# Research-Based Guidelines and Practices for School-Based Suicide Prevention

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**Section I. Background Information and Resources.**

### A. Statistical research synthesis about youth suicide prevention.

1. Incidence of suicide among adolescents and young adults nearly tripled between 1952 and 1995 (CDC, 2002).
2. In 1999, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined (CDC, 2002).
3. In 2000, suicide was the third leading cause of death among 10- to 14-year-olds and 15- to 19-year-olds in the United States (Anderson, 2002).
4. Teen suicide rates demonstrated a drop of 26 percent between1993 and 2000 in the year 2000 (Child Trends, 2002), but still ranked as the third leading cause of death for young persons 10-24 years of age.
5. 1.5 per 100,000 children in the 10-14 year age group took their own lives in 2000 (CDC, 2003).
6. Suicide rate of children 10-14 years of age is growing faster than any other demographic, nearly doubling in the past few decades (National Institute of Mental Health, 2000).
7. Teenagers in the 15-19-age bracket took their own lives at the rate of 8.2 per 100,000 in 2000, for a total of 3,994 deaths (Child Trends, 2002).
8. Hispanic students (12.1%) were significantly more likely than black or white students, (8.8% and 7.9%, respectively), to have attempted suicide (Grunbaum, et al., 2002).
9. Female students (11.2%) were significantly more likely to have attempted to kill themselves than male students (6.2%) (Grunbaum, et al., 2002).
9. Nearly five times more 15-19 year old boys commit suicide than females (MacKay et al., 2000).
10. American Indians and Alaska Native adolescents have the highest rates of suicide, being more than twice as likely to commit suicide as other racial/ethnic group (CDC Wonder, 1999; IHS, 1999).
11. In California, 1999-2000, young people, ages 20 to 24 years made 1,722 suicide attempts and 206 suicide completions (Suicide Prevention Resource Center (SRPC), 2004).
13. In California, 1999-2000, young people, ages 15-19 years made 2,421 suicide attempts and 116 suicide completions (SRPC, 2004).
14. In California, 1999-2000, young people, ages 0 to 14 years made 649 suicide attempts and 23 suicide completions (SRPC, 2004).

**B. Major Federal Initiatives Addressing Youth Suicide Prevention: 1985-2005**

| Date | Initiative Sponsoring Agency | Initiative |
|------|------------------------------|------------|
| 1985 | U.S. House of Representatives | Youth Suicide Prevention Act of 1985 |
| 1990 | U.S. Department of Health and Human Services | Health People Initiative 2000 |
| 1998 | United States Senate & House of Representatives | Senate Resolution #84 and House Resolution #212 |
| 1999 | U.S. Public Health Service | Surgeon General's Call to Action to Prevent Suicide |
| 2000 | U.S. Department of Health and Human Services | Healthy People Initiative 2010 |
| 2000 | U.S. Public Health Service | Surgeon General's Conference of Children's Mental Health |
| 2001 | U.S. Public Health Service | National Strategy for Suicide Prevention: Goals and Objectives for Action |
| 2002 | President's New Freedom Commission on Mental Health | Achieving the Promise: Transforming Mental Health Care in America Report |
| 2004 | U.S. Senate & House of Representatives | Garrett Smith Memorial Act Senate Bill# 2634 & House Resolution # 4799 |

**C. Federal Support for School-Based Suicide Prevention**

1. *The Surgeon General's Call to Action to Prevent Suicide* (U. S. Public Health Service (USPHS), (1999). http://www.surgeongeneral.gov/library
   This federal government document has published specific, serious concerns over youth suicide and its prevention. In its call to action it states four aims, which include:
   a. Prevent premature deaths due to suicide across the life span.
   b. Reduce the rates of other suicidal behaviors.
   c. Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends.
   d. Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities.
   e. This report calls for schools to be access and referral points for children's mental and physical health services.

2. *National Strategy for Suicide Prevention (NSSP)*
   http://www.mentalhealth.org/suicideprevention
   a. This is the companion volume to *The Surgeon General's Call to Action to Prevent Suicide* (U. S. Public Health Service (USPHS) (1999). It has eleven stated goals, accompanied by 68 objectives. The eleven goals of the NSSP include (USPHS, 2001):
      1) Promote awareness that suicide is a public health problem that is preventable.
      2) Develop broad-based support for suicide prevention.
      3) Develop and implement strategies to reduce stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
      4) Develop and implement community-based suicide prevention programs.
      5) Promote efforts to reduce access to lethal means and methods of self-harm.
      6). Implement training for recognition of at-risk behavior and delivery of effective treatment.
      7) Develop and promote effective clinical and professional practices.
      8). Increase access to and community linkages with mental health and substance abuse services.
      9). Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
      10) Promote and support research on suicide and suicide prevention.
      11) Improve and expand surveillance systems.
   b. Within the National Strategy schools are elevated as important venues for suicide prevention activities and are challenged to develop quality, safe, and effective school-based suicide prevention programs.
3. *The President's New Freedom Commission on Mental Health (NFCMH, 2003).* http://www.mentalhealthcommission.gov.
   In July 2003, the President released the report, Achieving the Promise: Transforming Mental Health Care in America (NFCMH, 2003). The report was created to address the problems in the current mental health system and underlined that mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe.
   a. The six goals in the President's report with recommendations under each are:
      (1) Americans understand that mental health is essential to overall health.
      (2) Mental health care is consumer and family driven.
      (3) Disparities in mental health services are eliminated.
      (4) Early mental health screening, assessment, and referral to services are common practice.
      (5) Excellent mental health care is delivered and research is accelerated.
      (6) Technology is used to access mental health care and information.

   b. The accompanying recommendations include the call to:

(1) Swiftly advance and implement a national campaign to reduce the stigma of seeking care.

(2) Promote the national strategy for suicide prevention.

(3) Create public-private partnerships to address suicide prevention in communities, including school personnel, local leaders, and representatives of the faith community.

(4) Create integrated systems of care for children with serious emotional disturbances and their families, a population known to be at high risk for youth suicide.

(5) Promotion of the mental health of young children.

(6) Provide early mental health screening, assessment, and referral to service.

(7) Strengthen school mental health services, as evidenced by an improvement and expansion of education and training, prevention, early identification, early intervention, and treatment services within the school.

   c. The report emphasizes the growing evidence that school mental health programs improve educational outcomes by decreasing absences and discipline referrals, as well as improving test scores (Jennings, Pearson, & Harris, 2000).

D. Federal Agency Resources for Suicide Prevention

1. Centers for Disease Control and Prevention (CDC) National Youth Violence Prevention Resource Center. http://safeyouth.org/home.htm.
Following a cluster of suicides in school aged children, in 1992, this agency created a resource guide that includes eight strategies for youth suicide prevention programs, most of which can be used to establish specific suicide prevention programs in schools. Those strategies include formation and implementation of:

   a. School gatekeeper training.
   b. Community gatekeeper training.
   c. General suicide education.
   d. Screening programs.
   e. Peer support programs.
   f. Crisis centers and hotlines.
   g. Means restriction.
   h. Intervention after a suicide.

2. *Human Resources Services Administration (HRSA).*
http://www.mchb.hrsa.gov/.
This agency gives out Maternal Child Health block grants that can be used in many ways, including youth suicide prevention projects.

3. *Indian Health Service (IHS).*
http://www.his.gov.
This agency seeks to raise the physical and mental health status of American Indians and Alaska Natives.

4. *National Council for Suicide Prevention Training.*
http://www.ncspt.org.

This is a national on-line training program to educate people about suicide prevention.

5. *National Institutes of Health/Mental Health (NIH/NIMH).* http://www.nimh.nih.gov

    NIH is the principal biomedical and behavioral research agency of the United States Government. NIMH is a part of NIH, with a mission to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior.

6. *Substance Abuse and Mental Health Services (SAMSA).* http://www.samhsa.gov.

    This agency funds the Suicide Prevention Resource Center (SPRC), a good resource for suicide prevention information.

## E. California Endeavors in School-Based Suicide Prevention.

1. *California Education Code:* www.schoolcounselor-ca.org/downloads/ California Education Code 49600.doc.

    The legal references to school-based suicide prevention related issues:
    a. *49602 Confidentiality of student information.*
    b. *9604 Suicide prevention training for school counselors.*

2. *California Department of Education Website.* http://www.cde.ca.gov/.

    This site includes current resource information and references to public and private sources of information, research, curriculum, screening tools, gatekeeper training, foundations, survivor support, prevention, intervention and postvention program materials, all related to youth suicide prevention.

3. *California Department of Education (CDE) – Counseling and Student Support Division.* http://www.newcde.ca.gov/ls/cg.

    In 1987, the CDE Instructional Support Division, School Climate Unit published the *Suicide Prevention Program for California Public Schools (SPPCPS)*, (ISBN#:0-8011-0682-6). The SPPCPS program materials include four guides: the Implementation and Resource Guide; the Lesson Guide; the Guide for Staff Awareness In-Service Training; and Guide for Parent Awareness Meeting. The SPPCPS, along with many other suicide prevention resources published in the1980s, is now referred to in the program evaluation literature as a "first generation program", because it is recognized that program development and evaluation occur in an iterative cycle (Kalafat & Lazurus, 2002). While this program still contains useful information, there has been much research on youth suicide prevention in the past seventeen years since its publication. Additional information has been learned about youth suicide behavior and school-based suicide prevention. New recommendations for current school-based suicide prevention program development are listed later in this document. The CDE Counseling and Support Office has recently updated its school-based suicide prevention resource website.

4. California School Boards Association (CSBA). http://www.csba.org.
    a. CSBA has created an optional board policy and administrative regulation for districts that wish to adopt policy providing for student, staff, and parent/guardian training in suicide prevention, which are:

          (1) *BP 5141.52*
          (2) *AR 5141.52*

    b. The courts have ruled that a district may be liable to parents/guardians of a student who committed suicide while under supervision of school staff.

    c. Before adopting policy on this topic, the Board should consider staff and capabilities to be sure that the policy will be fully enforced. Once a district has adopted a policy, it has a duty to enforce it.

5. California Strategy for Suicide Prevention.
On May 6-7, 2004, a collaborative group of individuals from many different organizations and vantage points (suicide prevention advocacy groups, government officials, education and business professionals, survivors of suicide, and public health professionals) met to devise a draft of the California Strategy for Suicide Prevention, modeled after the National Strategy for Suicide Prevention. This document will be in the formation stage for a period and then published. The document called for schools to be active participants in screening, prevention, intervention, and training.

6. *California Welfare and Institutions Code.*
www.leginfo.ca.gov/calaw.html.
The legal references to school-based suicide prevention related issues:
a. *5698 Emotionally disturbed youth; legislative intent*

7. Center for Mental Health in Schools (CMHS) – UCLA.
http://smhp.psych.ucla.edu.
The CMHS has created a comprehensive technical assistance sampler on school interventions to prevent suicide. It gives guidance about suicide, its prevention, suicide assessment, intervention planning and training, and aftermath (postvention) assistance and the prevention of contagion.

## F. Websites with Suicide Prevention Research

1. *International Academy for Suicide Research.*
http://www.uni-wuerzburg.de/IASR.

2. *National Library of Medicine.*
*http://mentalhealth.org/suicide prevention.*

3. *National Institute of Mental Health Suicide Research Consortium.*
http://www.nimh.nih.gov/research/suicide.cfm.

4. *Oxford University Centre for Suicide Research.*
http://cebmh.warne.ox.ac.us/csr.

5. *Suicide Information and Education Centre (SIEC).*
http://www.siec.ca.

6. *Unit for Suicide Research (Belgium).*
http: allserv.rug.ac.be/~cvheerin.

7. *Web-based Injury Statistics Query and Reporting System (WISQARS).*
http://www.cdc.gov.ncipc/wisqars/default.htm.

## G. Websites with Suicide Related Statistics

1. *Centers for Disease Control and Prevention.*
http://www.cdc.gov/scientific.htm.

2. *National Injury Data Technical Assistance Center.*

http://injurypreventionweb.org/info/data/htm.
3. *National Violent Injury Statistics System.*
   http://www.nviss.org.
4. *World Health Organization Statistical Information System (WHOIS).*
   http://www3.who.int/whois/menu.cfm.

**H. Professional Organizations Related to Suicide Prevention.**

1. *National Council for Suicide Prevention.*
   http://www.ncsp.org/.
   Coalition of organizations committed to suicide prevention including:
   a. American Association of Suicidology (AAS).
      http://www.suicidology.org.
   b. American Foundation for Suicide Prevention (AFSP).
      http://www.afsp.org.
   c. The Jason Foundation.
      http://www.jasonfoundation.com.
   d. The Kristin Brooks Hope Center.
      http://www.hopeline.com.
   e. The Link's National Resource for Suicide Prevention.
      http:www.thelink.org.
   f. National Organization for People of Color Against Suicide (NOPCAS).
      http://www.nopcas.com.
   g. Organization for Attempters and Survivors of Suicide in Interfaith Service (OASSIS).
      http://www.oassis.org.
   h. Samaritans USA.
      http://www.samaritans.org.
   i. Suicide Awareness\Voices of Education (SAVE)
      http://www.save.org.
   j. Suicide Prevention Action Network USA, Inc. (SPAN)
      http://www.spanusa.org.
   k. Yellow Ribbon Suicide Prevention Program
      http://www.yellowribbon.org.

**I. Ecological Theory of Suicide Prevention.**

1. Ecological theory useful to youth suicide prevention with intentional focus on specific risk factors most closely associated with completed youth suicide. Scientific criteria for selecting targeted risk factors are (Breton, Boyer, Bilodeau, Raymond, 2002):
   a. Modifiability - ability to change in structure or function due to internal, external or hereditary influences.
   b. Measurability – ability to be measured
   c. Degree of association with the health problem.
   d. Degrees of proximity – processes that involve patterns of progressively more complex reciprocal interaction with persons, objects, and symbols in the immediate environment and to be effective, occurring on a fairly regular basis over extended periods of time.

