Comprehensive Suicide Prevention Toolkit for Schools

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The San Ramon Valley Unified School District would like to thank the Palo Alto Unified School District for creating the Comprehensive Suicide Prevention Toolkit for Schools. San Ramon's toolkit has been modeled upon Palo Alto's to address the needs of suicidal youth in our district. Thank you again to the many educational professionals, parents and community leaders that made this document possible.

DEDICATION

This document is dedicated to the memory of all individuals in our community who we have lost to suicide. It is our sincere hope that the content and procedures within this document will support individuals who struggle with thoughts of suicide, and ultimately prevent loss of life within our district.

MESSAGE FROM THE SUPERINTENDENT

Student wellness is a top priority for the San Ramon Valley Unified School District. For years, the District has put into place education and prevention programs at all grade levels to assist students' mental health. This Comprehensive Toolkit will reinforce the District's on-going efforts to support student wellness. It is our privilege to guide and nurture students on their life journey to becoming healthy, well-adjusted and well-rounded adults.

A special thanks to the many counselors and school psychologists who created the district's comprehensive toolkit. Without their tireless efforts and many hours of research and editing, this district resource would not have been possible.

-Rick Schmitt, Superintendent

October 2017

SCHOOLS URGED TO INCLUDE MENTAL HEALTH POLICIES IN PLANS

School safety planning committees or site councils are encouraged to work together with county mental health programs and providers to develop policies to refer children who may have mental health issues to the appropriate services. This type of partnership between families and communities can help address the mental health needs of students as a strategy in school safety planning.

"Nothing is more important than our students' safety, and preparation is one of the first and most important steps a school can take in creating a more positive school climate."

--- Tom Torlakson, State Schools Chief

February 2014

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KEY TO TOOLKIT ACRONYMS

AB	Assembly Bill
AFSP	American Foundation for Suicide Prevention
AR	Administrative Regulation
BP	(School) Board Policy
CDC	Centers for Disease Control and Prevention
CRT	Crisis Response Team
CSSP	Comprehensive School Safety Plan
ERMHS	Educationally-Related Mental Health Services
FERPA	Family Educational Rights and Privacy Act
HIPAA	Health Insurance Portability and Accountability Act (Privacy and Security Rules)
IEP	Individualized Education Plan
LGBT(Q)	Lesbian, Gay, Bisexual, Transgender (or Questioning)
MYSPP	Maine Youth Suicide Prevention Program
PTA	Parent Teacher Association
PTSD	Post-Traumatic Stress Disorder
QPR	Question, Persuade, Refer – Gatekeeper Training
SAMHSA	Substance Abuse and Mental Health Services Administration
SOS	Signs of Suicide
SPRC	Suicide Prevention Resource Center
SRO	School Resource Officer
SRVUSD	San Ramon Unified School District
USF	University of South Florida

INTRODUCTION

Recognizing the tragedy of suicide, in 1999 the United States Surgeon General in his "Call to Action to Prevent Suicide" identified suicide as a serious public health problem. In it he states, "The public health approach focuses on identifying and understanding patterns of suicide and suicidal behavior throughout a group or population. The public health approach defines the problem, identifies risk factors and causes to the problem, develops interventions evaluated for effectiveness, and implements such interventions widely in a variety of communities." California has recognized schools to be an important community in which to implement youth suicide prevention efforts. The California Education Code Section 49604 directs the State Superintendent of Public Instruction to provide training on suicide prevention. To that end the California Department of Education issued its "Youth Suicide-Prevention Guidelines for California Schools" in 2005.

On March 22, 2016, the San Ramon Valley Unified School Board adopted Board Policy and Administrative Regulation 5141.52, Suicide Prevention. On September 26, 2016, California's governor approved Assembly Bill No. 2246: Pupil suicide prevention policies. This bill would require the governing board or body of a local educational agency, as defined, that serves pupils in grades 7 to 12, inclusive, to, before the beginning of the 2017–18 school year, adopt a policy on pupil suicide prevention, as specified, that specifically addresses the needs of high-risk groups (e.g., youth bereaved by suicide, students with disabilities and with mental illness, foster youth, homelessness, LGTBQ+). By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. The bill would require the department to develop and maintain a model policy to serve as a guide for local educational agencies. This toolkit is intended to accomplish the goals set forth in the School Board Policy and Administrative Regulations, and has drawn on evidence based national and state youth suicide prevention toolkits and guides.

According to the latest 2013 data from the federal Centers for Disease Control and Prevention, suicide is the second leading cause of death for youth and young adults 10 to 24 years of age, inclusive. As children and teens spend a significant amount of their young lives in school, the personnel who interact with them on a daily basis are in a prime position to recognize the warning signs of suicide and make the appropriate referrals for help. In a national survey conducted by the Jason Foundation, the number one person whom a pupil would turn to for helping a friend who might be suicidal was a teacher. It is imperative that when a young person comes to a teacher for help, the teacher has the knowledge, tools, and resources to respond. There are national hotlines available to help adults and lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth experiencing suicidal ideation, including the National Suicide Prevention Lifeline and the Trevor Project, respectively. According to the Family Acceptance Project, research has found that, for an LGBTQ youth, having at least one supportive adult can reduce the youth's risk of suicide. A model policy on suicide prevention created in consultation with suicide prevention experts and other stakeholders is available through the Trevor Project for adoption or adaptation, or both, by the State Department of Education and local educational agencies.

The likelihood of a student, faculty, or staff encountering a suicidal student is real. "Within a typical high school classroom it is likely that three students (one boy and two girls) have attempted suicide in the past year" (California Department of Education, 2005). A national survey conducted by the CDC found that about 18% of high school students have either considered, planned, or attempted suicide in the past year (CDC, 2015). SRVUSD's Healthy Kids Survey confirms that this phenomenon still occurs in the San Ramon Valley. The 2015-16 survey results indicate that 12% of 9th graders and 13% of 11th graders answered 'yes' to the question, 'During the past 12 months, did you ever seriously consider attempting suicide?' Suicide is the second leading cause of death for California youth aged 15 to 24, exceeded only by unintentional injury (NIMH, 2015). More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined (U.S. Department of Health and Human Services, 2008).

Statistics are startling, but they do not begin to compare to the grief, anguish, confusion, guilt and devastation felt by the family, friends and community of an adolescent who dies by suicide. The family and friends are themselves at increased risk of developing Post Traumatic Stress Disorder (PTSD) and other mental health problems as a result of their loss (Harvard Mental Health Letter, November 2009). In addition, when not properly addressed, the death of a student by suicide could put other students at risk, as adolescents are particularly vulnerable to contagion. "Compounding the tragedy of loss of life, suicide evokes complicated and uncomfortable reactions in most of us. Too often, we blame the victim and stigmatize the surviving family members and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in secrecy. Unfortunately, secrecy and silence diminish the accuracy and amount of information available about persons who have completed suicide - information that might help prevent other suicides" (U.S. Public Health Service, 1999).

Suicide tends to be preceded by a number of risk factors. There is a gradual progression from suicidal ideation to suicidal behavior to a suicide attempt. 75-90% of completed suicides occur in persons who have had a mental health disorder for at least a year (CDC, 2010). A recent editorial in the Journal of the American Academy of Child and Adolescent Psychiatry stated, "suicidal youth are more attracted to death and less able to generate alternatives to suicide when faced with stress" (Brent, 2011). Our schools can be part of a community effort to provide our youth with the skills they need to become resilient in the face of distress. Schools can play a positive role in enhancing those factors that protect against suicide and that develop resiliency-promoting skills.

Contrary to popular belief, talking about suicide or asking someone if they are feeling suicidal will NOT put the idea in their head or cause them to kill themselves. Evidence demonstrates that suicide is preventable and talking about it is one step toward prevention (California Mental Health Services Authority, 2012). Schools are essential community settings in which to engage in youth suicide prevention activities. "In schools rather than in the home or community, a student's problems with academics, peers and other issues are much more likely to be evident, and suicidal signals may occur here with the greatest frequency. At school, students have the greatest exposure to multiple helpers such as teachers, counselors, coaches, staff and classmates who have the potential to intervene" (USF, 2012).

Students themselves often know about a peer's suicidal thoughts "but do not tell adults because they do not know how adults will respond or think they cannot help" (Maine Youth Suicide Prevention Program). By providing our youth with the skills and education they need about the causes of suicide and its prevention, we provide them with information and resiliency that will serve them throughout their lives. It is equally important to provide our school personnel and families with the information and training they need to prevent youth suicide.

This Toolkit has drawn on evidence-based national and state youth suicide guidelines, including those issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Foundation for Suicide Prevention (AFSP), the Suicide Prevention Resource Center (SPRC), the University of South Florida (USF), and the states of California and Maine, among others. Advanced planning is critical in the effort to prevent youth suicide and to provide an effective crisis response. Key school personnel need to know that protocols exist to refer at-risk students to trained professionals.

"Schools have an essential role to play in preventing suicide and in promoting behavioral health among America's young people" (SAMHSA, 2012). The goal of this document is to ensure that our schools can participate fully in the broader community effort to prevent youth suicide and that, should a crisis arise, our schools are prepared to handle that crisis and restore the school to an environment focused on education as quickly as the situation allows.

SUMMARY

Schools have special reasons for taking action to help prevent the tragedy of suicide:

- A student's mental health can affect their academic performance. Depression and other brain conditions can interfere with the ability to learn.
- Maintaining a safe environment is part of a school's overall mission.
- A student suicide can significantly impact other students and the entire school community. Knowing what to do following a suicide is critical to helping students cope with the loss and preventing additional tragedies that could occur.
- Although this is a school-based toolkit, there is an understanding that children and teens are part of a community and that any comprehensive intervention includes not only members of the school, but also the family and selected members of the child's extended community (such as trusted adults, therapist, primary care, etc.).

Experts recommend that schools use an approach to suicide prevention that includes the following:

1. Provide training and suicide awareness education for key staff, administrators, and site-based partners
2. Educate parents regarding suicide risk and mental health promotion
3. Educate and involve students in mental health promotion and suicide prevention efforts
4. Screen students for suicide risk, as appropriate
5. Identify students at possible risk of suicide and refer them to appropriate services
6. Respond appropriately to a suicide death

Suicide Prevention: A Toolkit for High Schools, SAMHSA

This toolkit addresses suicide prevention and responses to suicidal behaviors in three irrevocably interconnected and interdependent areas:

1. **Promotion** of mental and physical health and well-being
2. **Intervention** in a suicidal crisis
3. **Postvention** response to a suicidal death

Each staff member takes responsibility for the part they can play in keeping students safe by becoming familiar with those aspects of this Toolkit that are pertinent to their role in student safety. Parents and the larger school community will be made aware that this toolkit is in place and of their role in youth suicide prevention efforts.

SECTION I: PROMOTION OF MENTAL HEALTH AND WELL-BEING

Promotion of mental health includes a comprehensive approach to wellness. Students need to be taught what mental health is and given the skills to achieve it, including the social-emotional skills needed for mental and physical well-being. These are defined in the Health Education Content Standards for California Public Schools (http://www.cde.ca.gov/be/st/ss/documents/healthstandmar08.pdf).

Educational opportunities that specifically relate to depression and suicidal ideation need to be provided for students, staff and parents. Mental health resources need to be compiled, reviewed, and regularly updated and disseminated to students, staff and parents. A safe and caring school climate needs to be maintained. Students of concern need to be identified, monitored and supported. Promotion of well-being is comprised of education, a safe and caring school environment, the identification and monitoring of students of concern, and the provision of mental health resources (see Appendix B1, "Mental Health Resources").

A. EDUCATION

1. Staff Education

Key staff and teaching faculty receive training in recognizing depressive symptoms; the warning sign, risk factors, and protective factors for suicide (see Attachment 1.2, "Risk Factors for Youth Suicide", Attachment 1.3, "Protective Factors Against Youth Suicide", and Attachment 1.4, "Recognizing and Responding to Warning Signs of Suicide"); and the procedures for referring students to the appropriate school personnel (e.g., principal, assistant principal, counselor or school psychologist). Training will be scheduled during the school year (e.g., staff development days; staff meetings; mandatory on-line trainings). New staff will receive suicide prevention training, resources, and information as part of their orientation.

Training for all staff members (e.g., administration, classified, and certificated) includes:

Yearly training

- **a.** Online training via Keenan and Associates on how to identify warning signs and symptoms of depression and suicidal ideation. Additional webinars are available (e.g., 13 Reasons Why).
- **b.** Anxiety and Depression Awareness presentations made by school counselors at the secondary level and school psychologists at the elementary level.
- **c.** Site administration introduces Site-Based CRT members who have been trained in the use of this toolkit and protocols (e.g., counselors and psychologists).
- **d.** The toolkit and additional resources for staff and students are on the San Ramon Valley website and school sites**.**
- **e.** Review Attachment 1.1, Los Angeles County Youth Suicide Prevention Project's "General Guidelines for Teachers and Staff" with site staff**.**
- **f.** Suicide prevention education and resources available online.
    - Suicide Prevention Resource Center (SPRC): http://training.sprc.org/
    - American Foundation for Suicide Prevention (AFSP): https://afsp.org/our-work/education/
    - The Jed Foundation: https://www.jedfoundation.org/what-we-do/schools/
    - The Trevor Project: http://www.thetrevorproject.org/

Training for key staff members (e.g., counselors, psychologists, and administration) includes:

- **a.** Psychologists, counselors, and resource officers to meet annually to review Comprehensive toolkit, protocol, assessment tools, and community resources (e.g., First staff development day of each school year).
- **b.** A selected group of counselors and psychologists are encouraged to attend the QPR Gatekeeper training to determine if it would be appropriate for SRVUSD. Gatekeeper training (QPR: Question-Persuade-Refer) and a refresher course every 2-3 years (see Attachment 1.5a, "QPR as a Universal Intervention," and Attachment 1.5b, "QPR Guidelines"). There is an online course appropriate for all district staff that takes about 90 minutes to complete. It is recommended that all mental health workers and administration receive this training.

Recommended training for Crisis Response Team (CRT) members includes:

- **a.** Dedicated training at the site level to review members and responsibilities of the CRT is required each year. Please refer to pages 30-31.
- **b.** Members of the district-based CRT need to collaborate and review their respective responsibilities and how they collaborate with the site-based CRT's. District-based CRT members will be notified of these responsibilities during Job Alike. Additionally, district-based CRT's need to meet annually to review the district's Crisis Intervention Team Manual.
- **c.** The school psychologist at each school site will review the district Crisis Intervention Team Manual with their site administration. Specifically, the psychologist shall review the crisis team activation process (see Page 6 of the manual) and the roles of site-based CRT versus district-based CRT (see Page 4 of the manual).

2. Student Education

Most youth who are suicidal communicate with peers about their concerns rather than with adults, yet as few as 25% of peer confidants tell an adult about their suicidal peer (Kalafat, 2003). Student programs that address suicide can play a significant role in reducing risk for suicide when they are used in conjunction with other strategies, such as intervention protocols and staff training. There are three types of student programs, each with different objectives. They are as follows:

a. Curriculum

- Best practice includes a comprehensive health curriculum for students at all elementary, middle and high schools that meet the Health Education Content Standards for California Public School.
- Curricula for all students informs them about suicide prevention, promotes positive attitudes about mental health, increases students' ability to recognize if they or their peers are at risk for suicide, and encourages students to seek help for themselves and their peers. San Ramon Valley Unified currently uses the Signs of Suicide (SOS), Suicide Prevention Program in middle school (7th grade) and high school (9th and 11th grade). Parents are informed about the topics of depression and suicide being presented, and are invited to a parent evening to view the video presentation and participate in a discussion. Mental health awareness trainings in the area of depression and anxiety awareness are also provided at the elementary school level by school psychologists.

b. Programs

- Skill building programs help identify and support at-risk students by building coping, problem-solving and cognitive skills while addressing related problems such as stress, depression and other brain conditions, and substance abuse (e.g., Second Step, Steps to Respect, Character Counts).
- Peer leadership programs teach selected students skills to identify and help peers who may be at risk. Some programs teach peer leaders to build connectedness among students and also between students and staff, which improves the school climate (e.g., student-led clubs, Let's Bring Change 2 Mind, Sources of Strength).
- Please refer to the district website for more information on programs being utilized. (http://www.srvusd.net/safe_school_programs)
- For more information about student-oriented programs see Attachment 1.5, "peer Leader Programs".

c. Resources for Students

- At the beginning of the school year each middle and high school will list their site resources and hotlines on the back of their student ID cards. Alternatively, this information should be listed in the student's binder reminder or other school materials that each student receives. These numbers may include such community resources as the Contra Costa Crisis Center, Crisis and Suicide Hotline, 800-833-2900, and Crisis Text Line, 20121; the NAMI Crisis Text Line, 741-741; or the National Suicide Prevention Lifeline 800-273-8255. Links to these will be provided on the school website. A full list of recommended resources can be found in Appendix B1, "Community Resources."

3. Parent/Community Education

Although parents may be aware that children and teens die by suicide, they often do not think it could happen to their child or in their community. Parents, primary caregivers and the entire school community need information about:

- The prevalence of suicide and suicide attempts among youth
- The warning signs of suicide
- How to respond when they recognize their child or another youth is at risk
- Where to turn for help in the community when a crisis occurs

a. The school sites will work with San Ramon Council of PTA's and strongly encourage them to have a parent education program. This program could incorporate information about social-emotional and physical wellness, and suicide prevention.

i. To promote attendance this program could be publicized as one of the following examples:

- "Promoting Behavioral Health and Wellness"
- "Eliminating Barriers to Learning"
- "Supporting Your Child with Transition from 8th grade or 12th grade"
- "Learning How to Keep Your Teenager Safe"

See Attachment 1.6, "Including Suicide Prevention in Other Efforts to Reach Parents", Attachment 1.7, "Ideas for Maximizing Parental Response Rate", and Attachment 1.8, "Suicide Prevention: Facts for Parents".

b. Offer parent education in the middle and high schools about depression and other behavioral health illnesses. San Ramon is using the Signs of Suicide curriculum, beginning in 7th grade and continuing on into high school.

c. Resources for parents and students can be found on the following websites:

- Suicide Prevention Resource Center: http://www.sprc.org/
- American Foundation for Suicide Prevention: https://afsp.org/
- The Jason Foundation: http://jasonfoundation.com/
- Jed Foundation: https://www.jedfoundation.org/what-we-do/
- SRVUSD Community Resources: http://www.srvusd.net/suicideprevention
- Individual School Websites

*Provide these links and a resource guide at the beginning of the school year and at educational events. (See Appendix B, "Mental Health Resources", and "Student Mental Health Handout")

d. Include information about reducing access to lethal means in educational activities.

1. Means restriction is proven to prevent suicide.
2. See Harvard School of Public Health, Means Matter: http://www.hsph.harvard.edu/means-matter/recommendations/families/index.html

B. SAFE AND CARING SCHOOL CLIMATE

A safe and caring school climate includes feeling safe at school, feeling part of decision-making, and having a sense of school connectedness, which "is the belief by students that adults and peers in the school care about their learning as well as about them as individuals." (CDC, 2009b, SAMHSA Toolkit, p. 12). Suicidal behavior can be reduced as a sense of school connectedness is increased. Combining suicide prevention with efforts to increase connectedness furthers both goals.

The Centers for Disease Control and Prevention has cited the promotion and strengthening of connectedness at personal, family, and community levels as a key suicide prevention strategy, explaining that "positive attachments to community organizations like schools and churches can increase an individual's sense of belonging, foster a sense of personal worth, and provide access to a larger source of support" (CDC 2012).

