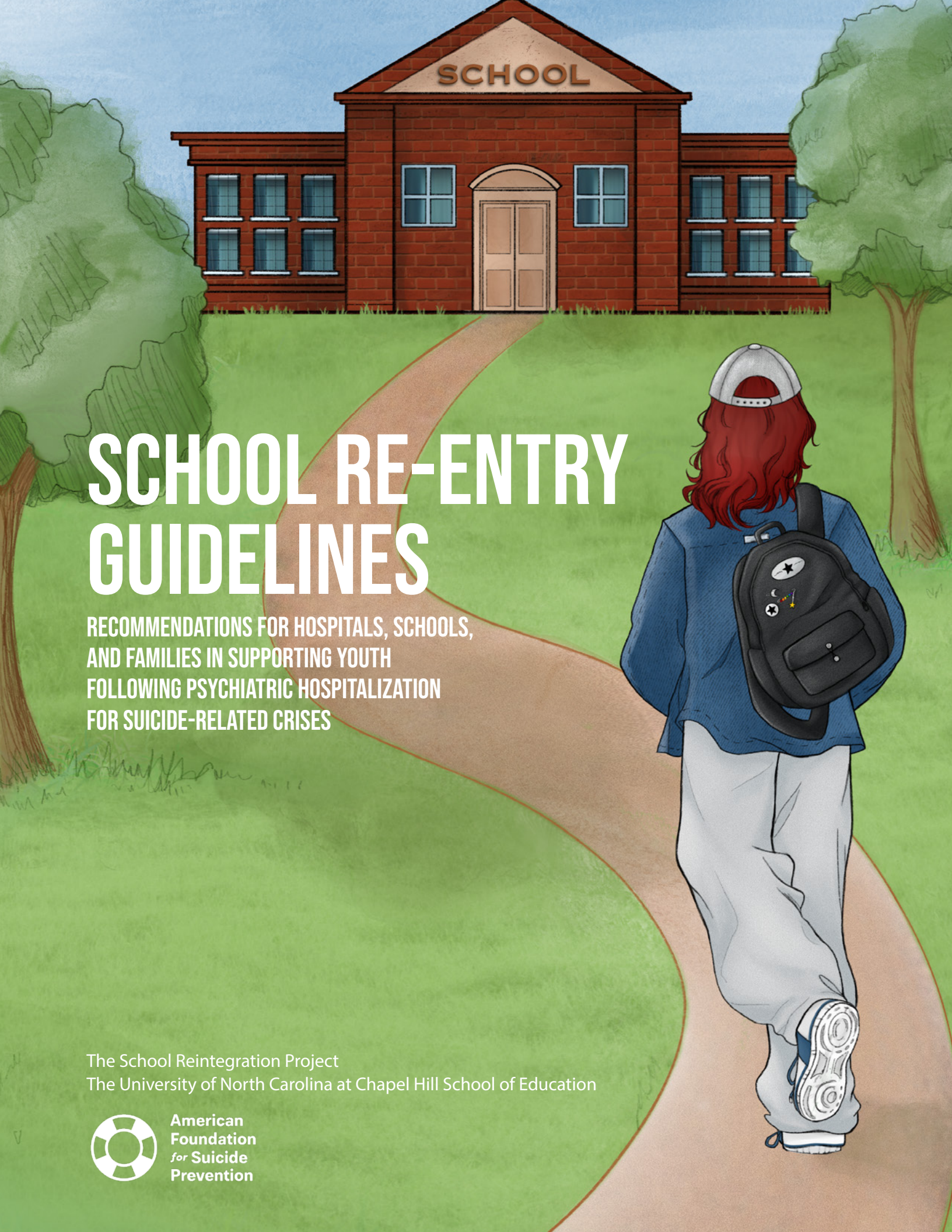

SCHOOL RE-ENTRY GUIDELINES

RECOMMENDATIONS FOR HOSPITALS, SCHOOLS, AND FAMILIES IN SUPPORTING YOUTH FOLLOWING PSYCHIATRIC HOSPITALIZATION FOR SUICIDE-RELATED CRISES

The School Reintegration Project
The University of North Carolina at Chapel Hill School of Education

American Foundation for Suicide Prevention

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Endorsement

American Foundation *for* Suicide Prevention

"This clear and evidence-based guidance for facilitating an adolescent's return to school after hospitalization for suicidal thoughts and behavior is an important tool for schools, hospital staff, students, and families. It offers an opportunity to effect positive change and reduce risk for subsequent suicidal behavior or rehospitalization. With this guidance, communities can focus on youth and their development."

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INTRODUCTION

When a student returns to school following a suicide-related crisis, reintegration can be complex and emotionally challenging. Although coordinated communication between schools, families, and hospitals, along with tailored modifications and interventions addressing student concerns, can ease this transition, there are numerous barriers preventing this continuum of care. The purpose of these guidelines is to provide a structured framework to support schools, families, and hospitals navigate school reintegration.

About These Guidelines

These guidelines are based on existing research and a North Carolina-based study, the School Reintegration Project, which explored the perspectives of youth previously hospitalized for a suicide-related crisis and their caregivers, school professionals, and hospital professionals.

To center student need and voice, throughout these guidelines we have prioritized the voices of youth with lived experiences to inform improved understanding of their experiences. Quotes from the youth, as well as from professionals and guardians participating in the School Reintegration Project, are embedded throughout this document.

Specifically, this mixed-methods study involved three phases of data collection completed between 2019 and 2021: (1) a survey of school professionals across one state; (2) in-depth interviews with adolescents previously hospitalized for suicidal thoughts and behaviors; and (3) iterative development of school re-entry guidelines based on feedback from adolescents. Quantitative data were analyzed by calculating descriptive statistics and qualitative data were analyzed using applied thematic analysis. Guidelines synthesized findings across all phases of the research, and incorporated additional research addressing school reintegration following psychiatric hospitalization. During the fall of 2025, the final draft of the guidelines was further refined based on feedback from nine technical experts representing local and nationally known researchers and practitioners with expertise and applied experience in suicide prevention, school reintegration, school-based mental health, inpatient psychiatry, and hospital schools.

Who Should Collaborate to Use These Guidelines

These guidelines are meant to be used by professionals in schools and hospitals supporting youth during and following a suicide-related crisis, professionals involved in making decisions about policies and procedures supporting these youth, and by families supporting youth during and following a crisis.

Family-school-community partnerships and interdisciplinary collaboration are integral to a student's successful school reintegration. Thus, while different sections may address specific roles and settings, all parties may benefit from becoming familiar with this guidance to help facilitate the four pillars of interdisciplinary collaboration[1]:

1. Relationship building, including mutual respect, communication, and trust
2. Shared values, such as shared goals and common understandings
3. Active engagement, allowing for different members to contribute expertise and decision-making reflective of their roles
4. Collaboration in implementation, resulting from successful relationship building, shared values, and active engagementv

How To Use These Guidelines

These guidelines are organized to mirror the continuum of care and collaboration needed before, during, and after hospitalization. We first include universal considerations schools can use to create environments that will proactively support students. Then we offer guidance aligned with the phases of hospitalization—during hospitalization, preparing for re-entry to school, and post-hospitalization. The "Key Concepts and Context" section includes foundational background on suicide risk, definitions and examples of psychiatric hospitalization experiences, and information on how protective factors can support recovery and reintegration, as well as legal considerations that play a crucial role in how schools and hospitals can support students, and a section on the role of schools in suicide prevention. At the end, a list of resources provides helpful additional information, links to crisis services, and an example of a re-entry plan.

While the guidelines are organized based on timing of hospitalization (before, during, and after), we recognize that the timeline for suicide-related crises does not follow a specific sequence. Accordingly, these guidelines are meant to provide a helpful framework, and individuals and organizations should adapt them to their own unique context and situations.

Organizations should always adhere to their internal policies and procedures first, and consider the guidelines documented here as a way to supplement or enhance existing practices, or support the development of new policies and procedures.

Note: For the purpose of these guidelines, "parents" includes legal guardians and may also include non-legal guardians engaged in primary caregiving, such as grandparents, aunts/uncles, and older siblings.

BRIEF DESCRIPTIONS OF THE GUIDELINES SECTIONS

These guidelines are organized based on timing of hospitalization (before, during, and after a crisis). At the end, we have included a section on frequently asked questions, key concepts and context, and resources.

Universal Considerations for Schools: Eight strategies a school can use to create a foundation to support students when they experience mental health crises and return to school, and may also benefit all students

During Hospitalization: Ways that both hospital and school professionals can begin to prepare for school reintegration during referral to the hospital and/or during a student's hospital stay

> **Information Sharing**: Approaches to sharing information between families, hospitals, and schools, which can be critical to facilitating a smooth transition, and can also involve both risks and benefits

Post-Hospitalization: How to facilitate a student-centered, strengths-based, and trauma-informed approach to school reintegration

> **Re-Entry Meeting**: Collaborating with the support team to develop and enact a re-entry plan that identifies how to support the returning student and provide the safest and healthiest transition back to school
>
> **Re-Entry Plan**: What should be included in a student's re-entry plan, including academics, social-emotional and behavioral concerns, and a plan for addressing risks
>
> **Safety Planning**: How to modify or develop a safety plan within a school setting

Reevaluation and Long-Term Recovery: Steps to re-evaluate and modify the recovery plan as needed

FAQs: Frequently asked questions by school professionals, including risks of delayed school re-entry, supporting peers, and how to address suspected or unconfirmed hospitalization

Key Concepts and Context: Background information on suicide, psychiatric hospitalization, demographics, symptoms and diagnoses, strengths, the protective roles of family and schools, experiences with emergency department and inpatient hospitalization, discharge, follow-up care, legal considerations, and the role of school in suicide prevention

Resources: Sample information to include on a website or in a handbook, crises services, examples of existing re-entry plans, and other mental health and safety planning resources

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UNIVERSAL CONSIDERATIONS FOR SCHOOLS

There are several universal strategies that can be used in schools **to help create a foundation to better support students when they experience mental health crises and return to school**, and that may also benefit all students:

1. Enact evidence-based, culturally grounded universal suicide-prevention programs.
2. Develop clear procedures, protocols, and roles regarding school reintegration and disseminate to school professionals, families, and clinicians.
3. Provide psychoeducation about suicide-related risk and recovery from mental health crises and support to the school community.
4. Foster a positive school psychosocial climate.
5. Emphasize bullying prevention.
6. Strengthen family-school partnerships.
7. Strengthen school-community partnerships and establish culturally grounded referral networks.
8. Collaborate with other local districts about school reintegration practices and procedures.

1. Enact evidence-based, culturally grounded universal suicide-prevention programs.

The CDC[2] recommends approaches that promote healthy connections, teach coping and problem-solving skills, and identify and support people at risk for preventing suicide. These interventions can be embedded in established tiered systems of support (e.g., multi-tiered system of supports [MTSS]) and aligned with state health education standards that include mental health and/or suicide prevention. Mental health, including addressing stigma, may be directly addressed in a school's health education curriculum. Examples of school-based programs in these areas include:

- **Promoting Healthy Connections:** Research suggests that school connectedness is associated with reduced suicide-related risk,[3] and approaches that promote feelings of connectedness and healthy peer norms may encourage help-seeking behaviors, as well as positive perceptions of adult and peer support in school.[2] The CDC[2] lists examples of in-school programs to enhance school connectedness with evidence for reducing risk for suicide, including Sources of Strength.
- **Teaching Coping and Problem-Solving Skills:**
    - Youth Aware of Mental Health (YAM) is a school-based program that includes role play and discussions about youth-relevant topics such as relationships, moods, and stress. A large, multi-country cluster-randomized controlled trial supported a significant reduction in suicide attempts and suicidal ideation.[4]

- Signs of Suicide (SOS) teaches students, staff, and other school-based mental health professionals about the signs and symptoms of suicide and mood disorders, using the acronym of ACT (Acknowledge there is a serious concern, show the person you Care, and Tell a trusted adult). A randomized control trial indicates that SOS was associated with a reduction in student-reported suicide attempts.[5]

- **Identify and Support People at Risk:** The CDC[2] recommends programs that train gatekeepers (e.g., peers, teachers, staff, school-based mental health professionals) to identify and refer students with suicide-related risk, and have established protocols for responding to crises (e.g., risk assessments, referral plans), as well as for safety planning or supporting individuals following a suicide-related crisis.

Comprehensive suicide prevention programs require specific cultural considerations based on the student body and community associated with the school that allows for a culturally grounded approach to suicide prevention.[6,7] Tailoring suicide prevention programs to the unique context of each school's culture requires an understanding of the core mechanisms of the program being implemented and partnerships with community and school representatives to adapt modifiable aspects of the program to the communities' needs.

Culturally adapted suicide prevention programs may involve adjustments to parts of the intervention (e.g., language, visuals, context) based on:[8,9]

- Cultural strengths, including known protective factors
- Partnerships with "student consultants" to work in focus groups to inform what adaptations may be needed
- Acknowledging historical trauma and the sociopolitical context
- Collaborations with the community

2. Develop clear procedures, protocols, and roles regarding school reintegration and disseminate to school professionals, families, and clinicians.

Well-developed procedures help facilitate a smoother school reintegration, as well as encourage improved information sharing between schools and families/schools and hospitals (see the AFSP Model School District Policy on Suicide Prevention and the Resources section for sample procedures). Identifying the roles of school members involved in the process is critical to ensure leadership through reintegration, including a designated person to coordinate reintegration and maintain relationships with local hospitals. It is helpful for districts to have their attorney review and provide feedback to procedures and protocols. Since families often do not have concrete guidance in these moments, school-led communication of protocols can be profoundly stabilizing and supportive. It may help families feel less isolated during a difficult time, and it may foster trust and confidence by offering reassurance that the school is prepared and experienced.