2. Risk factors most strongly associated with completed youth suicide are, in decreasing order (Bell & Clark, 1998; Brent, 1995, Moscicki, 1997):
   a. Prior suicide attempts.
   b. Depression.
   c. Substance abuse (including alcohol).
   d. Conduct disorder.
3. Vast majority of experts agree that suicide is a multi-dimensional problem and ecological model addresses multiple systems involved in emergence, development, and maintenance of suicidal behavior (Henry, Stephenson, Hanson, & Hargett, 1993; Shagle & Barber, 1995; White, 1998; Motes, Melton, & Simmons, 1999) which include:
   a. Personal.
   b. Family.
   c. School.
   d. Work.
   e. Community.
4. An effective ecological approach to school-based suicide prevention serves to reduce suicide rates and includes:
   a. Implementation with fidelity.
   b. Multiple levels of school and community
   c. Dissemination to enough sites to obtain large population samples for epidemiological impact assessment.
   d. Institutionalization long enough to detect epidemiological trends (Kalafat & Lazarus, 2002).
5. Ecological approach to youth suicide purports suicide emerges from adolescents' interactions and interdependencies within hierarchically organized multiple level ecological contexts (Henry, et al. 1993; Bronfenbrenner, 1979), therefore guidelines, programs and procedures for school-based suicide prevention, in this report will serve to:
   a. Target and reduce risk factors most strongly associated with completed youth suicide (Burns & Patton, 2000; Borowsky et al., 2001).
   b. Identify and enhancing protective factors related to youth suicide prevention and resilience (Burns & Patton, 2000; Borowsky et al., 2001).
   c. View suicide from a psychiatric illness model, rather than a stress model as many studies verify nearly 90% of those completing suicide suffer from a diagnosable mental illness that needs to be identified and treated (Beautrais, 2001; Brent et al., 1999; Shaffer et al., 1996).
   d. Emphasis identification, diagnosis, and treatment of the underlying psychiatric disorder are the most critical pieces of suicide prevention (Beautrais, 2001; Brent et al., 1999; Shaffer et al., 1996).
6. Risk Factors for Youth Suicide from an Ecological Approach.
   a. Personal Characteristics:
      (1) Psychopathology (particularly mood disorders, schizophrenia, anxiety, disorders, certain personality disorders, alcohol & other substance abuse disorders). (Beautrais, 2001; DHHS, 2001).
      (2) Prior suicide attempts (Shaffer et al., 1996).

        (3) Cognitive and personality factors (i.e. skill development delays, emotional difficulties; apathy, hopelessness, school problem, poor interpersonal problem-solving ability) (Russell & Joyner, 2001).

              (4)   Sexual orientation (homosexual, trans-gender, bisexual) (Blake et al., 2001, McDaniel et. al., 2001).

        (5) Biological factors (i.e. major physical illness, abnormalities of serotonin function) (DHHS, 2001; Arango, 2001).

  b.  Family Characteristics:

        (1) Family history of suicidal behavior (Gould et al., 1996; Agerbo et al, 2002).

        (2) Parental psychopathology (Gould et al., 1996).

        (3) Involvement in sports & physical activity and high academic achievement are protective (King et al., 2002; Resnick, Harris, & Blum, 1993; Jessor et al., 1995).

7.  Protective Factors for Youth Suicide from an Ecological Approach.

  a.  Emotional Well-being:

        (1) Emotional wellness especially protective for adolescent girls (Borowsky, Resnick, Ireland & Blum, 1999).

  b.  Gender:

        (1) Statistically, being female is more protective than being male (Kaslow, McClure & Connell, 2002; Maris, 2002).

        (2).Females make more suicide attempts, but males complete more suicides (Lacourse, Claes, & Villenueve, 2001).

  c.  Ethnicity/Race:

        (1) Overall, the rate of suicide is lower in ethnic minorities as a whole than whites (Maris, 2002), though there are some individual minority group exceptions (i.e., Native Americans).

        (2) Mexican-Americans were 1.8 times more likely to die by suicide than European-Americans.

        (3) Suicide attempts are 19.3% higher among Latina girls than in many other ethnic-gender groups (Rew et al., 2001).

  d.  Religiosity:

        (1) Religiosity is a protective factor (Fernquist, 2000; Forman & Kalafat, 1998; Foster, 2001; Maris, 2002).

        (2) Greater religiosity has been touted as the reason for the historically lower suicide rate among African-Americans (Glowinski et al., 2001).

**J. Definitions of Suicide Related Terminology.**

1. *Assisted Suicide*:
Completed suicide in which a person intended to die, but relied on the assistance of another individual (who becomes an agent of the suicide) to complete the act (Capuzzi, 2004).

2. *Completed Suicide*:
Self-inflicted lethal act resulting from intentional life-threatening action. The Centers for Disease Control and Prevention provided an Operational Criteria for the Classification of Suicides, listing the three essential elements of a completed suicide as: death; self-infliction; and intentionality (O'Carroll et al., 1998).

3. *Durkheim's four basic types of suicide* (Durkheim, 1897/1951):
   a. *Egotistical*: Not selfish, but rather lonely and isolationist, lack of integration.
   b. *Altruistic*: Enmeshed relationship to society, lack of individuation.
   c. *Anomic*: Situational crises and chaos.
   d. *Fatalistic*: Suppression of individual by society leading to pessimistic life outlook.

4. *Gatekeepers*:
Individuals who has face-to-face contact with large numbers of community members as part if their usual routine.

5. *Gatekeeper Training in Suicide Prevention*:
Training for gatekeepers to learn how to identify persons at risk of suicide and refer them to treatment or support services as appropriate.

6. *Means Restriction*:
Techniques, policies, and procedures designed to reduce access or availability to means of and methods of deliberate self-harm.

7. *Protective Factors*:
Factors that make it less likely an individual will develop a disorder. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

8. *Resilience*:
Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for negative health outcomes.

9. *Risk Factors*:
Factors that make it more likely an individual will develop a disorder: risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

10. *Screening*:
Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

11. *Self-harm/self injury*:
    Various methods individuals use to injure themselves, such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness.
12. *Stigma*:
    Object, idea, or label associated with disgrace or reproach.
13. *Suicide Prevention Levels (Primary, Secondary, Tertiary):*
    (a) *Primary Suicide Prevention (also referred to as Prevention)*:
        Primary suicide prevention involves activities and programs focused on preventing suicide from occurring, before it is considered or attempted.
    (b) *Secondary Suicide Prevention (also referred to as Intervention)*:
        Secondary suicide prevention involves activities and programs to be implemented when a person is actively considering or has attempted suicide.
    (c) *Tertiary Suicide Prevention (also referred to as Postvention)*:
        Tertiary prevention is the intervention conducted with survivors once a suicide has occurred.
14. *Tri-Levels of Suicide Intervention (Universal, Selected, Indicated)*:
    (a) *Universal Interventions:*
        Universal interventions are activities or programs directed at an entire population, rather than selected individuals, (i.e. a whole student body) to decrease suicide risk factors and enhance protective factors (Greenberg et al., 2001).
    (b) *Selected Interventions*:
        Selective interventions are activities or programs delineated for individuals or sub-groups believed to be high-risk based on biological or social risk factors that place them at significantly higher than average risk for committing suicide, yet they have not yet exhibited symptoms of a disorder that places them at high risk for suicide, such as depression, substance abuse, or deliberate self-harm (Greenberg et al., 2001).
    (c) *Indicated Interventions*:
        Indicated interventions are activities or programs designed for individuals already exhibiting symptoms of a disorder that places them at high risk for suicide, such as depression, substance abuse, or deliberate self-harm (Burns & Patton, 2000).
15. *Suicide Attempt or Parasuicide (With or Without Injury):*
    Suicidal act that has a nonfatal outcome in which the person has some    level of intention to die (Capuzzi, 2004).
16. *Suicide Gesture*:
    Gesture meant to portray an appearance of suicide and self-harm, but is without any real intention to kill oneself to accomplish an ulterior motive. (Capuzzi, 2004).

17. ***Suicide Threat***:
    Any behavior in form of some type of interpersonal communication, verbal or non-verbal, without physical harm, implying the individual has intention on some level to act in a suicidal manner (Capuzzi, 2004).
18. ***Suicidal Ideation***:
    Thinking about future or fantasized suicidal action (Capuzzi, 2004).

*Definitions from:*

Capuzzi, D. (2004). From Seneca to suicidology: A history of suicide. In D. Capuzzzi (Ed). *Suicide Across the Life Span: Implications for Counseling* (3-38). Alexandria, VA: American Counseling Association.

U. S. Public Health Service (2001). *National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP).* (196-204). (DHHS Publication No. 02NLM: HV 6548.A1 2001). Rockville, MD: Author.

**Section II. Planning of School-Based Primary Suicide Prevention Program (also called Prevention), involves planning activities and programs focused on preventing suicide from before it is considered or attempted.**

  A. **School District Level – Superintendent & School District Board of Education.**

  1. Formation and maintenance of policies and procedures.
      a. Imperative to create a school district board policy regarding suicide prevention to clarify and underline the district's commitment to suicide prevention (Cellota, Jacobs, Keys, & Cannon, 1989; Fetro, 1998). (See Section 6, Attachment 1 example from CA School Board Association).
      b. Include suicide prevention policies and procedures in the school district's mandated Comprehensive School Safety Plan.
      c. Essential to develop and implement policies and procedures in the event of a suicide attempt or completion by a staff member or student, including those occurring on and off campus. (Rowling & Holland, 2000).
          (1) If two or more school mental health professionals assess a student as being at risk for suicide:
              (a) Student's parents/guardians should be immediately contacted.
              (b) Referral should be made to a mental healthy agency or hospital emergency for immediate services.
              (c) If parent/guardian does not cooperate and agree to get the student outside help, the school must report this to local law enforcement or child protective services official (Lieberman & Davis, 2002; McEvoy & McEvoy, 1994).
          (2) If two or more school mental health professionals deem a student to be at risk for suicide and the student's parent or guardian (or emergency contact) cannot be reached, the local law enforcement should be called to escort the student to the nearest hospital emergency room for evaluation (Lieberman & Davis, 2002; Capuzzi, 1994; Capuzzi & Gross, 2004; King, 2001; McEvoy & McEvoy, 1994).
          (3) If two or more school mental health professionals assess a staff member as being at risk for suicide:
              (a) Staff member should be immediately referred to a mental healthy agency or hospital emergency for services.
              (b) Superintendent or designee must be notified and the staff member may be placed on administrative leave until cleared by a mental health
          (4) If two or more school mental health professionals assess a staff member as being suicidal and the staff member refuses to seek treatment:
              (a) Local law enforcement should be called to escort the staff member to the nearest hospital emergency room for evaluation.
              (b) The superintendent or designee must be notified and the staff member may be placed on administrative leave until cleared by a mental health official approved or designated by the school district.

2. Formation and maintenance of community partnerships & mutual aid agreements in youth suicide prevention ( See Section 6, Attachment 11) to facilitate collaborative work on youth suicide prevention throughout the school and its community (McKee, Jones, & Barbe, 1993), including:
   a. County Office of Education or Regional Education Agency.
   b. Neighboring School Districts' Crisis Team Representatives.
   c. Law enforcement and coroner.
   d. City and county government officials.
   e. Hospital emergency departments and emergency medical    personnel.
   f. Community fire and emergency services.
   g. Youth health services.
   h. Psychiatric facilities.
   i. Crisis hotline and suicide prevention center representatives.
   j. Religious/clergy associations.
   k. Survivor groups.
   l. Community social service and mental health agencies.
   m. After-school care providers.
3. .Make arrangements for school district representation in multi-disciplinary reviews of primary, secondary, and tertiary prevention efforts affecting decedents who are students or employees of the school district with the County Child Suicide Death Review Team.
4. Initiate school communication between hospitals and outpatient mental health and substance abuse centers to encourage a good professional working relationship, helping ensure continuity of care of district students who receive those services and return or continue in school (See Section 6, Attachment 11).
5. Formation and maintenance of a District Crisis Team as a back up support system to all schools and sites in the district for issues pertaining to suicide, crisis, death, and grief. (See Section 6, Attachment 4 for details on membership selection and roles) (Kalafat & Lazarus, 2002)
   a. Appoint/hire a Crisis Guidance Manager (see Section 6, Attachment 3)
   b. Have both a primary and secondary school District Crisis Teams (Section 6, Attachment 4)
   c. Minimum two-year commitment.
6. wide suicide prevention training for school district employees and parents and guardians of district students
   must create a sound infrastructure of staff trained in assessment, and gatekeeper skills early in school year in English (and Spanish if needed). (See Section 6, Attachment 7).
   a. Designate District Crisis Guidance Manager to recruit school or community mental health professionals knowledgeable about suicide and its prevention to conduct suicide prevention training with all district employees (See Section 6, Attachment 8 for recommended programs).
   b. Commit to and budget for district mental health professionals involved in training and suicide risk assessment to receive continuing education in suicide prevention methodology and research.

c. Prepare the infrastructure and community partnerships to support a systematic district suicide screening for secondary students.
    (1) Screening via individual interviews and self-report, used to identify students at risk for suicidal behavior shown to be efficacious in literature (Joiner, Pfaff, & Acres, 2002; Shaffer & Craft, 1999; Thompson & Eggert, 1999; Zametkin, Alter, & Yemini, 2002). (See Section 6, Attachment 8)
    (2) Must have lined up ample community referral sources to immediately direct students for follow up treatment if they have screened positive for being at risk for suicide (Gould et al., 2003).
    (3) Participate in a screening program that has strong empirical data behind it (Aseltine, 2003; Aseltine & DeMartino, 2004; Shaffer & Greenberg, 2002).
    (4) Anticipate resistance from professionals who prefer curriculum-based approaches (Miller et al., 2003) because screening approach is more complicated, yet defend via literature because it has been shown to be more effective.
d. Continue to prepare the infrastructure for school-based suicide prevention by creating a plan to implement gatekeeper training for all employees district-wide on a two-year year cycle (Adelman & Taylor, 2000; King, 2001; Kalafat & Lazarus, 2002).
    (1) Training to include (see Section 6, Attachment 7).
        (a) Clarification of school's role, policies and procedures relative to suicide and its prevention.
        (b) Role of mental illness in suicide.
        (c) Identification of suicide warning signs.
        (d) Identification of suicide contagion factors.
        (e) Identification of and promotion of protective factors.
        (f) Identification of referral resources and effective referral procedures.
        (g) How to respond to depressed and suicidal people.
        (h) Role of school connectedness, student aggression and bullying prevention, and substance abuse prevention in the prevention of suicide. (Gould et al., 2003; Kalafat & Lazarus, 2002; King, 2001; Speaker & Petersen, 2000).
        (i) Role of media in suicide and its prevention. (See Section 6, Attachment 5).
        (j) School mental health and nursing professionals should receive additional advanced suicide prevention training, in screening, risk assessment, and information on legal cases pertaining to student suicide on a two-year cycle.
e. Institute a parent and guardian education program on youth suicide prevention (in English and Spanish if needed) that covers the same topics as the employee training, with an increased emphasis on:
    (1) Means restriction strategies (Kalafat & Lazarus, 2002).