1. Connect students with caring adults to improve academic achievement and healthy behaviors. Strategies include:

a. For Staff:

i. Providing professional development and support for teachers and other school staff to enable them to meet the diverse cognitive, emotional and social needs of students.

ii. Using effective classroom management and teaching methods to foster a positive learning environment.

b. For Students:

i. Providing students with the academic, emotional and social skills necessary to be actively engaged in school.

c. For Families:

i. Providing education and opportunities to enable families to be actively involved in their children's academic and school life. Most schools are already actively engaged in this process (e.g., parent book groups, film screenings, parent nights).

d. For All:

i. Employing decision-making processes that facilitate student, family and community engagement, academic achievement, and staff empowerment.

ii. Creating trusting and caring relationships that promote open communication among administrators, teachers, staff, students, families, and communities. This is an ongoing effort that requires collaboration and evaluation with our community and school partners. Evaluation will occur on a regular basis through instruments such as the California Healthy Kids survey.

2. Comprehensive School Safety Plan (CSSP)

The development of a comprehensive school safety plan is mandated by **California Education Code 32281**. This mandate, which was established by Senate Bill 187, states that each school's Site Council, or a Safety Planning Committee authorized by the Site Council, shall develop a "safety plan" relevant to the needs and resources of the school. "Safety", in terms of these plans includes aspects of social, emotional, AND physical safety for both youth and adults at our schools. In order to improve the community's knowledge of what school sites are doing regarding these areas of "safety", we are developing a searchable database where anyone in the community can search by school, activity name/type, grade level, and even one of the District's six character traits (citizenship, empathy, fairness, respect, responsibility, and trustworthiness). Links to each school's individualized Comprehensive School Safety Plan can be found on the school websites, as well as on the district website (http://www.srvusd.net/CSSP).

C. IDENTIFY AND MONITOR AT-RISK STUDENTS

1. At each site the school psychologist or a selected counselor will maintain a separate file (e.g., the "Risk Assessment Binder") of students who may need added support during the school year; they will follow up with them as needed. The designated person will be determined at each school site and may be different at the elementary, middle, and high school levels. These records are only accessible to those staff members who "need to know." These are neither publicly accessible documents nor are they subject to a public records request. All health conditions are protected by FERPA and HIPPA privacy laws. This will include:

- Students exhibiting suicidal thoughts, behaviors, or risk factors
- Students who have been hospitalized for serious mental health issues
- District guidelines will need to be developed on how this will occur

For suggested information to be recorded see Attachment 2.12, "Student Suicide Risk Documentation Form". School psychologists and counselors should tailor this form to fit the needs of their school.

2. Alternative approaches to identifying students at risk are offered in the SAMHSA Toolkit, including on the basis of showing difficulty in three or more of the following areas:
    - Academic achievement
    - Effort
    - Conduct
    - Attendance
    - Negative report card comments
    - Code of student violations
    - Involvement with school police
3. Once at-risk students are identified, the counselor will meet with the student and the parent/guardian (when appropriate) to assess specific needs and work with other school staff to help the student succeed in school and cope better with emotional and/or behavioral difficulties, including any suicidal thoughts or behaviors. Refer to Section II: Intervention in a Suicidal Crisis for details on how to help the student and family if concerns about suicidality are present.

ATTACHMENTS FOR SECTION I: PROMOTION

Information for Teachers:

1.1 General Guidelines for Teachers and Staff, LA County Youth Suicide Prevention Project

1.2 Risk Factors for Youth Suicide, *SAMHSA Toolkit*

1.3 Protective Factors Against Youth Suicide, *SAMHSA Toolkit*

1.4 Recognizing and Responding to Warning Signs of Suicide, *SAMHSA Toolkit*

Information for Administrators:

1.5 Types of Student Programs Information Sheet, *SAMHSA Toolkit*

1.5a QPR as a Universal Intervention

1.5b QPR Guidelines

1.6 Including Suicide Prevention in Other Efforts to Reach Parents, *SAMHSA Toolkit*

1.7 Ideas for Maximizing Parental Response Rate, *SAMHSA Toolkit*

1.8 *13 Reasons Why* Netflix Series: Considerations for Educators, *NASP*

Information for Parents

1.9 Suicide Prevention: Facts for Parents, *SAMHSA Toolkit*

GENERAL GUIDELINES FOR TEACHERS AND STAFF

- Suicide is the third leading cause of death for youth aged 10-24 in the United States. *
- In recent years more young people have died from suicide than from cancer, heart disease, HIV/AIDS, congenital birth defects and diabetes combined. *
- For every young person who dies by suicide, between 100-200 attempt suicide
- Males are four times as likely to die by suicide as females – although females attempt suicide three times as often as males. *

SUICIDE IS PREVENTABLE

Here's what you can do:

- Talk to your student about suicide, don't be afraid, you will not be "putting ideas into their heads". Asking for help is the single skill that will protect your student. Help your student to identify and connect to caring adults to talk to when they need guidance and support
- Know the risk factors and warning signs of suicide.
- Remain calm. Becoming too excited or distressed will communicate that you are not able to talk about suicide.
- Listen without judging. Allow for the discussion of experiences, thoughts, and feelings. Be prepared for expression of intense feelings. Try to understand the reasons for considering suicide without taking a position about whether or not such behavior is justified.
- Supervise constantly. Do not leave the individual alone until a caregiver (often a parent) or school crisis team member has been contacted and agrees to provide appropriate supervision.
- Ask if there is a plan. If so remove means. As long as it does not put the caregiver in danger, attempt to remove the suicide means.
- Respond Immediately. Escort the student to a member of your school's crisis team. If you are unsure of who is on your school crisis team, find the Principal, Assistant Principal or school social worker, psychologist, counselor or school nurse.
- Join the crisis team. You know your student the best. Provide essential background information that will help with assessing the student's risk for suicide. When a teacher says, "this behavior is not like this student", this is critical information indicating a sudden change in behavior.

*M. Heron, D.L. Hoyert, S.L. Murphy, J. Xu, K.D. Kochanek, & B. Tejada-Vera. (2009, April) Deaths: Final Data for 2006. National Vital Statistics Reports 57(14)
**Lieberman, R., Poland, S. & Cassel, R. (2008) Suicide Intervention. In Thomas, A. & Grimes, J., Best practices in school psychology V. Bethesda, MD: National Association of School Psychologists.

Source: Los Angeles County Youth Suicide Prevention Project

GENERAL GUIDELINES FOR TEACHERS AND STAFF

Youth Suicide Risk Factors

While the path that leads to suicidal behavior is long and complex and there is no "profile" that predicts suicidal behavior with certainty, there are certain risk factors associated with increased suicide risk. In isolation, these factors are not signs of suicidal thinking. However, when present they signal the need to be vigilant for the warning signs of suicide. In addition, they are also appropriate targets for suicide prevention programs. Specifically, these risk factors include the following:

- History of depression, mental illness or substance/alcohol abuse disorders
- Presence of a firearm or rope
- Isolation or lack of social support
- Situational crises
- Family History of suicide or suicide in the community
- Hopelessness
- Impulsivity
- Incarceration

Suicide Warning Signs

Warning signs are observable behaviors that may signal the presence of suicidal thinking. They might be considered "cries for help" or "invitations to intervene." These warning signs signal the need to inquire directly about whether the individual has thoughts of suicide. If such thinking is acknowledged, then suicide interventions will be required. Warning signs include the following:

- ***Suicide threats***. It has been estimated that up to 80% of all suicide victims have given some clues regarding their intentions. Both direct ("I want to kill myself") and indirect ("I wish I could fall asleep and never wake up") threats need to be taken seriously.
- ***Suicide notes and plans***. The presence of a suicide note is a very significant sign of danger. The greater the planning revealed by the youth, the greater the risk of suicidal behavior.
- Prior suicidal behavior. Prior behavior is a powerful predictor of future behavior. Thus anyone with a history of suicidal behavior should be carefully observed for future suicidal behavior.
- ***Making final arrangements.*** Making funeral arrangements, writing a will, and/or giving away prized possessions may be warning signs of impending suicidal behavior.
- ***Preoccupation with death***. Excessive talking, drawing, reading, and/or writing about death may suggest suicidal thinking.
- ***Changes in behavior, appearance, thoughts, and/or feelings.*** Depression (especially when combined with hopelessness), sudden happiness (especially when preceded by significant depressions), a move toward social isolation, giving away personal possessions, and reduced interest in previously important activities are among the changes considered to be suicide warning signs.

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Source: Los Angeles County Youth Suicide Prevention Project

RISK FACTORS FOR YOUTH SUICIDE

Risk factors for suicide refer to personal or environmental characteristics that are associated with suicide. The environment includes the social and cultural environment as well as the physical environment. People affected by one or more of these risk factors may have a greater probability of suicidal behavior. Some risk factors cannot be changed – such as a previous suicide attempt – but they can be used to help identify someone who may be vulnerable to suicide.

There is no single, agreed-upon list of risk factors. The list below summarizes the risk factors identified by the most recent research.

Behavioral Health Issues/Disorder:

- Depressive disorders
- Substance abuse or dependence (alcohol and other drugs)
- Conduct/disruptive behavior disorders
- Other disorders (e.g., anxiety disorders, personality disorders)
- Previous suicide attempts
- Self-injury (without intent to die)
- Genetic/biological vulnerability (mainly abnormalities in serotonin functioning, which can lead to some of the behavioral health problems listed above)

Note: The presence of multiple behavioral health disorders (especially the combination of mood and disruptive behavior problems or substance use) increases suicide risk.

Personal Characteristics:

- Hopelessness
- Low self-esteem
- Loneliness
- Social alienation and isolation, lack of belonging
- Low stress and frustration tolerance
- Impulsivity
- Risk taking, recklessness
- Poor problem-solving or coping skills
- Perception of self as very underweight or very overweight
- Capacity to self-injure
- Perception of being a burden (e.g., to family and friends)

Adverse/Stressful Life Circumstances

- Interpersonal difficulties or losses (e.g., breaking up with a girlfriend or boyfriend)
- Disciplinary or legal problems
- Bullying, either as victim or perpetrator
- School or work problems (e.g., actual or perceived difficulties in school or work, not attending school or work, not going to college)
- Physical, sexual, and/or psychological abuse
- Chronic physical illness of disability
- Exposure to suicide of peer

Risky Behaviors

- Alcohol or drug use
- Delinquency
- Aggressive/violent behavior
- Risky sexual behavior

Family Characteristics

- Family history of suicide or suicidal behavior
- Parental mental health problems
- Parental divorce
- Death of a parent of other relative
- Problems in parent-child relationship (e.g., feelings of detachment from parents, inability to talk with family members, interpersonal conflicts, family financial problems, family violence or abuse, parenting style either under-protective or overprotective and highly critical)

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings and interactions of staff and students
- Lack of acceptance of differences
- Expression and acts of hostility
- Lack of respect and fair treatment
- Lack of respect for the cultures of all students
- Limitations in school physical environment, including lack of safety and security
- Weapons on campus
- Poorly lit areas conducive to bullying and violence
- Limited access to mental health care
- Access to lethal means, particularly in the home
- Exposure to other suicides, leading to suicide contagion
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as being overweight.

Stigma and discrimination lead to:

- Victimization and bullying by others, lack of support from and rejection by family and peers, dropping out of school, lack of access to work opportunities and health care
- Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay, which can lead to low self-esteem, social isolation, and decreased help-seeking
- Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture, which can lead to family conflict and rejection

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from Preventing Suicide: A Toolkit for High Schools, SAMHSA

PROTECTIVE FACTORS AGAINST YOUTH SUICIDE

Protective factors are personal or environmental characteristics that reduce the probability of suicide. Protective factors can buffer the effects of risk factors. The capacity to cope positively with the effects of risk factors is called "resilience." Actions by school staff to enhance protective factors are an essential element of a suicide prevention effort. Strengthening these factors also protects students from other risks, including violence, substance abuse, and academic failure.

There is no single, agreed-upon list of protective factors. The list below summarizes the protective factors identified by the most recent research.

Individual Characteristics and Behaviors

- Psychological or emotional well-being, positive mood
- Emotional intelligence: the ability to perceive, integrate into thoughts, understand, and manage one's emotions
- Adaptable temperament
- Internal locus of control
- Strong problem-solving skills
- Coping skills, including conflict resolution and nonviolent handling of disputes
- Self-esteem
- Frequent, vigorous physical activity or participation in sports
- Spiritual faith or regular church attendance
- Cultural and religious beliefs that affirm life and discourage suicide
- Resilience, ongoing or continuing sense of hope in the face of adversity
- Frustration tolerance and emotional regulation
- Body image, care, and protection

Family and Other Social Support

- Family support and connectedness to family, closeness to or strong relationship with parents, and parental involvement
- Close friends or family members, a caring adult, and social support
- Parental pro-social norms, that is, youth know that parents disapprove of antisocial behavior such as beating someone up or drinking alcohol
- Family support for school

School

- Positive school experiences
- Part of a close school community
- Safe environment at school (especially for lesbian, gay, bisexual, and transgender youth)
- Adequate or better academic achievement
- A sense of connectedness to the school
- A respect for the cultures of all students

Mental Health and Healthcare Providers and Caregivers

- Access to effective care for mental, physical, and substance abuse disorders
- Easy access to care and support through ongoing medical and mental health relationships

Access to Means

- Restricted access to firearms: guns locked or unloaded, ammunition stored or locked
- Safety barriers for bridges, buildings, and other jumping sites
- Restricted access to medications (over-the-counter and prescriptions)
- Restricted access to alcohol (since there is an increased risk of suicide by firearms if the victim is drinking)

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from Preventing Suicide: A Toolkit for High Schools, SAMHSA

RECOGNIZING AND RESPONDING TO WARNING SIGNS OF SUICIDE

Warning signs are indications that someone may be in danger of suicide, either immediately or in the near future.

Warning Signs for Suicide Prevention is a consensus statement developed by an expert working group brought together by the American Association of Suicidology. The group organized the warning signs by degree of risk, and emphasized the importance of including clear and specific direction about what to do if someone exhibits warning signs. This consensus statement describes the general warning signs of suicide. Warning signs differ by age group, culture, and even individual.

The recent advent of social media has provided another outlet in which warning signs may be exhibited. The differences in how and where warning signs may be exhibited demonstrate the importance of adapting gatekeeper training for the age group and cultural communities with whom the gatekeepers will be interacting.

Warning Signs for Suicide and Corresponding Actions

Seek immediate help from a mental health provider, 9-1-1 or your local emergency provider, or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) when you hear or see any one of these behaviors:

- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person

Seek help by contacting a mental health professional or calling 1-800-273-TALK for a referral if you witness, hear, or see anyone exhibiting one or more of these behaviors:

- Hopelessness-expresses no reason for living, no sense of purpose in life
- Rage, anger, seeking revenge
- Recklessness or risky behavior, seemingly without thinking
- Expressions of feeling trapped-like there's no way out
- Increased alcohol or drug use
- Withdrawal from friends, family, or society
- Anxiety, agitation, inability to sleep, or constant sleep
- Dramatic mood changes

If you or someone you know is in a suicidal crisis,

call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

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from Preventing Suicide: A Toolkit for High Schools, SAMHSA

TYPES OF STUDENT PROGRAMS INFORMATION SHEET

CURRICULA FOR ALL STUDENTS

Purpose: These curricula:

- Provide information about suicide prevention
- Promote positive attitudes
- Increase students' ability to recognize if they or their peers are at risk for suicide
- Encourage students to seek help for themselves and their peers

Content: Typical content includes:

- Basic information about depression and suicide
- Warning signs that indicate a student may be in imminent danger of suicide
- Underlying factors that place a student at higher risk of suicide
- Appropriate responses when someone is depressed or suicidal
- Help-seeking skills and resources

Participants: These curricula are usually offered to all students in a class or a grade. Some programs, schools, districts, and funders require consent from parents for their child to participate. The children of parents who do not give consent are provided with an alternative activity.

Format: These curricula are typically given in one to four class periods of 45-60 minutes each. They are often given as part of a class, such as a health, family life, or life skills class, which addresses related topics (e.g., mental health issues, substance abuse, bullying, and other violence). This enables the connections between the issues to be highlighted. Sometimes they are implemented during other classes, such as English.

Heath education standards: Almost all of the curricula address at least some, if not most, of the National Health Education Standards. Some states have their own standards. State standards are typically aligned with the national standards.

SKILL-BUILDING PROGRAMS FOR STUDENTS AT RISK OF SUICIDE

Purpose: These programs help protect at-risk students from suicide by:

- Building their coping, problem-solving, and cognitive skills
- Addressing related problems such as depression and other mental health issues, anger, and substance abuse

Content: Typical content includes exercises and activities to:

- Increase problem-solving and coping skills
- Improve resilience and interpersonal relationships
- Prevent or reduce self-destructive behavior

Format: These programs fit into regular class periods and are given as a separate class. They typically last from 12 weeks to a semester.

PEER LEADER PROGRAMS

Purpose: Peer leader programs teach selected students skills to identify and help peers who may be at risk. The most effective programs teach peer leaders to build connectedness not only among students but also between students and staff, which improves the school environment.

Format: These programs are usually held outside of class time. Peer

Leader Roles: Roles vary greatly by program and may include:

- Listening to and supporting peers, educating them about mental health problems, and encouraging them to seek help, as well as talking with adults about students possibly at risk for suicide and other mental health problems
- Presenting lessons to their peers in high school classes, to middle school students, and/or to youth in the community
- Developing and promoting messages to change the school environment through public service announcements, posters, videos, Web sites, and text messaging

Peer Leader Training: The training varies according to the roles taken on by the peer leaders. Basic components of these trainings include:

- Teaching about the risk factors and warning signs of suicide
- Dispelling myths about suicide
- Destigmatizing mental illness and seeking help
- Learning about other physical and mental health problems, as well as other common issues teenagers face

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

QPR as a Universal Intervention
A Brief Review

The following document describes the QPR Gatekeeper Training for Suicide Prevention as a universal intervention in the detection of those as risk for suicide, as well as those who may not be at risk for suicidal behaviors, but may need assistance, assessment, and treatment for any number of mental health issues or problems.

The basic QPR Gatekeeper Training for Suicide Prevention program has been taught to more than one million people by more than 5,500 Certified QPR Instructors in the US and other countries. The QPR program meets the requirements for listing in the National Registry of Evidence-based Practices and Policies (NREPP). This version of QPR training also includes a developer-approved, abridged module of the best practice registered CALM training program (Counseling on Access to Lethal Means).

NREPP Listing for QPR: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=299

SPRC.ORG listing for CALM: http://www.sprc.org/bpr/section-III/calm-counseling-access- lethal-means

Universal Intervention

While the QPR method was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely applied as a universal intervention for anyone who may be experiencing emotional distress. It has been suggested by independent researchers and federal leadership that funded the original assessments of QPR that the QPR intervention could be useful in a much broader application, and not just for the detection of persons at risk for suicide.

Limiting the utility of QPR to the single goal of suicide risk detection accounts for the intervention's origination, but it is not known how many persons emitting distress signals recognized and responded to by individuals trained in QPR methodology were false positives (not suicidal), but still in need of assistance, assessment, and perhaps intervention and treatment. An RO3 research proposal is being submitted to the National Institute of Health at this writing to explore the impact of QPR-trained gatekeepers on not only potentially suicidal persons identified through the intervention, but those experiencing non-suicidal distress.

For example, one can imagine that a youth experiencing a personal crisis may very well send interpersonal distress signals/warning signs and would benefit from help of some kind, but may not be considering suicide as a solution. In fact, the NIMH-funded National Comorbidity Survey-Adolescent Supplement (NCS-A) found that about 20 percent of youth are affected by a mental health disorder sometime in their lifetime, but the vast majority of these young people never attempt suicide. These disorders - mood, anxiety, ADHD, eating disorder, or substance abuse disorder - resulted in a functional impairment of the child's role in family, school, or community activities, but did not lead to a suicide attempt or completion. (Kessler, et al., 2012). Similar findings for adults have been reported as well.