> "I think it would be helpful for there to be some sort of resource to direct parents to on making that transition easier, I don't know. I just felt very much, it's like when you have your first kid and they just send you home with the baby and you're like, 'What am I supposed to do with this?' I'm so lost and I don't really—I felt very similar to that. I'm lost, I don't know what to do differently to make sure this doesn't happen again. It's isolating. You can't just call your friend. I talked to my friends about it, but none of them have gone through it, so they didn't really know what to say. **(PARENT, P. 10[10])**

Some of the approaches schools can take to disseminate information about school reintegration procedures include:

- Student and family handbooks should describe how to involve schools in the case of psychiatric hospitalization.
- School websites should identify who families and clinicians should contact to provide information about mental health crises and concerns.
- Orientations for students and families should include information about safeguarding processes.
- Consider other ways of communicating about mental health (e.g., parent workshops, flyers for suicide prevention month, school website).
- Orient staff and school-based mental health professionals (administrators/counselors/social workers/nurses) to the process.

3. Provide psychoeducation about suicide-related risk and recovery from mental health crises to the school community.

Attitudes and beliefs embedded in the school can influence student experience upon return. Below are mental health trainings that can help improve student, teacher, staff, and school-based mental health professional attitudes, stigmas, and misconceptions around suicide:

- **Gatekeeper Training Programs** such as Signs of Suicide (as previously described for enhancing coping and problem solving skills) are designed to increase awareness of suicide risk and build skills in identifying, supporting, and referring students at risk, as well as improving attitudes about supporting students post-crisis.
- **Mental Health First Aid (MHFA)** is a widely implemented program that educates school personnel on common mental health issues. MHFA includes modules specific to youth and schools, often improving staff/school-based mental health professional comfort and attitudes toward students with mental health challenges.
- **Seize the Awkward** offers tools for high school students and their peers in identifying and addressing mental health concerns.
- **The American Foundation for Suicide Prevention (AFSP)** has resources to dispel common myths about suicide. Good resources include the "it's real" campaign for middle, high school, and college students and community programming such as "Talk Saves Lives."
- **The Trevor Project** offers several programs designed for youth-serving professionals that aim to teach professionals about: lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) identities, as well as risk and protective factors (called "Ally Training"); suicide prevention with LGBTQ+ youth (called "CARE Training"); and focus specifically on LGBTQ+ athletes geared towards coaches, parents, and students (called "LGBTQ+ Athletes Training").

> If they could, when you go into middle school, tell the parents, 'look out for these signs.' If you see these signs, talk to your kids with an open mind and try and get it resolved early. Then that could have been a huge difference for us, but we didn't even realize there was a mental health problem. **(PARENT[11])**

- **Substance Abuse and Mental Health Services Administration (SAMHSA)** houses prevention training addressing a range of issues, including behavioral health disparities and SAMHSA's Strategic Prevention Framework.

Note that these are examples, and each school should individually research the evidence and appropriateness for their setting.

Below are powerful strategies to incorporate into psychoeducation:

- **Highlight similarities and parallels between mental and physical health.** Calling attention to the effects of missing school for psychiatric crises and for other medical conditions, such as surgeries, chronic illnesses, or accidents, can help advocate for equal treatment and support systems for all students navigating health challenges—physical or psychiatric. It can encourage schools to treat mental health as health, which is key.
- **Include education about the physiological aspects of mental health.** Physiological health is affected by mental health, meaning depression increases the risk of physical illnesses just as mental health conditions can result in conjunction with physical conditions (e.g., Lyme disease or PANDAS syndrome). Addressing mental health needs can improve overall health.[12] Certain mental health conditions can also contribute to reduced energy, poor sleep, difficulty with concentration/planning, etc.[13] For more information, see https://cdc.gov/mental-health/about/index.html.
- **Address risk factors for suicide, warning signs about suicide-related risk, and trajectory of recovery following a crisis.** This includes:
    - Reinforcing diverse trajectories of what risk and recovery look like. For example, research suggests fluctuations in suicidal ideation among adolescents following hospital discharge, with individual variability across time.[14]
    - Dismantling harmful misconceptions like suicide ideation is a "cry for attention." Instead, it is a call for help for someone who may not have effective strategies for asking for help. Trainings should reinforce that taking suicidal ideation seriously is crucial to suicide prevention. Irrespective of the reason students may express suicidal thoughts, they are "reaching out for help." Professional development can help educators deconstruct stigma and address misconceptions about suicide with research-based facts.[15,16]
    - Addressing how mental health is shaped by and changes in response to many interconnected factors—biological, psychological, social, and environmental—all interacting over time. Due to the complexity of mental health, psychiatric disorders are some of the most difficult conditions to fully understand and treat.[17] Psychoeducation should address the complexity of mental health to better support students' recovery, resilience, and well-being.

> "I think that our school definitely does not take mental health seriously. If I had cancer, they would be like, 'Oh, what can I do to help since you're getting treatment today,' or 'you're sick because you're just sore and tired, so it's fine for you to take a day off. We'll help you make up your work.' Then, if it's 'I couldn't sleep last night because I was having a panic attack,' or, 'I've been having consistent panic attacks and, mentally, I cannot handle today. I need a day,' then they'd be like, 'Just skipping. You're just lazy.'
> (ADOLESCENT, AGE 17[18])

> "Just be on the lookout for them, 'cause they're probably still a little bit hazardous. No one's going to completely get better the first time they go to the hospital.
> (ADOLESCENT, AGE 15, P. 110[11])

- **Provide clear guidance on reporting pathways for suicide-related concerns, ensuring all members of the school community understand how and where to seek assistance.** When school professionals become aware of a student's mental health struggle or have concerns about a student, they must know the proper channels for sharing these concerns and connecting the student to appropriate resources and support. (See the AFSP Model School District Policy on Suicide Prevention.)

> I think you should consider that this is a lot of stuff [guidance for supporting youth returning to school following hospitalization] to dump on teachers, and I don't think it should all be done in one day. I also think it needs to be done at least every couple of years. Again, that's a lot of information and unless the teacher specializes in it, they're going to forget at least half of it by halfway through the year. **(PARENT, PROVIDING FEEDBACK ON GUIDELINES)**

- **Incorporate opportunities for staff and school-based mental health professionals to express concerns, fears, and perceived challenges.** School professionals have expressed fears about legal liability and uncertainty in responding to suicide-related concerns,[19] reinforcing the importance of having the district's attorney review and provide feedback to procedures and protocols. Moreover, staff and school-based mental health professionals may experience secondary trauma as a result of supporting students with complex mental health concerns. Staff describe discomfort with assessing risk or taking the next steps after identifying risk, while students and families report how that anxiety could lead to insensitive or hesitant responses.[20] Professional development should create space for staff to voice fears and concerns, clarify legal and ethical responsibilities, learn practical strategies for supporting students, emphasize a whole-child approach. Training should validate staff and school-based mental health professionals concerns while reinforcing that prioritizing student well-being and emotional support. More generally, it is important to enhance protective factors and implement supports for school staff and school-based mental health professionals who work with students with suicide-related risk, as they may feel overwhelmed and emotional exhausted from their experiences.

Each member of the school plays an important role in the process. Comprehensive suicide prevention requires collaboration across teachers, staff, and school-based mental health professionals. For example, teachers and others often play a key role in the referral process. School nurses often have direct involvement with youth who self-harm, and are among the first to identify suicide-related concerns and/or receive medication for mental health disorders.

4. Foster a positive school psychosocial climate.

School climate refers to the norms, expectations, and beliefs that shape the social and psychological environment of a school, and it influences how safe individuals feel physically, emotionally, and socially. Research has found that social connectedness, school safety, school connectedness, and academic environment are all linked to student mental health and well-being outcomes.[21]

In particular, positive student-adult relationships are key to increasing recognition of suicide risk, as well as empowering students to seek help for suicide-related crises.[22] Positive student-teacher relationships are also associated with recovery from suicide attempts.[23]

> The thing is, even just not in this situation, even just in life in general, teachers and staff members in the school system don't fully understand just how big of an impact they have on these children's lives. Some of these staff members are around these children more than the parents are even. **(ADOLESCENT, PROVIDING FEEDBACK ON GUIDELINES, AGE 19)**

Adults who cultivate positive adult-student relationships often show the following characteristics:[24]

- being friendly, trustworthy, and open
- being warm, welcoming, and empathetic
- reaffirming with words of encouragement
- investing in lives of their students, going out of their way to cheer students up
- developing supportive and mutually respectful relationships with students
- welcoming diverse communities (create an inclusive environment)
- being involved in extracurricular activities
- using humor with students to create a relaxed environment
- supporting and hold students accountable
- providing emotional support systems
- sharing resources with students
- intervening when needed
- self-disclosing (as appropriate)

> "But my SRO [school resource officer], you know, like, if I looked sad or mad or something like that, you know, she always knew what it was. And she would always, you know, like, talk to me, like take me up to her office. You know, she'd make me laugh somehow. And so did my counselor. So during that time, you know, I felt safe going to school, you know? I felt good, you know? I was like, 'You know, even though this is happening, you know, I still got these people to talk to.' **(ADOLESCENT, AGE 14, P. 108[18])**

Having a team of adults and multiple ways of connecting has also been shown to help with recognizing warning signs, improving early detection and timely support.

Other elements of a positive psychosocial climate in schools involve positive peer relationships (and bullying prevention, as described in subsequent section) and promoting a sense of safety and inclusivity. Ensuring that there are numerous student-led and adult-supported activities (e.g., clubs, organizations) that reflect the identities of the student body at large may be key to building a safe space for students. Examples include gender and sexuality alliances supportive of students identifying as LGBTQ+ and transformative social-emotional learning (SEL) curricula, which support skill development, promote collective action, and reinforce antiracist school climates.[25]

Examples of formal interventions addressing school climate include SEHER (Strengthening Evidence base on scHool-based intErventions for pRomoting adolescent health) aimed at improving school climate have also shown promising effects[26], with additional support for initiatives such as school-wide behavior support and social-emotional learning demonstrating improved effects on school climate.[27]

5. Emphasize bullying prevention.

Research has demonstrated that bullying can precipitate suicidal thoughts and behaviors. This has been found for both those who are bullied and people who bully.[28,29]

Research on bullying prevention programs reveals that important core elements include consistent use of disciplinary methods, classroom management, school-wide and classroom rules related to bullying, teacher training, parent training, and meetings.[30]

To ensure bullying prevention efforts are successful, all school staff and other school-based mental health professionals need to be trained on what the school's policies and rules are, and how to enforce the rules.

Below are some additional bullying prevention resources:

- https://www.stopbullying.gov
- https://www.stopbullying.gov/prevention/at-school

> The bullying was not too bad, but it was bad enough to kind of make me very, very just tired of life, and just—I just didn't want to be here anymore 'cause I just—I was just so tired of the BS and all the lies and stuff like that. …I think maybe it was a little bit of a contributor to what happened, but I don't think it was necessarily a big reason. **(ADOLESCENT, AGE 14[18])**

LGBTQ+ Acceptance and Bullying Prevention

Youth with diverse sexual and gender identities face greater risks for mental health challenges, including suicide-related crises, particularly when exposed to hostile or discriminatory school climates. It is imperative for schools to foster environments that are welcoming and inclusive to youth with diverse sexual and gender identities, in addition to diverse racial and ethnic identities.[31]

Recommendations to Schools for Preventing LGBTQ+ Bullying:[11,31,32]

- Policies and Leadership:
    - Adopt explicit inclusive and nondiscriminatory policies addressing homophobia, transphobia, and bias-based bullying.
    - Ensure policies include clear expectations, reporting pathways, and consequences for discrimination.
    - Allocate resources to support policy enforcement and inclusive initiatives.
- School Personnel:
    - Provide staff and school-based mental health professionals training on how to recognize, respond to, and report LGBTQ+ bullying, with emphasis on smaller forms of bullying and a collective awareness of homonegativity and transnegativity that are often ignored.
    - Encourage staff and school-based mental health professionals to set aside personal beliefs to ensure students feel supported.
    - Integrate expectations into classroom management, syllabi, and mental health discussions.
- Curriculum and Programs:
    - Reshape curricula to integrate LGBTQ+ identities and perspectives into classroom materials.
    - Make LGBTQ+ resources available in libraries.
    - Implement peer-led workshops, assemblies, or after-school programs.
    - Implement evidence-based diversity and intergroup education programs to strengthen peer relationships.

- Student and Parent Engagement:
    - Encourage students to challenge peer-group norms, advocate for fair and equal treatment, and support inclusivity and mutual respect.
    - Provide voices to those who feel marginalized.
    - Support student participation in diversity education opportunities.
    - Make parents aware of school policies, and encourage them to advocate for students and support diversity initiatives.

6. Strengthen family-school partnerships and share resources with families who may be having difficulties of any kind.

Effective family-school partnerships are an important way to support students' mental health and build a welcoming school community.[33] These partnerships can be critical to ensure there is a strong foundation in case a child is hospitalized and the school and family have to partner together during that difficult time. When schools actively engage families as equal partners, it builds trust, enhances communication, and promotes consistent support between home and school environments and the student will likely benefit from this partnership.

Key considerations to building family-school partnerships include:[34]

- Two-way communication involves listening deeply to families—with an understanding that they are the experts on their children.
- Collaborative problem-solving with families.
- Creating opportunities for families to be involved in the school and helping to dismantle barriers to school engagement.
- Providing culturally responsive training for school staff and school-based mental health professionals on how to engage respectfully and effectively with families from diverse backgrounds.

While there are different versions of family-school partnerships, all should aim to build relationships, link to learning, address differences, support advocacy, and share power.[35]

Culturally Grounded Approaches to Family-School Partnerships

Culturally grounded approaches to family-school partnerships require viewing cultural differences from a strength-based perspective, valuing diversity, countering stereotypes and negative assumptions, and promoting authentic collaboration with families.[36] For example, understanding that families who miss meetings due to transportation challenges, work schedules, or communication barriers may be involved in their child's education in more nontraditional ways—and considering how they face systemic obstacles that schools can address with understanding and flexibility. Schools may consider and appreciate intersectionality of identities and practice cultural humility, or be open to learning about other cultural identities.[37]

Cultural beliefs can strongly influence how parents respond to suicide risk. In some communities, cultural sanctions may discourage disclosures of mental health concerns, particularly to individuals outside their own cultural group.[38]

In these cases, students may be less likely to seek help in school, even if they trust school staff or school-based mental health professionals. They may also experience tension when messages from home conflict with school expectations.