(2) Introduction of suicide prevention strategies children in the school district will be taught.

(3) Availability of community resources for referring their children or themselves if help is needed (Capuzzi & Gross, 2004; Kalafat & Lazarus, 2002).

(4) Invite nursery and pre-school teachers, after-school program personnel, and known childcare providers in the district, also.

g. Formation and maintenance media relationships and agreements. (See Section 6, Attachment 5).

(1) Assign a district media spokesperson.

(2) Designated school mental health person(s) should develop and provide press an updated information kit each August for district media spokesperson and local media outlets to include information about reporting on suicide and the sensitive issues included in media coverage of suicide, as well as contact information for district's designated media spokesperson (USPHS, 2001).

**B. School/Site Level – Building Administrators, School Mental Health and Medical Professionals**

1. Formation and maintenance of school/site policies and procedures (see

2. Formation and maintenance of a school/site crisis team (see Attachment 6).

    a. Obtain school district level and Board of Education administrative support (Capuzzi & Gross, 2004; Huberman & Miles, 1984).

    b. Establish and train a building/site crisis response team with a diverse group of professionals, (principal, counselor, teacher, school nurse, school psychologist) (Brock et al., 1994; Brock, 2000, 2002).

    c. Designate a team leader (typically the principal) and alternate to    ensure leadership presence in each school building at all times.

    d. Crisis response team leader should schedule and arrange for annual suicide intervention training and suicide intervention rehearsals for entire staff (Siehl, 1990).

3. Formation and maintenance of student suicide prevention program plan (see Section 6, Attachment 8)

    a. Be aware of tension in the literature over suicide awareness curriculum & and make informed decisions (see Attachment #2) (Aseltine, 2003; Capuzzi, 1998; 1994; Capuzzi & Golden, 1988; Capuzzi & Gross, 2000; Curran, 1987; Kalafat & Elias, 1994; Ross, 1980; Sudak, Ford, & Rushforth, 1984; Zenere & Lazarus, 1997).

    b. Some advocates support suicide prevention education and discussion curriculum in a forum that allows for accurate information, asking questions, and learning how to obtain help for self and friends in the context of a school wide prevention effort (Capuzzi & Gross, 2004).

    c. Some advocates have found suicide prevention curriculum to be without benefit or even detrimental for school students of all ages (Shaffer,

Garland & Whittle, 1988; Shaffer et al., 1991; Vieland et al. 1991; Mazza, 1997; Garland, 1989; Ciffone, 1993).

d. Some researchers believe there remains insufficient evidence to definitively either support or not support curriculum-based suicide awareness programs in school (Guo & Harstall, 2002), making alternative school-based strategies such as identification of suicidal warning indicators, monitoring of students predisposed to suicide, and crisis intervention viable options (Helsel, 2001; Range, 1993, Capuzzi, 1994; Freeman, 1998).

4. The Suicide Prevention Resources Center (SPRC), with help from the American Foundation for Suicide Prevention (AFSP), developed a National Registry of Effective Programs, (NREP) This registry is was cancelled after January 2005 and is to be subsumed by a new registry, the National Registry of Evidence-Based Programs and Practices, (NREPP) anticipated to be in place sometime in the Fall of 2005.

5. Programs that were registered on the NREP are described more fully in District Crisis Guidance Manager – Attachment and they include:

   a. *C-Care/CAST (***Thompson, Eggert, Randell, & Pike, 2001***)*:
      (1) SPRC Classification: Effective
      (2) Target Age: 14-18
      (3) Gender:  Male & Female
      (4) Ethnicity/Race: Multiple
      (5) Level of Intervention: Selective, Indicated

   b. *SOS: Signs of Suicide* (Aseltine & DeMartino, 2004)
      (1) SPRC Classification: Promising
      (2) Target Age: 14-18
      (3) Gender:  Male & Female
      (4) Ethnicity/Race: Multiple
      (5) Level of Intervention: Universal

   c. *Columbia TeenScreen* (Shaffer, Scott, Wilcox, Maslow, Hicks, Lucas, et al., 2004):
      (1) SPRC Classification: Promising
      (2) Target Age: 11-18
      (3) Gender:  Male & Female
      (4) Ethnicity/Race: Varied
      (5) Level of Intervention: Universal

   d. *Lifelines* (Kalafat & Elias, 1994)
      (1) SPRC Classification: Promising
      (2) Target Age: 12-17
      (3) Gender:  Male & Female
      (4) Ethnicity/Race: Multiple
      (5) Level of Intervention: Universal

   e. *Reconnecting Youth Class* (Eggert & Nicholas, 2004)
      (1) SPRC Classification: Promising
      (2) Target Age: 14-18
      (3) Gender:  Male & Female

(4) Ethnicity/Race: Multiple
(5) Level of Intervention: Selective, Indicated
f. ***Zuni Life Skill Development*** (LaFromboise, 1995)
(1) SPRC Classification: Promising
(2) Target Age: 14-18
(3) Gender:  Male & Female
(4) Ethnicity/Race: American Indian
(5) Level of Intervention: Selective
g**.** The NREP noted two programs under consideration, but in need of more study and not registered**:**
(1) ***ASIST***
(a) SPRC Classification: Unrated at this time
(b) Target Age: 18+
(c) Gender:  Male & Female
(d) Ethnicity/Race: Multiple
(e) Level of Intervention: Selective, Universal
(2) ***Yellow Ribbon***
(a) SPRC Classification: Unrated at this time
(b) Target Age: All Ages
(c) Gender:  Male & Female
(d) Ethnicity/Race: Multiple
(e) Level of Intervention: Selective, Universal
6. Since January 2005, the NREP Registry has closed.
   a. Programs recognized by the former program, the National Registry of Effective Programs (NREP), will need to be reviewed under the new criteria of the National Registry of Effective Programs and Practices (NREPP) and will be administered under  the Substance Abuse and Mental Health Services Administration (SAMHSA) with new standards and criteria for inclusion as a model program.
   b. SAMSHA anticipates the new NREPP website will be on-line in late 2005 at www.nationalregistry.samhsa.gov with newly reviewed model programs.
   c. The NREPP goal is to provide the public with contemporary and reliable information about the scientific basis and practicality of interventions to prevent suicide and mental illnesses.
7. Include skill instruction in: bullying prevention, conflict resolution, coping communication , decision-making, assertiveness, self-awareness, help-seeking, and cognition to help reduce suicide risk factors, (such as depression, hopelessness, and drug abuse) Gould et al., 2003; Zenere & Lazarus, 1997; Eggert, Thompson, Herting et al., 1995; Randell et al., 2001; Thompson et al., 2000, 2001).
8. Implement school-wide direct screening of students (see Attachment #3) (Joiner, Pfaff & Acres, 2002; Shaffer & Craft, 1999; Zametkin, Alter, & Yemini, 2002).
   a. Screening done via individual interviews and self-report, used to identify students at risk for suicidal behavior, and has shown to be efficacious in

the recent literature (Joiner, Pfaff & Acres, 2002; Shaffer & Craft, 1999; Thompson & Eggert, 1999; Zametkin, Alter, & Yemini, 2002).

    b.   Some barriers to overcome in school-wide screening suicide screening procedures include:

        (1)  Need for multiple screenings to minimize "false –negatives" on screenings (Berman & Jobes, 1995).

        (2)  Resistance by some school psychologists and high school principals who prefer curriculum based approaches (Miller et al., 2003; Miller et al., 1999).

        (3)  Need for effective, numerous referral resources for student screening positive for suicide risk (Gould et al, 2003).

9.  Schedule specific yearly collaboration/in-service time among teachers, nurses, and school mental health professionals to coordinate and implement suicide prevention programs (King, 2001; CDC, 1992; Ollendick, Greene, Werst, & Oswald, 1990).

10.  Establish protocol that when any staff member recognizes a student or staff member at risk for suicide, the individual must immediately convey that information to school nurse and mental health professional (counselors, psychologists, and social workers) (King, 2001) and proceed with district policy.

11.  Implement school activities aimed at increasing school connectedness, as National Longitudinal Study on Adolescent Health (Resnick et al., 1993) found adolescents perceive school connectedness as a leading protective factor against youth suicide.

12.  Provide and encourage opportunities for participation in after-school clubs and activities, and a comfortable physical environment because they are known protective factors against suicide (King, 2001).

13.  For suicide attempts or completions on campus, principal or designee should provide information to local public mental health agencies and local child death suicide review teams to help improve and expand surveillance (USPHS, 2001).

14.  Implement the parent/guardian suicide prevention education program developed by the district (see Section 6, Attachment 7).

**Section III. School-Based Secondary Suicide Prevention Program, (also called Intervention), refers to steps school personnel on scene should take when a student or staff member threatens or attempts suicide (King, 2001).**

    **A. School/ Site Level**

1. Goals to maintain in extreme risk situation (McKee et al., 1993):
   a. Prevent suicide completion.
   b. Move others to safety.
2. Have risk person escorted by an adult employee to non-threatening environment with access to phone, **never** leave risk person alone, even to go to restroom.
3. Alert building/site crisis team (and police if warranted).
4. Do not make promises of confidentiality—no deals.
5. Question specificity of plan.
6. Trained school mental health professional, with the witness and help of another mental health or medical colleague, should conduct a suicide risk assessment when a student or staff member threatens or attempts (Capuzzi & Gross, 2004; Davis & Brock, 2002).
   a. Extreme risk:  Has specific plan, has dangerous instrument or means to carry out plan.
   b. Severe risk: Has specific plan, but no current means to accomplish it.
   c. Moderate risk: Suicidal ideation verbalized without plan or means Notify parents or legal guardians if student threatens or attempts suicide.
7. Failure to notify parents/guardians of suicide threats or attempts has resulted in school districts being sued. (Poland & McCormick, 1999).
   a. Mental health professionals should document all that is done in an intervention on behalf of a suicidal student or staff member, keep a copy, and turn a copy into the building administrator (Capuzzi & Gross, 2004).
   b. Follow up and support suicidal student and family or suicidal staff member, and document those efforts:
8. Counselor and school psychologist should offer support for child to parents/guardian, needed educational modification, and assessment as appropriate.
9. School mental health professionals should offer community agency or social support program referrals to parents/guardians in writing and keep a copy (Capuzzi & Gross, 1994; Lieberman & Davis, 2002).
10. Encourage continuity of care by facilitating communication between school, hospitals, and outpatient mental health and substance abuse providers by encouraging parents/guardians of suicidal student or the suicidal adult staff member to sign appropriate forms consenting to exchange of information between parties.
11. After an intervention with a student or staff member:
    a. Notify and debrief school staff on a need-to-know basis, (nurse, teachers of student, supervisors of staff member, rest of the crisis team, district office contact, Crisis Guidance Manager).
    b. Debrief and evaluate strategies employed and maintain or modify them based on their effectiveness (King, 2001; Callahan, 1996).

**Section IV. School-Based Tertiary Suicide Prevention Program, (also called Postvention), refers to the provision of crisis intervention, support, and assistance for those affected by a completed suicide (American Association of Suicidology, 1999; Brock, 2002; Leenaars & Wenckstern, 1998).**

    **A. School District Level Responsibilities (with some Building/Site level overlap)**

        1. Principal, or designee, verifies facts with the police, hospital, or family of the victim (Brock, 2002) and reports to the superintendent or designee, District Crisis Guidance Manager, Media Coordinator, District Crisis Team, and site/building crisis team.

        2. Death should never be referred to as a suicide unless there has been verification by the coroner (Wenckstern & Leenaars, 1993; Poland & McCormick, 1999).

        3. Principal or designee will notify appropriate involved school personnel, (ideally within the hour of death verification) (Siehl, 1990).

            a. Notify all personnel in all district schools and neighboring school districts who will be affected by the death.

            b. Notify all after-school care providers who will be affected by death.

            c. Notify all personnel who will participate in postvention responses quickly.

            d. If possible, notify all school employees impacted by the suicide before the school day begins if death happened outside school hours (American Association of Suicidology, 1999).

            e. Keep Media Liaison updated about facts as they are received.

    **B. Building/Site Level Responsibilities:**

        1. Principal or designee mobilizes District Crisis Guidance Manager and building/site crisis team whose members generally have specific team members filling specific roles in postvention efforts (Brock, 2002). Specific roles and duties commonly included are below (see Attachment #8):

            a. ***Team Leader/Crisis Response Coordinator*** (usually, school principal or designee):

                (1) Verifies death.

                (2) Mobilizes and coordinates crisis response team and its actions.

                (3) Assesses impact of suicide on the school.

                (4) Determines if postvention response is warranted.

                (5) If response is warranted, assess what level of response needed (e.g., few individuals, entire school), being careful to estimate accurately (Brock, Sandoval, & Lewis, 2001).

                (6) Keeps superintendent or designee informed of the events and responses.