Moreover, a number of known-at-risk populations e.g., police, soldiers, veterans, farmers, athletes and others, may be suffering from treatable disorders that are largely undetected and that go untreated despite public health messaging that attempt to encourage help-seeking behavior.

Since those most at risk of suicide are the least likely to ask for help, the application of QPR- based knowledge, compassion and understanding may prove the intervention to be useful for the detection of a wide range of treatable problems, e.g., non-suicidal self-injury (NSSI), perfectionism, eating disturbances, PTSD, TBI, sleep problems, bullying, depression, and other "easily masked" disorders that often lie "upstream" of the onset of suicidal ideation.

The QPR Concept and Theory

The QPR concept is adapted from the CPR "Chain of Survival" literature for how lay and professional citizens can respond to persons experiencing acute cardiac events. A suicide crisis is a life-threatening event which - if not responded to in a helpful fashion - may progress to a self-inflicted injury or death. In a systems approach, multiple levels of recognition and intervention are required to avoid an adverse outcome. These include the following four links in the chain:

1. Awareness and recognition of suicide warning signs/distress signals
2. Early application of QPR
3. Early intervention, initial screening and referral by professionals
4. Early access to mental health professionals fully trained and competent to assess, treat and manage suicidal behaviors

The theory behind the outreach nature of the QPR intervention rests on the following evidence that most suicidal people:

- Tend not to self-refer
- Tend to be treatment resistant
- Often abuse drugs and/or alcohol
- Dissimulate their level of despair
- Go undetected
- Go untreated

Thus, passive systems, e.g., social marketing efforts to "encourage help-seeking behavior" will be largely unsuccessful with those most at risk of suicidal self-directed violence.

QPR differs from other suicide prevention programs in the following ways:

- Recognizes that even socially isolated suicidal individuals have contact with potential rescuers, e.g., friends, family, school officials
- Reaches out to high-risk people *within* their own environments and *does not require suicidal people to ask for help*
- Teaches specific, real-world suicide warning signs
- Has been heavily researched
- Is deliverable in person, online, or in a blended format of online and classroom

Research Highlights

Program adopters must often justify their decision to use one program over another by the application of due diligence in exploring the scientific basis that supports the proposed training. Below is a brief summary of major studies that support the QPR Gatekeeper Training for Suicide Prevention program.

Official QPR training outcomes as determined by independent research reviewers of published studies for National Registry of Evidence-based Practice and Policies found that trained gatekeepers have increased knowledge, confidence and gatekeeper skills per these measures:

- Increased declarative knowledge
- Increased perceived knowledge
- Increased self-efficacy
- Increased diffusion of gatekeeper training information
- Increased gatekeeper skills (ability to engage in active listening, ask clarifying questions, make an appropriate referral)

Source: Cross, W.F., Seaburn, D., Gibbs, D., Schmeelk-Cone, K. et al. (2011); Matthieu, M.M., Cross, W., Batres. A.R., Flora et al. (2008); Wyman, P.A., Brown, C.H. Inman, J., Cross W., et al (2008). (See NREPP web site for full descriptions of support research and citations).

Methods: Three randomized studies conducted in school, outpatient and workplace settings examined the impact of the Question, Persuade, Refer (QPR) training on stratified samples of (1) 340 teachers and parents in a US public school community and (2) 602 community based counseling center staff from the US Department of Veteran Affairs. One study included a 1-year average follow-up assessment and a second study included a 3-month follow-up assessment.

Results: Findings reported an immediate increase in declarative knowledge, perceived knowledge, self-efficacy, diffusion of gatekeeper training information and gatekeeper skills. Results persisted in the 3-month and 1-year follow up with marginal decrements.

Reference:

Kessler R, Avenevoli S, Costello J, Georgiades K, Green JG, Gruber M, He J, Koretz D, McLaughlin K, Petukhova M, Sampson N, Zaslavsky A, Merikangas K. Prevalence, persistence and Sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. Archives of General Psychiatry. April 2012; 69(4):372-380.

QPR Guidelines

Safe Delivery of Suicide Prevention Training to Youth

- Training for students should only be undertaken once adults in the school (including teachers and staff) have completed QPR Gatekeeper Training (or QPR Advanced Training for school counselors, nurses, social workers, psychologists or other mental health clinicians).
- Training should, initially, be offered exclusively to students in grades 10 to 12 (entering sophomores through seniors).
- Ideally, any student engaged in training should be screened for risk by a school counselor who has participated in one or more advanced QPR training programs.
- Any student excluded from training based on evidence of risk will be followed up and supported by school health professionals.
- Training will be delivered in facilitated small groups (maximum of 12-15 students) with a supervising school counselor or nurse attending who will be available to students for support and follow-up as needed.
- Several key core messages regarding suicide risk and protection are as follows:
- Friends never let friends keep secrets about suicide --- Tell an Adult! (Therefore, we want to be very sure that any adult approached by a young person concerned about suicide risk have QPR training such that they know how to respond and what to do)
- No student should ever feel that they are totally responsible for the safety of another student.
- Ideally the teacher is present at the youth training and receives a QPR certificate or has already been trained in QPR

Adapted from: "QPR for Schools and School Health Professionals: Nurses, Social Workers, School Counselors and Psychologists (Revised July 2013)"

3-13-14

INCLUDING SUICIDE PREVENTION IN OTHER EFFORTS TO REACH PARENTS

Schools have integrated suicide prevention outreach into other activities by:

- Holding a parents' night about student safety that included suicide prevention
- Sponsoring events for the parents of 8th graders or 12th graders that focused on their children's upcoming transition and addressing issues such as anxiety, depression, substance use, and bullying, in addition to suicide prevention
- Sending material--sometimes in the form of a card that fits into a wallet or purse or can be put on the family bulletin board to the parents of every middle and high school student with information about how to help a child in crisis
- lncluding suicide awareness as part of freshman orientation, safety days, or other health events at the school that involve parents
- Including suicide prevention in parenting classes
- Presenting suicide prevention education at a PTA meeting

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

IDEAS FOR MAXIMIZING PARENTAL RESPONSE RATE

These ideas can help maximize the return rate of parental consent forms, whether the response is "yes" or "no" (Rodgers, 2006, except where otherwise noted):

- Send the consent form home with students with a registration or "back to school" packet, other important forms, or a report card. Return rates improve if the form is sent with other materials that need to be signed by parents and returned to the school.
- Have parents sign the consent form at parent-teacher meetings or a school-based function, such as Back to School Night. Station school staff at a location where parents have to stop to complete forms.
- Provide incentives for returned forms (regardless of whether the response is "yes" or "no"):
- Student incentives: Pencils, t-shirts, candy, movie cards, sports memorabilia (Brown & Grumet, 2009), or a class party. Extra credit in health class or another class (Gutierrez & Osman, 2008).
- Parent incentives: Gift cards for local stores or entries for prize drawings.
- Teacher incentives: Gift cards when a specific number or percent of students return the form.
- Use a simple, easy-to-read, eye-catching, and culturally relevant letter and form printed on colored paper.
- Send a reminder notice with an additional form to parents who do not respond, or call them.

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from Preventing Suicide: A Toolkit for High Schools, SAMHSA

NASP
NATIONAL ASSOCIATION OF School Psychologists

13 Reasons Why Netflix Series: Considerations for Educators

Schools have an important role in preventing youth suicide, and being aware of potential risk factors in students' lives is vital to this responsibility. The trending Netflix series 13 Reasons Why, based on a young adult novel of the same name, is raising such concerns. The series revolves around 17-yearold Hannah Baker, who takes her own life and leaves behind audio recordings for 13 people who she says in some way were part of why she killed herself. Each tape recounts painful events in which one or more of the 13 individuals played a role.

Producers for the show say they hope the series can help those who may be struggling with thoughts of suicide. However, the series, which many teenagers are binge watching without adult guidance and support, is raising concerns from suicide prevention experts about the potential risks posed by the sensationalized treatment of youth suicide. The series graphically depicts a suicide death and addresses in wrenching detail a number of difficult topics, such a bullying, rape, drunk driving, and slut shaming. The series also highlights the consequences of teenagers witnessing assaults and bullying (i.e., bystanders) and not taking action to address the situation (e.g., not speaking out against the incident, not telling an adult about the incident).

CAUTIONS

We do not recommend that vulnerable youth, especially those who have any degree of suicidal ideation, watch this series. Its powerful storytelling may lead impressionable viewers to romanticize the choices made by the characters and/or develop revenge fantasies. They may easily identify with the experiences portrayed and recognize both the intentional and unintentional effects on the central character. Unfortunately, adult characters in the show, including the second school counselor who inadequately addresses Hannah's pleas for help, do not inspire a sense of trust or ability to help. Hannah's parents are also unaware of the events that lead to her suicide death.

While many youth are resilient and capable of differentiating between a TV drama and real life, engaging in thoughtful conversations with them about the show is vital. Doing so presents an opportunity to help them process the issues addressed, consider the consequences of certain choices, and reinforce the message that suicide is not a solution to problems and that help is available. This is particularly important for adolescents who are isolated, struggling, or vulnerable to suggestive images and storylines. Research shows that exposure to another person's suicide, or to graphic or sensationalized accounts of death, can be one of the many risk factors that youth struggling with mental health conditions cite as a reason they contemplate or attempt suicide.

What the series does accurately convey is that there is no single cause of suicide. Indeed, there are likely as many different pathways to suicide as there are suicide deaths. However, the series does not emphasize that common among most suicide deaths is the presence of treatable mental illnesses. Suicide is not the simple consequence of stressors or coping challenges, but rather, it is most typically a combined result of treatable mental illnesses and overwhelming or intolerable stressors.

School psychologists and other school-employed mental health professionals can assist stakeholders (e.g., school administrators, parents, and teachers) to engage in supportive conversations with students as well as provide resources and offer expertise in preventing harmful behaviors.

GUIDANCE FOR EDUCATORS

1. While we do not recommend that all students view this series, it can be appreciated as an opportunity to better understand young people's experiences, thoughts, and feelings. Children and youth who view this series will need supportive adults to process it. Take this opportunity to both prevent the risk of harm and identify ongoing social and behavior problems in the school community that may need to be addressed.
2. Help students articulate their perceptions when viewing controversial content, such as 13 Reasons Why. The difficult issues portrayed do occur in schools and communities, and it is important for adults to listen, take adolescents' concerns seriously, and be willing to offer to help.
3. Reinforce that school-employed mental health professionals are available to help. Emphasize that the behavior of the second counselor in the series is understood by virtually all school-employed mental health professionals as inappropriate. It is important that all school-employed mental health professionals receive training in suicide risk assessment.
4. Make sure parents, teachers, and students are aware of suicide risk warning signs. **Always take warning signs seriously, and never promise to keep them secret. Establish a confidential reporting mechanism for students.** Common signs include:
   - Suicide threats, both direct ("I am going to kill myself." "I need life to stop.") and indirect ("I need it to stop." "I wish I could fall asleep and never wake up."). Threats can be verbal or written, and they are often found in online postings.
   - Giving away prized possessions.
   - Preoccupation with death in conversation, writing, drawing, and social media.
   - Changes in behavior, appearance/hygiene, thoughts, and/or feelings. This can include someone who is typically sad who suddenly becomes extremely happy.
   - Emotional distress.
5. Students who feel suicidal are not likely to seek help directly; however, parents, school personnel, and peers can recognize the warning signs and take immediate action to keep the youth safe. When a student gives signs that they may be considering suicide, take the following actions:
   - Remain calm, be nonjudgmental, and listen. Strive to understand the intolerable emotional pain that has resulted in suicidal thoughts.
   - Avoid statements that might be perceived as minimizing the student's emotional pain (e.g., "You need to move on." or "You should get over it.").
   - Ask the student **directly** if they are thinking about suicide (i.e., "Are you thinking of suicide?").
   - Focus on your concern for their well-being and avoid being accusatory.
   - Reassure the student that there is help and they will not feel like this forever.
   - Provide constant supervision. **Do not leave the student alone.**
   - Without putting yourself in danger, remove means for self-harm, including any weapons the person might find.
   - **Get help.** Never agree to keep a student's suicidal thoughts a secret. Instead, school staff should take the student to a school-employed mental health professional. Parents should seek help from school or community mental health resources. Students should tell an appropriate caregiving adult, such as a school psychologist, administrator, parent, or teacher.
6. School or district officials should determine how to handle memorials after a student has died. Promote memorials that benefit others (e.g., donations for a suicide prevention program) and activities that foster a sense of hope and encourage positive action. The memorial should not glorify, highlight, or accentuate the individual's death. It may lead to imitative behaviors or a suicide contagion (Brock et al., 2016).
7. Reinforcing resiliency factors can lessen the potential of risk factors that lead to suicidal ideation and behaviors. Once a child or adolescent is considered at risk, schools, families, and friends should work to build these factors in and around the youth.

- Family support and cohesion, including good communication.
- Peer support and close social networks.
- School and community connectedness.
- Cultural or religious beliefs that discourage suicide and promote healthy living.
- Adaptive coping and problem-solving skills, including conflict resolution.
- General life satisfaction, good self-esteem, and a sense of purpose.
- Easy access to effective medical and mental health resources.

8. Strive to ensure that all student spaces on campus are monitored and that the school environment is truly safe, supportive, and free of bullying.
9. If additional guidance is needed, ask for support from your building- or district-level crisis team. The team may be able to assist with addressing unique situations affecting your building.

See Preventing Suicide: Guidelines for Administrators and Crisis Teams for additional guidance.

Suicide Awareness Voices of Education (SAVE) and the JED Foundation have created talking points for conversations with youth specific to the 13 Reasons Why series, available online.

GUIDANCE FOR FAMILIES

1. Ask your child if they have heard or seen the series 13 Reasons Why. While we don't recommend that they be encouraged to view the series, do tell them you want to watch it, with them or to catch up, and discuss their thoughts.
2. If they exhibit any of the warning signs above, don't be afraid to ask if they have thought about suicide or if someone is hurting them. Raising the issue of suicide does not increase the risk or plant the idea. On the contrary, it creates the opportunity to offer help.
3. Ask your child if they think any of their friends or classmates exhibit warning signs. Talk with them about how to seek help for their friend or classmate. Guide them on how to respond when they see or hear any of the warning signs.
4. Listen to your children's comments without judgment. Doing so requires that you fully concentrate, understand, respond, and then remember what is being said. Put your own agenda aside.
5. Get help from a school-employed or community-based mental health professional if you are concerned for your child's safety or the safety of one of their peers.

See Preventing Youth Suicide Brief Facts (also available in Spanish) and Preventing Youth Suicide: Tips or Parents and Educators for additional information.

SAFE MESSAGING FOR STUDENTS

1. **Suicide is never a solution. It is an irreversible choice regarding a temporary problem. There is help. If you are struggling with thoughts of suicide or know someone who is, talk to a trusted adult, call 1-800-273-TALK (8255), or text "START" to 741741.**
2. Don't be afraid to talk to your friends about how they feel and let them know you care about them.
3. Be an "upstander" and take actions to reduce bullying and increase positive connections among others. Report concerns.
4. Never promise to keep secret behaviors that represent a danger toward another person.
5. **Suicide is preventable.** People considering suicide typically say something or do something that is a warning sign. Always take warning signs seriously and know the warning signs.
    - Suicide threats, both direct ("I am going to kill myself.") and indirect ("I wish I could fall asleep and never wake up."). Can be verbal, written, or posted online.
    - Suicide notes and planning, including online postings.
    - Preoccupation with death in conversation, writing, drawing, and social media.
    - Changes in behavior, appearance/hygiene, thoughts, and/or feelings.
    - Emotional distress.

6. Separate myths and facts.
   - **MYTH:** Talking about suicide will make someone choose death by suicide who has never thought about it before. **FACT:** There is no evidence to suggest that talking about suicide plants the idea. Talking with your friend about how they feel and letting them know that you care about them is important. This is the first step in getting your friend help.
   - **MYTH:** People who struggle with depression or other mental illness are just weak. **FACT:** Depression and other mental illnesses are serious health conditions and are treatable.
   - **MYTH:** People who talk about suicide won't really do it. **FACT:** People, particularly young people who are thinking about suicide, typically demonstrate warning signs. Always take these warning signs seriously.
7. **Never leave the person alone; seek out a trusted adult immediately**. School-employed mental health professionals like your school psychologist are trusted sources of help.
8. Work with other students and the adults in the school if you want to develop a memorial for someone who has died by suicide. Although decorating a student's locker, creating a memorial social media page, or other similar activities are quick ways to remember the student who has died, they may influence others to imitate or have thoughts of wanting to die as well. It is recommended that schools develop memorial activities that encourage hope and promote positive outcomes for others (e.g., suicide prevention programs).

Read these **helpful points** from SAVE.org and the JED Foundation to further understand how 13 Reasons Why dramatizes situations and the realities of suicide. See Save a Friend: Tips for Teens to Prevent Suicide for additional information.

ADDITIONAL RESOURCES

- National Suicide Prevention Hotline, 1-800-273-TALK (8255), or text "START" to 741741
- Center for Disease Control Suicide Datasheet
- SAMHSA Prevention Suicide: A Toolkit for High Schools
- Suicide Prevention Resource Center, After a Suicide: Toolkit for Schools
- Memorials: Special Considerations for Memorializing an Incident

WEBSITES

- National Association of School Psychologists, www.nasponline.org
- American Association of Suicidology, www.suicidology.org
- Suicide Awareness Voices of Education, www.save.org
- American Foundation for Suicide Prevention, https://afsp.org
- www.stopbullying.gov
- Rape, Abuse & Incest National Network, www.rainn.org

REFERENCES

Brock, S.E., Nickerson, A. B., Louvar Reeves, M. A., Conolly, C., Jimerson, S., Pesce, R, & Lazarro, B. (2016). School crisis prevention and intervention: The PREPaRE model (2nd ed.). Bethesda, MD: National Association of School Psychologists.

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SUICIDE PREVENTION: FACTS FOR PARENTS

HIGH SCHOOL STUDENTS EXPERIENCE UNIQUE CHALLENGES

High school can be a rewarding time for young people. But for some students, it can also be emotionally difficult, especially in 9th grade during the transition to high school and again in 12th grade during the transition out of high school. The stresses of high school and the mental and emotional stage of adolescence can combine with risk factors for suicide, such as depression, and increase the risk of suicide for some teens. Parents and school staff can help identify students at risk of suicide and help them get treatment before a tragedy occurs.

Many high school students reported that they had seriously considered suicide in the past year.

- In the United States, one out of every 53 high school students (1.9%) reported having made a suicide attempt that was serious enough to be treated by a doctor or a nurse.
- Suicide is now the leading preventable cause of death among teenagers.
- The toll among some groups, such as Native Americans, is even higher.

Source: Centers for Disease Control and Prevention (CDC)

WHY HIGH SCHOOLS ADDRESS SUICIDE

- Administrators and staff care about the well-being of their students.
- Maintaining a safe and secure school environment is part of a school's overall mission.
- Depression and other mental health issues can interfere with students' ability to learn and affect their academic performance.
- Although few suicides take place on high school campuses, students spend much of the day in school. This puts high schools in a position to identify and help students who may be at risk for suicide and related behavioral health issues.

PREVENTING SUICIDE CAN PREVENT OTHER BEHAVIOR PROBLEMS

Students at risk of suicide may also be at risk of other problem behaviors, such as violence and bullying, and substance abuse. Reducing the risk of suicide can help reduce the likelihood of these other behaviors.