Building trusting relationships with families can help bridge these differences. When families feel respected and understood, they may be more willing to support their child in seeking help. Research shows that parental interest and engagement in education can serve as protective factors against suicide risk.[39,40] At the same time, studies suggest weaker effects of parent engagement among racially and ethnically minoritized families may reflect a lack of trust in schools.[39] School advocates (e.g., psychologists, counselors, social workers, and nurses) working as part of a multidisciplinary team can partner with parents, caregivers, and community leaders to promote resiliency and support youth in navigating suicide-related risk.[41]

Practical strategies include:

- Engaging parents and guardians in leadership and decision-making positions. For example, implementing a parent advisory group, allowing parents to provide input and feedback about a number of topics, including mental health programming.
- Hosting parent workshops to share resources on recognizing and responding to bullying and suicide warning signs.
- Offering workshops in accessible locations (e.g., community centers) and at convenient times (e.g., evenings and weekends).
- Creating opportunities for parents to serve as mentors to other parents.
- Integrating culturally informed practices into all family engagement efforts.[42]

By embracing cultural diversity and engaging families as partners, schools can build stronger, more effective supports for students at risk.

These considerations should be applied preventatively, and also when school professionals face tension in communicating with families about mental health concerns. For example, families may respond to suicide-related risk referrals by minimizing the seriousness or existence of a student's symptoms, or refusing to share information about their child's recent hospitalization with the school. In these cases, school professionals may feel frustrated or tempted to blame the family. Instead, they can use the opportunity to engage in collaborative problem-solving, and support families by listening and addressing the concerns they identify as most pressing.

7. Strengthen school-community partnerships and establish culturally grounded referral networks.

Schools alone cannot meet all the complex mental health needs of students. Proactive collaboration with community-based organizations, healthcare providers, mental health specialists, and cultural institutions expands the resources and expertise available to students and families. These active partnerships should be fostered to allow for ongoing communication about successes and challenges, with relationships constantly evolving as opposed to static.

School-community partnerships should:

- Focus on the whole child, the need for relationships between family members and students, and the importance of understanding worldviews, lived experiences, and multiple identities of students and families.[37]

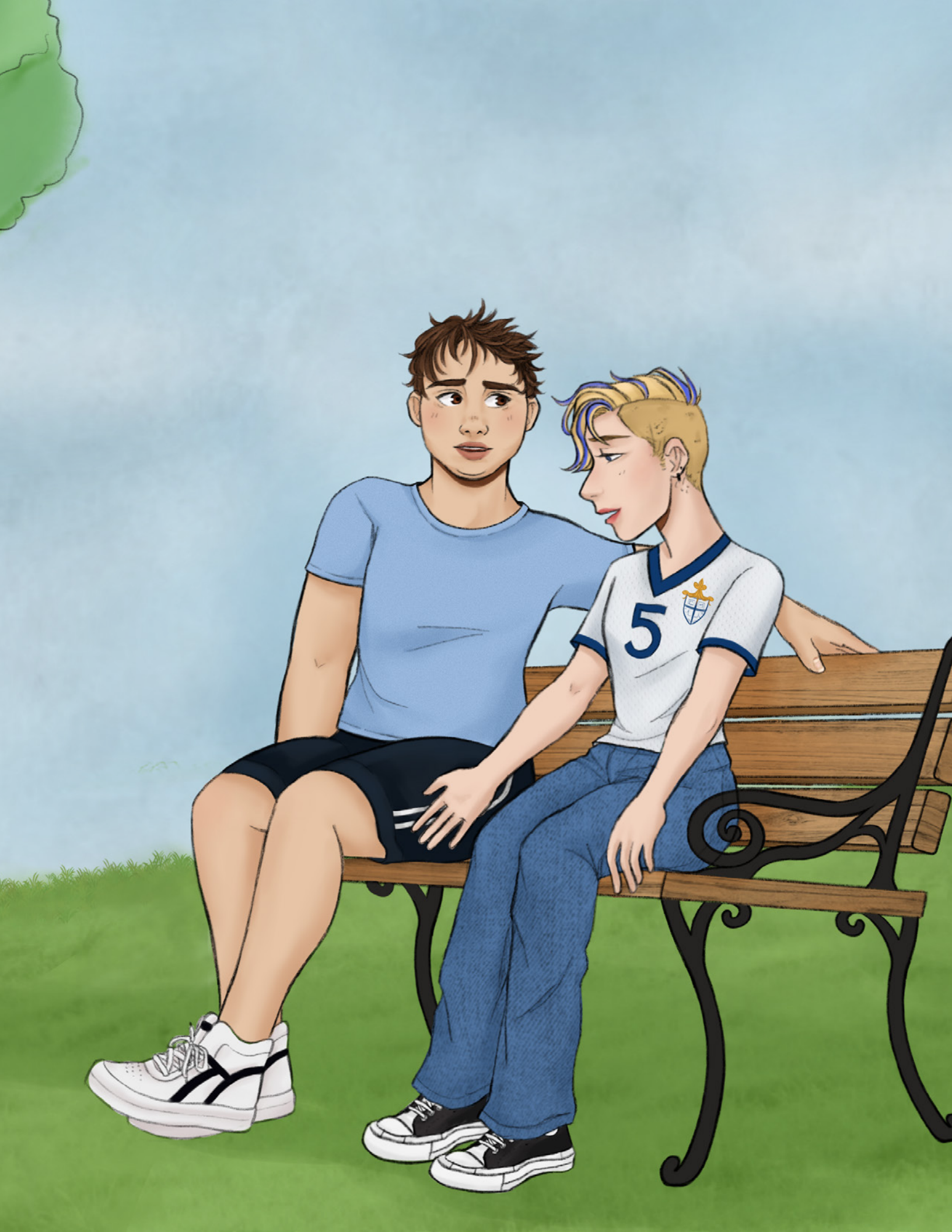
- Emphasize multicultural care and focus on strengths, intersectionality, values, and cultural diversity.[37]
- Include strong leadership, foster an inviting school culture, empower educator commitment, provide opportunities to collaborate and communicate, and work to build an inclusive culture.[43]

Proactive collaborations with communities may include integration of community members into school activities, building relationships with specific providers/establishing protocols for communication, having release of information forms available to communicate with various local mental health providers and hospitals, and formal agreements via memorandums of understanding (MOU) with community agencies providing dedicated mental health services to students. Schools and behavioral health staff in emergency departments and other settings can also plan and schedule regularly occurring (e.g., annual) meetings with one another to identify strengths and improvements to referral and treatment processes. Providing hospitals with a fact sheet describing school-based mental health services and the multi-tiered system of supports (MTSS) framework may help hospitals provide relevant recommendations to schools. These should be living documents and ongoing partnerships that will be evaluated and updated over time.

8. Collaborate with other local districts about school reintegration practices and procedures.

While each school should develop a reintegration plan that best meets the needs of their own community, they may also consider collaborating with other districts to learn from one another. Schools may consider cultivating a shared resource of districts willing to connect and collaborate regarding practices and procedures for school reintegration, including specific examples of re-entry planning documents and protocols. Local, regional, or state-wide school mental health groups may facilitate such sharing, which can be particularly helpful when there is overlap in community based resources.

For example, North Carolina has a School Mental Health Initiative that brings together community mental health providers, educators, advocates, lawyers, university officials, and parents, with the goal to provide policy/legislative support and recommendations for accessible, high-quality and coordinated mental health services.[44]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DURING HOSPITALIZATION

Both hospital and school professionals should begin to prepare for school reintegration during referral to the hospital and/or during a student's hospital stay.[45] In cases where the referral to the hospital comes from the school, school divisions can ask for a release of information to facilitate information sharing and transition into hospital care (with parental consent). Protecting privacy is critical, only necessary information ought to be shared.

In hospitals where hospital-based school support staff are available, hospital teachers and/or school liaisons can help facilitate preparation for school reintegrations throughout a patient's stay. In hospitals without school support, understanding of school context may be limited, but can still be prioritized by the appropriate staff member (e.g., social worker, therapist, or psychologist with school-based training or knowledge).

Preparing for Re-Entry: Hospitals

Hospital professionals can enhance inpatient care by considering school context throughout a patient's stay, and they can also help prepare for school reintegration by considering treatment implications for patients when returning to school context.[45]

Discuss Information Sharing with the Family

When partnering with the family to consider sharing information across settings, hospitals should consider the potential benefits and cautions regarding providing permission to do so. Reframe the conversation away from if the family should share information with the school toward what information could be shared with the school that might benefit the returning student. Consider both risks and benefits to sharing information (as described in more detail in Information Sharing) and seek release of information for two-way communication between point person at school and hospital.

Consider Return to School Throughout Hospitalization

Integrate discussions around school-related stressors and supports (academic, social, emotional) with the patient and their family into hospital treatment and discharge planning. School-related information may inform case conceptualization, treatment, de-escalation strategies, and academics that a student may need to attend to during their stay.

Integrate Preparation for School Return into Treatment

Discuss what concerns the patient has about returning to school, including academic (e.g., catching up on missed coursework), social (e.g., handling peer questions about absence), and emotional (e.g., handling symptoms in school). When possible, role play with the patient about what it might be like when they return to school, and help the patient make a plan for answering questions from teachers and peers about their absence. The patient may want to have different answers to this question prepared for different people asking questions (e.g., close friends versus acquaintances).[46]

Summarize Key Information for the School

- **Patient Summary.** A patient summary that is part of the discharge summary or a supplemental document may involve collaborating with the family to consider sharing the following information with the school, which may support the school's re-entry planning (also see Table 1 in Information Sharing for specific considerations related to each category):

- School-related stressors and triggers that can inform school supports for the returning student
- Any diagnoses that could be used for formal supports requiring an IEP or 504 plan can be clearly identified
- Reasons for hospitalization if applicable to school settings
- Medications that may impact the student's functioning in school or require medication management in school
- Coping strategies that can be used by the student in school

> We're told that his mental illness can be included in the 504 Plan. Nobody told me that. . . When I was meeting the principal on Friday, we were talking about getting that meeting, and she just implied something, and I'm like, 'Whoa, whoa, whoa, wait. Are you saying that we can incorporate that into the 504 Plan?' She's like, 'Yeah, if you have a note from the doctor.' It took me asking the question. **(PARENT, P. 9[10])**

- **Psychoeducation on Hospitalization and Re-Entry Protocols.** Provide an overview of goals related to psychiatric hospitalization, and information about general procedures used by the school to facilitate student re-entry.
- **Safety Planning Intervention.** Integrate the school environment into safety planning intervention procedures (e.g., identify trusted adults in school in addition to those available at home, identify coping strategies that can be appropriate for classroom settings) and, with authorization from the family, consider sharing with the school.

Provide Recommendations for Schools

When the family provides authorization to share information with the school, hospital clinical and school staff can provide written, tailored recommendations for relevant school-related supports for returning students. Try to speak with the school to formulate the plan and identify the point of contact for the school, student, and family for the reintegration process. Ideally, hospital-school partnerships established at the forefront involve regular meetings to develop and improve upon communication protocols and psychoeducation about school-based mental health services and multi-tiered system of supports (MTSS) frameworks. In all cases, **be careful to make general recommendations that schools can tailor to their own context, as opposed to making specific recommendations that may not be feasible in that school's setting.**

- **Recommendations for Modifications**

  The following modifications may be available in schools for returning students, and can be tailored to each student's needs. When implementing these modifications, it is important to consider the timing (are these modifications the student may need long-term, or modifications that should be reassessed regularly?). Schools may benefit from recommendations about what not to modify in addition to what to modify, given some modifications may actually make reintegration more difficult. For example, consider the potential for gradual return to school to complicate issues for youth with school avoidance, or the restrictions that may be required for a universal pass when students may need practice at building tolerance to day-to-day stressors they face in school. It is also important to note that some modifications may require an individualized education program (IEP) or 504 Plan.

  - Gradual return to school
  - Pass to attend school late or leave school early

- Alternative location for lunch/breaks (i.e., quite/calming space)
- Consideration of missing work forgiveness
- Consideration of extended deadlines or reduced assignments/work load* opportunity to retake tests*
- Opportunity to take tests in a quiet location*
- Extended time limits for tests*

** May require an IEP or 504 Plan*

> We've had some cases where we have modified the school day. We've had cases where we've done some online—doing like a hybrid schedule, so maybe an online class and coming for a period or two…I'm hesitant not to have the kid in school because I'm worried about what's going to be happening at home. I want them to have as much normalcy as possible. It worries me when we push too much for homebound and stuff, because I feel like we're making the problem worse in a lot of situations. **(SCHOOL PSYCHOLOGIST, P. 15[45])**

- **Recommendations for Interventions**

  Hospitals may provide recommendations about what interventions and services may benefit the returning student, and also identify what may be contraindicated. When implementing interventions, it is important to consider the timing of the intervention (are these interventions students may need long-term, or modifications that should be reassessed regularly?) Although access to specific interventions and services vary from school to school, the following interventions may be available for returning students, and can be tailored to each student's needs.

  - Support with work completion/time management
  - Tutoring or learning specialist
  - Check-in/check-out (e.g., regularly occurring meetings with an identified school member to check in about social, emotional, and academic needs and progress)[47]
  - Individual counseling
  - Group counseling
  - Access to a transition classroom within school (e.g., a separate space for academic and/or social-emotional support)
  - Self-monitoring instruction
  - Social skills groups
  - Peer or adult mentoring programs
  - School-based mental health

Consider Variability Across Schools

Setting appropriate expectations for families is important since schools may vary in the ability to provide supports and services to returning students. General recommendations that schools can tailor to their context can help set appropriate expectations for families.

Preparing for Re-Entry: What the School Can Do

When a school is aware of a hospitalization, staff and school-based mental health professionals can take steps to support the family and begin preparing for student reintegration.[45]

Discuss Information Sharing with the Family

When partnering with the family to consider sharing information across settings, schools may consider the potential benefits and cautions regarding providing permission to do so. Reframe the conversation away from if the family should share information with the hospital toward what information could be shared with the hospitals that might benefit the returning student. Consider both risks and benefits to sharing information (as described in more detail in **Information Sharing**). Obtain release of information for sharing information between point person at hospital and school.