                (7) Contact family of the suicide victim within 24 hours of the death, in person if possible (Poland & McCormick, 1999; Siehl, 1990).

                    (a) Offer postvention assistance.

                    (b) Ask if they can help identify any of victim's friends who may need intervention (Davis & Sandoval, 1991; American Association of Suicidology, 1999).

(c) Verify with parents what details about the death can be shared with outsiders (Brock, 2002; Roberts et al., 1998), without agreeing to keep it a secret that the death was a suicide.

(8) With crisis team, determine how to share about the death.
    (a) Create a basic written message regarding the death to inform students, parents, and the media.
    (b) Inform school personnel first, if possible in pre-school meeting.
    (c) If pre-school meeting not possible, attempt basic message delivery to each classroom simultaneously, with instructions for teacher or designee to share information with students, and place other staff members there to assist as needed.
    (d) Make arrangements for individuals or small groups of students who are particularly vulnerable or were close to the student who committed suicide to receive counseling with school mental health professionals (American Association of Suicidology, 1999; Berman & Jobes, 1991).
    (e) Principal generally informs parents/guardians via a letter sent home on the day of student notification of suicide and for students most affected by the death; a personal call would be in good form.
    (f) Schedule a parent/guardian meeting to address concerns of the parent and offer helping resource information for their children (Brock, 2002) if deemed appropriate and of interest to parents/guardians.

(9) With crisis team, initiate comprehensive crisis intervention service plans, ideally initiated in the first 24 hours following the suicide and will include (Leenaars, Wenckstern, 1998; Davis & Sandoval, 1991; Davidson, 1989):
    (a) Individual meetings.
    (b) Group crisis intervention.
    (c) Classroom activities and/or presentations.
    (d) Staff meetings.
    (e) Parent meetings.
    (f) Referrals to community agencies

(10) Conduct a faculty planning session.
    (a) Include all classified and certificated employees.
    (b) Provide updated information about the death, background information on the suicide postvention process.
    (c) Clarify school's postvention role.
    (d) Inform about suicide contagion, suicide risk factors, and crisis prevention and intervention services that are planned (American Association of Suicidology, 1999; Berman & Jobes, 1991; Poland & McCormick, 1999; Thompson, 1990).
    (e) Give teachers specific charges to perform, including (Berman & Jobes, 1991).
        (i)    Replacing rumors with facts.

              (ii)    Encouraging discussions of feelings and the normality of grief and stress reactions; discouraging any romanticizing of suicide.

             (iii) Necessity of identifying any at-risk students.

             (iv) Make appropriate referrals

       (f) Stress the importance of keeping school open, following normal bell schedule, and continuity (Berman & Jobes, 1991; Davis & Sandoval, 1991).

       (g) Allow opportunity for staff to process their own feelings and issues (Davis & Sandoval, 1991; Brock, 2002).

    (11)  Crisis team should meet at least once a day throughout the postvention period to review progress and make additional plans (Berman & Jobes, 1991)

  b.  *Community Liaison*:

    (1) Networks with community agencies involved.

    (2) Coordinates community involvement with crisis intervention coordinator.

    (3) Keeps records of all community agency involvement at site.

  c.  *Parent Liaison*:

    (1) Coordinates with principal reproduction and distribution of all written communication to be sent home to families of students following suicide.

    (2) Organizes and facilitates comfortable parent gathering place on campus if needed.

    (3) Helps prepare, advertise, and organize parent information meeting if appropriate.

  d.  *Medical Liaison* (typically a school nurse):

    (1) Work to ensure student and staff health following the suicide.

    (2) Act as a liaison with outside medical personnel involved.

  e.  *Crisis Intervention Coordinator* (usually a school-based mental health professional such as head school counselor, school psychologist, or school social worker).

    (1) Identify students and staff most affected by the suicide and initiate postvention assistance and referral procedures.

    (2) Create and maintain a list identifying students most affected.

    (3) Begin this process within the first three hours following death verification, with physical and/or emotional proximity to the suicide being key identification variables (Brent et al., 1992; Callahan, 2000; Garfinkel et al., 1988b).

    (4) Special attention must be given to students believed to be at high-risk themselves for suicide, to include (Davidson, 1989; O'Carroll et al., 1998):

    (a) Siblings and friends of the suicide victim.

    (b) Previous suicide attempters.

    (c) Clinically depressed students.

    (d) Students known to be with limited social resources

(5) Arrange for trained counselors to screen all high-risk persons, as well as any other student who wants to talk about the death (O'Carroll et al., 1998; Davis & Sandoval, 1991).

(6) With community liaison, secure mutual aid community mental health resource assistance if necessary (Brock, 2002).

(7) Due to correlation with the presence of support and less distress among suicide survivors (Callahan, 2000), drop-in counseling centers should maintain operations for several days following the suicide.

(8) Crisis team member should follow the suicide victim's class schedule, help teacher discuss the death with children, and reduce the stigma of the "empty chair" (Poland & McCormick, 1999).

(9) Individuals who were emotionally or physically proximal to the suicide should be met with separately.

(10) No student should be allowed to leave campus without parent consent (Poland & McCormick, 1999).

(11) Notify parents in the event any student expresses suicidal ideation.

(12) Facilitate distancing the students from identification with the victim in all crisis interventions and ensure students do not glorify the suicidal behavior (Davis & Sandoval, 1988).

f. *Media Liaison* (usually superintendent, school principal, or designee).

(1) Avoid identification of the death as a suicide until it is verified by coroner (Garfinkel et al., 1988a).

(2) Once the death ruled a suicide by coroner, this information should be acknowledged with discretion in tandem with warnings about suicide contagion, and crisis intervention referrals (American Association of Suicidology, 1999).

(3) Needs to work with the press to downplay the incident and not romanticize the death, which has been associated with increases in the suicide rate (Brock, 2002; Davis & Sandoval, 1991; Gould, 2001).

(4) Shares essential facts, without excessive details, to quell rumors, which create greater anxiety and can stir factors related to contagion (Davidson, 1989; American Association of Suicidology, 1999).

(5) Acts as the single spokesperson for the district, constructing an accurate, singular account of the death for the public as appropriate, while cooperating as much as possible with wishes of decedent's family, without agreeing to keep it a secret that the death was a suicide (Davidson, 1989; Berman & Jobes, 1991).

g. *Security Liaison* (typically a school vice-principal or designee):

(1) Ensuring student safety after the crisis.

(2) Acts as a liaison with law enforcement officials

(3) Responsible for crowd control and monitoring common areas, finding students who are out of their classrooms who might need help (Berman & Jobes, 1991).

h. *Staff Liaison*:

(1) Keep staff informed of crisis action plans in progress.

(2) Coordinate classroom activities dealing with the trauma of the suicide.

        (3) Coordinate staff referral of highly traumatized students or staff members.

        (4) Conduct staff debriefing as necessary in between the times meetings of the whole are conducted.

## C. Memorials.

1. Funerals (Poland & McCormick, 1999; Ruof & Harris, 1988).
   a. Attendance by students is a parental decision.
   b. School should not be canceled if the service is during school time.
   c. School should not be funeral or memorial site.
   d. For some students, the suicide death may be first encounter with death, and they might appreciate some information about what occurs at a funeral (Berman & Jobes, 1991).
2. School should advise the family of the suicide victim (and the clergy person, if one is involved), to avoid glorification of the act and the need for survivors to distance themselves from the person who committed the act (Ruof & Harris, 1988).
3. Choice of memorial should also not glamorize or glorify the suicide act.
4. Avoid memorial plaques, yearbook dedications, and other song or event tributes in memory of the suicide victim (Brock & Sandoval, 1997; Garfinkel et al., 1988b; Ruof & Harris, 1988).
5. Consider developing a living memorial, such as a contribution to a suicide prevention or student assistance, which will serve to help others cope with problems (Brock & Sandoval, 1997).

## D. Postvention De-Briefing.

1. Provide a debriefing for all who helped in the crisis intervention (Ward, 1995).
2. Review and evaluate crisis intervention activities and plan for follow up actions (Brock, 2002).
3. Provide opportunity for mutual support for crisis interveners to help them cope with the crisis as they have been directing their energy to caring for others (Davidson, 1989).

**Section V.  School-Based Suicide Prevention Program Evaluation Plan**

**A. Formation and maintenance of program evaluation plan.**

(1) The District Crisis Guidance Manager should coordinate the program evaluation of the school district's suicide prevention program including:

    a.  Develop an assessment tool to evaluate gatekeeper training every even

    b.  Develop an assessment tool to evaluate level of functioning of the District Crisis Team every even year by its participants and building administrators.

    c.  Develop an assessment tool to evaluate the parent/guardian suicide prevention training every even year by the trainers and trainees.

    d.  Develop an assessment tool to help building/site administrators evaluate and document that selected suicide prevention programs are empirically-based and are being implemented with fidelity.

    e.  Each August update the district's suicide prevention program, ensuring the resource and referral names and contact numbers are accurate and current.

**Section VI.  Useful Sample Forms, Checklists, Job Descriptions & Guidelines**

  **A.  Twelve Attachments**
   1. Sample Policy from CA School Boards Relating to School-Based Suicide Prevention
   2. School District Crisis Response (Including Suicide): District Office Responsibilities
   3. District Crisis Guidance Manager Responsibilities &Responsibilities & Job Description
   4. District Crisis Support Team: Membership & Roles
   5. District Media Guidelines
   6. Establishing School Crisis Team: School Site Responsibilities
   7. School-Based Suicide Prevention Gatekeeper Training Checklist
   8. School-Based Suicide Prevention Program Recommendations
   9. School Crisis Immediate Response Checklist
   10. School Crisis Team Quick Checklist Following a Suicide
   11. Suicide Prevention Community Coordination.
   12. Sample Form Letters
       a. **Parent/Guardian Letters**
          (1) Sample parent/guardian letter inviting to Gatekeeper Training
          (2) Sample parent/guardian letter in death by accident
          (3) Sample parent/guardian letter in death by suicide.
          (4) Sample parent/guardian letter in death by murder
          (5) Sample parent/guardian letter after a natural disaster
          (6)  Sample parent/guardian informational evening guidelines
       b. **Staff Letters/Announcements/Documentation/ Forms**
          (1) Sample staff letter advising of meeting to introduce Crisis and Suicide Prevention Handbook.
          (2) Sample staff letter advising of schedule of mandatory gatekeeper meetings.
          (3) Sample staff script to inform students of death of another student or staff member.
          (4) Sample staff announcement of death of a staff member or his/her

**Attachment 1**

**SAMPLE DOCUMENT FOR SCHOOL BOARDS RELATING TO SCHOOL-BASED SUICIDE PREVENTION
PARTS A & B**

The California School Boards Association (CSBA) provides the following sample school board policy and administrative regulations pertaining to suicide prevention for use by California public school districts.

*Part A: Sample School Board Policy for School-Based Suicide Prevention*

Students                                    BP 5141.52(a)

SUICIDE PREVENTION

**Note:  The following optional policy and regulation are offered for districts that wish to adopt policy providing student, staff and parent/guardian training in suicide prevention. The courts have ruled that a district may be liable to the parents/guardians of a student who committed suicide while under supervision of school staff. Before adopting policy on this topic, the Board should consider district staff and capabilities to ensure the policy will be fully enforced. Once a district has adopted a policy, it has a duty to enforce it.**

The Governing Board recognizes that suicide is a major cause of death among youth and that all suicide threats must be taken seriously. The Superintendent or designee shall establish procedures to be followed when a suicide attempt, threat or disclosure is reported. The district shall also provide students, parents/guardians and staff with education that helps them recognize the warning signs of severe emotional distress and take preventive measures to help potentially suicidal students.

**Note: The following sentence may be expanded to designate the grade levels and subject areas, such as health or physical education, into which this instruction will be integrated.**

**The Superintendent or designee shall incorporate suicide prevention instruction into the curriculum. The Superintendent or designee shall also offer parent education or information, which describes the severity of the youth suicide problem and the district's suicide prevention curriculum. This information shall be designed to help parents/guardians recognize warning signs of suicide, learn basic steps for helping suicidal youth and identify community resources that can help youth in crisis.**

Suicide prevention training for certificated and classified staff shall be designed to help staff recognize sudden changes in students' appearance, personality or behavior which may indicate suicidal intentions, help students of all ages develop a positive self-image and a realistic attitude towards potential accomplishments, identify helpful community resources, and follow procedures established by the Superintendent or designee for intervening when a student attempts, threatens or discloses the desire to commit suicide.

The training shall be offered under the direction of a trained district counselor/psychologist or in cooperation with one or more community mental health agencies.