HOW PARENTS CAN HELP PROTECT THEIR CHILDREN FROM SUICIDE

- Maintain a supportive and involved relationship with their sons and daughters
- Understand the warning signs and risk factors for suicide
- Know where to turn for help

HOW SCHOOLS CAN HELP PREVENT SUICIDE

- Experts recommend that schools use an approach to suicide prevention that includes the following:
- Identifying students at possible risk of suicide and referring them to appropriate services
- Responding appropriately to a suicide death
- Providing training and suicide awareness education for staff
- Educating parents regarding suicide risk and mental health promotion
- Educating and involving students in mental health promotion and suicide prevention efforts
- Screening students for suicide risk

You should encourage your high school to implement some or all of these strategies to prevent suicide and protect the well-being of your children. You can work with the school on these important efforts as well as use the school as a resource for help with your child's needs.

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

SECTION II: INTERVENTION IN A SUICIDAL CRISIS

Intervention protocols to assist students in a crisis involving suicidal thoughts or behaviors are a critical component of both district and school responses. These protocols aid school personnel in intervening effectively with suicidal students. School administrators play a crucial role in establishing a school climate that requires key school personnel to be familiar with and responsive to a suicidal crisis in order to help prevent a youth suicide. Students of concern may be referred to counselors by staff, parents, peers, or self-referral. Intervention protocols vary based on the determined degree of suicide risk.

Key principles to remember in any crisis:

1. **Ensure that the student in crisis is safe:** Remain with the student until a Site-Based Crisis Response Team (CRT) member arrives.
2. **Send someone for help:** While you remain with the student, send someone to retrieve the nearest available Site-Based CRT member.
3. **Listen to the student:** Acknowledge their feelings, allow them to express their feelings, avoid giving advice or opinions, and listen for warning signs.
4. **Be direct:** Ask openly about suicide (QPR training) "Suicide is a crisis of non-communication and despair; by asking about it you allow for communication to occur and provide hope" (USF, 2003). Asking about suicide does not put the idea into a student's mind.
5. **Be honest:** Offer hope but do not condescend or offer unrealistic assurance.
6. **Know your limits:** Involve yourself only to the level you feel comfortable. If you are uncomfortable or feel the situation is beyond your capacity to deal with, refer the student to someone in a better position to help. If you feel the student is in immediate danger, escort the student to the referral. If not, check to see that the referral was followed up on.
7. **Inform student:** At each stage, be sure the student knows what is going on. Provide Appendix B2, "Student Mental Health Handout".
8. **Inform parents (when appropriate):** Their child is experiencing a crisis. Reassure them that he/she is currently safe. Inform them of community supports that are available to them during and after the crisis. Work with the parents to develop a plan of action for getting their child help. As needed, provide Appendix B1, "Mental Health Resources" and/or Appendices B3i, B3ii, B3iii, and B3iv, "Parent Handouts".
9. **Keep other students in a safe area**: Allow students to express their fears and concerns or feelings of responsibility or guilt. Let students know that the student in crisis is receiving help, maintain confidentiality and **keep details of the crisis to a minimum.** Let students know where they can get help. Provide Appendix B2, "Student Mental Health Handout".
10. **Monitor:** Friends of the student and others who are potentially at-risk for suicide.
11. **Debrief:** All faculty and staff involved in the crisis are given opportunities to discuss their reactions and are offered support. Allow expression of feelings, worries, concerns, and suggestions of what was done well and what could have been done better during and following the crisis.

SITE BASED CRISIS RESPONSE TEAM CONTACT INFORMATION FOR SECONDARY SCHOOL:

_____

ROLE	NAME	ROOM	EMAIL	OFFICE PHONE	CELL PHONE
CRT LEADER					
ALTERNATE CRT LEADER					
PRINCIPAL					
ASSISTANT PRINCIPAL					
SCHOOL PSYCHOLOGIST					
COUNSELOR					
COUNSELOR					
COUNSELOR					
COUNSELOR					
OTHER MENTAL HEALTH PROVIDER					
TEACHER LIAISON					
SCHOOL SECRETARY					
NURSE/HEALTH TECH					
CAMPUS SUPERVISOR					
SCHOOL RESOURCE OFFICER					
MEDIA SPOKESPERSON: DISTRICT					

SITE BASED CRISIS RESPONSE TEAM CONTACT INFORMATION FOR ELEMENTARY SCHOOL:

_____

ROLE	NAME	ROOM	EMAIL	OFFICE PHONE	CELL PHONE
PRINCIPAL/ACTING PRINCIPAL/CRT LEADER/MEDIA SPOKESMAN					
SCHOOL PSYCHOLOGIST					
COUNSELOR/OTHER MENTAL HEALTH PROVIDER					
TEACHER LIAISON					
DESIGNATED TEACHER					
DESIGNATED TEACHER					
DESIGNATED TEACHER					
SCHOOL SECRETARY					
CUSTODIAN					

INTERVENTION IN A SUICIDAL CRISIS

Use when a peer, parent, teacher, or school staff identifies someone as potentially suicidal because of directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs. *Recognizing and Responding to Warning Signs of Suicide*, Attachment 1.4

Low Risk Level for Suicide

Students with a low risk level for suicide display suicidal ideation only.

Take every warning sign or threat of self-harm seriously.

- ☐ Take immediate action by sending someone to inform the counselor or school psychologist of the situation.
- ☐ Remain with the student until the counselor/school psychologist talks with him/her in a quiet, private setting to clarify the situation, and assess suicide risk level.
- ☐ Counselor or school psychologist will contact an administrator or designee to inform him/her of the situation once risk assessment is complete.
- ☐ Counselor, school psychologist and/or administrator will notify parent/guardian of situation unless this will exacerbate the situation. Refer to *Guidelines for Notifying Parents, 2.4 Supporting Parents Through Their Child's Suicidal Crisis, 2.5*, and *Contact Acknowledgement Form, 2.6.*
- ☐ Develop a safety plan with the student and parents. Refer to *Safety Planning Guide, 2.10*, and *Personal Safety Plan, 2.11*.
- ☐ Refer to primary health care provider or mental health services if necessary. Refer to *Guidelines for Student Referrals, 2.7, Referral Process for Special Education Mental Health Assessment, 2.8*, and *Release of Information Form, 2.9*.
- ☐ Document actions on appropriate forms *Student Suicide Risk Documentation Form, 2.12.*
- ☐ Counselor or school psychologist will follow up with the student and family as often as necessary until the student is stable.

Moderate Risk Level for Suicide

Students with a moderate risk level for suicide display suicidal ideation and some combination of planning, access to means, intent, history of ideation/attempts, and/or lack of support.

- ☐ Keep student under close supervision.
- ☐ Notify nearest mental health provider or Site-Based Crisis Response Team (CRT) member who will evaluate the situation and then notify a school administrator.
- ☐ Counselor, school psychologist, or Site-Based CRT member will conduct a suicide risk assessment to determine student's risk level and convey to administrator. If necessary, an SRO will be called in to support site staff.
- ☐ Counselor, school psychologist, administrator, SRO or designee notifies parents/guardians. Refer to *Guidelines for Notifying Parents, 2.4, Supporting Parents Through Their Child's Suicidal Crisis, 2.5*, and *Parent Contact Acknowledgement Form, 2.6*. Arrange to meet with parents.
- ☐ Create a safety plan, or if already in place, review and update.
- ☐ Confirm understanding of next steps for student's care.
- ☐ Ensure that student and parents, with the assistance of a counselor, school psychologist, administrator, Site-Based CRT member, and/or SRO, have discussed importance of lethal means restriction and share *Attachment 2.19, Means Matter: Recommendations for Families.*
- ☐ Sign the *Release of Information Form, 2.9* and *Parent Contact Acknowledgment Form, 2.6*.
- ☐ Provide referrals and resources for parent/guardians including *What to Expect; When Your Child Expresses Suicidal Thoughts, Appendix B3*.
- ☐ Explain that a designated school professional will follow up within the next two days.
- ☐ Establish a plan for periodic contact from school personnel
- ☐ Document actions taken *Student Suicide Risk Documentation Form*, *2.12*.
- ☐ Debrief with all staff members who assisted with the intervention, providing for the expression of feelings, worries, concerns, and suggestions.

High Risk Level for Suicide

Students with a high risk level for suicide display suicidal ideation with ready access to or possession of means and strong intent to carry out a plan as soon as possible.

- ☐ Ensure that a school staff member remains with the student at all times.
- ☐ Clear the area and ensure that all other students are safe.
- ☐ Alert administrator and/or Site-Based CRT member(s).

Mobilize community links (e.g. SRO and/or 911)

- ☐ If not life threatening, call SRO. If not available, contact 911.
- ☐ If a life threatening emergency, call 911. Note: 911-responder will determine if emergency treatment or hospitalization is required and will arrange transport
- ☐ Counselor, school psychologist, administrator, SRO, and/or designee notifies parents about the seriousness of the situation, unless this will exacerbate the situation. In certain cases, it may be necessary to wait to notify parents due to clinical circumstances as determined by counselor, school psychologist, SRO or other Site-Based CRT member.

If the student has lethal means on their person:

- Do not attempt to take a weapon by force
- Talk with the student calmly
- Have someone call 911
- Clear area for student safety
- Once the student gives up the potentially lethal means, stay with the student until the Site-Based CRT member, administrator, and/or SRO or 911 emergency support arrives.

At this level of risk, the student may require hospitalization

- ☐ Counselor or school psychologist will collaborate with student's doctor/ therapist. Frequency of check-in with the student, family, doctor and/or therapist will be determined by the level of student need.
- ☐ Before student returns to school, initiate re-entry plan.

A. LOW RISK LEVEL OF SUICIDE

Students with a low risk level for suicide display suicidal ideation only. This typically includes warning signs of suicide and/or express thoughts of killing themselves with no intent to act on these thoughts.

1. When a peer, parent, teacher, or other school employee identifies someone as potentially suicidal because s/he has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs (see Attachment 1.4, "Recognizing and Responding to Warning Signs of Suicide"), consider the following:
   a. Take every warning sign or threat of self-harm seriously.
   b. Take immediate action by sending someone to inform the counselor or school psychologist of the situation.
   c. Remain with the student until the counselor/school psychologist talks with him/her in a quiet, private setting to clarify the situation, and assess suicide risk level.
   d. Counselor or school psychologist will contact an administrator or designee to inform him/her of the situation once risk assessment is complete.
   e. Counselor, school psychologist and/or administrator will notify parent/guardian of situation unless this will exacerbate the situation (see Attachment 2.4, "Guidelines for Notifying Parents", Attachment 2.5, "Supporting Parents Through Their Child's Suicidal Crisis" and Attachment 2.6 "SRVUSD Contact Acknowledgement Form").
   f. Develop a safety plan with the student and parents (see Attachment 2.10, "Safety Planning Guide", and Attachment 2.11, "SRVUSD Personal Safety Plan").
   g. Refer to primary health care provider or mental health services if necessary (see Attachment 2.7, "Guidelines for Student Referrals", Attachment 2.8, "Referral Process for Special Education Mental Health Assessment", and Attachment 2.9, "SRVUSD Release of Information Form")
   h. Document actions on appropriate forms (Attachment 2.12, "SRVUSD Student Suicide Risk Documentation Form").
2. The counselor or school psychologist will follow up with the student and family as often as necessary until the student is stable and no longer of concern.

B. MODERATE RISK LEVEL OF SUICIDE

Students with a moderate risk level for suicide display suicidal ideation and behavior with an intent or desire to die. Do the following:

1. Keep the student safe and under close supervision. **Never leave the student alone.** Designate one or more staff members to stay with and support the individual in crisis while help is being sought.
2. Notify nearest mental health provider or Site-Based CRT member who will evaluate the situation and then notify a school administrator that a student has expressed the intent to engage in suicidal behavior.
3. Counselor, school psychologist, or Trained Site-Based Crisis Response Team (CRT) member will conduct a suicide risk assessment to attempt to determine the student's risk level and then convey this information to school administrator. If necessary, a School Resource Officer (SRO) will be called in to support site staff.
4. Counselor, school psychologist, administrator SRO or designee notifies parents/guardians (see Attachment 2.4 "Guidelines for Notifying Parents", Attachment 2.5, "Supporting Parents Through Their Child's Suicidal Crisis", and Attachment 2.6, "SRVUSD Parent Contact Acknowledgement Form"). Arrange to meet with parents whenever appropriate.
5. Create a safety plan or, if a student already has a safety plan, review and update (see Attachment 2.10, "Safety Planning Guide", and Attachment 2.11, "SRVUSD Personal Safety Plan").
6. If the student does not require emergency medical treatment or hospitalization based on the assessment, and the immediate crisis is under control; before the student is released to the parent/guardian review the following:
   a. Confirm an understanding of what next steps for the student's care will be.
   b. Ensure that student and parents, with the assistance of a counselor, school psychologist, administrator, Site-Based CRT member, and/or SRO, have discussed the importance of lethal means restriction (see Attachment 2.19, "Means Matter: Recommendations for Families," or Harvard School of Public Health "Means Matter: Recommendations for Families: http://www.hsph.harvard.edu/means-matter/recommendations/families/index.html).

c. Sign both Attachment 2.9, "SRVUSD Release of Information Form", and Attachment 2.6, "Parent Contact Acknowledgment Form".
d. Provide referrals and resources for parent/guardians (See Appendix B, "Student and Parent Handouts and Resources").
e. Explain that a designated school professional will follow-up with parents and student within the next two days.
f. Establish a plan for periodic contact from school personnel.

7. Document actions taken (see Attachment 2.12, "SRVUSD Student Suicide Risk Documentation Form").
8. Debrief with all staff members who assisted with the intervention, providing for the expression of feelings, worries, concerns, and suggestions.

C. HIGH RISK LEVEL OF SUICIDE

Students with a high risk level for suicide have voiced the intent to engage in a suicidal act, have access to the lethal means needed to carry out the act, and may have lethal means on his/her person. Do the following:

1. Ensure that a school staff member remains with the student at all times.
2. Clear the area and ensure that all other students are safe.
3. Alert administrator and/or Site-Based CRT member(s).
4. Mobilize community links (e.g. SRO and/or 911)
   - If not life threatening, call SRO. If not available, contact 911.
   - If a life threatening emergency, call 911.

   Note: 911-responder will determine if emergency treatment or hospitalization is required and will arrange transport
5. Counselor, school psychologist, administrator, SRO and/or designee to notify parents about the seriousness of the situation unless this will exacerbate the situation. In certain cases, it may be necessary to wait to notify parents due to clinical circumstances as determined by counselor, school psychologist, SRO or other Site-Based CRT member.
6. If the student has lethal means on his/her person:
   a. Do not attempt to take a weapon by force
   b. Talk with the student calmly
   c. Have someone call 911
   d. Clear area for student safety
   e. Once the student gives up the potentially lethal means, stay with the student until the Site-Based CRT member, administrator and/or SRO or 911 emergency support arrives.
7. At this level of risk, the student may require hospitalization.
8. Counselor or school psychologist will collaborate with student's doctor and/or therapist treating the student. Frequency of check-in with the student, family, doctor and/or therapist will be determined by the level of student need.
9. Before student returns to school, initiate re-entry plan.

D. PROCESS FOR RE-ENTRY TO SCHOOL AFTER EXTENDED ABSENCE OR HOSPITALIZATION

Students "need considerable support and monitoring, especially during the first several months they are back at school, during any school crisis, or near the anniversary of their attempt or mental health crisis" (SAMHSA Toolkit). It is critical to create or review the Safety Plan at the first 'return to school meeting' with the student and parents. (See Attachment 2.13, "Guidelines for Facilitating a Student's Return to School", Attachment 2.14, "Guidelines for When a Student Returns to School Following Absence for Suicidal Behavior", and Attachment 2.16 "SRVUSD Mental Health Re-Entry Meeting Form") A student is at increased risk of attempting suicide in the days and weeks immediately following discharge from the ER, hospital or care facility.

Important points to remember in facilitating a successful student re-entry:

1. A Mental Health Re-Entry meeting will be held with family and relevant staff (counselor, school psychologist, and/or administrator) to discuss necessary steps and/or accommodations to aid in a successful re-entry before the student returns or as soon as staff are informed of his/her return. Inviting the student to this meeting will be determined by the Site-Based CRT team. Refer to Attachment 2.13, "Guidelines for Facilitating a Student's Return to School", Attachment 2.14, "Guidelines for When a Student Returns to School Following Absence for Suicidal Behavior", and Attachment 2.16 "SRVUSD Mental Health Re-Entry Meeting Form."

2. Ensure that the appropriate staff (counselor, school psychologist, administrator) have the pertinent information from the student's doctor, psychiatrist, psychologist or therapist necessary to discuss necessary steps and/or accommodations. It is strongly recommended that Attachment 2.9 "SRVUSD Release of Information Form" be offered and signed by the student's parent/guardian during the mental health re-entry meeting.
3. Details of the student's mental health history should be shared only as needed to support the student's successful re-entry. It is recommended that that the Re-Entry team clarify the extent of information to be shared with staff. Refer to Attachment 2.18, "Sample Email to Staff Following Re-Entry Meeting".
4. A completion of Attachment 2.11, "SRVUSD: Personal Safety Plan" is strongly recommended before re-entry.
5. If the student receives Special Education and related services and services are changed or added to aid in successful re-entry, this meeting shall be held as part of an Addendum IEP and Attachment 2.16, "SRVUSD Mental Health Re-Entry Meeting Form," shall be attached to the student's IEP.

E. SITE CRISIS RESPONSE TEAM MEMBERS AND ROLES

Administrative support is necessary for the successful implementation of this toolkit. In order to respond appropriately, all site-based CRT members must understand their role in suicide prevention. The team is made up of a diverse group of individuals within the school. Possible members are the principal, assistant principals, guidance counselor, school psychologist, ERMHS school therapist, a teacher, school nurse or health tech, information technology staff, and a member of office staff (secretary). Alternates are designated for key roles, such as Site-Based CRT leader.

1. Crisis Response Team Leader responsibilities:

a. Coordinates annual training for the Crisis Response Team and for school faculty and staff
b. Mobilizes team members as needed
c. Coordinates team member assignments
d. Acts as the liaison between the school principal and district office when district support is deemed necessary

2. Team member responsibilities include:

a. All Members:

- Respond to urgent situations when needed
- Call 911 if needed
- Inform Team Leader about students of concern or at-risk
- Provide first aid when needed (Nurse/Health Technician, Other Trained Staff)
- Clear area and ensure safety of all students

b. Principal/Assistant Principal:

- Assumes responsibility for decisions made and actions taken
- Acts as liaison with police or other authorized outside agency
- Briefs district office administration
- Notifies family members of student crisis
- Modifies school schedule if necessary
- Resumes normal schedule as soon as possible
- Calls on community resources for assistance if needed
- Secures campus (assistant principal)
- Communicates with other sites as needed
- Evaluates school crisis response and revise as needed

c. School Psychologist/Counselors

- Conducts student interviews to assess for level of risk
- Contacts community links and resources
- Contacts and works with parents
- Documents actions

d. School Nurse or Health Technician

- Administers first aid, triage
- Locates emergency card information for injured student

e. **School Secretary**
   - Maintains up-to-date contact information for Site-Based CRT members
   - Maintains communication with principal
   - Responds to crisis-related inquiries (see Attachment 3.4, "Sample Script for Office Staff", and modify with principal to fit current situation)

f. **Media Spokesman/Associate Superintendent**
   - Fields and responds to media inquiries --- review Attachment 3.18, "Guidelines for Working with the Media"

g. **Campus Supervisor**
   - Coordinates immediate security and protections
   - Roams campus to help identify students in need

h. **Teachers**
   - Take every warning sign seriously
   - Ensure the safety of students during and after an emergency
   - If stay-put situation exists, do not allow students to enter or leave room
   - Keep students informed as directed by principal: control rumors
   - Assure students the crisis is being handled and they are safe
   - Focus discussion on reactions students are having in the moment and how to support each other
   - Refer students in need to the Crisis Team Leader

ATTACHMENTS FOR SECTION II: INTERVENTION

2.1 Self-Injury and Suicide Risk Information Sheet, *SAMHSA Toolkit*

2.2 Suicide Prevention Awareness Session Appropriate for All School Personnel, *Maine Youth Suicide Prevention Program (MYSPP)*

2.3 SRVUSD Assessment Tool for Student Suicide Risk

2.4 Guidelines for Notifying Parents, *SAMHSA Toolkit*

2.5 Supporting Parents Through Their Child's Suicidal Crisis, *SAMHSA Toolkit*

2.6 Parent Contact Acknowledgement Form, *SAMHSA Toolkit*

2.7 Guidelines for Student Referrals, *SAMHSA Toolkit*

2.8 Referral Process for Special Education Mental Health Assessment

2.9 SRVUSD Release of Information Form

2.10 Safety Planning Guide: A Quick Guide for Clinicians, *WICHE & SPRC*

2.11 SRVUSD: Personal Safety Plan (to be used with attachment 2.10)

2.12 Student Suicide Risk Documentation Form, *SAMHSA Toolkit*

2.13 Guidelines for Facilitating a Student's Return to School, *SAMHSA Toolkit*

2.14 Guidelines for When a Student Returns to School Following Absence for Suicidal Behavior, MYSPP

2.15 Other Issues and Options Surrounding a Student's Return to School, MYSPP

2.16 SRVUSD Mental Health Re-Entry Meeting Form

2.17 School Psychologist Counseling Consent Form

2.18 Sample Email to Staff Following Re-Entry Meeting

2.19 Means Matter – Suicide, Guns & Public Health

SELF-INJURY AND SUICIDE RISK INFORMATION SHEET

Self-injury (also known as self-mutilation or deliberate self-harm) is defined as intentionally and often repetitively inflicting socially unacceptable bodily harm to oneself without the intent to die. Self-injury includes a wide variety of behaviors, such as cutting, burning, head banging, picking or interfering with healing of wounds, and hair pulling.