Provide a Student Summary

When authorized by the family, specific information that may be helpful to share with the family and hospital may include:

- **Academics:** Organize and share appropriate lessons, learning materials, and assignments with the family and/or hospital, providing simple checklists or ways to monitor work completion.
    - Defer to the hospital about appropriateness of engaging in academics during hospitalization. Many child and adolescent hospitals provide teachers or school liaisons to support this decision-making.
    - Begin to consider what work can be forgiven, and a plan for addressing missed content and work that cannot be forgiven.
- **Schedule:** Review the student's schedule and share updates with appropriate individuals as recommended by the family (e.g., if the student is enrolled in community college, help assure they are made aware).
- **Point Person:** Identify a point person to facilitate communication and the re-entry process, and share the name and contact information with the family and hospital.

Begin to Prepare the Re-Entry Plan

When the school is aware of a student's hospitalization, staff and school-based mental health professionals can begin to gather data to inform a re-entry plan. With the family's permission, engage in standard operations for when a student has been hospitalized or out of school for a prolonged period for any reason.

Preliminary information that helps initiate a successful re-entry plan includes:

- Listening to the student and family's perspectives regarding current experiences and ongoing needs.
- Identifying individuals within the school who are trusted by the family and student to support the student's return.
- Gathering existing student data that may inform the re-entry plan, and collecting perspectives from the school staff, school-based mental health professionals, and faculty.
- Collaborating with the school staff, school-based mental health professionals, and faculty and family to identify personnel who may need to be notified, as appropriate.
- For additional concrete strategies and data involved in re-entry planning, see the **Re-Entry Plan section**.

Assess and Prepare the School Environment

Preparing for a student's return requires monitoring the school environment, including:

- **Attitudes and Rumors:**
    - Address mental health stigma, misunderstandings, or other negative attitudes among educators and students (leveraging existing universal prevention programs when possible).
    - Address student rumors/questions about student in crisis, maintaining FERPA and student privacy in discussions.
- **Environment:** Address any specific stressors (e.g., access to sharps, known bullying) the school is aware of, in preparation for student's return.

Collaborate with the Family to Support the Family and Student

Although the family may be overwhelmed while their child is in the hospital, inviting them to meet in advance of their child's discharge can both provide support to the family and help initiate preparations for school reintegration. When collaborating, explain the purpose of information sharing (e.g., diagnosis is used for 504/IEP eligibility, nurses benefit from medication information, recommendations assist with re-entry planning, safety concerns support safety planning including understanding a student's warning signs and informing environmental modifications. See more detail in **Information Sharing**).

- **Offer to Meet with Family:** Reach out to the family to set up a meeting prior to re-entry, providing an opportunity for the family to share their experience and perspective.
- **Seek Authorization of Release of Information:** Seek authorization of release of information from the family to communicate with inpatient and outpatient providers.
- **Offer Expressions of Support:** Offer expressions of support to the hospitalized student. For example, offer to send a card, email, or even visit (if feasible), first asking the family's permission and respecting their wishes if they decline.

Questions for the Family

In addition to completing an authorization to release information (allowing the school and hospital to share information with one another), below are a list of questions the school may consider asking the family regarding preparation for reintegration:

- Who in the school would you like me to notify/not notify?
- What would you like me to tell the people we are notifying?
- What academic work would you like me to collect?
- Do you want me to reach out to the hospital?

In addition to family input, the school point person should use judgement to consider best methods of sharing information internally, including considerations of staff, school-based mental health professionals, and faculty sensitivity to student mental health needs.

School and Hospital Discussion Topics

A key barrier to information sharing is finding time and the ability for the school and hospital professionals to connect. Following authorization for release of information, a simple, five-minute phone call can be enough to gather the essential information needed to begin re-entry planning. The list below offers key topics and questions schools and hospitals can cover in five minutes or less when preparing for a student's return.

1. Identify the point person at the school and hospital for communication.

   School/Hospital: Who should we contact at the school/hospital?

2. Confirm academic work completion expectations: Is the student allowed, encouraged, or discouraged to complete academic work during hospitalization? If allowed/encouraged, what is the best way for the school to share academic content and assignments?

   School: Would you like us to share academic content and assignments? If so, what is the best way to share this with the student? Is there academic support available for the student in the hospital?

3. Identify any academic, behavioral, or social-emotional data from the school that might support understanding of the case.

   Hospital: Does the student have an IEP, 504 Plan, or Functional Behavior Assessment (FBA)/Behavior Intervention Plan (BIP)? If so, what are they for? What strengths and areas of concern do you have for this student socially, academically, emotionally, and behaviorally?

4. Identify any school-related stressors or supports.

   School/Hospital: What school-related stressors or concerns has the student described or have you observed?

   School: What recommendations do you have for supporting the student when they return to school?

5. Establish a communication plan for the student during hospitalization.

   School/Hospital: What additional information can we expect and how will we communicate next?

Information Sharing

During hospitalization, information sharing between families, hospitals, and schools can be critical to facilitating a smooth transition; however, information sharing can involve both risks and benefits from a family's perspective, and these should be considered carefully by all parties.[48]

It is important to note that students may present differently across different settings. For example, they may have behaviors in the hospital that are dissimilar or opposing to those they had in school, and so the recommendations from one setting to another may not align. All parties should be aware that the student may seek to get their needs met in different ways in different environments.

Cautions

Policies exist to protect individual and family rights to privacy. Determining whether and what information to share across sites will be determined by the family's perspective on information sharing.

Some of the reasons a family may not want to share information across sites include:

- **Privacy and Confidentiality:** The family may not fully understand the limits to privacy and confidentiality in school settings. Discussing FERPA and considering how well the specific school handles confidentiality can help the family consider the process. For example, some families may believe that information shared with schools will remain in a student's permanent record and/or be shared with colleges during student applications. Addressing these misunderstandings is critical. Additionally, ensuring that schools are a safe place to share information (by creating a culture where confidentiality of mental health difficulties is maintained) is a crucial aspect to facilitating information sharing.

> Just that, if the hospital shares stuff about mental health, what's the school gonna do with that information? Are they gonna tell teachers? You don't know if that teacher is gonna take it home and talk to their husband about it, or their kid. Be like, 'Oh, yeah, this student is coming back' because you share with family stuff like that. You don't know where that information is gonna go. With schools, they're not like hospitals. They're not institutionalized, like everybody's got this strict codes of conduct. Schools are a lot more loose, so you don't know where that information is gonna go. **(ADOLESCENT SHARING PERSPECTIVE ON SCHOOL RE-ENTRY, AGE 16)**

- **Concerns About Appropriate Use:** Without an understanding of how information will be used, a family may be hesitant to share information (and rightfully so). Not all information needs to be shared. Always ask, how will this information benefit the returning student? Encourage families to discuss the purpose of information sharing with the school in addition to the hospital.

- **Fears Related to Stigma:** Unfortunately, stigma related to mental health is perceived by families, adolescents, hospital clinicians and staff, and school professionals. Perceived stigma related to mental health difficulties and suicide may prevent families from wanting to share information with schools; additionally, the psychosocial climate around mental health across settings (hospitals, home, school) all play a role in the appropriateness of sharing information.

> [The] struggle between you wanting them to know that it's not him just acting out and having behavioral [difficulties], but you also wanna protect his privacy and confidentiality and not share really personal information. It sort of—it's like this push and pull between these two issues.
>
> **(PARENT, P. 12[48])**

- **Lack of Awareness:** The family may not know or think to share information with schools. If a school does not have transparent procedures accessible to families, they may not know who to contact about their child's hospitalization. It is also important to remember that the family is facing a crisis, and the school may not be at the forefront of their mind as they are navigating this stressful experience.

Benefits

Benefits from information sharing range from the practical logistics of returning to school (e.g., attendance policies) to improved intervention support (e.g., eligibility determination).

Some of the benefits perceived by families and professionals include:

- **Informed Hospital Diagnosis and Treatment:** The hospital can integrate school context into case conceptualization, treatment decisions, and diagnoses.
- **Attendance Policies:** Many schools have strict attendance policies requiring documented reasons for absences.
- **IEP (Individualized Education Plan)/504 Plan:** Data and diagnoses during hospitalization can support modifications to existing IEP/504 Plans, or provide necessary documentation to initiate an evaluation for one.
- **Informed Re-Entry Planning:** Awareness of a crisis allows for initiation of a re-entry meeting to outline how best to support returning students.
- **Informal Supports:** The school can provide a number of information supports (not requiring an IEP or 504 Plan) that may be available to returning students. These may include adult check-ins, social-emotional learning, and encouragement of specific activities or opportunities.
- **Increased Monitoring of Students:** The school can serve as an additional support for safety monitoring and interventions.
- **Ongoing Care and Support Navigating Follow-Up Recommendations:** Recommendations from the hospital may help with a continuum of care, depending on resources and supports in the school, including school-based mental health services that can allow for more targeted treatment provided in the community. More generally, it is helpful for schools to know the names of providers/agencies involved or being referred and the types of treatment and medication to support the students and family with these referrals.

> "I feel like that was also hard for me too, especially in the beginning of my journey, I was very, very worried and very, very hush, hush 'cause I know there's so much stigma around the topic of discussion. I guess I just didn't want as many people knowing. I guess I did open up a little bit more, but I still am pretty closed-off about it. At the end of the day it can be hard, and especially in a school setting because teachers can be very gossipy [laughter] at times. I feel like it's—I don't know. Maybe just figuring out a way to make sure it is a force, but to only disclosing—I guess what's needed—because at the end of the day you don't have to know all my business in order for my plan to be successful. You know what I mean?
> **(ADOLESCENT PROVIDING FEEDBACK ON GUIDELINES, AGE 19)**

> "I took a parent to court for attendance, and I found out in the courtroom that her son had been hospitalized. She didn't tell us… She told us in court, and so it was like, 'That would've been something that would've been excused. We would've wanted to know to support you, and we could've avoided this.' We felt like she was just keeping him out of school. She wouldn't respond to us.
> **(PARENT, P. 16[45])**

Key Considerations

Key considerations when sharing information between the hospital and school include:

- **Environmental Relevance of Information:** When deciding whether to share information that may be sensitive, health-related, or private, the family and school professionals can ask: How will sharing this information benefit the student returning to school? For example, in a school setting, will it help better provide supports? In a hospital, will it enhance case understanding or treatment?
- **Sharing Information on a Case-by-Case Basis:** The type of information shared across entities will depend on the individual student's needs and context. There is no one-size-fits-all approach for information sharing.
- **Different Parties May Have Different Perspectives on the Amount and Type of Information to Be Shared.** The family and student may be hesitant to share detailed, personal information with the schools whereas school professionals may believe this information to be critical to supporting a successful re-entry. School professionals, the family, and hospital staff should prepare to navigate tension between differing opinions, and the school professionals and hospital staff must respect families wishes.

> If a student [is] just coming out and saying that they were sexually abused a year or two ago or whatever, we don't need to know all the nitty-gritty, but if they're not feeling safe changing in the locker room for gym, and that's why they're not doing gym, stuff like that is very practical. That practical stuff we could really do something with.
>
> (SCHOOL PROFESSIONAL, P. 8[48])

Table 1 presents specific information that school professionals, the family, and hospital may consider sharing in light of these key considerations.

Table 1

Type of Information	***Considerations***
Reason for Hospitalization	• When related to school, reason for hospitalization may inform specific interventions or supports needed to address ongoing stressors
Diagnosis	• Diagnoses may or may not be used to initiate access for special education (e.g., specific learning disability, autism) or modifications (e.g., mood disorders, anxiety disorders, ADHD) • Some diagnoses may be more stigmatized or associated with negative outcomes in school settings (e.g., those leading to identification of special education under the category of Emotional Disturbance)
Medications	• Side effects may impact functioning in school or require in-school monitoring • Medication may need to be delivered or managed in school
Coping Strategies	• Not all coping strategies can be accessed across school settings, consider those relevant to class time and transition time and weigh the risks versus benefits (e.g., some comfort items may be banned in school, but may be especially important for a returning student)
School-Related Stressors or Supports	• Any school-related stressors or supports that are identified during hospitalization can help inform re-entry plan interventions and supports
Psychoeducation About Hospitalization and Youth in Crisis	• School professionals may lack insight into the types of treatment provided during hospitalization, or the experiences of adolescent patients
Recommendations for School	• Specific recommendations for schools need to account for variability in schools and student needs (i.e., it is critical that hospitals only make recommendations that are feasible to school settings and do not inadvertently pit families and schools against one another when they are not)
Safety Planning Intervention	• Safety planning interventions are meant to address multiple settings during recovery, and they likely look different across settings, including schools

POST-HOSPITALIZATION

Holding at least one school re-entry meeting is essential to develop a plan, collaborate on a safety planning intevention, and establish a long-term plan for monitoring student growth and challenges following recovery.[49,50] Considerations will vary.

During school reintegration, a student-centered, strengths-based, and trauma-informed approach to school reintegration is most effective.

What is Student-Centered?

A student-centered approach places the student's needs and strengths at the center of the process. It allows the school to consider the unique aspects of the returning student, as opposed to taking a one-size-fits-all approach to supporting their recovery. This approach prioritizes involving the student in discussions whenever possible (or as appropriate).

What is Strengths-Based?

A strengths-based approach prioritizes a student's strengths throughout the process. Instead of focusing solely on risk, the school can consider the resilience of youth navigating their recovery and leverage strengths for informing intervention. For example, youth may draw on friendships and peer support when they return to school.

What is Trauma-Informed?