> *(cf. 1020 – Youth Services)*
>
> *(cf. 4131 – Staff Development)*
> *(cf. 4231 – Staff Development)*
>
> *(cf. 4331 – Staff Development)*
>
> *(cf. 6164.2 – Guidance/Counseling Services)*

**SUICIDE PREVENTION**                    **BP 5141.52(b)**

**Note: Education Code 49602, which requires confidentiality of information disclosed to a school counselor by students 12 years of age or older, specifically allows such information to be reported to the principal; or parents/guardians of the student when the counselor has reasonable cause to believe that disclosure is necessary to avert a clear and present danger to the student's health or safety.**

**Staff shall promptly report suicidal threats or statements to the principal or mental health counselor, who shall promptly report the threats or statements to the student's parents/guardians. These statements shall otherwise be kept confidential.**
*(cf. 5141 – Health Care and Emergencies)*

The Board endorses the use of peer counselors who can provide an effective support system for students who may be uncomfortable communicating with adults. Peer counselors shall first complete the suicide curriculum and demonstrate that they are able to identify the warning signs of suicidal behavior and rapidly refer a suicidal student to appropriate adults.
*Legal Reference:*

*EDUCATION CODE*
*49602 Confidentiality of student information*
*49604 Suicide prevention training for school counselors*
*WELFARE AND INSTITUTIONS CODE*
*5698 Emotionally disturbed youth; legislative intent*
*Management Resources:*
*CDE PUBLICATIONS*
*Suicide Prevention Program for California Schools, 1987*
*Health Framework for California Public Schools, 1994*

*Part B: Sample School Board Administrative Regulation for Suicide Prevention*

**Students**                    **AR 5141.52(a)**

**SUICIDE PREVENTION**

**Curriculum**
**The district's suicide prevention instruction shall be designed to help students:**
1. **Understand how feelings of depression and despair can lead to suicide**
2. **Identify alternatives to suicide and develop new coping skills.**
3. **Recognize the warning signs of suicidal intention in others.**
4. **Learn to listen, be honest, share feelings and get help when communication with friends who show signs of suicidal intent.**
5. **Identify community intervention resources where youth can get help.**

**Crisis Intervention Procedures**
**District procedures to be followed when a suicide attempt, threat or disclosure is reported shall:**
1. **Ensure the student's short-term physical safety by one of the following, as appropriate:**
   a. **Securing immediate medical treatment if a suicide attempt has occurred.**
   b. **Securing police and/or other emergency assistance if a suicidal act is being actively threatened.**
   c. **When a suicidal act is less actively threatened but is a serious possibility, keeping the student under continuous adult supervision until the parent/guardian can be contacted and has the opportunity to intervene. If an unsuccessful suicide attempt has been reported or threatened, monitoring the student's actions until the parent guardian can be contacted and has the opportunity to intervene.**
2. **Designate specific individuals to be promptly contacted, including:**
   a. **The school counselor, psychologist, nurse, and/or principal**
   b. **The student's parent/guardian**
   c. **As necessary, local police or counseling agencies**
3. **Set forth one or more plans by which the school can transfer responsibility for the student's welfare to the parent/guardian and/or the appropriate support agent or agency.**
4. **Provide for the timely follow-up by designated school staff regarding the parent/ guardian and student's contact with an appropriate support agent or agency.**
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**Attachment 2**

<div align="center">

**School District Crisis Response:**

*District Office Responsibilities*

</div>

_____ Develop and implement District Crisis Intervention policies and procedures.

_____ Establish a District Crisis Support Team.

_____ Train administrators and District Crisis Support Team in polices and procedures

_____ Facilitate establishment of crisis teams at all district school and non-school sites.

_____ Involve the District Crisis Support Team in all district-wide crisis planning, exercises and prevention program evaluation.

_____ Coordinate district-wide crisis suicide prevention gatekeeper skill training

_____ Establish and maintain district-wide suicide intervention and postvention protocols and procedures.

_____ Establish and maintain a call list of District Crisis Support Team members.

_____ Establish and maintain close relationships with community mental health agencies and secure their involvement in planning, training, and mutual aid...

_____ Request mutual aid assistance when necessary from neighboring school districts.

_____ Establish and maintain list of names and phone numbers for community support systems needed to provide additional services when required.

_____ Collect and maintain current psycho-educational materials and other supplies that may be needed to support crisis intervention activities.

_____ Respond to requests for assistance 24/7 from local schools and support by mobilizing district resources and providing on-site support to School/Site Crisis Team Leader and District Crisis Guidance Manager

_____ Support mutual aid system for neighboring school crisis intervention teams.

Adapted with permission from *School Mental Health Crisis Intervention Teams* – Los Angeles County Office of Education.

**Attachment 3**

## DISTRICT CRISIS GUIDANCE MANAGER RESPONSIBILITIES

The District Crisis Guidance Manager functions as a general consultant to all schools and departments in the district for issues pertaining to suicide, crisis, death, and grief.

*District Crisis Guidance Manager is contacted*:
1. For support and resources whenever an issue of suicide, crisis, death, or grief impacts student or staff members.
2. In consultation with School Crisis Team, to determine if the help of the District Crisis Support Team is needed at the site.
3. To further decide if any other support staff or outside resources need to be called to offer assistance.
4. To mobilize outside resources if appropriate.

*District Crisis Guidance Manager Responsibilities:*
1. Make sure school district employees know the identity and function of the District Crisis Guidance Manager and how to access that person.
2. Introduce self and role to parents of students via PTA newsletters and meetings.
3. Contact and enlist the cooperation of community resources.
4. Be available for on-going review and debriefing post-crisis.
5. Maintain a file of letters, memos, and other exchanges developed to communicate the crisis information.
6. Prepare and provide resource materials on grief, loss, traumatic stress reactions and make them available for loan to individuals and sites needing them.
5. Develop, coordinate and lead prevention program plan evaluations.

Adapted with permission from: School Crisis Response Teams: Lessening the Aftermath Training Manual. 1993 by Mary Schoenfeldt. Third Edition.

**Attachment 4**

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**DISTRICT CRISIS SUPPORT TEAM:**

**MEMBERSHIP & ROLES**

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The District Crisis Support Team functions as a back up support system to all schools and departments in the district for issues pertaining to suicide, crisis, death, and grief.  The District Crisis Support Team responds when asked by a school site administrator or the crisis guidance manager. They are not immediately deployed into service for every crisis.

*District Crisis Support Team Membership:*
1.  District Crisis Guidance Manager should serve on teams at all levels.
2.  Team should also include building principals, psychologists, nurse, counselors, social workers, and other support staff.
3.  Volunteers commit to a minimum of two years and perform this duty in addition to regularly assigned roles.
4.  All members should have crisis intervention experience and be provided training.
5.  Team members share information with co-workers as appropriate.
6.  Team members make arrangements with supervisors so they can respond if needed to other sites in the school district.
7.  There should be 4-5 members of a team for each level (elementary, junior high/middle school, senior high).
8.  Ad-hoc members may be added if necessary to respond to a crisis, (to include any staff member deemed helpful to a given situation by virtue of background, skill, or relationship to the people in crisis).
9.  Volunteers from departments of Student Services, Special Education, E.S.L./Bilingual and other departments as appropriate.

**District Crisis Support Team Role:**

1.  As a **BACK-UP** when a School Crisis Team is unable to handle a situation according to their site plan in situations such as:
    a.  Number of students traumatized so large it is not possible to support them without extra help.
    b.  School staff members so shocked or saddened by event they want assistance to provide crisis intervention.
    c.  The School Crisis Team is unsure of appropriate way to handle the particular situation and asks for help.
2.  Help facilitate establishment of crisis teams at school and non-school district sites if needed.
3.  Help with district-wide training, exercises, and prevention program evaluation.

Adapted with permission from*: School Crisis Response Teams: Lessening the Aftermath Training Manual*. 1993 by Mary Schoenfeldt. Third Edition.

**Attachment 5**
### DISTRICT MEDIA GUIDELINES

1. **General Guidelines for School Administrators /Designated Media Liaison.**
   a. Designated media liaison is individual who interacts with reporters, nobody else.
   b. Assist news professionals in reporting responsibly and accurately.
   c. Avoid "no comment", instead using media request as an opportunity to influence content of story, always being sure to give information about community crisis resources and other services available.
   d. Develop a district policy that gives media professionals seeking to report on sensitive stories related to school some clear and fair guidelines in advance of a tragedy.
   e. Crisis Manager annually prepares media kits for local media professionals annually, sharing the research on media and suicide contagion and name designated media liaison and designee.
   f. Strive to have a positive relationship with media professionals as it benefits both parties--this creates more opportunities for positive messages and helpful information to be shared.

2. **Specific Guidelines for School Administrators /Designated Media Liaison in event of suicide.**
   a. Explain to media professionals the potential for suicide contagion linked with certain types of reporting and ways to minimize risk:
      (1) Presenting simplistic explanations for suicide is a problem.
      (2) Suicide usually a result of complex interaction of factors.
      (3) Most people have a history of problems, often unknown in aftermath of suicide.
      (4) Detailed descriptions of suicide not needed, but acknowledgement of problems is recommended.
      (5) Engaging in repetitive, prominent, and excessive reporting of suicide prolongs preoccupation with suicide among those at risk and is associated with suicide contagion.
   b. Reinforce with media professionals that sensationalized news coverage of a suicide also raises people's preoccupation with suicide and has been linked to suicide contagion.
      (1) Limit morbid details to tone the sensationalism down.
      (2) Decrease prominence of suicide story.
      (3) Avoid using dramatic images related the suicide.
   c. Reporting technical details of the means that a suicide was completed is also related to suicide contagion and is known to encourage imitation.
   d. Stories that paint suicide as an acceptable coping mechanism for stress or problems may encourage that as a solution for at-risk people. Instead:
      (1) Use the suicide story as opportunity to present alternative, more positive ways to cope, which has been related to prevention of further suicide attempts.
      (2) Encourage reporters to report about times that other people who, when challenged, chose a more pro-life option.
   e. Community expressions of grief over a suicide should not be focused on in a large way by the media.

       (1) Such actions exacerbate suicide contagion by the suggestion the suicidal behavior is being honored, rather than the dead person mourned.

       (2) Limit reporting of large memorial gestures, (public eulogies, half-mast flags, permanent memorials).

f. Only focusing on the positive characteristics of a suicide completer in the news and in public forums may elicit contagion if not accompanied by acknowledgement of the deceased person's problems. A person vulnerable to suicide contagion may interpret such press as positive reinforcement for imitating the suicidal act.

g. News stories dealing with suicide are given an important opportunity to feature information about seeking help and illuminating that suicide can be prevented.

h. Be proactive with media professionals around difficult issues. Contact editor before reporters come to site and re-iterate media guidelines and threat of suicide contagion.

**Attachment 6**

ESTABLISHING SCHOOL CRISIS TEAM:

*SCHOOL SITE RESPONSIBILITIES*

The School Crisis Team is a group of employees from the school site who are knowledgeable enough about their school community, its students and staff, to make necessary decisions when a crisis occurs in the district for issues pertaining to suicide, crisis, death, and grief. The school crisis team leader (usually the principal) should convene the school crisis team in the event of a completed suicide or a serious suicide attempt by a student or staff member.

\_\_\_\_\_ **Establish School Crisis Team Leader/Designee** (Typically the Principal):

\_\_\_\_\_ **Team Leader: Assigned**: _____
Call team together to plan response; summarize crisis situation; facilitate development of School Crisis Response Plan; respond to media personally or through District Office; act as District Office liaison; conduct debriefing/evaluation of response plan.

**School Crisis Team Membership:**

Team leader should select the team from willing staff volunteers who agree to a one-year term or longer. Size of team varies with school size. Try to include volunteers from these ranks:

| | |
|---|---|
| \_\_\_\_ Asst. Principal | \_\_\_\_ School Psychologist |
| \_\_\_\_ Campus Security Supervisor | \_\_\_\_ School Secretary |
| \_\_\_\_ School Counselor | \_\_\_\_ School Teacher |
| \_\_\_\_ School Nurse | \_\_\_\_ Ad-hoc, as needed: _____ |

The Team Leader should request the following information be assembled and distributed to Crisis Team:

\_\_\_\_Names and phone numbers of members of the District Crisis Support and School Crisis Teams (home and work).

\_\_\_\_Name and phone number of Team Leader and at least two back-up leaders.

\_\_\_\_Responsibilities of each member depending on the crisis.

\_\_\_\_Determine person (and back-up) responsible to call team together following Roles of School Crisis Team

**Suggested Team Member Roles**:

\_\_\_\_ **Community Liaison**: Assigned:_____
Network with community agencies involved in plan; coordinate community involvement with school psychologist; keep records of all community agency involvement at site; update other team members as needed.

\_\_\_\_ **Parent Liaison**: Assigned: _____
Contac family of deceased; contact parents as needed; coordinate any communication to be sent home; conduct parent meeting if appropriate.

_____ **Medical Liaison**: Assigned: _____

Typically school nurse; plan to ensure student health following the crisis and act as a liaison with medical personnel.

_____ **Crisis Intervention Coordinator**: Assigned: _____

Typically school counselor/psychologist; acts as referral resource for students and staff; serve as in-take counselor for highly traumatized students; consult with staff; help screen students at risk; develop support systems as needed; conduct group meetings with parents/staff as needed.

_____ **Security Liaison**: Assigned: _____

Typically school administrator; plans to ensure student safety after crisis and acts as liaison with law enforcement; responsible for crowd control and monitoring common areas to find students who might need help or are out of class.

_____ **Staff Liaison**:

Assigned: _____

Keep staff informed of action plan; coordinate classroom activities dealing with trauma; coordinate referral system for highly traumatized students; conduct staff debriefing.

### Suggested Training for School Crisis Team:

_____Critical incident stress debriefing     _____Violence/bully prevention

_____Team building     _____Drug abuse prevention

_____Active Listening     _____Effective media relations

_____Small group techniques for children and adults     _____Grief and loss intervention

_____First aid and how to call for medical assistance     _____Suicide intervention skills

_____Crowd control and evacuation of students and staff     _____Anger management

Adapted with permission from: School Crisis Response Teams: Lessening the Aftermath Training Manual. 1993 by Mary Schoenfeldt. Third Edition.

**Attachment 7**

## SCHOOL-BASED SUICIDE PREVENTION GATEKEEPER TRAINING CHECKLIST

Gatekeepers in the school setting are adult employees who have contact with students and colleagues as part of their usual routine. Gatekeeper training provides these gatekeepers information that will help them identify signs that may indicate suicidality or other mental health issues. It and instructs them on who they should inform and how to make a referral when they have concerns.  It gives research-based information about risk and protective factors. District Crisis Guidance Manager will organize this training and manage data about training attendance and frequency.

**School-Based Suicide Prevention Gatekeeper Training Checklist:**

_____ Recruit school or community mental health professional(s) knowledgeable in suicide prevention to conduct training.

_____ Plan for trainer(s) to receive continuing education in suicide prevention methodology and research to remain current.

_____ Institute mandatory school gatekeeper training and repeat the training every two years for all school and non-school site personnel, certified and classified.

_____ Training to develop and increase knowledge, attitude, and skills in:

      _____ The nature of suicidal behavior

      _____ De-stigmatizing mental illness

      _____ Depression and biological basis of some mental illness.

      _____ Identification of students/staff who may be at risk for suicide or mental illness, warning signs, and contagion.

      _____ Knowledge of school's policy and procedures when a student or staff member threatens suicide and/or exhibits suicidal behavior either verbally, in writing, or by action.