The relationship between self-injury and suicide is complicated. Researchers believe self-injury is a behavior separate and distinct from suicide and the result of a very complex interaction among cognitive, affective, behavioral, environmental, biological, and psychological factors. However, in some people the self-destructive nature of self-injury may lead to suicide.

Students who injure themselves intentionally should be taken seriously and treated with compassion. Teachers or other staff who become aware of a student who is intentionally injuring himself or herself should refer the student to the school counselor, psychologist, social worker, or nurse. Staff should offer to accompany the student to the proper office and help broach the issue with the relevant mental health professional.

School mental health staff should:

- Assess the student for both self-injury and risk of suicide
- Notify and involve the parents/guardians
- Design appropriate treatment for the student's current behaviors or refer the student to a mental health provider in the community for treatment

The following resources can be used to understand and prepare to respond to self-injury by students:

- Prevention Researcher. February 2010, Vol. 17, No.1 focuses on adolescent self-injury: http://www.tpronline.org/issue.cfm/Adolescent_Self_lnjury
- Self-Injurious Behavior Webcast. October 2006, 1 hour, includes an interview with Dr. Janice Whitlock: http://www.albany.edu/sph/coned/t2b2injurious.htm
- Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults. Web site contains numerous informational materials: http:/ /www.crpsib.com

Developed in consultation with Richard Lieberman MA, NCSP,
School Psychologist/Coordinator, Los Angeles Unified School District, Suicide Prevention Unit

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

SUICIDE PREVENTION AWARENESS SESSION APPROPRIATE FOR ALL SCHOOL PERSONNEL

A one and one-half to two-hour workshop provides enough time to share basic information, teach and practice basic suicide intervention skills. All school personnel will benefit from having this basic information.

This section outlines the contents of the basic youth suicide prevention workshop. Training and resource materials to conduct a session are available from the MYSPP.

The Problem of Youth Suicide in California

- Suicide is the 3rd leading cause of death for California youth ages 16-25, exceeded only by unintentional injury (mostly car accidents) and homicide.
- In 2010, there were 150 suicides among youth ages 15-19 in California: 114 males and 36 females.
- In 2010, there were 279 suicides among youth ages 20-24 in California: 227 males and 52 females.
- In 2011, there were 6,341 non-fatal suicide attempt ER visits (treat and release or transfer to another care facility) among youth ages 15-19 in California: 2,249 males and 4,092 females. In Santa Clara County, there were 235 visits: 73 males and 162 females.
- In 2011, there were 2,004 non-fatal suicide attempt hospitalizations for youth ages 15-19 in California: 678 males and 1,326 females. In Santa Clara County, there were 81 hospitalizations: 23 males and 58 females.
- In 2011, there were 4,512 non-fatal suicide attempt ER visits among youth ages 20-24 in California: 2,060 males and 2,452 females. In Santa Clara County, there were 156 visits: 63 males and 93 females.
- In 2011, there were 1,900 non-fatal suicide attempt hospitalizations for youth ages 20-24 in California: 889 males and 1,011 females. In Santa Clara County, there were 73 hospitalizations: 27 males and 46 females.

Source: California Department of Public Health Epicenter, California Injury Data Online

A Few Basic Facts About Suicide

- Contrary to popular belief, talking about suicide or asking someone if they feel suicidal will NOT put the idea in their head or cause them to kill themselves.
- Research has demonstrated that in over 80% of suicides, warning signs were given.
- Suicide crosses all socioeconomic backgrounds.
- It is NOT true that "once a person is suicidal, s/he is always suicidal." People can receive help to make other choices.
- Suicide IS often preventable. Not every death is preventable, but many are.
- Suicidal behavior should not be dismissed as "attention getting" or "manipulative"; it may be a serious cry for help. People who talk about suicide DO kill themselves.
- We must take every threat seriously.
- Most suicidal youth do not really want to die; they want to escape their pain and may see no other alternative course of action.
- Youth who are discriminated against or victimized because of physical differences, sexual orientation, or other reasons are at higher risk for attempting suicide.
- Any trained individual can greatly increase the likelihood of a youth getting the help they need and may very well make the difference between life and death.
- A previous suicide attempt is the single greatest predictor of future suicidal behavior.

A Complicated Human Behavior

Suicide is a rare event. While many think about it, far less than I% of the population kill themselves. This information is important and reassuring because it provides us with a measure of hope. If we can learn to recognize the warning signs, and gain confidence in our ability to intervene with suicidal youth, we may be able to prevent many youth suicides.

Here Is What We Know:

- There is no typical suicide victim.
- There are no absolute reasons for suicide.
- Suicide is always multi-dimensional.
- Preventing suicide must involve many approaches and requires teamwork.
- Most suicidal people do not want to die; they do want to end their pain.

Suicidal People Share Some Unique Characteristics:

- A suicidal person sees suicide as the "solution" to his or her problems.
  - Efforts to discuss alternative solutions are very worthwhile.
- A suicidal person is in crisis. Suicidal people are experiencing severe psychological distress. They need help in handling the crisis.
- Almost all suicidal people are ambivalent, they wish to live, AND they wish to die. We MUST support the side that wants to live and acknowledge the part that wants to die. Talking about these mixed feelings lowers anxiety. Listening and caring may save a life.
- Suicidal thinking is frequently irrational. Depression, anxiety, psychosis, drugs, or alcohol often distorts the thought process of people when they are feeling suicidal.
- Suicidal behavior is an attempt to communicate. It is a desperate reaction to overwhelming circumstances. We need to pay attention!

Warning Signs

Listen and look for these warning signs for suicidal behavior. Warning signs are the earliest detectable signs that indicate heightened risk for suicide **in the near-term** (i.e., within minutes, hours, or days), as opposed to risk factors which suggest longer-term risk (i.e., a year to a lifetime). Note that aside from direct statements or behaviors threatening suicide, it is often a group of signs that raises concern, rather than one or two symptoms alone. These are presented in a hierarchical manner, organized by degree of risk, and were developed by an expert working group convened by the American Association of Suicidology.

Warning signs are things you can see or hear that tell you someone may be suicidal today. If you notice any of these things you need to act quickly. In all cases, do **NOT** leave the person alone.

Take immediate action and call the Contra Costa Crisis Center Suicide and Crisis Hotline (1-800-833-2900) if: Someone makes a threat to kill themselves by saying:

- I wish I were dead
- If such and such doesn't happen, I'll kill myself
- What's the point of living?

Someone is looking for a way to carry out a suicide plan

- They are looking for a gun, pills or other ways to kill themselves
- They have a plan about where they can get these things

Someone is talking or writing about death or suicide

- In text messages
- On social networking sites
- In poems, music

Call 911 if:

- A suicide attempt has been made
- A weapon is present
- The person is out of control

Get professional help if you notice any of the following:

Signs of Depression:

- Mood: sad, irritable, angry
- Withdrawing from friends, family, activities
- Significant change in sleep, appetite or weight
- Hopelessness: sees no chance of improvement
- Feeling worthless or excessively guilty
- Unable to think or concentrate

Anxiety: Restlessness, agitation, pacing

Feeling like a burden, people would be better off if I were dead

Alcohol or Drug use is increased or excessive **Feeling trapped** with no way out of the situation **Neglecting appearance**

Drop in grades or increased absences

These are all signs that something is wrong and that help is needed.

Risk Factors

Risk factors are stressful events, situations, or conditions that exist in a person's life that may increase the likelihood of attempting or dying by suicide. There is no predictive list of a particular set of risk factors that spells imminent danger of suicide. It is important to understand that risk factors DO NOT cause suicide. Many things can increase someone's risk for suicide. "Risk Factors" may be things that happened in the past or are happening now that cause stress and make it hard to cope. Suicide is not caused by just one thing and these risk factors affect everyone in different ways.

Risk factors most strongly linked with suicidal behavior are:

- One or more suicide attempts (this is strongly linked to future suicide risk)
- Mental illness
- Exposure to suicide
- Access to firearms or other lethal means
- Loss of any kind
- A history of abuse or trauma

Other common risks factors are:

- Acting on impulse
- Bullying and harassment
- Substance abuse
- Lack of coping or problem solving skills

Protective Factors:

Protective factors are the positive conditions, personal and social resources that promote resiliency and reduce the potential for youth suicide as well as other high-risk behaviors. For youth these can be:

Coping Skills and Personal Traits

- Decision making, anger management, conflict resolution, problem solving and other skills
- A sense of personal control
- A healthy fear of risky behavior and pain
- Hope for the future

Connections

- Religious/spiritual beliefs about the meaning and value of life
- Positive relationships with family, friends, school, or other caring adults
- Responsibilities at home or in the community

Health and Home

- A safe and stable environment
- Not using drugs and alcohol
- Access to health care
- Taking care of self

HELPING SUICIDAL YOUTH

Three Steps to Help a Suicidal Person:

1. Show you care

- Listen carefully, remain calm, don't judge
- "I'm concerned about you... about how you're feeling."
- "You mean a lot to me and I want to help."

2. Ask about suicide

- Be direct and caring
- "Are you thinking about killing yourself?"
- "When people are in as much pain as you seem to be, they sometimes think about suicide. Are you thinking about suicide?"

3. Persuade the suicidal person to get help and make sure that they get it

- Never leave a suicidal person alone
- "I know where we can get some help."
- "I can go with you to get help, you're not alone."

If you believe a person might be in danger of suicide, make sure they receive the help they need. Call the Contra Costa Crisis Center Suicide & Crisis Hotline 1-800-833-2900 for an evaluation or 911 to ensure their immediate safety.

WHAT IS NOT HELPFUL WHEN WORKING WITH SOMEONE WHO MIGHT BE SUICIDAL

- **Ignoring or dismissing the issue**. This sends the message that you don't hear their message, don't believe them, or you don't care about their pain.
- **Acting shocked or embarrassed.**
- **Panicking, preaching, or patronizing**.
- **Challenging, debating, or bargaining.** Never challenge a suicidal person. You can't win in a power struggle with someone who is thinking irrationally.
- **Giving harmful advice,** such as suggesting the use of drugs or alcohol to "feel better." There is a very strong association between alcohol use and suicide.
- **Promising to keep a secret**. The suicidal person is sharing his/her feelings hoping that someone will recognize the pain and help, even though they may verbally contradict this.

Resources for Help

It is necessary to maintain lists of resources available for use by school personnel so that they know exactly who to contact when they are working with a student who might be suicidal. Generate your own list with local and state contact information. Update this list regularly.

It's important to get a suicidal person help so that they:

- Get through the crisis without harm
- Know that hope exists
- See that there are other options
- Identify and obtain available help

School Resources for Help

- School Administrators
- School Nurses
- School Gatekeepers (trained to recognize and respond to suicidal behavior)
- Social Workers & Guidance Counselors
- School Resource Officers

Community Resources

- **Contra Costa Crisis Center 24/7 Suicide and Crisis Hotline 1-800-833-2900**
- Contra Costa Crisis Center 24/7 Crisis Text Line; Text "HOPE" to 20121
- National Suicide Prevention Lifeline 1-800-273-TALK (8255)
- Mental Health Agencies
- Private Clinics/facilities
- Hospital emergency rooms
- Police
- Local Religious Leaders
- Emergency Medical Services

Take Care of Yourself! Working with Suicidal People is Challenging

- Acknowledge the intensity of your feelings.
- Seek support.
- Avoid over-involvement. It takes a team of people to help a suicidal individual.
- Never do this work on your own. Always inform your supervisor or other designated person as outlined in school protocol.
- Recognize that you are not responsible for another person's choice to end his/her life.

from the Maine Youth Suicide Prevention Program

CONFIDENTIAL: To Be Kept in Personal Working File

SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

699 Old Orchard Dr. Danville, California 94526

Assessment Tool for Student Suicide Risk

Student's Name: _____ Referred by: _____

Person Conducting Assessment: _____ Date: _____

1. Circumstances preceding referral for suicide risk assessment/summary of reason for concern:

2. Stressors/precipitants from student's perspective *(i.e., What's going on in your life right now?)*

3. Current and Recent Mood
   a. *On a scale of 0-10 (0 being the worst and 10 the best), how have you been feeling over the **past week**? Have you been feeling depressed, hopeless, helpless, or overwhelmed?*

   b. *How would you describe how you are feeling **right now**?*

4. Current Ideation
   a. Assess the student's current level of suicidal ideation:

	Yes	**No**	**Unsure**
In the past few weeks, have you wished you were dead?			
Have you felt that you or your family would be better off if you were dead?			
Have you felt that your life is not worth living?			
Have you been thinking about ending your life or killing yourself?			

If yes or unsure for any of the above:

   b. *How long have you been feeling this way?*

   c. *Have you thought about ending your life **today or very soon**?*

5. Plan
   a. Do you have a plan for how you would end your life?
      - ☐ Yes/detailed and thought-out
      - ☐ Considering means/details are vague
      - ☐ No/thoughts of death without consideration of how they would kill themselves
   b. If yes or considering: *What is your plan (including how, when, where)?*

6. Means
   a. *Do you have access now to whatever you need to carry out your plan?* If yes: *Where?*

7. Intent
   a. *Do you intend to carry through with your plan to end your life soon?*
      - ☐ Denies intent
      - ☐ Endorses intent
      - ☐ Unclear/passive
      - ☐ Evasive in answering question
   b. *Do you intend to end your life if something does or doesn't happen? Is there anything that would make you more likely to want to end your life?*

   c. *Is there anything that would make you more likely to want to live?*

8. History of Suicidal Ideation/Attempts
   a. *Have you ever thought about attempting suicide in the past?*
      - ☐ No
      - ☐ Yes. *When?* _____
   b. *Have you ever attempted suicide before?*
      - ☐ No
      - ☐ Yes

   If yes, description of past attempt(s), including trigger for attempt, how student attempted and what happened:

9. Resources/Support
   a. *Do you have someone in your life whom you can turn to for support?*
      - ☐ No, feels isolated.
      - ☐ Yes. *Who?* _____
   b. If yes: *Have you talked to them about how you are feeling?*
      - ☐ Yes
      - ☐ No. *Why not?* _____

Determining Protocol to Follow:

- ☐ **Low Risk Protocol:** Student demonstrates suicidal ideation only (#4). Student does NOT have a detailed plan (#5), access to means (#6), intent to attempt (#7), history of ideation/attempts (#8), or lack of support (#9).
- ☐ **Moderate Risk Protocol:** Student demonstrates suicidal ideation (#4) with some combination of planning (#5), access to means (#6), intent (#7), history of ideation/attempts (#8), and/or lack of support (#9).
- ☐ **High Risk Protocol:** Student demonstrates suicidal ideation (#4) and reports ready access to or possession of means (#6) and strong intent (#7) to carry out plan (#5) as soon as possible.

GUIDELINES FOR NOTIFYING PARENTS

Parents or guardians should be contacted as soon as possible after a student has been identified as being at risk for suicide. The person who contacts the family is typically the principal, school psychologist, or a staff member with a special relationship with the student or family. Staff need to be sensitive toward the family's culture, including attitudes towards suicide, mental health, privacy, and help-seeking.

1. Notify the parents about the situation and ask that they come to the school immediately.

2. When the parents arrive at the school, explain why you think their child is at risk for suicide.

3. Explain the importance of removing from the home (or locking up) firearms and other dangerous items, including over-the-counter and prescription medications and alcohol.

4. If the student is at a low or moderate suicide risk and does not need to be hospitalized, discuss available options for individual and/or family therapy. Provide the parents with the contact information of mental health service providers in the community. If possible, call and make an appointment while the parents are with you.

5. Ask the parents to sign the Parent Contact Acknowledgement Form confirming that they were notified of their child's risk and received referrals to treatment.

6. Tell the parents that you will follow up with them in a few days. If this follow-up conversation reveals that the parent has not contacted a mental health provider:
   - Stress the importance of getting the child help
   - Discuss why they have not contacted a provider and offer to assist with the process

7. If the student does not need to be hospitalized, release the student to the parents and/or designated guardian.

8. If the parents refuse to seek services for a child under the age of 18 who you believe is in danger of self-harm, you may need to notify child protective services that the child is being neglected.

9. Document ***all*** contacts with the parents.

Adapted from DiCara, C., 0'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.govlsuicide/docs/Guidelines'%2010-2009--w%20discl.pdf

SUPPORTING PARENTS THROUGH THEIR CHILD'S SUICIDAL CRISIS

Family Support is Critical. When an adolescent experiences a suicidal crisis, the whole family is in crisis. If at all possible, it is important to reach out to the family for two very important reasons:

First, the family may very well be left without professional support or guidance in what is often a state of acute personal shock or distress. Many people do not seek help--they don't know where to tum.

Second, informed parents are probably the most valuable prevention resource available to the suicidal adolescent.

Remember, a prior attempt is the strongest predictor of suicide. The goal of extending support to the parents is to help them to a place where they can intervene appropriately to prevent this young person from attempting suicide again. Education and information are vitally important to family members and close friends who find themselves in a position to observe the at-risk individual.

The following steps can help support and engage parents:

1. Invite the parents' perspective. State what you have noticed in their child's behavior (rather than the results of your assessment) and ask how that fits with what they have observed.
2. Advise parents to remove lethal means from the home while the child is possibly suicidal, just as you would advise taking car keys from a youth who had been drinking.
3. Comment on how scary this behavior is and how it complicates the life of everyone who cares about this young person.
4. Acknowledge the parents' emotional state, including anger, if present.
5. Acknowledge that no one can do this alone-appreciate their presence.
6. Listen for myths of suicide that may be blocking the parent from taking action.
7. Explore reluctance to accept a mental health referral, address those issues, explain what to expect.
8. Align yourself with the parent if possible…explore how and where youth get this idea…without in any way minimizing the behavior.

Adapted from DiCara, C., 0'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.govlsuicide/docs/Guidelines'%2010-2009--w%20discl.pdf

CONFIDENTIAL: To Be Filed in the Risk Assessment Binder

SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

699 Old Orchard Dr. Danville, California 94526

PARENT CONTACT ACKNOWLEDGEMENT FORM

Student Name:_____ Date of Birth:_____

School:_____ Grade:_____

This is to verify that I have spoken with a member of the school's mental health staff,

_____ *(name of staff member)* on_____*(date)* concerning my child's suicidal risk. I have been advised about mental health services on campus as well as in the community. I have been provided with a copy of the Mental Health Resources List and Student/Parent Handouts.