Having a history of traumatic experiences is common among youth hospitalized for suicide-related crises, and trauma exposure is associated with having made a suicide attempt.[51] Although not all hospitalized youth will have had a traumatic experience, taking a trauma-informed approach allows the school to be sensitive to the potential for trauma exposure without necessitating specific information about trauma. Trauma-informed approaches draw from six key principles:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical, and gender issues.[52]

> I think they [the school] had a thought that it would be a much more safer and better choice that they got into a relationship with me. You know, like, um, getting to me, you know, just, like, showing me that they were safe, they were kind. You know, just building that trust between them. **(ADOLESCENT, AGE 14, P. 7[46])**

> Like the first day, I was pretty nervous. I was pretty like, 'Ah,' but I had my friends there and they were really supportive, and they were really nice, and they were like, 'Hey, if you don't wanna be here [difficult space in school], just tell me, and we'll go somewhere else.'
>
> **(ADOLESCENT, AGE 15, P. 8[46])**

> They need to have different words, I guess. She was very accusatory. I felt embarrassed. I felt like I had done something very wrong for just saying that. Yeah. More like, 'I noticed that you were struggling a little bit.' …Use 'I.' Don't use 'you.' I think that could be really helpful. **(ADOLESCENT, AGE 17, P. 11[46])**

Consider Timing of School Year:

Considerations will vary according to the timing of the school year. For example, opportunities for excused work, making up missed academic content, and changes in coursework/course schedules may look different at the start of the year compared to the end of the year, and for different types of curricula (e.g., general education and younger grades may offer more flexibility than IB and AP courses and older grades).

Re-Entry Meeting

The purpose of the re-entry meeting is to collaborate with the support team to develop and enact a re-entry plan that identifies what is needed to support the returning student and provide the safest and healthiest transition back to school.

> I think she really felt validated by that meeting and came out of it feeling like, 'Yeah,my school is for me, and is trying to help me, and wants me to succeed. **(PARENT, P. 7[10])**

Who is Involved?

- Identify a person to welcome the returning student and check-in. This person may be selected based on school role (e.g., school counselor), or a person identified as a trusted adult by the student and/or family.
- Distinguish between individuals serving as point person for information sharing and individuals the student/family has a connection with, prioritizing both (can be same or different people).
- Plan for staff and school-based mental health professional roles in supporting the student (checking in, available for crises, etc.)

> In our case I let my daughter drive who she was comfortable having a re-entry meeting with. It was just the counselor. Then the counselor was her point person. In our case, that seemed to work out well. **(PARENT PROVIDING FEEDBACK ABOUT GUIDELINES)**

Additional roles and considerations are outlined in Table 2. Note that specific individuals involved in re-entry planning will vary by the school and student, and that while teacher input is welcome, their engagement tends to be limited compared to student support staff and school-based mental health professionals unless explicitly requested by families. Likewise, input from hospital staff is welcome, but it is unusual for those working in hospitals to be present at a school meeting.

> I almost feel like the counselors at her high school, any high school, should be trained or taught or shown or given an actual run-through of what a child's life looks like…Let them really see the depth of what young people go through when they go into psychiatric hospital… **(PARENT, P. 8[10])**

It is important to limit the number of school staff and professionals involved in re-entry in order to put the student and family at ease. For example, one or two school professionals may collect questions from the larger school team and prepare the types of support that are available to implement in advance, representing the larger team in a smaller meeting with the student and family.

Considerations for the Re-Entry Meeting:

- **Student-Centered and Strengths-Based:** Ensure that the meeting prioritizes understanding student and family experiences at the onset, beginning with a discussion of the student's experiences that focus on both strengths and needs. Remember to introduce everyone at the meeting each time the meeting occurs—be sensitive that families may be overwhelmed and have met many different providers throughout hospitalization. Allow time for the student and family to share stories, ideas, and needs, engage in reflective listening, and respond to their needs as appropriate.

  Don't only ask "what can we do to help?" **Instead,** ask both open-ended questions and provide a menu of options to help collaborate on a plan.

  A key aim of these meetings should be to reduce the student and family's potential anxiety about returning to school, and ensuring that they feel welcome, safe, and included when returning.

- **Timing:** The timing of the meeting will vary based on individual circumstances and needs.

  Ideally, the re-entry meeting will be held prior to the student's return to school, immediately after hospitalization or as soon as possible;[110] however, it is never too late to hold a re-entry meeting so when necessary, the meeting can occur after school return.

  Student return to school should not be contingent on meeting timing or requirement of any other documents, as this violates principles of Free Appropriate Public Education (FAPE) **(see FAQs for more information)**.

> When I sit there, I ask what worked for the child at the hospital, and what they think that they need now to be successful coming back to school. I try to talk about the strengths of that child and build upon those strengths to put a plan in place for that kid. I ask them what they need. I don't try to just throw accommodations at them or ideas at them without hearing from the kid.
>
> (SCHOOL PSYCHOLOGIST, P. 17[45])

- **Student Engagement:**
  - Offer to hold an individual meeting with the student and the family in advance of formal re-entry meeting, especially if the student is not comfortable attending the formal meeting.
  - Discuss with the student and the family if it makes sense for the student to be at the meeting. Consider having multiple meetings as needed, and respect the student's preferences about with whom they wish to meet.
  - Provide support to the student in planning to address peer and adult questions about absences. Planning may involve role playing, encouraging the student to practice what they will say to peers who are acquaintances versus close friends.[53]
  - Prepare the returning student for other students who may know about their hospitalization, or any misinformation or rumors that may be circulating.
  - Help the student plan how they will discuss missing work or content with teachers.
- **Information Sharing:**
  - Collaborate with the family to determine what information shared by the family and hospital will be shared with whom (teachers, staff, school-based mental health professionals). Balance communicating information in a way that ensures adolescents can receive support, but also keeps information on a "need-to-know" basis.
  - If not already completed, request authorization for release of information from and for outpatient therapists and other relevant mental health providers.

Table 2

Individual/Role	***Considerations***
Student	• Opportunity for self-advocacy • Emotional comfort and comfort with adults may influence decision to hold one-on-one vs. group meetings
Family	• Ensure opportunity for all key members of family to participate • Welcome and include nontraditional members who may be important to include (e.g., aunts, guardians) • Be sensitive to parental separation/divorce, foster care, and loss • Be sensitive to negative parent-child dynamics
Point Person	• Identify someone who can coordinate information sharing and meetings to support re-entry.[72,110,111] Examples include counselor, social worker, psychologists; however the point person is not limited to these roles
Special Education/504 Plan Coordinator	• Special education teacher and/or 504 Plan Coordinator may be required if student has or may be eligible for IEP or 504
Administrator	• Administrators may oversee school-wide decisions • Consider school policy implications
Nurse	• May support medication management • May be involved in identifying risk and/or delivering social-emotional supports
Student Support Staff	• Individual delivering social-emotional supports (e.g., counselor, nurse, social worker, psychologist) • Individual conducting/supporting additional assessments • Facilitation of community resources/supports
Adult Connected to Student	• A person in school identified by student or family as trusted who student can reach out to • Consider all faculty and staff and define role according to training and expertise
Mental Health Provider or School-Based Mental Health Professional	• Community or school-based therapist/clinician who can provide information about supports in school

Note that while clinicians and teachers from the hospital may also provide input, they are rarely available to attend formal school meetings following patient discharge.

Re-Entry Plan

The re-entry plan should address the student's immediate needs when returning to school, including academics, social-emotional and behavioral concerns, and a plan for addressing ongoing risk.[54,55] Specific elements should address:

1. **Logistics and Timing (absences, timing of return, timing of reevaluation of plan)**
2. **Designation of Key Roles**
3. **Student Overview (including student's strengths and areas of need)**
4. **Identification of School-Related Stressors**
5. **School Environmental Preparation**
6. **Academic Plan (support for addressing missed work and modifications as needed)**
7. **School-Related Supports and Services (identification of interventions, social-emotional supports, counseling, and including a safety plan adapted for the school)**

Information informing the re-entry plan can be gathered from several sources, including (but not limited to):

- Involved parties during hospitalization and at meetings (at a minimum, student and family)
- Hospital (e.g., patient summary and recommendations, clinician/hospital school input)
- Outpatient/community provider or clinician
- School (e.g., school records, previous evaluations)

You can find an example re-entry plan in the Resources section of this document.

Areas of Re-Entry Plan:

1. Logistics and Timing:

- **Attendance:** Document hospitalization to ensure absences are excused.[45]
- **Return to School:** Designate a specific time and location for school return (considering gradual versus immediate return to school, access to separate room or setting prior to immediate return, etc.)[45,46]
- **Check-Ins:** Designate times and locations for checking in with a trusted adult and/or point person (identifying specific person who will check in).[46]
- **Reevaluation:** Establish a timeline and plan for reevaluating the re-entry plan to change, continue, or phase it out.

> "I would say for the teachers that they trust or for teachers who hopefully are educated through these guidelines to take the initiative to check in with a student…The more checking in, the better, because that offers the student the opportunity to open up and share their experience or share how re-entry's going, hopefully in a real way. Not in a 'Yeah, everything's great.' **(PARENT PROVIDING FEEDBACK ABOUT GUIDELINES)**

2. Designation of Key Roles:

- **Point Person:** Identify the point person in charge of facilitating communication and organizing re-entry meeting, plan, and monitoring, and establish a plan for regular check-ins with the student and family.
- **Family Contact:** Identify the best point of contact in the family (e.g., parent or legal guardian) when there are risk-related or other concerns, or to share updates about progress.
- **Clinician or Therapist:** Confirm authorization of release of information is completed (as appropriate) and identify primary clinician to contact with risk-related or other concerns or to share updates about progress.
- **Trusted School Adult:** Collaboratively identify a trusted school adult to check in with the student during school reintegration,[45,46,53,56] designating the time and location of meetings. Note that frequency and type of check-ins will vary according to the role of the trusted adult (e.g., check-ins with a classroom teacher or other non-support staff should not include mental health-related interventions, but check-ins with a support staff or school-based mental health professional may involve such interventions).

> "I think it would've just made me feel like maybe someone was actually there to—I wasn't less lonely there or I didn't feel I was—you know. When you're there, it just feels like nobody really knows what you're going there. At home, at least, my parents knew that I was struggling. They knew that sometimes I would need time alone. When it came to school, nobody knew that, so it would be nice if I had somebody there who seemed like they understood my situation and stuff like that. **(ADOLESCENT, AGE 15[46])**

3. Student Overview:

- **Background:** Describe the student and their background, including their cultural background, family context, and anything else that is relevant.
- **Clinical Summary:** Include an overview of information related to suicide-related risk and/or mental health disorders (diagnosis and symptoms), as well as the type of after care/treatment (as available).
- **Student Strengths and Skills:** Collaborate with the student, family, staff, and school-based mental health professional to identify student strengths and skills on which they can draw.
- **Area of Needs:** Outline areas of need that are relevant for school.

4. Identification of School-Related Stressors

Consider and screen for school-related stressors to target for intervention:

- Academics
- Victimization experiences
- Specific individuals
- Environment (e.g., rumors or negative peer reactions, mental health stigma)
- Self-concept and peer impressions

> "I think just having teachers watch out for other students and the bullying, especially with those kids who are out of class because they're always bullied. I think that's also very important. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 16)**

5. School Environmental Preparation:

Review and discuss any environmental concerns, and enact a plan to address them. Examples to consider include:

- **School Staff:** Prepare teachers and other staff for the student's return to the classroom/school,[45,49,57] sharing information as appropriate and agreed upon with family and ensuring they are aware of modifications or coping strategies used in the classroom.
- **School Psychosocial Climate:** Prepare the psychosocial climate for the student's return, including addressing any stigma or negative reactions among teachers and peers.[46,53,54,57]
- **Physical Environment:** Consider and address any physical safety concerns (e.g., access to sharps in classrooms, discussion of safety in private bathrooms).

> I had a teacher—she didn't know anything about me. She didn't know anything about me. [Laughter] When I came back from the hospital, she pulled me aside and she started crying. She said, 'If you ever need anything, please come to me.' That really meant something. I will never forget her name…She is awesome. I think I go visit her every once in a while even though I graduated high school, but she was awesome. That's very important. My counselors, my guidance counselors were the exact same way, and that really helped me out. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 16)**

6. Academic Plan:

Organize and plan for missed academic work completion.[46] **Make it realistic, write it down and distribute it to relevant faculty and staff.** Review all coursework and plan for discussing missed content and make-up work with each teacher (note that different teachers may require different communication approaches). Ensure that the student and family have clear understanding of the deadlines for completing missed work and expectations for what needs to be completed and how it will be graded.[46]

Consider additional academic supports and modifications as needed:[46,58]

- Modifying the course schedule
- Modifying academic expectations (e.g., extended deadlines, reduced assignments/workload, missing work forgiveness)
- Time devoted to making up missed work and/or access to study hall
- Support for addressing missed work (e.g., time management strategies)
- Tutoring or support for addressing missed academic content
- Other specific academic modifications/interventions as needed, for example:
    - Modifications to test taking (e.g., extended time, open-book, quiet locations, retaking tests, breaking long tests into shorter time blocks, alternative assignments)
    - Support for time management
    - Support for assignment make-up (e.g., breaking tasks up into smaller components)

> …there was not much communication or help. They always tell you in high school, 'you're on your own' and stuff, but you can at least try to help me. Come on. I've been gone for a week and a half. Can't you just please make this easier on me? Especially when coming back from a place like that and you have to readjust yourself to being back into normal life and stuff, it's like you're just throwing this all at me and expecting me to be able to focus on it. Yeah, I wasn't ready for that. **(ADOLESCENT, AGE 15[46])**

7. School-Related Supports and Services:

Identify and provide the appropriate social and emotional supports and services to assist the student returning to school. These can include:[45]

- Medication management
- Special education (evaluation for or modification of IEP)
- Safety monitoring (see Safety Planning)
- Peer mentoring
- Adult mentoring
- Check-in/check-out
- Support space in school (e.g., separate transition area for supports) or outside of school (e.g., separate transition facility for supports)[45,54,59]
- School-based mental health services (individual/group counseling, school-based community providers)
- Social skills groups
- Support for family

> It was kind of like people—like my therapist and that type of thing—they were like, 'oh, you should put yourself first.' But it was not like a—you can't have both. It's like—you can drop out of school. Like, you can put yourself first and just—you can choose to put yourself first over schoolwork. But then it'd be like I'd have to drop out the [advanced] program. I could potentially fail all my classes, or get incompletes for them.
> **(ADOLESCENT, AGE 16[46])**

> I make a big deal to talk to my teachers—and say, 'Hey, this is a thing that's going on I need your help with.' Or, like, 'Hey, I missed that one. I need a refresher.'… Most kids just fall behind and don't get back.
> **(ADOLESCENT, AGE 15[46])**

Safety Planning

Safety plans are meant to help individuals with risk for suicide to have a clear plan for mitigating risk and increasing safety during a crisis. Ideally, the student will share an existing safety plan that can be modified for the school environment, and the school should collaborate with the student and family to adapt the safety plan for the school setting. If the student and family do not already have an existing safety plan, and the school has a trained professional available to engage in safety planning, the school can work with the student, family, and clinician to develop one.