      _____ Steps used in determining levels of risk and who does that.

      _____ Referral procedures and school and community referral resources.

      _____ Schools role in suicide prevention.

      _____ Means restriction.

      _____ Understanding content of suicide prevention programs that will be taught to students.

      _____ Understanding of roles and responsibilities of District Crisis Guidance Manager, District Crisis Support Team, and School Crisis Team, and identification of the members of each.

      _____ Knowledge about how to interact with and assist family and friends in the aftermath of a suicidal event.

**Attachment 8**

## SCHOOL-BASED SUICIDE PREVENTION PROGRAM RECOMMENDATIONS: CURRICULUM-BASED AND SCREENING PROGRAMS

There is tension in the literature about the usefulness and efficacy of curriculum-based suicide prevention/awareness programs. The National Strategy of Suicide Prevention (DHHS, 2000) put out a call for evidence-based suicide prevention programs and early mental health screenings, assessments, and referral services. With a sudden increase in the number of suicide prevention programs being developed, the Suicide Prevention Resources Center (SPRC), together with the American Foundation of Suicide Prevention (AFSP), began to develop a registry of effective programs, the National Registry of Effective Programs, (NREP). These effective programs had to meet certain standards in order to be found "evidence-based". These reviewed programs were classified as "effective", "promising", or "unrated" based on reviews using ten scoring criteria that were heavily weighted toward integrity and utility (SPRC, 2005). The NREP registry has been discontinued since January 2005 and its duties are being subsumed by the newly formed National Registry of Evidence-Based Programs and Practices (newly labeled the NREPP), which is under the Substance and Mental Health Services Administration (SAMSHA). The NREPP is a new rendition of the former NREP. All programs that had qualified as evidence-based suicide prevention programs under the NREP will have to undergo new review to be eligible for the new NREPP effective, evidence-based program registry.

**Summary of the reviewed programs found to be either "effective" or "promising":**

It is highly likely new programs will be continue to be reviewed and added as effective or promising. The list below identifies the programs currently identified as either effective or promising, giving a school district a good place to begin as it seeks to employ research-based suicide prevention methods in its pursuit to help students and staff prevent suicide. Schools have been asked to participate in suicide prevention and screening efforts by the National Strategy for Suicide Prevention and the President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America.

A. **C-Care/CAST** (Thompson, Eggert, Randell, & Pike, 2001):
This program is a school-based intervention for students at risk for suicide. It combines one-to-one (C-Care for Counselors Care) with a series of small group sessions (CAST for Coping and Support Training).
1. SPRC Classification: Effective.
2. Target Age: 14-18.
3. Gender: Male & Female.
4. Ethnicity/Race: Multiple.
5. Level of Intervention: Selective, Indicated.
6. Increased Protective Factors: Skills in problem solving, conflict resolution, and nonviolent handling of disputes.

7. Decreased Risk Factors: Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders, hopelessness.
8. Cost: Price not specified, but indicated cost involved.
9. Contact info:
   Reconnecting Youth Prevention Research Program
   Phone:  206-543-8555;
   Email: elainet@u.washington.edu;
   Elaine Thompson, PhD, RN
   Psychosocial &Community
   Health -Campus Box 357263
   UW School of Nursing - Seattle, WA 998195-7263

## B. SOS: Signs of Suicide (Aseltine & DeMartino, 2004)

This program uses a two-prong approach by combining a suicide awareness curriculum and a brief depression screening. It clearly teaches suicide as directly related to mental illness, and not a reaction to stressful circumstances. The Signs of Suicide (SOS) program has been designated as a "promising program" by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), becoming the only suicide prevention program selected for its National Registry of Effective Prevention Programs (the old NREPP) (Screening for Mental Health, Inc., 2002) and the first to empirically demonstrate significant reductions in self-reported suicide attempts.

1. SPRC Classification: Promising
2. Target Age: 14-18.
3. Gender:  Male & Female.
4. Ethnicity/Race: Multiple.
5. Level of Intervention: Universal.
6. Increased Protective Factors: Easy access to variety of clinical interventions & support for help seeking, cultural and religious beliefs that discourage suicide and support self-preservation, strong family and community support.
7. Decreased Risk Factors: Stigma associated with help-seeking behaviors.
8. Language Availability: Spanish language versions available.
9. Cost: Approximately $200
10. Contact Info: **Screening for Mental Health, Inc.**
    SOS Suicide Prevention Program for Secondary Schools
    One Washington Street, Suite 304
    Wellesley Hills, MA  02481
    Web site: www.mentalhealthscreening.org/sos_highschool
    Email: highschool@mentalhealthscreening.org
    Phone:  781-239-0071;    Fax: 781-431-7447

## C. Columbia TeenScreen (Shaffer, et al., 2004):

This program seeks to identify youth at risk for suicide and are suffering from mental illnesses yet to be diagnosed using screening instruments.

1. SPRC Classification: Promising.
2. Target Age: 11-18.
3. Gender:  Male & Female.
4. Ethnicity/Race: Varied.
5. Level of Intervention: Universal.
6. Increased Protective Factors: Easy access to clinical interventions and  support for help- seeking.
7. Decreased Risk Factors: Alcohol and substance abuse disorders; Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders, impulsive and/or aggressive tendencies; Relational or social loss.
8. Decreased Risk Factors: Barriers to accessing health care, particularly mental health and substance abuse treatment.
9. Cost: ColumbiaTeenScreen© is currently offering materials and consultation for free.
10. Contact Info: Columbia TeenScreen© Program
    1775 Broadway, Suite 715
    NY, NY  10019
    Phone: 1-800-TEENSCREEN (833-6727)
    Email: teenscreen@childpsych.columbia.edu
    Website: www.teenscreen.org

## D.  **Lifelines** (Kalafat & Elias, 1994)

Lifelines is a school-based program made up of four 45-lessons of suicide prevention awareness material. It also includes model policies and procedures for schools to adopt, as well as gatekeeper presentations for educators and parents/guardians.

1. SPRC Classification: Promising.
2. Target Age: 12-17.
3. Gender:  Male & Female.
4.  Ethnicity/Race: Multiple.
5.  Level of Intervention: Universal
6   Increased Protective Factors: Easy access to variety of clinical interventions & support for help-seeking; Strong family and community support connections.
7. Decreased Risk Factors: Stigma associated with help-seeking behavior.
8. Cost: Varies depending on number staff/students. Manual $40.
9. Contact Info:  John Kalafat, PhD
   Rutgers University
   Graduate School of Applied and Professional Psychology
   152 Frelinghuysen Road
   Piscataway, NJ 08854
   Phone: 732-445-2000 x121; FAX: 732-445-4888
   Email: kalafat@rci.rutgers.edu

## E.  **Reconnecting Youth Class (RY)** (Eggert & Nicholas, 2004)

This program targets students in grades 9-12 who are achieving poorly, potential for drop out, and other at-risk type behaviors. It endeavors to build resiliency skills against risk factors, give social support and life skills training, and reduce substance abuse and depression/aggression issues.

1. SPRC Classification: Promising.
2. Target Age: 14-18.
3. Gender: Male & Female.
4. Ethnicity/Race: Multiple.
5. Level of Intervention: Selective, Indicated.
6. Increased Protective Factors: Strong family and community support connections; Skills in problem solving, conflict resolution, and nonviolent handling of disputes.
7. Decreased Risk Factors: Alcohol & substance abuse disorders; Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders, impulsive and/or aggressive tendencies; Relational or social loss.
8. Costs: Curriculum Guide - $300; 10 Student Workbooks - $212; RY Training (8 participants/1 trainer) $3000; Other varies.
9. Contact Info: RY Program Information & Scheduling
   Ms. Beth McNamara
   Phone: 425-861-1177
   FAX: 206-726-6049
   Email: beth.mcnamara@comcast.net

F. **Zuni Life Skills Development (LaFromboise, 1995)**

This program is based on social cognition theory, is culturally tailored to American Indian youth, and seeks to develop competency in a range of life skills.

1. SPRC Classification: Promising
2. Target Age: 14-18
3. Gender:  Male & Female
4. Ethnicity/Race: American Indian
5.  Level of Intervention: Selective
6. Increased Protective Factors: Easy access to a variety of clinical interventions & support for help-seeking; Skills in problem-solving, conflict resolution, and nonviolent handling of disputes.
7. Decreased Risk Factors: Hopelessness.
8. Cost: Life Skills Curriculum Text - $30.00; Other materials vary.
   Contact info:
   Teresa D. LaFromboise, PhD, Associate Professor of Education
   Stanford University - Cubberely 216, 3096
   Stanford, CA  94305-3096
   Phone: 650-723-1202; FAX: 650-725-7412
   Email: lafrom@stanford.edu

G. The programs listed below were noted in the SPRC Registry as not yet proven, but SPRC gave information about them and indicated they will continue to see how the evidence for them does or does not continue to build.

1. **ASIST**
   This program is a 2 day workshop designed to impart gatekeeper skills & knowledge.
   a. SPRC Classification: Unrated at this time
   b. Target Age: 18+
   c. Gender:  Male & Female
   d. Ethnicity/Race: Multiple
   e. Level of Intervention: Selective, Universal
   f. Increased Protective Factors: Easy access to a variety of clinical interventions & support for help-seeking; Strong family and community support connections.
   g. Decreased Risk Factors: Lack of social support & sense of isolation; Barriers to accessing health care, particularly mental health & substance abuse treatment.
   h. Cost: Approximately $100.00.
   i. Contact Info:  LivingWorks Education, Inc.
   Website:  www.livingworks.net
   Email: info@livingworks.net
   Phone: 403-3009-0242
2. **Yellow Ribbon**
   This program is based on the model of promoting help-seeking behavior, gatekeeper training, and public awareness of suicide prevention.
   a. SPRC Classification: Unrated at this time
   b. Target Age: All Ages.
   c. Gender:  Male & Female.
   d. Ethnicity/Race: Multiple.
   e. Level of Intervention: Selective, Universal.
   f. Increased Protective Factors: Easy access to a variety of clinical interventions & support for help-seeking; Strong family and community support connections.
   g. Decreased Risk Factors: Stigma associated with help-seeking behavior.
   h. Costs: Variable; offered on a sliding scale.
   i. Contact info:  Yellow Ribbon Program
      Website: www.yellowribbon.org
      Email: Ask4help@yellowribbon.org
      Phone: 303-429-3530

**Attachment 9**

### SCHOOL CRISIS IMMEDIATE RESPONSE: BRIEF CHECKLIST

**I.      IMMEDIATE SCHOOL SITE RESPONSE: Team Leader/ Designee.**
_____A.    Identify problem/event and determine degree of impact on school.
_____B.    Be certain appropriate "alarms" have been sounded.
_____C.    Notify District Superintendent or Designee.

_____D.  Assemble Site Crisis Team, contact Superintendent (or designee), and District Crisis Guidance Manager.

_____E.  Designate individual coordinating responsibilities & locations.

_____F.  Clarify additional resources to be called in:
1.  American Red Cross.
2.  Children's Welfare - CPS.
3.  Fire Department.
4.  Police.
5.  Hospitals.
6.  Poison Control Center: 800-
7.  Suicide Prevention & Crisis Services.
8.  County Mental Health.
9.  Other: _____.

_____G.  Alter daily/weekly schedule as needed.

## II.  COMMUNICATION: Team Leader/ Designee

_____A.  Designate Crisis Coordinating Center

_____B.  Establish visitor sign-in Procedures (at all campus entry sites as possible/feasible)

_____C.  Principal or designee:
1.  Review facts & determine what information should be shared.
2.  Consider police investigation parameters.
3.  Notify family with sensitivity and dispatch. (Identify person to contact family).

_____D.  Develop and disseminate bilingual FACT SHEET (written bulletin) for
1.  Staff.
2.  Students.
3.  Parents/Community.

_____E.  Identify media liaison.
1.  Principal and media spokesperson confer on information to be shared.
2.  Designate a location for media representatives.

_____F.  Contact other district schools, (priority to schools of affected students' siblings).

_____G.  Principal and Crisis Counseling Coordinator coordinate counseling efforts:
1.  Classroom presentations/discussions.
2.  Parent/community meetings.
3.  School staff meeting.

_____H.  Provide for RUMOR CONTROL.
1.  Keep a TV set or radio tuned to a news station.
2.  Verify ALL facts heard.
3.  Update Fact Sheet as needed.
4.  Utilize student leaders, as appropriate: (as sources knowledgeable of student rumors; as peer leaders to convey factual info; as runners (written bulletins should be sealed when necessary).

## III.  FIRST AID AND EMERGENCY RELEASE PLAN: Nurse

_____A.  Initiate First Aid Team procedures

_____B.   Designate Emergency Health Office Location: _____.
_____C.   Initiate Emergency Release Plan procedures if necessary
_____D.   Designate student checkout location_____

## IV.  PSYCHOLOGICAL FIRST AID: Crisis Intervention Coordinator

_____A.   Logistics: Designate rooms/locations/areas and assign responsibilities.
     1.  Individual counseling-Location: _____     Whom:_____
     2.  Parents- Location: _____     Whom: _____
     3.  Staff: _____     Whom: _____
     4.  Sign-in for Support Services: _____     Whom: _____
_____B.   Initiate referral process, including procedures for self-referral.
     1.  Identify location of crisis team members.
     2.  Provide bilingual services as needed.
     3.  Distribute appropriate forms to staff for student counseling referrals.
     4.  Distribute summary of students who were referred to all staff daily.
_____C.   Disseminate appropriate supportive information to staff and parents.
_____D.   Identify and coordinate contact of high-risk students.
_____E.   Identify and coordinate contact other highly affected students & staff.
_____F.   Plan & initiate appropriate interventions (individual counseling, group counseling, parent/community meetings, meetings with ENTIRE staff, classroom activities/presentations, referrals to community agencies)
_____G.   Schedule support and time out breaks for crisis workers.