I understand that_____*(name of staff member)* will follow up with me, my child, and, if applicable, any mental health care provider(s), within two weeks.

Parent Signature:_____

Date:_____

Parent Contact Information:

Phone:_____

Email:_____

School Staff Member Signature: _____

Date:_____

From DiCara, C., O'Halloran, S., Williams, L. & Canly-Brooks, C. (2009). Youth Suicide Prevention, Intervention & Postvention Guidelines (p.45). Augusta, ME: Maine Youth Suicide Prevention Program.

GUIDELINES FOR STUDENT REFERRALS

Schools should be prepared to give the following information to providers.

Note: Parent permission may be required to share this information.

1. Basic student information (age, grade, race/ethnicity, and parents' or guardians' names, addresses, and phone numbers).
2. How did the school first become aware of the student's potential risk for suicide? *****
3. Why is the school making the referral?
4. What is the student's current mental status?
5. Are the student and parents/guardians willing or reluctant to meet with a mental health service provider?
6. What other agencies are involved (names and information)?
7. Who pays for the referral and possible treatment?
8. Where is the best place to meet with the student (e.g., school, student's home, therapist's office, emergency room)?

***** *Be sure that parental consent meets the requirements of FERPA as follows:*

1. *Specify the records that may be disclosed.*
2. *State the purpose of the disclosure.*
3. *Identify the party or class of parties to whom the disclosure may be made.*

From Preventing Suicide: A High School Toolkit, SAMHSA

SRVUSD Educationally Related Mental Health Services (ERMHS)

Referral Process

Tier II – Early Intervention (Step 1)

Definition

At Tier II, school based mental health professionals and/or specifically trained primary intervention paraprofessionals, will provide educationally related mental health services (ERMHS) to students in need. At this level, parent education, consultation, nondirective play, social skills, individual and/or group counseling are available to all students. Tier II services address emotional, social and behavioral issues. A student who is identified through the SST or 504 process, or by teacher or parent request, may be referred for ERMHS service.

Procedure

Elementary:

1. The referral form for the Rainbow Program and/or SCIP Discovery Counseling Program is completed by the classroom teacher. If there has been a parent request, the teacher is asked to fill out the referral form. A parent permission form is sent home. Services will not begin until written permission is received by the parent.
2. After Tier II ERMHS Interventions have been implemented with fidelity, from 8-15 sessions, (e.g., Rainbow, SCIP, Positive Discipline) then the effectiveness of the intervention will be reviewed and recommendations will be made. For example, Rainbow services may be discontinued given that the child has made the expected emotional or social progress. However, a child may require an additional Rainbow session (e.g., 12 weeks) to continue making progress. On occasion, a school psychologist may provide Tier II mental health services. Alternatively, the child's symptoms are greater than the scope of the Tier II intervention and an SST is required to discuss further recommendations.
3. If an SST meeting occurred, a copy of the SST notes is placed in the student's cumulative file.
4. If all Tier II interventions have been implemented with fidelity and deemed unsuccessful, then a referral for Special Education assessment may be considered. If the suspected disability is an Emotional Disturbance, the school psychologist will consult with the ED task force.

Middle/High School:

1. The Tier II Counseling Referral Form is completed by the Student Study Team and is forwarded to the student support counselor and to the Mental Health Collaborative: mentalhealth@srvusd.net
2. A list of ALL prior interventions must be included in the SST notes, which will be placed in the student's cumulative file.
3. After the interventions have been completed for a minimum of 15 sessions or one grading period, reconvene the SST team and determine the effectiveness of interventions. If there has been limited response to the interventions, determine if different Tier II interventions should be implemented.
4. If all Tier II interventions have been implemented with fidelity and deemed unsuccessful, then a referral for Special Education assessment should be considered. If the suspected disability is an Emotional Disturbance, the school psychologist will consult with the ED task force.

SRVUSD Educationally Related Mental Health Services (ERMHS)

Referral Process

Tier III – Intensive Interventions (Step 2)

Definition

At Tier III, short-term psychological services for students receiving Special Education services will be provided by the site school psychologist. Students may require a social emotional assessment, update on present levels, or review of records by the site school psychologist to determine unique needs. These needs may lead to specific goals that drive short-term treatment (a minimum of 15 sessions or one grading period). Services at this level are targeted to support any Special Education eligible student who is exhibiting social, emotional or behavioral challenges that negatively impact their educational performance.

Procedure

1. The school psychologist reviews the rationale for counseling with the student's case manager and determines if further recommendations are warranted and/or if an assessment should be initiated if it has not been done so before. The site school psychologist proposes an assessment plan and completes the assessment.
2. Following the assessment, if the student is eligible and counseling is recommended by the site school psychologist, goals are generated and services are offered at an IEP meeting.
3. If the 15 sessions of site based counseling services do not yield significant improvement, the IEP team should consider if the student should be evaluated for Special Education eligibility under the additional category of Emotional Disturbance. If this is the case, the site school psychologist contacts the district ED Task Force for completion of assessment to determine eligibility as Emotional Disturbance.
4. If the student meets ED eligibility criteria, the IEP team meets to determine the goals and services.

Tier III+ – Intensive Interventions (Step 3)

Definition

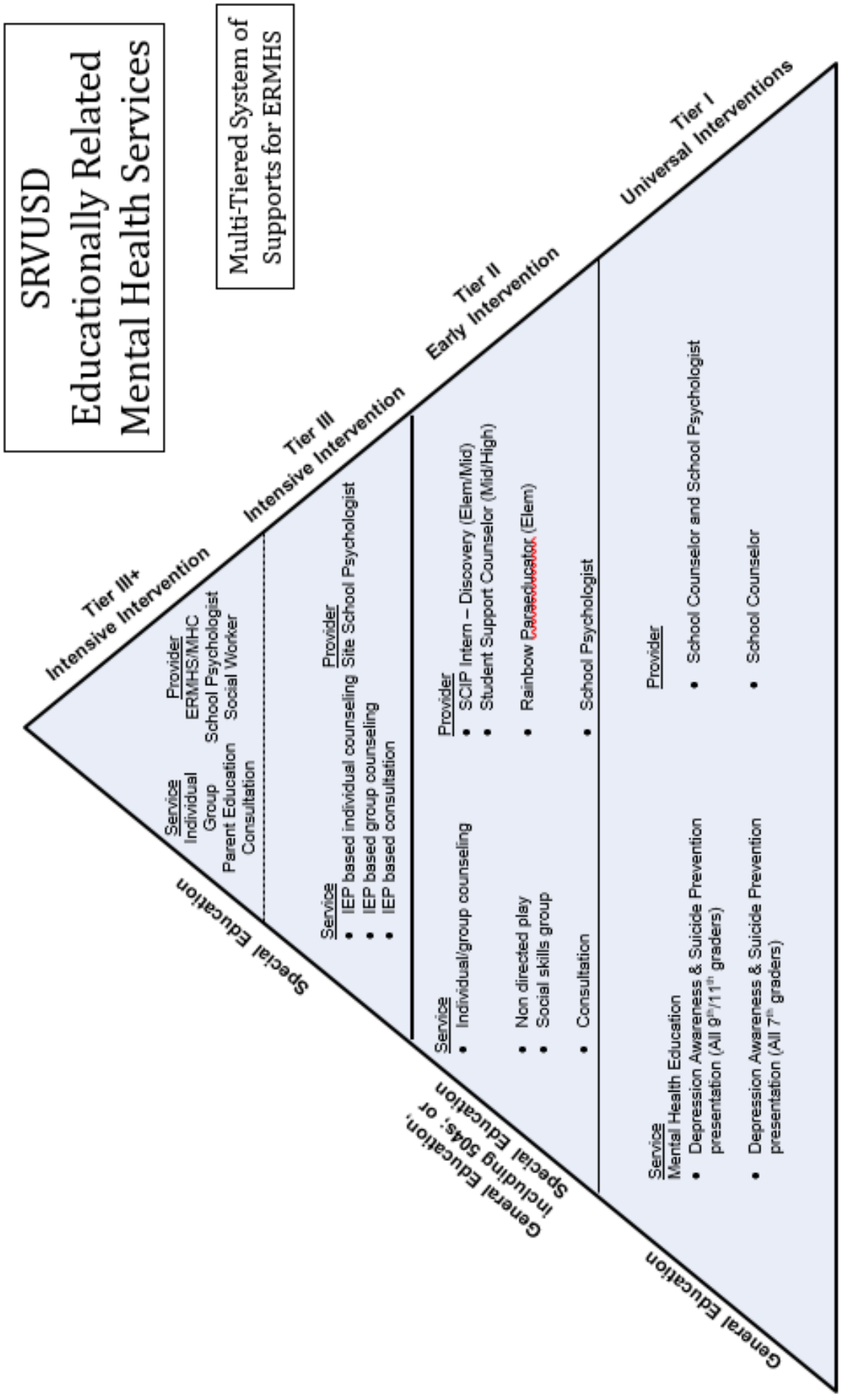
Tier III+ consists of the most intensive level of educationally related mental health services (ERMHS). These services can include individual and/or group counseling sessions with a school psychologist and/or school social worker that are driven by specific IEP goals. Services may also include short-term family outreach and support. A Special Education student who has participated in at least 15 sessions of counseling with progress monitoring, yet continues to exhibit marked emotional/social needs within an educational setting, may be referred to Tier III+.

Procedure

1. The site school psychologist completes the Tier III+ Mental Health Collaborative (MHC) Triage Team Worksheet. It should then be forwarded to the Mental Health Collaborative: mentalhealth@srvusd.net
2. The Tier III+ Mental Health Collaborative (MHC) Triage Team Worksheet may also include: SST notes, progress monitoring data from the counseling sessions, the most recent psychological report(s), current IEP, and other data collected to determine additional need for ERMHS support.
3. Following the referral process, if Tier III+ services are recommended, goals are generated and MHC counseling and/or MHC consultation services are offered at an IEP meeting.

County Referrals:

If a student has MediCal insurance, please contact County Mental Health 1-888-678-7277


SRVUSD
Educationally Related
Mental Health Services
Multi-Tiered System of
Supports for ERMHS
Tier III+
Intensive Intervention
Tier III
Intensive Intervention
Tier II
Early Intervention
Tier I
Universal Interventions
Special Education
General Education, including 504s, or Special Education
General Education
Service
Individual
Group
Parent Education
Consultation
Provider
ERMHS/MHC
School Psychologist
Social Worker
Service
IEP based individual counseling
IEP based group counseling
IEP based consultation
Provider
Site School Psychologist
Service
Individual/group counseling
Non directed play
Social skills group
Consultation
Provider
SCIP Intern – Discovery (Elem/Mid)
Student Support Counselor (Mid/High)
Rainbow Paraeducator (Elem)
School Psychologist
Service
Mental Health Education
Depression Awareness & Suicide Prevention presentation (All 9th/11th graders)
Depression Awareness & Suicide Prevention presentation (All 7th graders)
Provider
School Counselor and School Psychologist
School Counselor

SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION DEPARTMENT
699 Old Orchard Drive, Danville, California 94526
Office (925) 820-6815 • FAX (925) 820-5277

AUTHORIZATION TO USE AND/OR DISCLOSE CONFIDENTIAL INFORMATION

I hereby give my permission to the following school/agency/individual to disclose and release information:

Name of Disclosing School/Agency/Individual: _____

Address: _____

City: _____ State: _____ Zip: _____

To Disclose to:

San Ramon Valley Unified School District

Name of School: _____

Attention to: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Records, including confidential information, concerning the following student:

Full legal name of Student: _____

Birthdate: _____ Last School Attended: _____ Grade: _____

Specific Information includes:

____ Cum file: Immunization, enrollment and health records, report cards, assessment data, discipline records: all pertinent education information.

____ Special Education File: IEPs, assessments, developmental history, speech/language evaluation, etc.

____ Confidential File: Psychological evaluations/records

____ Specific Health and Medical Information: _____
_____

____ Other: _____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature.

Revocation: To revoke this request at any time before the disclosure, the parent or guardian must submit a written revocation. Copies of this signed authorization will be considered as valid as the original.

_____ _____
Signature of Parent, Guardian or Student (if 18 years old) **Date**

s/forms/auth to use and disclose info/rev 09.0519

- For methods with **low lethality**, clinicians may ask patients to remove or limit their access to these methods themselves.
- Restricting the patient's access to a **highly lethal method**, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

THE WICHE Center for Rural Mental Health Research is supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, U1CRH03713

WICHE

Western Interstate Commission for Higher Education
3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303.541.0200 (ph) 303.541.0291 (fax)
www.wiche.edu/mentalhealth/

Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

WICHE
Western Interstate Commission for Higher Education

SPRC

Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: **"How will you know when the safety plan should be used?"**
- Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's **own words**.

Step 2: Internal Coping Strategies

- Ask: **"What can you do, on your own, if you become suidical again, to help yourself not to act on your thoughts or urges?"**
- Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
- If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them if you think of them?"**
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve, as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- Instruct patients to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
- List names, numbers and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles, and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: **"Do you own a firearm, such as a gun or rifle??"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
- Collaboratively identify ways to secure or limit access to lethal means: Ask: **"How can we go about developing a plan to limit your access to these means?"**

SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

699 Old Orchard Dr. Danville, California 94526

SRVUSD Personal Safety Plan

Completed by: _____ Date: _____

STEP 1: I should use my safety plan when I notice these warning signs (thoughts, images, moods, situations, behaviors):
1.
2.
3.
STEP 2: Internal coping strategies – Things I can do by myself to help myself not act on how I'm feeling (e.g. favorite activities, hobbies, relaxation techniques, distractions):
1.
2.
3.
What might make it difficult for me to use these strategies?
Solution:
STEP 3: People and places that improve my mood and make me feel safe:
1. Name: Phone: _____
2. Name: Phone:
3. Place (day):
4. Place (night):
What might get in the way of me contacting these people or going to these places?
Solution:
STEP 4: People I trust who can help me during a crisis:
1. Name: Phone:
2. Name: Phone: _____
3. Name: Phone:
Why might I hesitate to contact these people when I need help?
Solution:
How will I let them know that I need their help?
STEP 5: Professional resources and referrals I should contact during a crisis (available 24/7):
1. Clinician Name: Phone_____
2. Local Urgent Care Services: _____ Address: _____ Phone: _____
3. Contra Costa Crisis Center Suicide & Crisis Center: 800-833-2900 or Text "HOPE" to 20121
4. National Suicide Prevention Lifelines: 1-800-784-2433 and 1-800-273-8255
5. Crisis Text Line: Text "HELP" to 741-741
6. **Call 911** if you need immediate help in order to remain safe.
STEP 6: Steps I can take to keep myself safe by reducing access to means I would consider using during a suicidal crisis:
1.
2.

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SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

699 Old Orchard Dr. Danville, California 94526

STUDENT SUICIDE RISK DOCUMENTATION FORM

STUDENT INFORMATION		
Date student was identified as possibly at risk:		
Name:		
Date of Birth:	Gender:	Grade:
Name of Parent/Guardian:		
Parent/Guardian's Phone Number(s):		

IDENTIFICATION OF SUICIDE RISK

Who identified student as being at risk? Indicate name where appropriate.

- ☐ Student him/herself
- ☐ Parent:
- ☐ Teacher:
- ☐ Other staff:
- ☐ Student/Friend:
- ☐ Other:

Reason for concern:

RISK ASSESSMENT

Assessment conducted by:

Date of assessment:

Results of assessment:
Level (Circle One): Low Moderate High
Outcome: returned to class, parent pick up, SRO involvement, 5150, other (Specify) _____

NOTIFICATION OF PARENT/GUARDIAN

Staff who notified parent/guardian:

Date notified:

Parent Contact Acknowledgement Form signed:

- ☐ Yes
- ☐ No

If no, provide reason:

MENTAL HEALTH Follow-Up

Personal Safety Plan developed with student and parent:_____(date)

Mental Health Resources List and Student/Parent Handouts given to:

- ☐ Student_____(date)
- ☐ Parent/Guardian_____(date)

Staff member to conduct follow-up:	Date of follow-up:

GUIDELINES FOR FACILITATING A STUDENT'S RETURN TO SCHOOL

These guidelines will help staff plan for a student's return to school after a suicide attempt or mental health crisis. In addition to meeting regularly with the student, the staff member facilitating the student's return should do the following:

1. Become familiar with the basic information about the case, including:
   - How the student's risk status was identified?
   - What precipitated the student's high-risk status or suicide attempt
   - What medication(s) the student is taking
2. With the family's agreement, serve as the school's primary link to the parents and maintain regular contact with the family:
   - Call or meet frequently with the family
   - Facilitate referral of the family for family counseling, if appropriate
   - Meet with the student and his or her family and relevant school staff (e.g., the school psychologist or social worker) about what services the student will need upon returning to school
3. Serve as liaison to other teachers and staff members, with permission of the family, regarding the student, which could involve the following:
   - Ask the student about his or her academic concerns and discuss potential options
   - Educate teachers and other relevant staff members about warning signs of another suicide crisis
   - Meet with appropriate staff to create an individualized reentry plan prior to the student's return and discuss possible arrangements for services the student needs
   - Modify the student's schedule and course load to relieve stress, if necessary.
   - Arrange tutoring from peers or teachers, if necessary.
   - Work with teachers to allow makeup work to be extended without penalty.
   - Monitor the student's progress.
   - Inform teachers and other relevant staff members about the possible side effects of the medication(s) being taken by the student and the procedures for notifying the appropriate staff member (e.g., the
   - school nurse, psychologist, or social worker) if these side effects are observed. When sharing information about medical treatment, you need to comply with FERPA and HIPAA.
4. Follow up behavioral and/or attendance problems of the student by:
   - Meet with teachers to help them understand appropriate limits and consequences of behavior
   - Discuss concerns and options with the student
   - Consult with the school's discipline administrator
   - Consult with the student's mental health service provider to understand whether, for example, these behaviors could be associated with medication being taken by the student
   - Monitor daily attendance by placing the student on a sign-in/sign-out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day
   - Make home visits or have regularly scheduled parent conferences to review attendance and discipline record
   - Facilitate counseling for the student specific to these problems at school
5. If the student is hospitalized, obtain the family's agreement to consult with the hospital staff regarding issues such as:
   - Deliver classwork assignments to be completed in the hospital or at home, as appropriate
   - Allow a representative from school to visit the student in the hospital or at home with the permission of the parents
   - Attend treatment planning meetings and the hospital discharge conference with the permission of the parents
6. Establish a plan for periodic contact with the student while he or she is away from school.
7. If the student is unable to attend school for an extended period of time, determine how to help him or her complete course requirements.

Compiled with information from DiCara, C., O'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program.

Retrieved from http://www.maine.gov/suicideldocs/Guidefines%20 I0-2009--w%20discl.pdf

GUIDELINES FOR WHEN A STUDENT RETURNS TO SCHOOL FOLLOWING ABSENCE FOR SUICIDAL BEHAVIOR

Students who have made a suicide attempt are at increased risk to attempt to harm themselves again. Appropriate handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school. This involvement helps the student to regain some sense of control.

Confidentiality is extremely important in protecting the student and enabling school personnel to render assistance. Although necessary for continuity of care, it is often difficult to obtain appropriate information in order to assist the student. If possible, secure a signed release from parents/guardians to communicate with the hospital or the student's therapist/counselor. Meeting with parents about their child prior to his/her return to school is integral to making decisions concerning needed supports and the student's schedule.