There is a process involved in making a safety plan, and it is meant to be developed with a trained person, such as a clinician. We have provided key ingredients below for reference, though they should not be used without trained help.

Safety plans generally include the following steps, meant to be employed sequentially:

1. Warning signs (including problems or stressors that may signal or lead to difficulties)[54,60]
2. Coping strategies and distractions that can be used by the student on their own, without help from others
3. People to go to for distractions to help de-escalate stress
4. People to go to for help where the student can talk about thoughts and feelings. (They need to know that they are playing this role.)
5. Professionals/agencies to contact in emergencies
6. At least one reason to keep going, something the student is looking forward to, reason to live
7. Making the environment safe

See https://suicidesafetyplan.com/ for more information about safety planning.

When integrating safety plan into school setting, consider the following:

- Ensure consistency in what is meant by safety plan, with safety plans sometimes reflecting school-wide plans for handling threats.
- Identify where the safety plan will be located, who will be included in supporting the safety plan, and if multiple copies are needed.

> At what point in time do we need to potentially look at more serious steps if that ends up becoming a problem? In other words, if you're making threat of harm to self, at what point are we activating the system again that got you in the hospital in the first place? Because, just 'cause a kid says, 'Hey, I wanna hurt myself,' doesn't mean that at that exact moment in time you're calling in the calvary. It may be this is a regular thing for this student, at which point, someone who is trained in it has an opportunity to do a basic suicide assessment to see where they're at.
>
> **(SCHOOL SOCIAL WORKER, P. 32[45])**

> They said it was just a blanket ban. There were no exceptions, even though that was his best coping skill, and then he had one where he was allowed to tear tissue paper, and he got in trouble with his teacher for tearing tissue paper, so he stopped using that coping skill…Some teachers don't acknowledge it, or they don't know about it, or they missed the meeting, and then they confront the kid in class about it, and then the kid's not happy, obviously, so they're not gonna do it. I think one of those things that [adolescent's name] would do is shuffle cards, and I think he had an issue with a teacher telling him he couldn't do it, even though it was in his plan. **(PARENT PROVIDING FEEDBACK ABOUT GUIDELINES[9])**

- Consider any school-specific barriers and facilitators, such as teacher/school rules, prohibiting any coping strategies.
- Consider alterations needed for different settings in the school (e.g., different coping strategies may be allowable in classrooms compared to hallways).
- Identify what other school members can do when the returning student reaches out to them or when they notice a warning sign.[54,60]
- Identify a plan of accountability for ensuring the safety plan is followed by appropriate members of school.
- Address inconsistencies in the safety plan at school versus other settings, including considerations of safety for all students in cases of co-occurring threats to self and others.
- Consider other adaptations that may be necessary for students with neurodiversity.[61,62]

> I think that you should rename 'safety plan,' frankly. It's kind of triggering for a lot of the kids, and not only that, but if it's a safety plan for only at school, then it's going to be either the same or different from the one that's the hospital that they save at home. When you make it a safety plan and…now they have multiple safety plans, and now they have to try and remember what each one is, and it's just overwhelming and frustrating.
> **(PARENT PROVIDING FEEDBACK ABOUT GUIDELINES)**

Modifications

Identify the appropriate modifications to support the student returning to school, considering how some modifications may not be appropriate for all returning students (e.g., if the student struggles with school avoidance, gradual re-entry may make re-entry more difficult).

Examples of social and emotional modifications include:[45]

- Pass to attend school/class late or leave early
- Flexibility to leave class (universal pass to visit school counselor or other support staff, with boundaries placed to ensure other strategies are used first)
- Gradual return to school

Reevaluation and Long-Term Recovery

Develop and implement a plan for reevaluating the re-entry plan,[46] considering integrating interventions and assessment into a tiered system of supports for assessing response to intervention. Consider the following elements:

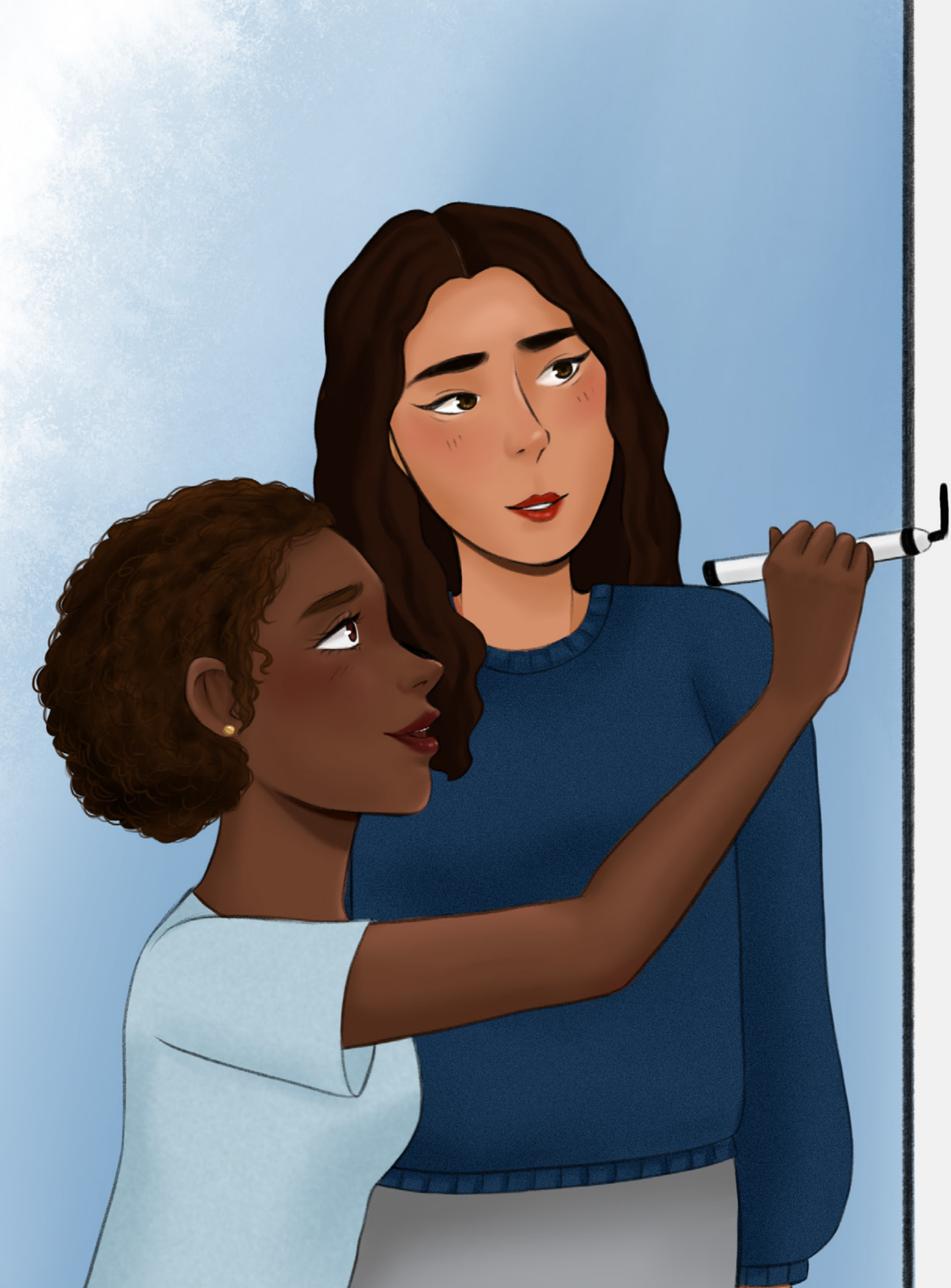
- Establish a timeline, such as 2–4 weeks, to reevaluate plan
- Identify data used to evaluate the plan, such as academics, attendance, behaviors, student self-report, check-in/check-out, therapist recommendations, etc., and consider data-based monitoring over time.
- Plan for check-ins with student, family, and teachers/support staff/school-based mental health professional
- Plan to scale the re-entry plan back over time based on data collected informing student recovery
- Plan for risk assessments and referrals given any chronic or ongoing suicidal thoughts and behaviors, ensuring that risk formulation accounts for long-term management of suicidal thoughts and behaviors
- Maintain ongoing collaboration with outpatient provider
- Identify person responsible for implementing and reevaluating plan

While re-entry plans typically address the initial adjustment period for a returning student, it is important to maintain appropriate supports throughout the student's time in school. Recovery from mental health crises is not linear.

> Yeah, I do wanna make it very obvious that mental health issues don't go away…They can get better, they can get worse, but they never go away. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 17)**

Longer-term, consider the returning student's treatment plan, maintain collaborations with the student's family and community providers, and continue monitoring and evaluating the student's social-emotional needs. Student support teams may monitor students receiving more intensive or targeted interventions (tiers 2 and 3) at designated times during the year, re-reviewing all students receiving these supports, including those with re-entry plans, tracking data and forwarding data to the next school within the district as students progress through their education. More generally, longer-term considerations include "help[ing] the kid while they're a kid" and preparing students in considering supportive mental health care as they transition from K-12 education into the community, college, and the workplace.

> The more support they can get at the high school level before they leave. It's exactly right. Help the kid while they're a kid. **(PARENT PROVIDING FEEDBACK ABOUT GUIDELINES)**



FREQUENTLY ASKED QUESTIONS BY SCHOOL PROFESSIONALS

Risks of Delayed School Re-Entry

How do I explain the dangers of requiring medical documentation clearing a student to return to school to my school administration?

Requiring a student to remain out of school until a re-entry meeting is held or until a physician provides written clearance can present significant risks and legal concerns, including:

- **Potential Violation of FAPE:** Excluding a student from school while awaiting clearance may violate their right to a Free Appropriate Public Education (FAPE) under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act, particularly if the exclusion is not supported by an individualized assessment and alternative services are not provided during the absence.[63]
- **Lack of Predictive Certainty in Suicide Risk:** There is no evidence-based tool or professional judgment that can guarantee a student is at "low risk" for suicidal behavior. Defining risk as "low," "moderate," or "high" is subjective, and is not found to be reliable or useful. Therefore, requiring a note that certifies a student as "safe" may create false security and places undue responsibility on medical professionals to predict risk.[64]
- **Isolation as a Risk Factor:** Extended absence from school may increase suicide risk, as isolation and disruption of routine can exacerbate emotional distress and remove students from protective factors such as peer support, trusted adults, and structured activities.[65]

> In my opinion, I feel like that's pointless. Having a doctor sign off for me is pointless because one, sorry, this is going to sound really, really bad, I'm only saying it because it was me. When you are suicidal, one thing you're gonna learn how to do is lie. You are going to learn how to lie, and you are gonna learn how to sell it. People are going to ask you, 'Are you OK?' You're going to say, 'Yes, I am fine.' You're gonna get them to believe you, and you're not [laughter] gonna be OK. You're gonna be nowhere near OK. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 19)**

> I don't think they should do that, because, what if you can't get in touch with that doctor? What if that doctor retired? You're stopping that child from their education, because you say they need a doctor's note. **(PARENT PROVIDING FEEDBACK ABOUT GUIDELINES)**

- **Best Practice:** The schools should aim to minimize time away from educational environment, support rapid reintegration, and collaborate with mental health professionals to assess readiness rather than requiring a blanket "doctor's note." Re-entry meetings should be timely, supportive, and flexible, focusing on individualized support and ongoing monitoring, not gatekeeping.

Supporting Peers

How do I support students asking questions who are worried or concerned for the hospitalized student, while also protecting the privacy of that student?

A mental health crisis can have a ripple effect on the entire school community, and depending on the circumstances it can lead to concern, fears, and rumors that may need to be addressed. While school professionals should dispel common misconceptions and any rumors related to the hospitalized student, they must also protect the privacy and confidentiality of the hospitalized student. Providing psychoeducation about mental health generally and teaching students about the complexity of mental health difficulties can help students cope with a peer's crisis.

Offer private opportunities for students and faculty to share their concerns and discuss ways to welcome the student back to school, without violating confidentiality.

> "The little cliques and the talking about—if a teacher walks by and they hear something like, 'Oh, she was gone for two weeks. I hear she overdosed or something. This and that.' Stopping that conversation dead in its tracks and saying, 'Go do your work. Just separate and go do your work.' It's more of a hear and listening kind of thing. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 16)**

Suspected or Unconfirmed Hospitalization

How do I address reintegration when I become aware of a student's hospitalization indirectly (e.g., rumors, seeing them in the hospital), but the family has not shared anything directly with me?

Schools may suspect a student's hospitalization, without any acknowledgement from a family. For example, they may learn about hospitalization from a peer, rumors, or a community member—or they may have been monitoring a specific student's mental health concerns. If a school learns about a student's hospitalization after returning to school, they can still develop and implement a re-entry plan. It is better late than never.

The family may not have communicated a student's mental health crisis to the school for many different reasons. For example, they may simply not have school front of mind while they handle their crisis, they may be fearful of stigma, or they may not know who to contact about the crisis. Irrespective of their reason, it is critical that schools are sensitive to the family's reasoning and respect the family's wishes about the information they are willing to share. When conversing with the family, it is essential to be respectful, adhere to standard privacy policies, and validate the family's concerns and reasoning.