## V.  DAILY DE-BRIEFING OF SCHOOL CRISIS-

## Team Leader, Team, District Crisis Guidance Manager:

_____A. Crisis Intervention Activities.
     1.  Review actions of each day.
     2.  Identify weaknesses & strengths of crisis responses.
     3.  Review status of referred students.
     4.  Prioritize needs/personnel needed next day & plan follow-up activities.
     5.  Allow time for emotional debriefing of each crisis team member.

**Attachment 10**

## SCHOOL CRISIS TEAM QUICK CHECKLIST FOLLOWING A SUICIDE

| Check if ✔done. | Tasks to be Done | Person Responsible for Task (Identify before a crisis) |
|---|---|---|
| | Verify Facts | |
| | Contact School Superintendent & District Crisis Guidance Manager | |
| | Contact Staff (phone tree) | |
| | Convene School Crisis Team | |
| | Identify Family Contact Person | |
| | Arrange for Substitute Teachers | |
| | Write Announcement to Students | |
| | Morning Staff Meeting | |
| | Set up Safe Rooms (places for very upset individuals to de-brief privately) | |
| | Distribute Suggestions for Classroom Discussion | |
| | Notify Students | |
| | Provide List of Readings & Materials to Teachers | |
| | Write & Send Letter to Parents/Legal Guardians | |
| | After School Staff Meeting | |
| | Parent, Family, Community Meeting | |
| | Carefully decide on a school memorial/remembrance not glorifying the act of suicide | |
| | Post Intervention Debriefing | |
| | Follow up with Students | |

Adapted with permission from: Canter, A. S., & Carroll, S. A. (Eds.). (1999).Crisis Prevention & Response: A Collection of NASP Resources. Bethesda, MD: National Association of School Psychologists

**Attachment 11**

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**SUICIDE/CRISIS PREVENTION AND RESPONSE:**
**COMMUNITY COORDINATION:**
Community Mutual Aid Checklist

*Every school district should have a formalized, coordinated agreement*
*and understanding about mutual aid in the event of a suicide that requires*
*help from one or more of the following type of community providers and*
*neighbors. This Checklist should be continually updated by the District Crisis*
*Guidance Manager, (annually at the minimum).*

</div>

| AGENCY/NAME | PHONE NUMBER | CONTACT PERSON |
|---|---|---|
| American Red Cross | | |
| City Fire Department | | |
| Clergy/Religious Leaders | | |
| Community/County Mental Health | | |
| Coroner's Office | | |
| County Juvenile Probation | | |
| County Office of Education | | |
| County Office of Emergency Services | | |
| County Sheriff | | |
| District Attorney | | |
| Hospice | | |
| Local Bus | | |
| Medical Hospital/Clinic | | |
| Neighboring School District(s) | | |
| Newspaper | | |
| Police Department | | |
| Psychiatric Hospital Facilities: | | |
| Radio Stations | | |
| Sexual Assault & Domestic Violence Center | | |
| Suicide Prevention Agency | | |
| Survivors' Group | | |
| TV Stations | | |

**Attachment 12**

<p align="center"><b>SAMPLE LETTERS AND FORMS FOR PARENT/GUARDIAN AND STAFF</b></p>

**In a crisis situation it is important that the voice of the individual site be heard in correspondences, but sometimes in times of crisis it helps to have a prompt. There are several sample letters/announcements below intended to help site administrators and Crisis Teams get started as they compose their own thoughts and words in the following situations. They serve as a rough template and it is expected that they will be tailored to your individual site and its situation and on your school site's own letterhead. (Adapted with permission from: School Crisis Response Teams: Lessening the Aftermath Training Manual. 1993 by Mary Schoenfeldt. Third Edition).**

1. **Parent/Guardian Letters**

   a. Sample parent/guardian letter inviting to Gatekeeper Training
   b. Sample parent/guardian letter in death by accident
   c. Sample parent/guardian letter in death by suicide.
   d. Sample parent/guardian letter in death by murder
   e. Sample parent/guardian letter after a natural disaster
   f. Sample parent/guardian informational evening guidelines

2. **Staff Letters/Announcements/Documentation/ Forms**

   a. Sample staff letter advising of meeting to introduce Crisis and Suicide Prevention Handbook.
   b. Sample staff letter seeking School Site Crisis Team volunteers.
   c. Sample staff application for School Site Crisis Team volunteers.
   d. Sample staff letter seeking District Crisis Support Team volunteers.
   e. Sample application for District Crisis Support Team volunteers
   f. Sample staff letter advising of schedule of mandatory gatekeeper meetings.
   g. Sample staff script to inform students of death of another student or employee.
   h. Sample staff announcement of death of a staff member or his/her family.
   i. Sample form for documentation of suicidal behavior or threat.
   j. Sample Guidelines after Assessing Suicidal Risk - Checklist
   k. Sample documentation & referral form for parent/guardians.

# 1. Parent/Guardian Letters

## a. Invitation to parents/guardians-Gatekeeper Training

Dear _____:

      Our school district has made a commitment to school-based suicide prevention education for our students, which includes gatekeeper training for staff and interested parents/guardians. Gatekeepers are people who see the children routinely and may notice when they are having difficulty emotionally. Gatekeeper training serves to teach gatekeepers to identify signs that may signal emotional difficulty and equip the gatekeepers with information about referral and getting the student the appropriate help. Parent/Guardian Gatekeeper Training will occur:

Date:

Time:

Place:

Child care will be provided by school employees who have volunteered to help make this opportunity available to more people.  This presentation will be jointly facilitated by _____, one of our school psychologists; _____, our District Crisis Guidance Manager; and _____, of our county Suicide Prevention Agency. We anticipate this information will help us all be more aware of individuals who may be considering suicide, who to contact if we are concerned, and what resources are available in the schools and the community.  Thank you for considering this important opportunity.

Sincerely,

**(<u>Principal name inserted</u>)**

**b. Sample parent/guardian letters in death by accident of student or staff member**

Dear Parents/Guardians:

It is with great sadness that I share the following news with you. (i.e. This morning one of our (**insert grade number)** grade students, (**insert name)**, hit by a car outside of **his/her** home in _____. According to **his/her** family, **he/she** ran out into the street and was seriously injured. **He/she** died at the hospital. We are profoundly saddened by **his/her** death).

We have shared this information and had discussions with all of our students at **(insert school's name)** School so they know what has happened. Counselors, teachers, and other support personnel have been on hand to assist and will continue to be available to students, staff, and parents as long as needed. Please call the school (**insert phone number**) if you want assistance.

As parents and guardians, we urge you to talk to your children about this sad event, also. The death of a (student/teacher) may affect a child in a variety of ways, depending on the age of the student, how well the child knew Sally, and the child's prior experience with death and grief. Typical reactions children have to a death include:

□ Appear to be unaffected      □ Think about it privately      □ Fright

□ Sadness & withdrawal      □ Agitation & anger      □ Ask many questions

□ Attempts to be extra good

May I suggest that you listen to your children intently? If your child seems to need to talk, answer their questions simply, honestly, and possibly over and over again. (optional) A Parent Informational Night is planned for:

Date:

Time:

Place:

At that time we can talk further about helping children through grief.

Our thoughts are with the family and friends of **(insert child's name).**

Sincerely,

**(Principal name inserted)**

**c. Sample guardian/parent letter in death by suicide-***ONLY share this information if the coroner has confirmed the death was a suicide and if the site administrator has so advised.*

Dear Parents and Guardians:

This letter is sadly to inform you a student, **(insert student's name),** has died. The coroner has reported the cause of death to be a completed suicide

We have shared this information and had discussions with all of our students at **(insert school's name)** School so they know what has happened. Counselors, teachers, and other support personnel have been on hand to assist and will continue to be available to students, staff, and parents as long as needed. Please call the school (**insert phone number**) if you want assistance.

We have had counselors and extra staff on campus today to help meet the emotional needs of students and staff who have been upset by this tragedy. We will continue to have extra mental health assistance for students and staff as long as it appears necessary. I urge you to discuss this event with your child and explain that suicide is not a positive response to life's challenges. Please explain that experts  tell us most people who attempt or complete suicide have many emotional problems for which there is help available. Emphasis the importance of people seeking help when needed. This death of a (**student/teacher**) may affect children in a variety of ways, depending on the ages of the students, how well they knew Sally, and the children's  prior experiences with grief and death, (particularly a suicide). Typical reactions children have:

□ Appear to be unaffected    □ Think about it privately    □ Fright

□ Sadness & withdrawal    □ Agitation & anger    □ Ask many questions

□ Attempts to be extra good    □ Guilt    □ Wanting to be with peers

This is an important time to listen to your children intently. If your children seem to need to talk, answer their questions simply, honestly, and possibly over and over again.

I have enclosed a flyer of community mental health resources that are available should this event trigger any undue or exaggerated reactions to your child or someone else you know. Please advise us if you have any serious concerns about the effect this event is having on your child or any of your child's friends. This is a time we must be eyes and ears for each other as we seek to nurture and protect the children in our midst and teach them how to seek help when it is needed.

Please join us in mourning the **(insert name) that** has died, but not glamorizing, and thereby positively reinforcing, the method by which **he/she** died.  Suicide contagion is always an issue we must be mindful of in matters such as these. A positive way to honor this child is to use this tragic suicide as a teachable moment. We must reinforce positive options our children can employ when life is difficult and how to access those options.

*(Optional)* A Parent Informational Night is planned for:

Date:

Time:

Place:

At that time we can talk further about helping children through the grief and unsettled feelings they might be having in the wake of this tragedy.

Our thoughts are with the family and friends of (**insert name of deceased).**

Sincerely,

(**Principal name inserted**)

**d. Sample parent letter in death by murder**

Dear Parents/Guardians:

A very sad thing happened today that I need to share with you. A student, **(insert child's name)**, an **(insert grade number)** grade student at **(insert name of school)** was murdered **(insert when & where if known).** We are profoundly saddened by **his/her death.**

We have had counselors and extra staff on campus today to help meet the emotional needs of students and staff who have been upset by this tragedy. We will continue to have extra mental health assistance for students and staff as long as it appears necessary. This death may affect children in a variety of ways, depending on the ages of the students, how well they knew **(insert child's name)**, and the children's prior experiences with grief and death, (particularly a violent one such as this). Typical reactions children have:

| | | |
|---|---|---|
| □ Appear to be unaffected | □ Think about it privately | □ Fright |
| □ Sadness & withdrawal | □ Agitation & anger | □ Ask many questions |
| □ Attempts to be extra good | □ Wanting to be with peers, especially older students | |

This is an important time to listen to your children intently. If your children seem to need to talk, answer their questions simply, honestly, and possibly over and over again. I have enclosed a flyer of community mental health resources that are available should this event trigger any undue or exaggerated reactions to your child or someone else you know. Please advise us if you have any serious concerns about the effect this event is having on your child or any of your child's friends. This is a time we must be eyes and ears for each other as we seek to nurture and protect the children in our midst and teach them how to seek help when it is needed.

*(Optional)* A Parent Informational Night is planned for:

Date:

Time:

Place:

At that time we can talk further about helping children through grief.

Our thoughts are with the family and friends of **(insert child's name).**

Sincerely,

(**Principal name inserted)**

**e. Sample parent/guardian letter about coping with child's reaction to disaster natural or other)**

Dear Parents/Guardians:

The **(insert name of disaster)** we have experienced is profoundly troubling to everyone. Below are some coping strategies we offer that we hope will help you respond positively to your child.

**FEAR AND ANXIETY:**
1. Normal reaction to any danger that threatens one's life or well-being
2. What triggers the fear after a disaster?
   - ✓ Fear of reoccurrence
   - ✓ Fear of separation from family
   - ✓ Fear of being left alone
3. First priority as parents is to understand the kinds of fears and anxieties children experience.

**ADVICE TO PARENTS:**
1. Important for the family to be together
2. Children need reassurance by parents' words and actions
3. LISTEN to
   - ✓ What your children tell you about their fears
   - ✓ How they feel and what they think about what has happened—validate them.
4. Explain the disaster and known facts to children & listen carefully to what they say and ask—encourage them to talk.
5. Children's fear does not need to completely disrupt their own and the family's activities.
6. Communicate and work cooperatively with the school crisis team at your children's school.

**SETTLING DOWN:**
1. Parents need to communicate they are maintaining control; they need to be understanding, but firm, supportive, and make decisions for children.
2. Bedtime problems
   - ✓ Children may refuse to go to bed alone
   - ✓ They make have difficulty sleeping when they do go to bed
   - ✓ They may wake up repeatedly in the night and have difficulty falling back to sleep.
3. It is natural for children to want to be close to their parents and for parents to want their children near them.
4. Parents should be aware of their own fears, their own uncertainty, and of the effect these have upon their children.
5. Children may demonstrate regressive behavior such as:
   - ✓ Bedwetting
   - ✓ Clinging to parents
   - ✓ Thumb sucking
6. Children respond to praise; parents should make a deliberate effort not to focus on the child's regressed or immature behavior.
7. Specific fears

- ✓ Refusal to go to school
- ✓ Fear of the dark
- ✓ Fear of going to bed
- ✓ Fear of "monsters"

**WHEN IT IS TIME FOR PARENTS TO SEEK PROFESSIONAL HELP:**

1. If sleeping problem continues for more than a few weeks, if the clinging behavior does not diminish, or if the fears become worse, it is time to ask for professional advice.
2. Mental health professionals are specially trained to help people in distress. They can help parents cope with and understand the unusual reactions of the child. By talking to the parents and child, either individually or in a group, a therapist can help a child overcome fears more easily.

By working with the school crisis team at their child's school, parents can gain access to resources and obtain recommendations.

We hope these suggestions are helpful to you. Please contact me or our school support staff (school counselor, nurse, or psychologist) if we can we of further help.