Suggestions to ease a student's return to school:

1. Prior to the student's return, a meeting between a designated school staff such as the school nurse, social worker, administrator, or designee who is trusted by the student and parents/guardian should be scheduled to discuss possible arrangements for support services and to create an individualized re-entry plan.
2. The designated school staff should:
   a. Review and file written documents as part of the student's confidential health record.
   b. Serve as case manager for the student. Understand what precipitated the suicide attempt and be alert to what might precipitate another attempt. Be familiar with practical aspects of the case, i.e. medications, full vs. partial study load recommendations.
   c. Help the student through re-admission procedures, monitor the re-entry, and serve as a contact for other staff members who need to be alert to re-occurring warning signs.
   d. Serve as a link with the parent/guardian, and with the written permission of the parent/guardian, serve as the school liaison with any external medical or mental health service providers supporting the student.
3. Classroom teachers do need to know whether the student is on a full or partial study load and be updated on the student's progress in general. They do not need clinical information or a detailed history.
4. Discussion of the case among personnel directly involved in supporting the student should be specifically related to the student's treatment and support needs. Discussion of the student among other staff should be strictly on a "need to know" basis. That is, information directly related to what staff has to know in order to work with the student.
5. Discussion of any specific case in classroom settings should be avoided entirely since such discussion would constitute a violation of the student's right to confidentiality, and would serve no useful purpose to the student or his/her peers.
6. It is appropriate for school personnel to recommend to students that they discuss their concerns or reactions with an appropriate administrator or other designated school personnel. The focus of these discussions should not be on the suicidal individual, but on building help seeking skills and resources for others who might be depressed or suicidal.

Any number of issues are likely to surface and will need to be considered on a case-by-case basis and addressed at the re-entry planning session. It is very likely that some of the school staff, the family, the mental health professional, and the student will express concerns regarding the transition process.

from the Maine Youth Suicide Prevention Program

OTHER ISSUES AND OPTIONS SURROUNDING A STUDENT'S RETURN TO SCHOOL

Any number of issues are likely to surface and will need to be considered on a case-by-case basis and addressed at the re-entry planning session. It is very likely that some of the school staff, the family, the mental health professional and the student will express concerns. Some of the more common issues are listed below:

1. **Issue: Transition from the hospital setting**
   Options:
   - Visit the student in the hospital or home to begin the re-entry process with permission from the parent/guardian.
   - Consult with the student to discuss what support he/she feels that he/she needs to make a more successful transition. Seek information about what the student would like communicated to friends and peers about what happened.
   - Request permission to attend the treatment planning meetings and the hospital discharge conference.
   - Arrange for the student to work on some school assignments while in the hospital.
   - Include the therapist/counselor in the school re-entry planning meeting.

2. **Issue: Family concerns (denial, guilt, lack of support, social embarrassment, anxiety, etc.)**
   Options:
   - Schedule a family conference with designated school personnel or home-school coordinator to address their concerns.
   - Include parents in the re-entry planning meeting.
   - Refer the family to an outside community agency for family counseling services.
   - Include information about those with sliding fee scale.

3. **Issue: Social and Peer Relations**
   Options:
   - Schedule a meeting with friends prior to re-entry to discuss their feelings regarding their friend, how to relate and when to be concerned.
   - Place the student in a school-based support group, peer helpers program but not as the helper, or buddy system.
   - Arrange for a transfer to another school if indicated.
   - Be sensitive to the need for confidentiality and how to restrict gossip.

4. **Issue: Academic concerns upon return to school**
   Options:
   - Ask the student about his/her academic concerns and discuss potential options.
   - Arrange tutoring from peers or teachers.
   - Modify the schedule and adjust the course load to relieve stress.
   - Allow make-up work to be adjusted and extended without penalty.
   - Monitor the student's progress.

5. **Issue: Medication**
   Options:
   - Alert the school nurse to obtain information regarding prescribed medication and possible side effects.
   - Notify teachers if significant side effects are anticipated.
   - Follow the policy of having the school nurse monitor and dispense all medication taken by the student at school.

6. **Issue: Behavior and attendance problems**
   Options:
   - Meet with teachers to help them anticipate appropriate limits and consequences of behavior.
   - Discuss concerns and options with the student.
   - Consult with discipline administrator.
   - Request daily attendance report from attendance office.
   - Make home visits or regularly schedule parent conferences to review attendance and discipline record.
   - Arrange for counseling for student.
   - Place the student on a sign in/out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day.

7. **Issue: Ongoing support***
   Options:
   - Assign a school liaison to meet regularly with the student at established times. Talk to the student about his/her natural contact at school – try to assign the person who already has a relationship with the student.
   - Maintain contact with the therapist and parents.
   - Ask the student to check in with the school counselor daily/weekly.
   - Utilize established support systems, Student Assistance Teams, support groups, friends, clubs and organizations.
   - Schedule follow-up sessions with the school psychologist or home school coordinator.
   - Provide information to families on available community resources when school is not in session.

*In the event that a student loses a family member to suicide, school personnel should understand that suicide evokes a special, complicated grief and most of the on-going support considerations mentioned in #7 would also apply.

from the Maine Youth Suicide Prevention Program

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SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

699 Old Orchard Dr. Danville, California 94526

SRVUSD MENTAL HEALTH RE-ENTRY MEETING FORM

Student Name:	
Date:	**Grade:**
Describe student's mental health status or the recent event that has triggered this meeting (i.e. hospitalization; ER visit; suicide ideation; suicide attempt; recent diagnosis; follow-up re-entry meeting; etc.):	
Please note any psychological supports outside of the school setting that are in place or in progress: ☐ Individual Counseling ☐ Group Counseling ❑ Family Counseling ❑ Outpatient Program ☐ Prescription Medication ☐ Other, Please Specify: _____ ***If present, please note the details on the lines below:***	
Provider (s):	
Frequency:	
Names and dosage of Medication (s):	
Will medication need to be administered in the school setting? ❑ Yes (Consider Referral to Nurse) ☐ No ☐ Not Applicable	
ACTIONS TAKEN	
Mental Health Resources List and Student/Parent Handouts Provided? ❑ Yes ❑ No	
Release of information form presented to the family in order to authorize consultation between any medical or mental health professionals and the school staff? (e.g. Hospital Discharge Paperwork) ❑ Yes ❑ No ❑ Parents will consider and return later if in favor.	
Safety Plan Created? ❑ Yes ☐ No (Please specify date to be created): _____	
Input for Safety Plan Gathered Today? ❑ Yes ❑ No If yes, please note input here:	
Who will meet individually with the student to complete the safety plan? ❑ School Counselor ❑ School Psychologist ❑ Administrator ❑ Not Applicable (Already Created)	
Referral to School Counselor or School Psychologist recommended? ☐ Yes ❑ No	
Parent in agreement with Referral to School Counselor or School Psychologist? ☐ Yes ❑ No	
If referring to the School Psychologist, a counseling consent form must be completed. Was this signed by parent, guardian or adult student today? ❑ Yes ❑ No ❑ Not Applicable	
Please note the date and time of a scheduled follow-up re-entry meeting to reevaluate the success of the student's transition back to school: **Date:** **Time**:	

Accommodations

Identify any accommodations to help the student successfully transition back into the routine of school. The following accommodations are recommended to assist students during re-entry to school. Please notify the student's teachers of these recommendations.

❑ Change/Reduce Academic Schedule: _____
❑ Reduce Homework/Classwork: _____
❑ Extended Deadlines: _____
❑ Testing Accommodations: _____
❑ Excuse missed assignments during school absence
❑ Other. Please Specify: _____

General Meeting Notes:

Signatures of Attendees (if applicable)

Parent/Guardian:

Parent/Guardian:

Parent/Guardian:

Student:

School Counselor:

School Counselor:

School Psychologist:

Administrator:

Other:

Other:

Other:

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SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

699 Old Orchard Dr. **Danville, California 94526**

SCHOOL PSYCHOLOGIST COUNSELING CONSENT FORM

I, _____, give permission for my child, _____,

to participate in psychological counseling services provided by a School Psychologist at

_____ School.

Please contact _____ at _____@srvusd.net or

(925) _____-_____ with any questions.

_____ _____

Signature Date

SAMPLE EMAIL TO STAFF FOLLOWING RE-ENTRY MEETING

Dear Staff,

As you know, ***STUDENT*** has been absent from school for ***X NUMBER OF DAYS*** due to mental health reasons. ***STUDENT*** will be returning on ***DATE OF RETURN***. The parent/guardian has given us permission to share the following information with you to aide in a successful re-entry to school. ***(Insert parent statement)***. The team has discussed the following accommodations and/or recommendations to assist the student in transitioning back to school. These accommodations include: ***(Transfer List of accommodations/recommendations from Re-Entry Meeting Form).***

If you notice that *STUDENT*'s mental health is impacting their functioning within the classroom, please contact *DESIGNATED SCHOOL MENTAL HEALTH PROVIDER*.

Sincerely,

Principal/Admin/Team

Means Matter
Suicide, Guns & Public Health

Recommendations for Families

If you're concerned that a member of your household may be suicidal, there are steps you can take to help keep them safe.

Three practical steps:

1. Call the National Suicide Prevention Lifeline, 1-800-273-TALK (1-800-273-8255) for support and to find out about resources in your area. You can also urge the family member to call the hotline him or herself for support. It's accessible around the clock.
2. Reduce easy access to dangerous substances at home. That includes:
    - Firearms - Because firearms are the most lethal among suicide methods, it is particularly important that you remove them until things improve at home, or, second best, lock them very securely. Please see below for further information on removing and storing firearms.
    - Medications - Don't keep lethal doses at home. Your doctor, pharmacist, or the poison control center (1-800-222-1222) may be able to help you determine safe quantities for the medicines you need to keep on hand. Please see below for more information on how to dispose of excess medications safely. Be particularly aware of keeping prescription painkillers (such as oxycodone and methadone) under lock and key both because of their lethality and their potential for abuse.
    - Alcohol - Alcohol can both increase the chance that a person makes an unwise choice, like attempting suicide, and increase the lethality of a drug overdose. Keep only small quantities at home.
3. There are also steps you can take to help a family member who is feeling suicidal or has recently attempted suicide. Please visit the websites listed below for more information.

SECTION III: POSTVENTION RESPONSE TO SUICIDE OF A SCHOOL COMMUNITY MEMBER

Postvention (interventions that are conducted after a suicide) assists students in ways that promote the mental health of the entire school community and supports students experiencing a mental or suicidal crisis after the suicidal death of a school community member. These interventions are meant to help manage the various aspects of the crisis and prevent contagion. Support and resources are provided for students, staff, parents and the entire community. All aspects of postvention strive to treat the loss in similar ways to that of other deaths within the school community and to return the school environment to its normal routine as soon as is possible. In this way, postvention is inextricably linked to prevention.

A. STEPS TO TAKE IN THE IMMEDIATE AFTERMATH

1. Day Zero (day of event)

a. Contact key individuals

i. Principal or Designee Verifies Death

- Verify details of death with police or other local authority (see Attachment 3.16, "Working with the Community")

ii. Principal or Designee Contacts Family (see "Guidelines for Working with the Family", Attachment 3.3)

- Express sympathy as you would for any sudden death (see Appendix C5, "Comforting a Grieving Individual")
- Inquire about what the school can share about their loss. If family is unwilling or not ready to share, help the family craft a message that they do want released in order to minimize rumors, misinformation, and speculation. Acknowledge that this is a great tragedy and assist them in understanding that crafting a message about the cause of death will help their child's friends who are suffering.
- Ask what the school can do to support siblings.
- Ask what school can do to support them (e.g., PTA to assist providing meals, inform family about community grief support and AFSP "Surviving Suicide Loss" support such as the "Survivor Outreach Program" etc.)
  - AFSP's Surviving a Suicide Loss: A Resource and Healing Guide: http://www.afsp.org/files/Surviving/resource_healing_guide.pdf
  - AFSP Survivor Outreach Program
  - Call: 212-363-3500, ext. 2035 Email: survivingsuicideloss@afsp.org
- Let them know the school will be checking in with them in the coming days and weeks to determine what support the school can provide

iii. Principal Notifies Superintendent or Director of Student Services Who Notifies Schools Where Siblings and Close Relatives Attend

- Shut down deceased student and his/her siblings in attendance system so no automated messages regarding absence are sent home
- Shut down face-page on SRVUSD IT system

iv. Principal Notifies Director of Communication

- Director of Communication will work with principal and Site-Based Crisis Response Team to communicate with school community (see Attachment 3.16, "Working with the Community").

v. Site-Based CRT leader notified who then activates Site-Based Crisis Response Team. If necessary, the SELPA Director will activate the district-based CRT.

vi. Ensure office staff knows how to respond to inquiries (see Attachment 3.4, "Sample Script for Office Staff")

vii. Campus Supervisor to prevent unauthorized visitors on campus
viii. Work with district to secure external mental health providers (e.g., Discovery Center, Contra Costa Crisis Center) and grief support (e.g., Hope Hospice)

b. Notify School Community
i. CRT Leader to notify all faculty and staff (see Attachment 3.5, "Guidelines for Notifying Staff,)
ii. Principal to notify families of students about the death and the school's response (see Attachment 3.6 "Sample Letter to Families", and Attachment 3.7, "Sample Death Notification for Parents")
- Communicate letter to families in the most expedient way so they will know what their student will be facing at school when the death is announced.
- Letter should include a list of local resources (refer to Appendix B1, "Mental Health Resources")

2. Day One (first school day after event)

a. Initial All-Staff Meeting (before school)
i. Crisis Response Team Leader conducts the initial all-staff meeting with principal or designated administrator. For a suggested meeting agenda, refer to Attachment 3.8, "Sample Agenda for Initial All-Staff Meeting"
ii. A few goals of this meeting are to:
1. Convey what information can be relayed to students
   - For sample announcements, refer to Attachment 3.9, "Sample Announcements" and "Sample Death Notification Statement for Students"
   - Prepare staff to inform students in first period classes. In order to deal with student reactions, provide them with copies of:
     - Attachment 3.10, "Talking About Suicide"
     - Attachment 3.11, "Talking Points for Students and Staff After a Suicide"
     - Attachment 3.12, "Sample Grief Discussion with Students"
     - Attachment 3.13, "Facts About Suicide and Mental Disorders in Adolescents"
   - Identify staff uncomfortable with notifying students of the death. Designate CRT members or counselors to support those staff members in their classrooms throughout the school day. Substitute teachers should not notify students. Any classrooms with substitute teachers will be designated a CRT member or counselor to notify students of the death.
   - Remind staff who the designated media spokesperson is and that they should refer any outside requests for comments or information to this individual.
2. Control rumors
3. Provide staff support
   - Inform teachers that roving substitute teachers are available for those instructors who may need a short break.
   - Advise staff that extra support is available for those who need it.
   - Offer end of day meeting for staff to debrief and to obtain support.
   - Provide staff with resources for themselves and the community (see Appendix B1, "Mental Health Resources").
4. Remind staff of risk factors and warning signs (see Attachment 1.2, "Risk Factors for Youth Suicide", and Attachment 1.4, "Recognizing and Responding to Warning Signs of Suicide") and to use QPR training as situation warrants, etc.
5. Inform staff where to send at-risk students and that they must be sent with another student or escorted by adult --- never alone (see Attachment 1.1, "General Guidelines for Teachers and Staff").

6. Identify designated locations on campus for students who would like to support one another with a trusted adult nearby. Determine who should monitor these stations (activities director, other mental health providers). Provide snacks if possible along with art and writing supplies for creative expression that may later be preserved for the student's family.
7. Share parent location designated for parents who come to campus to ask questions and express concerns.
8. Send follow up email after the staff meeting with information discussed in the first meeting and any additional details, such as list of local resources.

b. Support Students During the School Day
- **i.** Counselors (preferably two) follow deceased student's schedule to assess students and to assist teachers
- **ii.** Identify, monitor, and support students who may be at risk
  - Recognize that students who were close to deceased and known vulnerable students may be at-risk for suicide. Assign a CRT member to develop a list of students of concern with input from others.
  - Meet with at-risk students, document, and follow-up as needed.
- **iii.** Designate someone to circulate on campus to determine who might be in need and to monitor for rumors (e.g. campus supervisor).
- **iv.** Meet with students in small groups including established groups of the deceased (e.g. sports, clubs, friend groups) to provide emotional support. Meeting should be facilitated by counselor, school psychologist, CRT member, or other mental health providers. To guide the meeting refer to Attachment 3.10, "Talking About Suicide", Attachment 3.11, "Talking Points for Students and Staff After a Suicide", and Attachment 3.12, "Sample Grief Discussion with Students".

c. After-School Staff Meeting
- **i.** Acknowledge that it's been a difficult day for everyone and that this meeting is an opportunity to share experiences from the day and what their needs for support will be for the next day.
- **ii.** Inform staff as to the continued availability of roving substitute teachers and counselors. Determine this based upon expressed need and day one experiences in the classroom.
- **iii.** Allow staff to express concerns and ask questions.
- **iv.** Emphasize self-care for teachers/staff since they have been primarily focused on taking care of students.
- **v.** Reminder to continue to identify, monitor, and support students who may be at risk.

3. Advise on Appropriate Memorialization

In the interest of identifying a meaningful, safe approach to acknowledging the loss, schools should both meet with the student's friends and coordinate with the family. The school's goal should be to balance the students' need to grieve with the goal of limiting the risk of inadvertently glamorizing the death. In all cases, schools should have a consistent policy so that suicide deaths are handled in the same manner as any other deaths. Refer to Attachment 3.14, "Memorialization" for more information from the AFSP & SPRC.

Key Considerations for Memorialization
- Any memorial should have the goals of being life-affirming, raising awareness, and reducing stigma.
- Encourage contributions to suicide prevention or mental health organizations such as AFSP, or to an organization designated by the family.
- Because adolescents are especially vulnerable to the risk of suicide contagion (increased suicide ideation, gestures, and attempts following a completed suicide), it's important to memorialize the student in a way that doesn't inadvertently glamorize, romanticize, or sensationalize either the

student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying brain conditions such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse). See Attachment 3.15, "Guidelines for Memorial Activities Following a Suicide".

- Determine a date/time to gather materials from spontaneous memorials so that they can be organized and given to the family. Well in advance of this time, let students know when this will occur.
- CRT should be available to students concerned about rumors or social media postings about the death. Social media can be used effectively for the dissemination of accurate information and to promote suicide prevention efforts. See Attachment 3.19, "Social Media", for recommendations.

4. Key Considerations for Funeral/Memorial Service (see Attachment 3.14, "Memorialization")

a. Discuss with the family the importance of informing clergy or whoever will be conducting the funeral about the risk of suicide contagion among adolescents.

b. Communicate the importance of emphasizing the connection between suicide and underlying brain conditions (such as depression), as noted in the key considerations for memorialization listed above.

c. Encourage the family to consider holding the funeral outside of school hours if at all possible.

d. If family asks, principal should communicate with the funeral director about logistics, including need for mental health professionals and/or grief counselors to be present at the funeral.

e. Depending on family wishes, the Principal will disseminate information about the funeral to students, parents, and staff as soon as it becomes available. Include the following information in the announcement:

i. Location of the funeral

ii. Time of the funeral (keep school open if the funeral is during school hours)

iii. What to expect (e.g. whether there will be an open casket)

iv. Guidance regarding how to express condolences to the family (e.g. treat like any other sudden death, family wishes for charitable donations vs. flowers, etc.). See Appendix C5, "Comforting a Grieving Individual" for helpful recommendations.

v. School policy for releasing students during school hours to attend (i.e., students will be released only with permission of parent, guardian, or designated adult).

vi. Consider having a trusted adult or family member accompany students who choose to attend the funeral to provide support.