If a school suspects that a student had a mental health crisis, they should be sensitive to a family's wishes to maintain privacy, and use the information they have (e.g., monitoring attendance and drawing from existing academic, social, emotional, and behavioral data) to develop and enact a plan to address areas of concern (e.g., interventions to address social and emotional needs, supports for missed work or academic content). Schools may consider the following specific actions when suspecting an unconfirmed hospitalization:

- Monitor attendance and follow-up accordingly
- Provide supports and services based on observed behaviors/needs
- Address and dispel rumors

Schools may also consider contacting the family/parents and share what they have heard, offering the family an opportunity to discuss, including requests they may have for privacy. Approaching the family directly could be the start of the school and family working together. Importantly, however, the family does not have to provide information if they prefer not to.

Emergency Department Visits

What can I do to support a student returning to school following an emergency department visit that does not lead to inpatient hospitalization? Are they still at risk?

Although these guidelines are focused on inpatient hospitalization, they extend to re-entry for emergency department visits as well. Although the time period may be shorter and the school may be less likely to learn about an emergency department visit compared to a longer stay, a student seeking emergency services for mental health crises still requires many of the same considerations.

KEY CONCEPTS AND CONTEXT

Understanding Suicide, Psychiatric Hospitalization, Legal Considerations, and the Role of the School in Suicide Prevention

Brief Overview of Child and Adolescent Suicide

According to the Centers for Disease Control and Prevention (CDC),[66] suicide was the third leading cause of death in 2023 among adolescents, ages 10–19 (2024). Data indicate rates of suicide-related thoughts and behaviors have significantly increased from 2013 to 2023 among high school students.[67] Although hospitalization for individuals considered at high risk for making a suicide attempt is standard practice,[68] it is extremely difficult to identify individuals who are likely to act on suicidal thoughts or determine risk for those leaving medical units after a suicide attempt.[69]

Between 2008 and 2015, the number of emergency department visits for suicide-related crises nearly doubled. The number of children and adolescents seen in the emergency department for suicide-related concerns who are admitted for psychiatric care varies, with estimates ranging between 8% to more than 50%.[70–72]

Risk for suicide is complex, with biological, psychological, and environmental risk factors. Research has identified both risk and protective factors related to suicide. For more information, see: https://afsp.org/risk-factors-protective-factors-and-warning-signs.

What is Acute Psychiatric Hospitalization?

Psychiatric hospitalization refers to an intensive inpatient mental health treatment for individuals experiencing severe crises, such as suicidal thoughts or attempts, severe depression or anxiety, psychosis (hallucinations, delusions, or severe disorganization), manic episodes, or behaviors that pose a danger to themselves or others. Psychiatric hospitalization can be voluntary or involuntary, with stays lasting days to weeks depending on the severity of the condition and insurance availability.

Although the quality of care during an inpatient stay appears to vary across sites,[73] treatments provided within inpatient programs typically prioritize safety, stabilization, and psychopharmacotherapy,[74,75] with the goal of transitioning to community or long-term care or discharge. Adolescents may be hospitalized in a child, adolescent, or adult unit, depending on their age and hospital availability.

Who is Psychiatrically Hospitalized for Suicide-Related Crises?

Hospitalized youth represent a diverse group of students, including students of all racial, ethnic, sexual, and gender identities, cultural and linguistic backgrounds, and socioeconomic statuses. Risk factors for suicide/suicide-related thoughts and behaviors and the ways symptoms are related to co-occurring conditions present may vary according to an individual's background and experiences.

> I think it's important to bring up that depression and suicidal thoughts happen in anyone. It can be someone who is the most popular kid who is happy, who is outgoing, who is trying to make everyone else laugh, can be really depressed on the inside. Those are the people who you don't see it coming with. I think that by bringing up the range of kids helps in the sense it helps them understand the signs and the warning signs.
> **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 16)**

Demographic Characteristics

Although specific demographic characteristics, such as female sex, White race, and private insurance, have been found to be associated with hospitalization for suicidal thoughts and behaviors,[76] overall, hospitalized patients reflect diverse identities that may vary based on location and hospital.[73,77,78] Obstacles to treatment such as inconsistent screening, identification of mental health difficulties, financial barriers (including being uninsured/underinsured), stigma, access to mental health care, mental health literacy, and availability of psychiatric emergency services may influence the characteristics of hospitalized patients.

> I feel like it's easy to categorize a lot of people in the same group because a lot of us do have very similar experiences, but because we're each unique and different people, it affects us in different ways. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 19)**

Symptoms and Diagnoses

When youth are hospitalized for suicide-related risk, they can present with a range of mental health symptoms that may contribute to their crisis. Frequent diagnoses include:[79]

- Mood disorders
- Anxiety disorders
- Alcohol and substance misuse
- Attention-deficit/hyperactivity disorder (ADHD)
- Conduct disorders
- Psychosis

> I feel like they should be informed of the different disorders that there are, 'cause just because you have a mental health crisis doesn't mean it's depression or doesn't mean it's anxiety, and how to differentiate and know which ones are which. **(ADOLESCENT PROVIDING FEEDBACK ABOUT GUIDELINES, AGE 17)**

It is important to consider mental health symptoms in addition to formal diagnoses, given school members may not always have access to diagnoses and students may not have prior diagnoses.

Strengths

Youth hospitalized for suicide-related crises are a diverse group, each bringing unique strengths and protective factors that can support their recovery and reintegration. These strengths, which are often overlooked, are essential to recognize and build upon during the transition process. Research exploring the strengths of adolescents facing mental health difficulties in a range of areas and circumstances has identified their adaptive use of coping strategies, resilience, optimism, self-esteem, and strong sense of personal identity.[80-83] In our aligned work, we have found that youth with lived mental health difficulties can safely collaborate with each other and with researchers to provide insight into the challenges they face.[84] That insight can be valuable and help inform solutions for others who are experiencing similar challenges.[85,86]

Throughout these guidelines, we have included the voices of youth with lived experiences to inform improved understanding of their experiences and draw on their valuable insights.

The Protective Role of Family

Family engagement can be a particularly important protective factor during and after psychiatric hospitalization. Parenting behaviors characterized by warmth, support, validation, nonjudgement and emotional care have

been shown to buffer against suicidal ideation, suicide attempts, and non-suicidal self-injury.[87] High levels of parental engagement and emotional support are associated with significantly lower rates of suicidal thoughts and behaviors.[39,40]

Family connectedness is a powerful buffer against suicide risk across racial, ethnic, and sexual minority groups.[87] One study found that family connectedness was more associated with lower rates of suicidal thoughts and behaviors than peer, school, or other adult connections for Black, Hispanic, and White youth, and similarly protective for sexual minoritized youth and those who have experienced sexual abuse.[88] Increased family cohesion is also linked to lower rates of suicidal thoughts and behaviors and serves as both a moderator and mediator for suicide risk among youth with depression and anxiety.[87]

Specific aspects of family relationships, such as open communication with parents—especially fathers—engaging in shared activities, and discussing personal challenges are associated with better mental health outcomes. Some research has identified gender differences in the protective effects of family support, with stronger buffering effects observed among girls than boys.[87]

The Protective Role of Schools

School connectedness is a strong protective factor associated with lower rates of suicide-related thoughts and behaviors.[3,89] Supportive relationships with teachers are associated with lower rates of suicidal thoughts and behaviors over time,[90] and may even play a role in recovery from a suicide-related crisis.[23] Interventions and support that strengthen students' connectedness and sense of belonging and build problem solving and coping skills may further help protect against suicidal ideation.[23,91] Both adolescents and parents have described the added value of having school activities and positive relationships with adults in supporting students' suicide-related risk mental health.[18] Other school-based protective factors include having formal clubs and alliances around gender identity and sexual orientation and parent engagement in education, both of which have shown promise for protecting against suicide-related risk.[6,91]

School-based comprehensive suicide prevention programs, including suicide risk screenings and targeted interventions, can help address suicide-related risk. However, it is important to recognize that for interventions delivered without adequate supervision, or when students have close ties with peers engaged in risky or harmful behaviors, the risk for suicide-related thoughts may increase.[92,93]

Acute Psychiatric Hospitalization Experiences

Emergency Department

Most help-seeking youth with acute suicide-related risk will first be brought to an emergency department for evaluation. Typically, upon arriving at the emergency department, youth first are registered, then they will have a brief assessment to determine the urgency of care. Next, they will be seen by an emergency department clinician who may seek consultation with a psychiatric clinician, who will conduct a further evaluation and work with family and staff to formulate the next step of a treatment plan. Typically the disposition options will include inpatient hospitalization on a medical unit, inpatient psychiatric hospitalization or discharge to home with referral to outpatient treatment. Examples of treatment include medications, crisis counseling, an explanation of what's happening, and a referral for treatment after discharge.[94] When appropriate, a safety plan will be developed before discharge. Youth with acute risk for suicide may be transferred to an inpatient setting.

Unfortunately, emergency departments may face staffing issues such as insufficient suicide-related care training, limited access to behavioral health specialists, and high turnover rates.[95] Mental health training for emergency department staff is often quite limited.

In the emergency department, youth can experience seclusion, physical restraint, long wait times and loud or crowded environments. Staff may not be adequately trained to handle mental health crises in the emergency department, meaning youth do not necessarily receive mental health care while in the process and are simply boarded while waiting for a bed to open. In addition, research has shown there are ethnic and racial disparities in the boarding process and youth may interact with staff without training in pediatric care.[96]

The adolescents and caregivers who spoke about their experiences as part of the School Reintegration Project described intense emotions during their emergency department visits, calling it "jail-like," "humiliating," and "nerve-wracking."

Inpatient Hospitalization

Inpatient experiences vary across individuals and hospitals. Ideally, each patient's treatment plan is individualized, so the length of stay varies based on previous hospitalizations, a history of trauma exposure, self-injurious behavior, and intensity levels of suicidal ideation and behaviors.[97] Most practices aim to hospitalize a child or adolescent no longer than necessary.

Adolescents have described both positive and negative experiences during inpatient hospitalization. Some challenges include peer interactions with other youth who have a range of psychological needs and trauma, separation from family, regulated clothing choices, phone and computer removal that limits access to family and friends, loud noises throughout the day and night, and restraints and seclusion.[98] Although youth may feel a sense of relief and safety, they may also feel strong negative emotional reactions such as fear, anxiety, shock, or ambiguity.[98–102]

> The whole process was horrible. I understand why it is what it is, but it doesn't make it less awful to see your kid have to get let off—here, we're trying to say, 'we're not punishing you, but go with the police officer to this next place.' **(P. 5[99])**

"A Day in the Life"

An average stay may begin with an intake evaluation, which is typically brief and addresses the risk of harm to self and others. Teams may also decide on the level of observation needed for the patient and will continuously reassess based on symptomatology and behavior. Treatment teams typically include a psychiatrist, nurse practitioners, psychologists, social workers, nurses, and other staff.[103] Despite interest in reducing restraints and seclusions,[104] such approaches are still frequently employed to de-escalate crises.[105]

Psychiatric facilities follow structured schedules designed to provide stability, treatment, and support. A typical day for a hospitalized adolescent may include psychoeducation groups, group and independent therapies, medication management, school or educational activities, regular monitoring for safety and emotional support, as well as recreational, occupational, and physical therapies, and family sessions.[106] The structured environment is intended to help patients develop coping strategies, improve mental health stability, and prepare for discharge with a treatment plan.

> I've been inpatient four times at four different places, and each and every single last one of those times was completely different. **(ADOLESCENT AGE 19[11])**

Discharge

Discharge planning is a key component of treatment to ensure safety, continuity of care, and a smooth transition back into the family and community. The decision to discharge is typically made collaboratively by the hospital treatment team, the adolescent, the parent, and, when relevant, school personnel or community agencies.[107]

Discharge Criteria

Discharge is typically considered when there is a significant reduction in suicide risk, the adolescent's mental state is stable enough to be managed by community-based mental health services, and a comprehensive follow-up plan is in place. Patients may be considered ready for discharge when they can receive safe and appropriate care in a less restrictive setting.[108]

> It was so weird because everybody wanted to go home…I really wanted to go home, but at the same time, I liked it there but I would just say I hated it there. **(ADOLESCENT, AGE 15[99])**

Discharge Process

The discharge process includes communicating with outpatient providers about follow-up care and collaborating with patients and families around lethal means restrictions.[13] For example, inpatient treatment providers usually support the development of a safety plan intervention,[109] which is a brief, evidence-based collaborative plan addressing coping skills and sources of support for individuals to use during a crisis.[110]

> On top of everything else going on and coming back, it was sensory overload. It was really hard. My parents really didn't want me leaving early, and I understand that they wanted me to get back into school, get back into the rhythm of things, but what I had been through, I was definitely struggling staying there the whole day. It was so weird because everybody wanted to go home…I really wanted to go home, but at the same time, I liked it there but I would just say I hated it there.
>
> **(ADOLESCENT AGE 16, P. 375[46])**

Post-Discharge Risk

Youth discharged from the hospital remain at risk for suicide attempt or rehospitalization.[111] They must deal with academic difficulties, missed assignments, social difficulties, reacclimating to routine, and managing symptoms while in school.[46,112]

Although communication between hospitals and schools varies across settings, some hospitals have a hospital school, which tries to support academics during hospitalization and may also support preparation for school reintegration.[113,114] In general, however, communication appears limited between these entities.[48,53]

Follow-Up Care

Continued treatment after discharge is critical for recovery. Treatment can range from psychotherapy and/or medication management, to wrap-around services, to an intensive outpatient program or residential treatment. Ideally, social workers or those in comparable roles work closely with families and the community to plan the discharge and to arrange for immediately accessible resources, as well as to begin the process of accessing less readily available resources such as residential treatment. Safety planning is a priority regardless of the availability of recommended services.