Sincerely,

**(Principal name inserted)**

**f. Sample parent/guardian invitation to informational evening guidelines**

## PARENT INFORMATIONAL EVENING GUIDELINES

| | |
|---|---|
| **INVITE:** | Send a note home to inform parents of the Parent Informational Night. Send an e-mail if your school has a list of parents, also. |
| **FACILITATE:** | Have enough support person for every 15 parents estimated to attend. |
| **INTRODUCE:** | Introduce the evening as a time for parents to express their concerns and ask questions of the school and school crisis team in regards to the (death or disaster) that has impacted their children and families. |
| **SHARE:** | Divide into circles of no more than 15 participants with a facilitator for each group. |

✓ Go around circle, one at a time, starting with facilitator
✓ Ask that each person share his/her concerns, feelings, questions and experiences in regards to the (death or disaster)
✓ Do not encourage discussion at this time. Facilitator takes notes to be addressed at end of sharing circle.

| | |
|---|---|
| **BREAK:** | Take a break after sharing circle. |
| **REJOIN:** | Rejoin as one group for feedback session. |
| **FEEDBACK:** | A designated facilitator addresses the questions and concerns raised by parents. This may include material about: |

✓ Family dynamics during grieving process
✓ Adult grief
✓ Neighborhood and school safety
✓ Suicide and violence prevention
✓ Information on how school is responding
✓ Other topics

| | |
|---|---|
| **ENCOURAGE:** | The facilitator closes the evening with a statement of encouragement and faith in the family's ability to respond to the individual needs of the family members and with appreciation for the great difficulties facing the families. |

**Staff Letters/Announcements/Documentation/ Forms**

**a. Sample staff letter advising of meeting to introduce Crisis and Suicide Prevention Handbook and the District Crisis Guidance Manager.**

Dear Staff Member:

      Members of our school district have worked very hard on the creation of a **(insert school district name)** Crisis and Suicide Prevention Handbook. It is important that each staff member know the contents of this handbook and where it is located in the building. The (**insert name of Crisis Guidance Manager),** will come to our school to present and explain the handbook and answer questions you might have.  Please attend this important meeting.

Date:

Time:

Place:

      As our school forms its own school site crisis team, this handbook will serve as an important tool. I look forward to seeing you there.

Sincerely,


**(Principal name inserted)**

**b. Sample staff letter seeking School Site Crisis Team volunteers.**

Dear Staff:

With the introduction of the DJUSD Crisis and Suicide Prevention Handbook to help facilitate a district-wide crisis plan this year, we are going to formalize a school site crisis team. I have attached the form, *Establishing School Crisis Team: School Site Responsibilities*, (from the Handbook, Section 6, Attachment 6). Please read it over and consider if you would be interested in applying.

We are looking for school crisis team members: comfortable dealing with crisis situations; knowledgeable about community and district-wide resources; able to work well with others on a team; and would be willing to spend the time to meet regularly for training and coordination. If you are interested, please submit the attached application to me before (**insert date).**

See me if you have any questions or would like more information.

Sincerely,

(**Principal name inserted**)

**b. Sample staff application for School Site Crisis Team volunteers. Application for School Site Crisis Team**

**Name:** _____

**Assignment:** _____

**I am interested in being assigned to the School Site Crisis Team. I have experience in:**

____Critical incident stress debriefing      ____Violence/bully prevention
____Team building      ____Drug abuse prevention
____Active Listening      ____Effective media relations
____Small group techniques for children and adults   ____Grief and loss intervention
____First aid and how to call for medical assistance   ____Suicide intervention skills
____Crowd control and evacuation of students and staff   ____Anger management

Please comment below on items checked. If you need more space use the back or attach another paper):




Thanks for applying. Please turn into (**insert principal's name)** by (**insert date)**.

**d. Sample staff letter seeking District Crisis Support Team volunteers.**

Dear Staff:

With the introduction of the DJUSD Crisis and Suicide Prevention Handbook to help facilitate a district-wide crisis plan this year, we are going to formalize a school site crisis team. I have attached the form, *District Crisis Support Team: Membership & Roles,* (from the Handbook Section 6, Attachment 8). Please read it over and consider if you would be interested in applying.

We are looking for District Crisis Support Team members: comfortable dealing with crisis situations; knowledgeable about community and district-wide resources; able to work well with others on a team; and would be willing to spend the time to meet regularly for training and coordination. If you are interested, please submit the attached application to me before (**insert date).** You must have your supervisor's approval to apply as there is a possibility your presence on the team could take you from your building periodically.

See me if you have any questions or would like more information.

Sincerely,

**(Crisis Guidance Manager name inserted)**

**e.  Sample staff application for District Crisis Support Team volunteers Application for District Crisis Support Team**

**Name:** _____  **School Site:** _____

**Assignment**_____

**Supervisor Signature approving application:** _____

**I am interested in applying to become a member of the District Crisis Support Team. I have experience in:**

____Critical incident stress debriefing               ____Violence/bully prevention
____Team building                                     ____Drug abuse prevention
____Active Listening                                  ____Effective media relations
____Small group techniques for children and adults    ____Grief and loss intervention
____First aid and how to call for medical assistance  ____Suicide intervention skills
____Crowd control and evacuation of students and staff   ____Anger management

Please comment below on items checked. If you need more space use the back or attach another paper):

Thanks for applying. Please turn into (**insert name of Crisis Guidance Manager)** at (**insert location**) by (**insert date)**.

**f. Sample staff letter advising of schedule of mandatory gatekeeper meetings.**

Dear Staff,

There have been many requests for staff in-service on suicide prevention and a delineation of the roles and responsibilities we have to students and colleagues when we work for the school district. In a sense we are all the eyes and ears of the school community.  Adults who see members of the school community on a routine basis are "gatekeepers", people who help others be safe. Beginning this year we will be providing gatekeeper training so our employees know what to do when they suspect someone in the school community is contemplating suicide or is in some other kind of profound danger. We all need to know the protocol of who to inform, what resources are available, and how to best help. These are all issues of compassion as well as liability. The gatekeeper training for our school will be:

Date:

Time:

Place:

I look forward to joining each of you at this important meeting.

Sincerely,

**(Principal's name inserted)**

**g. Sample staff script to inform students of death of another student or employee, (after they have been told personally by Crisis Team Leader/Designee).**

Dear Staff;

It is a hard task to tell your students about the death of (insert name of deceased).

**FIRST AND FOREMOST:** If you do not feel you want to be the one to tell your students, then <u>do not</u>! The school crisis team will provide someone who can lead the discussion for you, or take over your class while you seek the support you need. Please take advantage of this resource. We care about you and your needs in this sad time and want you to feel our support.

If you would like to lead the discussion yourself, here are the facts and some suggestions for procedures; please make appropriate developmental adjustments according to the age of students in class:

"I have something very sad I want to share with you. **<u>Here you will read the factual information (agreed upon by the school crisis team), e.g.:</u>**

> *This morning a student who attends our school in (**<u>insert grade number</u>**), (**<u>insert name</u>**), was hit by a car outside of **<u>his/her</u>** home in _____. According to **<u>his/her</u>** family, **<u>he/she</u>** ran out into the street and was seriously injured. **<u>He/she</u>** died at the hospital.*
> *(**<u>Then in your own words continue on with the following or something similar</u>**):*

*I am feeling very sad about what has happened. I would like to spend some time together now to share with each other. Maybe we could help each in expressing how we feel about (**<u>insert name</u>**). Maybe we could help each other in expressing how we feel about (**<u>insert name</u>**) and how **<u>he/she</u>** died."*

- ✓ Take some time for discussion
- ✓ See the two attached handouts: "Guidelines for Teachers on How to Tell Students about a Death" and "Guidelines for Teachers on How to Lead a Discussion with Grieving Students"
- ✓ After discussion, tell students there are counselors in the building if they need to talk further and arrange a procedure for them going to see the counselor.
- ✓ After your discussion you may want to: take a break or recess; playground play; do some drawing, art project or other projects-subject matter student choice; journal writing-any thoughts about whatever is on the child's mind.
- ✓ These activities may be useful to continue to do at intervals during the day and to intersperse throughout curriculum in coming days.

**If you need support, please call the office. Do not hesitate to ask.**

**THANK YOU FOR BEING THE WONDERFUL STAFF THAT YOU ARE…...**

**h. Sample staff announcement of death in a staff member's family.**

Dear Colleagues:

Many of you are dealing with a number of very difficult emotions around the death of (**insert name of staff member's family member**).

**(Give accurate information.) e.g.: (Insert staff member's name)** was informed that **(his/her) (insert family member)** died of **(insert condition)** while **(insert location).**

This loss has left (**insert staff member's name**) and (**his/her**) family with a void that can only be understood by those of you who have experienced such a loss. Your love and support for (**insert staff member's name**) will be an important part in **(his/her)** ability to cope with this loss and at the same time continue on with **(his/her)** personal and professional life.

I have talked with (**staff member**) and shared the fact that so many of you are concerned and that you wished to do something for **(her/him)** to show your feelings and send comfort. (**He/She**) was touched by this and appreciated each of you and your caring ways.

In discussing ways people could demonstrate their caring, (**staff member**) and (**his/her**) family has decided that **(he/she)** would like people to make contributions to (**insert name of charity or cause**) in (**insert deceased's name**). (**He/She**) had a special connection to that work.

Funeral services for (**deceased)** will be held at (**time**) on (**day of the week**) at (**location**). Everyone is invited to **(place)** following the service. The address is (insert **address**).

Your caring ways and support has been, and will continue to be, important to (**staff member**). (School name) is fortunate to be made up of so many wonderful human beings who take such good care of one another.

Sincerely,

(**Principal's name inserted**)

**I. Sample form for documentation of suicidal behavior or threat.**

## SUICIDAL ASSESSMENT CHECKLIST**

**Name of person at risk:**_____ **Date:**_____

**Interviewer:**_____

(Suggested points to cover with person at risk & later with family member of at-risk person)

**A. PAST ATTEMPTS, CURRENT PLANS, & VIEW OF DEATH**

    1. Does the individual have frequent suicidal thoughts?            Y      N

    2. Have the individual or a significant other in his or her life
       ever attempted suicide?          Y      N

    3. Does the individual have a detailed, feasible suicide plan?     Y      N

    4. Has the individual made special arrangements such as giving away prized?
       possessions?          Y      N

    5. Does the individual fantasize about suicide as a way to make others?
feel guilty or as a way to get a happier afterlife?     Y      N

**B. REACTIONS TO PRECIPITATING EVENTS**

    1. Is the individual experiencing severe psychological distress?    Y      N

    2. Have there been major changes in recent behavior along
       with negative feelings and thoughts?     Y      N

       *(Such changes are often related to recent loss or threat of loss of significant others or of positive status and opportunity. They may also stem form sexual, physical, or substance abuse. Negative feelings & thoughts are often expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes anger directed inward).*

**C. PSYCHOSOCIAL SUPPORT**

    1. Is there a lack of significant other to help individual survive?    Y  N

    2. Does the individual feel alienated?     Y  N

**D. HISTORY OF RISK-TAKING BEHAVIOR**

    1. Does the individual take life-threatening risks or display poor impulse
control?     Y  N

*\*\*Use this checklist as an exploratory guide with individuals you are concerned about. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts is a sufficient reason for action. High risk is also associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and location where it is unlikely the act would be disrupted. Further high risk indicators include individual making final arrangements and information about a recent, critical loss. Because of informal and confidential nature of this type of assessment, it should NOT be filed as part of a student's regular school records.* (Adapted and used with permission of UCLA: Center for Mental Health in Schools, May 2004)

**j. Sample Guidelines after Assessing Suicidal Risk - Checklist**

## FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK CHECKLIST

___ (1) In assessment process, efforts will have been made to discuss problem openly and non-judgmentally with individual. Remember how seriously devalued individual feels. Avoid saying anything demeaning; convey warmth, empathy, and respect. If individual resists talking about the matter, give another effort because the more the individual shares, better change of engaging individual in problem-solving.

___ (2) Explain to individual importance of your responsibility to break confidentiality in matters of suicidal risk. Ask if individual would prefer to take the lead or at least be present during process of informing parents and/or other concerned parties.

___ (3) Try to contact parents by phone to:
   a. Inform about concern
   b. Gather more info to assess risk
   c. Provide info about problem and available resources
   d. Offer help in connecting with appropriate resources++

++*Note: In case of a minor, if family is uncooperative, it may be necessary to report child endangerment after taking the following steps*

___ (5) If an individual is considered to be in danger, only release him/her to parent (in case of child) or adult family member (in case of adult) who is equipped to provide help. In high risk cases, if parent or family are unavailable or uncooperative, and no one else is available to help, you must contact the A local public agency, (children's services, local law enforcement, services for emergency hospitalization). These agencies will need and want the following info:
   a. Individual's name, address, birth date, Social Security number
   b. Data about individual's suicide risk (see Suicide Risk Checklist)
   c. Stage of parent (child) or family (adult) notification
   d. Language spoken by individual and family
   e. Health coverage plan if there is one
   f. Location of at-risk individual

___ (6) Follow-up with individual and adult family member to determine what steps have been taken to minimize risk.

___ (7) Document all steps taken and outcomes. Plan for aftermath intervention & support.

___ (8) Report child endangerment if necessary.

**k. Sample documentation & referral form for parent/guardians.**

**Advise of At-Risk Individual and Referral Form**

I, **(insert name of parent/guardian for child or adult family member for adult)**, am (**state relationship to at-risk person**) of (**insert name of at-risk individual**). I have been advised by (**insert name of school employee)** of the (**insert name of school district**) that (**name of at-risk person**) is considered to be at-risk for suicide based on the following: (**School mental health person should briefly write in space below what was said, done, or written to cause this concern**).

I acknowledge that I have been advised to seek mental health care for my child via my family doctor, the local mental health agency, or a private mental health therapist**.(In case of child)** I have been advised and understand I have the right to ask for a special education assessment if I deem that necessary. I have been given the name and phone number of (**insert name(s) of District Crisis Guidance Manager, school psychologist, nurse, or counselor**) should I have further questions of concerns.

Signed:_____

Relationship to At-Risk Individual: _____

Date:_____

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