Post-discharge care settings may include:[115]

- **Primary care** (family and/or pediatric medical services)

- **Outpatient care,** including psychiatry/psychology or other therapeutic services (e.g., medication management, individual, group, or family therapy with a licensed clinician), suggested for adolescents who have moderate mental health concerns that can be effectively managed while at home
- **Intensive outpatient programs (IOP),** which offer more frequent and a comprehensive approach to therapy and support than typical therapy
- **Partial hospitalization programs (PHP),** providing structured daily care while the adolescent lives at home
- **Residential treatment,** for children and adolescents who need intensive and immersive care, and hospitalization is no longer required

Unfortunately, as many as half of children enrolled in Medicaid have been identified as not receiving follow-up care within the week following a medical encounter for suicide-related risk.[116] Experts attribute this to shortages of providers and other difficulties in connecting youth to care.[116]

Family Experiences with Hospitalization

A systematic review of caregiver experiences identified several reactions to psychiatric hospitalization of youth, including emotional distress (e.g., depression, anxiety, and somatic symptoms), financial strain, perceived stigma, and difficulties coping.[117] This distress may occur in an already strained or difficult social environment,[118] and can be especially heightened during and immediately after hospitalization.[119] Even in the best situations, patients and families may face a range of disruptions and difficulties, including parental conflict and self-blame.[120,121]

> They tied her down. I don't [know] what all they did. I didn't even want to think about it, because it seemed horrifically traumatic for this child. It happened. We can't go back. We have to go forward. OK. She was restrained by guards…She gets watched 24/7. **(PARENT[99])**

> The whole thing, and another word that I'm hoping is going to come up, is just the whole sadness that's involved with this because the sadness smothers. If you are smothering—it doesn't matter if you're the adolescent, you're the parent, you're the counselor. If you are smothering, it is hard to breathe, to move, to do, to remember, to act, to respond, to react. What I've learned, in my experience, is that sadness with mental illness—and you got an adolescent that you're not kissing good night, your adolescent getting awakened with people in uniforms and pills and little cups, that creates sadness. **(PARENT[11])**

Legal Considerations

When a student is reintegrating to school following hospitalization, schools may need relevant health information to provide appropriate support such as safety planning, accommodations, or counseling. HIPAA (Health Insurance Portability and Accountability Act) and FERPA (Family Educational Rights and Privacy Act) are two federal laws that play crucial roles in protecting students and families, and they must be considered prior to communication. Professionals must defer to student and family decisions regarding what and how information can be shared, requesting a release of information, and these decisions may change over time.[48,53]

Adhering to HIPAA

HIPAA is a federal law in place to protect the use and disclosure of patients' health information. It generally prevents hospitals and mental health professionals from sharing a student's health information with schools without explicit consent from the student's parent or guardian. For more information, visit the CDC website.

Adhering to FERPA

FERPA is a federal law that protects the privacy of student educational records, including those maintained by school counselors or psychologists. If a school receives medical or mental health information from a provider (with consent), it becomes part of the student's educational record and falls under FERPA regulations. This applies to schools receiving funds from the U.S. Department of Education. For more information, visit the U.S. Department of Education website.

Other Relevant Laws and Policies

In addition to HIPAA and FERPA, several other federal and state laws, as well as local school policies (e.g., related to student conduct and safety), impact student reintegration. Note that this is not an exhaustive list, and each organization should become familiar with their own district, region, and state.

Americans with Disabilities Act (ADA)

This ensures that students with disabilities, including mental health conditions and suicide risk, are not discriminated against in schools. It requires schools to provide reasonable accommodations upon the student's return.

Section 504 of the Rehabilitation Act

Students recovering from a suicide-related crisis may qualify for Section 504 Plans that provide accommodations such as schedule adjustments or modified coursework. This applies to schools that receive federal funding.

Individuals with Disabilities Education Act (IDEA)

If a student's mental health condition significantly affects their ability to learn, they may qualify for an Individualized Education Program (IEP) under IDEA. Schools must provide special education and support services tailored to the student's needs.

Family and Medical Leave Act (FMLA) (For Parents/Guardians)

If a parent needs to take time off work to care for a child recovering from a mental health crisis, FMLA may provide job-protected leave.

State-Specific Laws on Student Mental Health

Many states have laws requiring schools to have suicide prevention policies, train faculty, staff, and school-based mental health professionals on mental health awareness, and establish re-entry protocols for students after hospitalization. Some states mandate that schools allow excused absences for mental health reasons. For more information on model school district policies on suicide prevention visit https://afsp.org/model-school-policy-on-suicide-prevention.

Role of School in Suicide Prevention

Although the focus of these guidelines is on school reintegration following a suicide-related crisis, it is important to acknowledge the larger role schools can play in suicide prevention. Schools are considered an important context for addressing suicide prevention given they are a de facto setting for mental health treatment and where most children and adolescents spend time. In many states, schools are both legally and ethically required to provide some form of suicide prevention. As of 2022, suicide prevention training was mandated in 22 states (and encouraged in 13 additional states).[122]

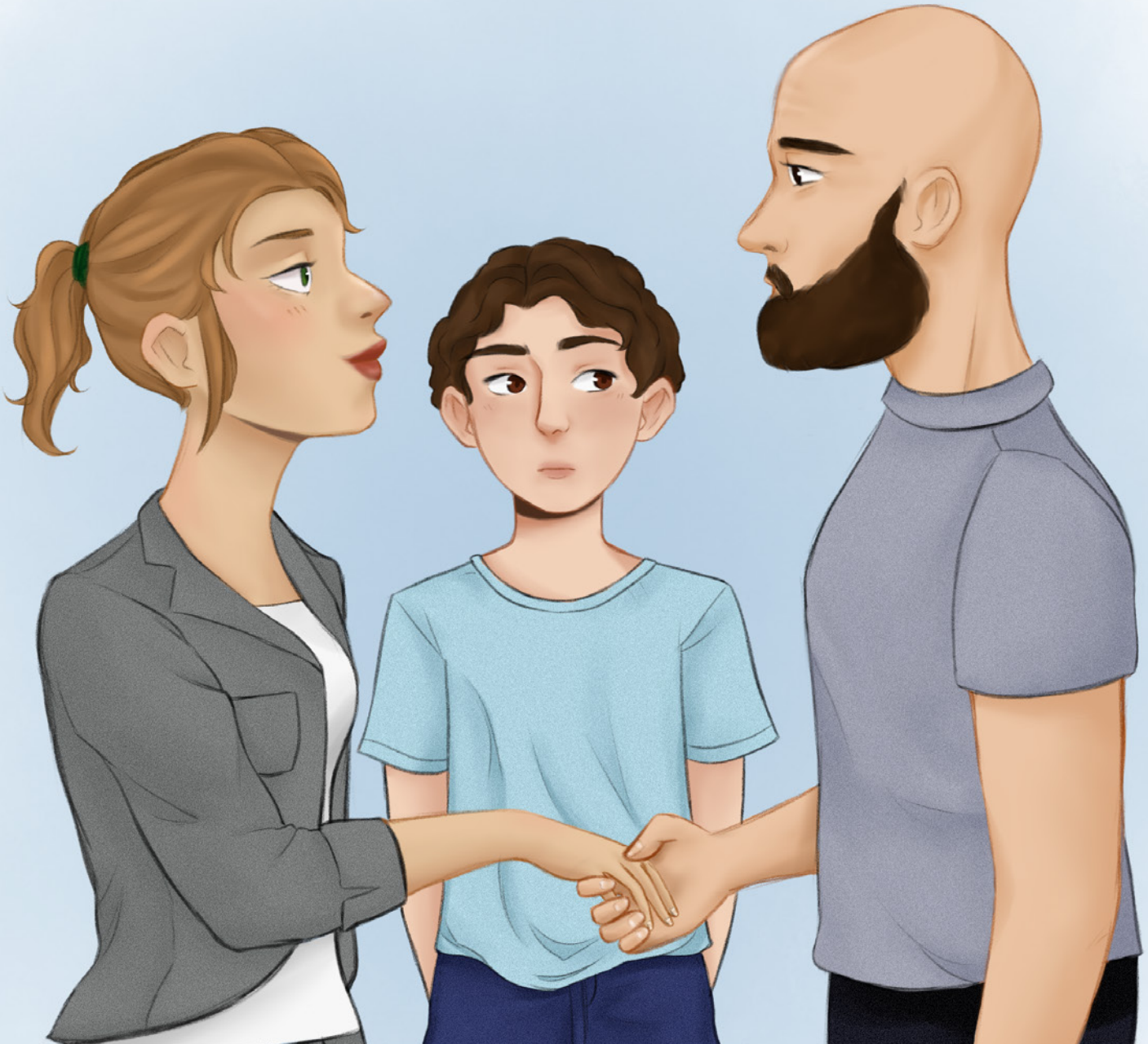
Comprehensive suicide prevention programs include:

- "Upstream" approaches, which aim to prevent risk prior to the onset of any symptoms, such as improving school climate and supporting social-emotional learning.[123]
- Targeted approaches that screen for and address risk for suicide, such as mental health symptoms and disorders, suicidal thoughts, and non-suicidal self-injury. Key components include:
    - Screening and risk assessments to identify and refer individuals with suicide-related risk[124]
    - Gatekeeper trainings, which teach individuals in the school to identify signs and symptoms of suicide and how to seek help in these instances[125]
    - Referrals to appropriate levels of care, in and out of school settings[58,126]
    - Intensive interventions for students identified with suicide-related risk (e.g., safety planning interventions, re-entry plans following hospitalization)[127]

As discussed in in previous sections, school-based comprehensive suicide prevention programs can also help cultivate an environment that supports students returning following a mental health crisis.

LIMITATIONS OF THE GUIDELINES

These guidelines were developed based on existing research and findings from a mixed methods study exploring adolescent, caregiver, school professional, and hospital professional perspectives of school reintegration in the state of North Carolina. They are not meant to be exhaustive or final, and should be updated based on ongoing research and tailored to the specific circumstances of each student, family, school, hospital, and community. Guidelines may also need to be updated based on emerging research and changes in policies and practice. Individuals following these guidelines should prioritize principles of ethics, as well as the specific laws and policies of their communities, above any guidance provided here. Future work is needed to evaluate the effectiveness of the implementation of these guidelines.



RESOURCES

Sample Information to Include on Website or in Handbook

Below is an example from Richmond County Schools of information schools may include describing reintegration procedures to families and the community, and which could be displayed on a website and/or handbook.[128]

When a child is hospitalized or cannot attend school due to medical concerns, including psychiatric, emotional, and behavioral difficulties, please contact the school immediately so we can continue to support your child and your family. Below are the steps involved:

1. Families, please contact NAME/ROLE by calling or emailing: EMAIL

   NAME/ROLE will discuss your situation with you and collaborate to initiate a plan for continued support and reintegration into school.

2. Families may provide an authorization to release information between your provider and the school. Providing this release will allow NAME/ROLE to communicate with your provider and share/receive additional information in support of their treatment (for example, by sharing assignments and information about your child's school supports). We will discuss the types of information you are comfortable having us communicate about.

3. NAME/ROLE will set up a re-entry meeting with you and your child, and other individuals you agree are important to support your child's return to school. The re-entry meeting will involve:

   Discussion of student strengths and needs

   Identification of a key members supporting student's return

   Development of a re-entry plan (including academic make-up, and social, and emotional supports)

   Plan for managing ongoing support

Who to Call in a Crisis

Emergency resource:
911

Crisis services:

24/7 Crisis Hotline: 988 Suicide & Crisis Lifeline
988lifeline.org
If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat 988lifeline.org. Veterans, press 1 when calling.

Crisis Text Line
Text TALK to 741-741 to text with a trained crisis counselor from the Crisis Text Line for free, 24/7

Veterans Crisis Line
Send a text to 838255

Vets4Warriors

SAMHSA Treatment Referral Hotline (Substance Abuse)
1-800-662-HELP (4357)

RAINN National Sexual Assault Hotline
1-800-656-HOPE (4673)

National Teen Dating Abuse Helpline
1-866-331-9474

The Trevor Project
1-866-488-7386

Also visit your:
Primary care provider
Local psychiatric hospital
Local walk-in clinic
Local emergency department
Local urgent care center

Mental Health and Coping Skill Resources

- Find a Mental Health Professional (American Foundation for Suicide Prevention)
- Mental Health Resources (National Association of School Psychologists)
- Free Downloadable Patient Pamphlets (Beck Institute)
- Resources on Depression and Mood Disorders (Child Mind Institute)
- 30 Days of Mindfulness in the Classroom (Calm Schools)
- Mental Health Resource Center (The Jed Foundation)
- Establish Your College Mental Health Team (The Jed Foundation)
- Suicidology Resources and News (CAMS Care)

Safety Planning Intervention Resource

- The Stanley-Brown Safety Planning Intervention

School-Specific Suicide Prevention Resource

- Model School District Policy on Suicide Prevention (American Foundation for Suicide Prevention)

Example of Existing Re-Entry Plan

Provided with permission from Nash County Schools

Student Information:

Student Name:	**DOB:**	**School:**	**Grade:**
Parent/Guardian(s):	**Cell #:**	**Work #:**	

Involved Agency	**Contact Person**	**Phone #**	**Obtained Signed Release**
			☐
			☐

RE/ENTRY TRANSITION INTERVENTIONS (Check all that apply)	**DETAILS**
▢ Check in/out with *staff* upon arrival/departure daily/ weekly	**Staff Name:**
▢ Provide access to Student Support Staff as needed to address *(conflicts/potential conflicts/feelings/emotional difficulties)*	**Staff Name:**
▢ Assigned Student Support or Other Staff to provide specific intervention (Consider District Substance Use Prevention BSS if needed)	**Staff Name:** **Interventions:**
▢ Support student with recovering missed academics	**Staff Name:**
▢ Provide opportunities to improve peer-relations by assisting peers and engaging in leadership activities in structured, supervised setting	**Recommendations:**
▢ Refer to school-based mental health supports	**Agency:** **Date of Referral:**
▢ Refer to community *mental health/substance abuse/health* services or related resources	**Agency:** **Date of Referral:**
▢ Refer to BAIT Team	**Date of Referral:**
▢ Implement or update BIP	**Date completed:**
▢ Implement or update 504	**Date completed:**
▢ Review/Update IEP	**Date completed:**

OTHER

PROGRESS MONITORING

▢ Academics:_____	▢ Agency Updates
▢ Attendance	▢ Check In/Out Documentation
▢ Behavior ▢ ODR ▢ Behavior Tracking Form ▢ Other:_____	

Role	**Signature**	**Date**
Student	_____	_____
Parent/Guardian	_____	_____
Administrator	_____	_____
Counselor	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Follow-up meeting to occur on: _____
(not to exceed 45 school days from initial meeting)

For hospital medical records, use consent for release forms on agency website

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