5. Minimize Risk of Suicide Contagion by Working with the Media

a. Principal, district administrator, or CRT leader to direct all media inquiries to the district media spokesperson.

b. Assemble media packet.

i. A statement is prepared in advance and a hard copy provided by media spokesperson when contacted by outside organizations for comments or information regarding the death.

ii. For guidelines and sample statements refer to:

- Attachment 3.18, "Guidelines for Working with the Media"
- Attachment 3.20, "Sample Media Statement"
- Attachment 3.21, "Key Messages for Media Spokesperson"

iii. Include Appendix B1, "Mental Health Resources" for local resources and hotline numbers

iv. Provide media with SPRC/AFSP media guidelines (see Attachment 3.22, "Recommendations for Reporting on Suicide").

- http://www.sprc.org/resources-programs/recommendations-reporting-suicide
- https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf

B. STEPS TO TAKE IN THE LONG-TERM AFTERMATH

1. Coordinate implementation of long-term response protocol
   a. Schedule daily debriefs with Crisis Response Team while in initial assessment period to discuss at-risk students who need follow-up and to review confidential database. This generally lasts 1-2 weeks, but can vary with the situation.
   b. Discuss with family of deceased student any concerns they may have for siblings, friends or acquaintances and follow up accordingly. Counselor monitors and checks in with at-risk students as long as needed. Documents name of student, date/time of check-in, assessment of areas of concern, follow-up referrals and notifications on standardized forms (see Attachment 2.12, "SRVUSD Student Suicide Risk Documentation Form").
   c. Send e-mail updates to staff to keep them informed about funeral arrangements; resources and supports available for them; physical, emotional, cognitive, and social manifestations of grief in students; referral process for students of concern, etc. This generally lasts 1-2 weeks, but can vary with the situation.
   d. Develop prearranged protocol for removing personal items from locker or desk, respecting family wishes for privacy and/or support
   e. Convene CRT and facilitate a tactical debriefing of what worked and what could be improved upon during the initial assessment period (1-2 weeks post-intervention). Team leader documents successes, challenges, and recommendations for improvement to be incorporated into the Comprehensive Suicide Prevention Toolkit.
2. Enhance identification and support of vulnerable students
   a. Identify students in need and refer to counselor (note alternative approaches to identifying students at risk in Section I: Promotion). Attendance office to alert health tech or counselor about increased student absences.
   b. Continue to monitor for rumors.
   c. Campus supervisor to rove on campus throughout the day and monitor the emotional climate (e.g., an increase in fights or school delinquency).
   d. Continue to meet with students in small groups, especially those groups of which the deceased student was a member.
   e. Recommend more individual supports (make sure to offer continued support if needed).
3. Prepare for anniversaries and special events
   a. Prior to graduation ceremonies for the deceased student's class, check with family about any requests. Acknowledgment of a student who has died by suicide should be consistent with acknowledgement of a student who has died by any other means.
   b. Be aware of special events (e.g. proms, birthday etc.), holidays, and anniversaries, as these may activate possible stress/grief responses (physical, emotional, social, cognitive) in students or staff. See Attachment 3.17, "Guidelines for Anniversaries of a Death".
   c. The probability of contagion is heightened on the anniversary of the death as well as on other meaningful days.
4. Expect the possibility of long term memorials (see Attachment 3.14, "Memorialization") and continue to work with family, students, and social media.
5. Provide support as needed for siblings of the deceased enrolled in the district. Coordinate with parents. Refer to and choose among the resources located in Appendix B for more information as needed.
6. Principal or designee to remain in contact with family through the funeral and in the weeks following death.
7. Communicate with and support the broader school community.
   a. Provide parent/community education about suicide, grief, and self-care within the first month following death.

ATTACHMENTS FOR SECTION III: POSTVENTION

3.1 Suicide Postvention Protocol Flowchart

3.2 District-Based Crisis Response Team Activation Flowchart

3.3 Guidelines for Working with the Family, *SAMHSA Toolkit*

3.4 Sample Script for Office Staff, *SAMHSA Toolkit*

3.5 Guidelines for Notifying Staff, *SAMHSA Toolkit*

3.6 Sample Letter to Families, *SAMHSA Toolkit*

3.7 Sample Death Notification Statement for Parents, *AFSP & SPRC Toolkit*

3.8 Sample Agenda for Initial All-Staff Meeting, *AFSP & SPRC Toolkit*

3.9 Sample Announcements, *SAMHSA Toolkit*

3.10 Talking about Suicide, *AFSP & SPRC Toolkit*

3.11 Talking Points for Students and Staff After a Suicide, *SAMHSA Toolkit*

3.12 Sample Grief Discussion with Students, *Kara*

3.13 Facts about Suicide and Mental Disorders in Adolescents, *AFSP & SPRC Toolkit*

3.14 Memorialization, *AFSP & SPRC Toolkit*

3.15 Guidelines for Memorial Activities Following a Suicide

3.16 Working with the Community, *AFSP & SPRC Toolkit*

3.17 Guidelines for Anniversaries of a Death, *SAMHSA Toolkit*

3.18 Guidelines for Working with the Media, *SAMHSA Toolkit*

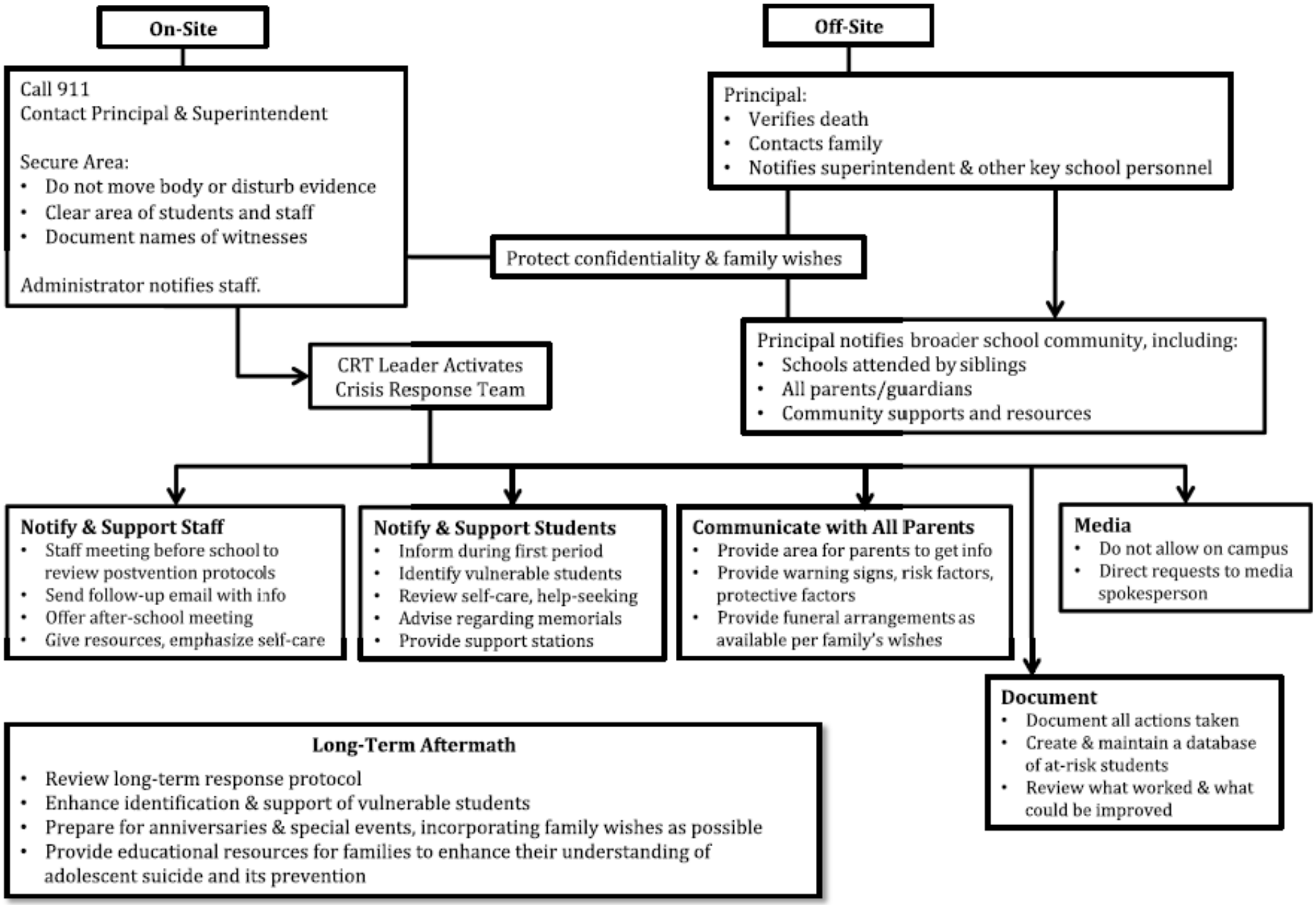
3.19 Social Media, *AFSP & SPRC Toolkit*

3.20 Sample Media Statement, *AFSP & SPRC Toolkit*

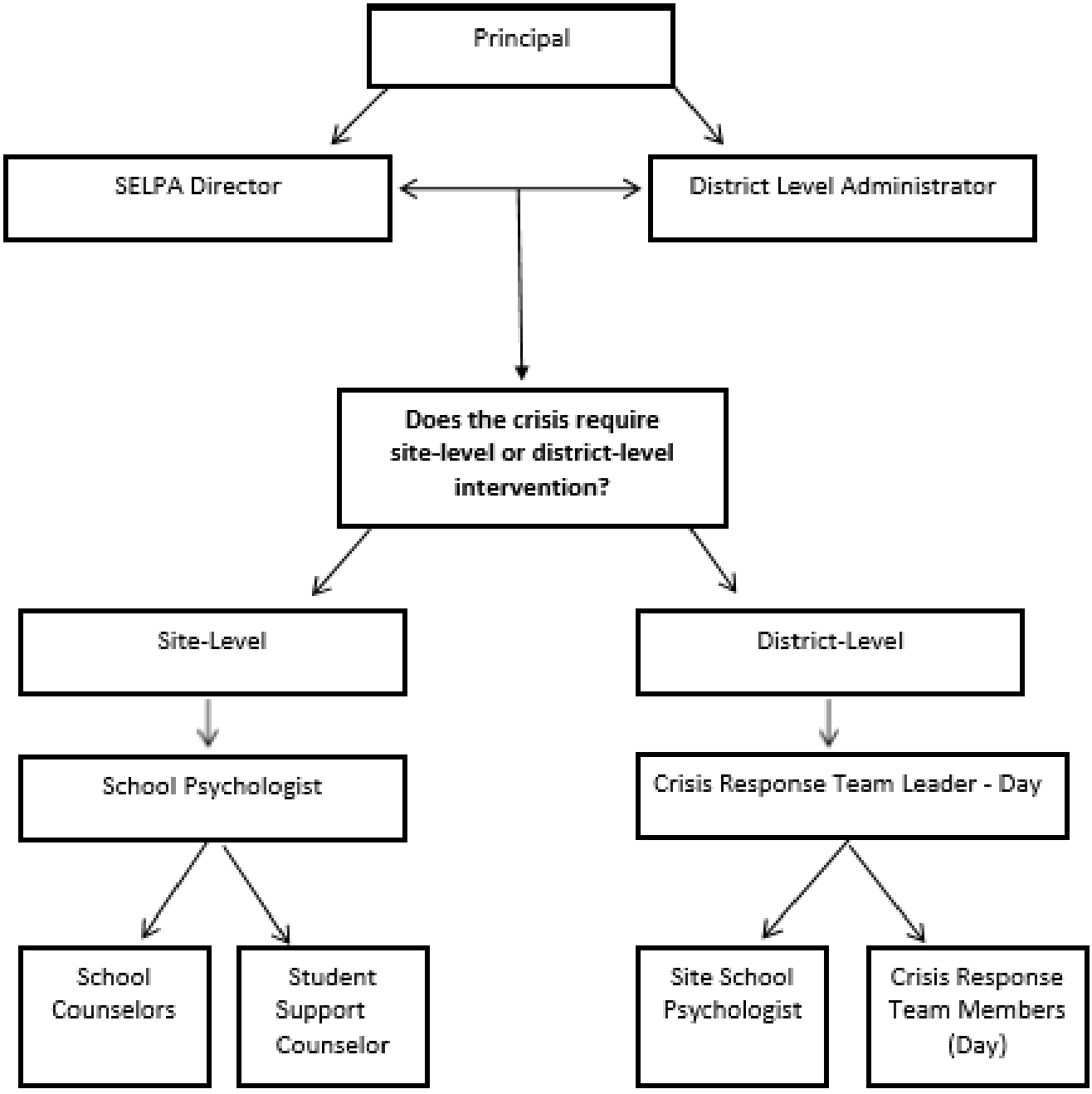
3.21 Key Messages for Media Spokesperson, *AFSP & SPRC Toolkit*

3.22 Recommendations for Reporting on Suicide, *AFSP & SPRC Toolkit*

Suicide Postvention Protocol Flowchart



Crisis Management & Activation



GUIDELINES FOR WORKING WITH THE FAMILY

It is important to work with the family of a student who died by suicide. They will often appreciate the support of the school community, and their cooperation can be valuable for effective postvention. The principal or a representative of the school should request to visit the family in their home. It may be useful for a pair of representatives to visit together so that they can support one another during the visit. It is important to respect the cultural and religious traditions of the family related to suicide, death, grieving, and funeral ceremonies.

The school representative(s) should:

- Offer the condolences of the school.
- Inquire about funeral arrangements. Ask if the funeral will be private or if the family will allow students to attend.
- Ask if the parents know of any of their child's friends who may be especially upset.
- Provide the parents with information about grief counseling.
- Ask the family if they would like their child's personal belongings returned. These could include belongings found in the student's locker and desk as well as papers and projects they may want to keep.
- Briefly explain to the parents what the school is doing to respond to the death.

From Preventing Suicide: A High School Toolkit, SAMHSA

SAMPLE SCRIPT FOR OFFICE STAFF

This script can help receptionists or other people who answer the telephone to respond appropriately to telephone calls received in the early stages of the crisis.

Hello, _____ School. May I help you?

Take messages on non-crisis-related calls.

For crisis-related calls, use the following general schema:

- **Police or other security professionals:** Immediate transfer to principal.
- **Family members of deceased**: Immediate transfer to principal or anyone else they want to reach at the school. If principal is not available immediately, ask if they would like to speak to a school psychologist or social worker.
- **Other school administrators:** Give out basic information on death and crisis response and offer to transfer call to principal or others.
- **A parent regarding their child's immediate safety:** Reassure parents if you know their child was not involved and outline how children are being served and supported. If their child may have been involved, transfer to a crisis team member who may have more information.
- **Persons who call with information about others at risk:** Take down information and get it to a crisis team member. Take a phone number where a crisis team member can call the person back.
- **Media**: Take messages and refer to principal.
- **Parents generally wanting to know how to respond:** Explain that children and staff are being supported. Take messages to give to Student Services staff from parents needing more detailed information.
- **Where to send parents who arrive unannounced on the scene:** Set aside a space for parents to wait and get information. Any person removing a student from school must be on the annual registration form as the parent or guardian. Records must be kept of who removed the child and when.

From Madison Metropolitan School District. (2005). Sudden death-suicide-critical incident: Crisis response procedures for principals and student services staff. http://www.mhawisconsin.org/Data/Sites/1/media/gls/gls_madisoncrisisplan.pdf

GUIDELINES FOR NOTIFYING STAFF

These preparations should be made by the individual responsible for notifying faculty and staff about a suicide so that a system will be in place in the event of a death.

- Create two telephone trees:
  1. To notify the Suicide Response Team
  2. To notify all staff members of a suicide that occurs during non-school hours

- Hold a staff meeting before school opens to review the postvention process. Provide staff with any information they may need to address the situation when the students arrive.

- Identify which Suicide Response Team members will be responsible for notifying staff if news of a suicide arrives while school is in session. These people should be provided with completed copies of a suicide death announcement (examples can be found in Attachments 3.9 and 3.10).

- Announcements should always be made in classrooms. They should never be made over the school's public address system or in assemblies. In classrooms, school staff familiar to the students can make the announcements and then assess students' reactions, respond to students' concerns, provide support, and identify those who may need additional help. This will help students cope with intense emotions they may experience.

From Preventing Suicide: A High School Toolkit, SAMHSA

SAMPLE LETTER TO FAMILIES

Dear Parents,

I am writing this letter with great sadness to inform you that one of our sophomore students took his life last evening. Our thoughts and sympathies go out to his family and friends.

All of the students were given the news of the death by their teacher in homeroom this morning. I have included a copy of the announcement that was read to them. Members of our crisis team met with students individually and in groups today and will be available to the students over the next days and weeks to help them cope with the death of their peer.

Information about funeral services will be given to the students once it has been made available to us. Students will be released to attend services only with parental permission and pick up, and we strongly encourage you to accompany your child to any services.

I am including information about suicide and some talking points that can be helpful to you in discussing this issue with your teen. I am also including a list of school and community resources should you feel your child is in need of additional assistance. If you need immediate assistance, call the Contra Costa Crisis Center Suicide and Crisis Hotline 24/7 at 1-800-833-2900 or Text "HOPE" to 20121.

Please do not hesitate to call me or one of the counselors if you have questions or concerns. Sincerely,

(Principal)

Adapted from AFSP. After a suicide: A toolkit for schools. Newton, MA: Education Development Center, Inc. Available online at http://www.sprc. org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf

SAMPLE DEATH NOTIFICATION STATEMENT FOR PARENTS

To be sent by e-mail or regular mail

OPTION 1: WHEN THE DEATH HAS BEEN RULED A SUICIDE

Dear Parents,

I am writing with great sadness to inform you that one of our students,_____has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The cause of death was suicide. We want to take this opportunity to remind our community that suicide is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking dearly about his or her problems and how to solve them. Sometimes these disorders are not identified or noticed; other times, a 'person with a disorder will show obvious symptoms or signs. I am including some information that may be helpful to you in discussing suicide with your child.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

The school will be hosting a meeting for parents and others in the community at [date/time/location]. Members of our Crisis Response Team [or mental health professionals] will be present to provide information about common reactions following a suicide and how adults can help youths cope. They will also provide information about suicide and mental illness in adolescents, including risk factors and warning signs of suicide, and will address attendees' questions and concerns.

Please do not hesitate to contact me or one of the school counselors with any questions or concerns.

Sincerely,

[Principal]

OPTION 2 - WHEN THE CAUSE OF DEATH IS UNCONFIRMED:

Dear Parents,

I am writing with great sadness to inform you that one of our students,_____has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we have asked the students not to spread rumors since they may turn out to be inaccurate and can be hurtful and unfair to_____as well as [his/her] family and friends. We'll do our best to give you accurate information as it becomes known to us.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

Please do not hesitate to contact me or one of the school counselors with any questions or concerns.

Sincerely,

[Principal]

OPTION 3 - WHEN THE FAMILY HAS REQUESTED THAT THE CAUSE OF DEATH NOT BE DISCLOSED:

Dear Parents,

I am writing with great sadness to inform you that one of our students,_____has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The family has requested that information about the cause of death not be shared at this time. We are aware that there have been rumors that this was a suicide death. Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking clearly about the problems in his or her life and how to solve them. Sometimes these disorders are not identified or noticed; other times, a person with a disorder will show obvious symptoms or signs.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of additional school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

Please do not hesitate to contact me or the school counselors with any questions or concerns.

Sincerely,

[Principal]

From After a Suicide a Toolkit for Schools 2011, AFSP & SPRC

SAMPLE AGENDA FOR INITIAL ALL-STAFF MEETING

This meeting is typically conducted by the Crisis Response Team Leader and should be held as soon as possible, ideally before school starts in the morning.

Depending on when the death occurs, there may not be enough time to hold the meeting before students have begun to hear the news through word of mouth, text messaging, or other means. If this happens, the Crisis Response Team Leader should first verify the accuracy of the reports and then notify staff of the death through the school's predetermined crisis alert system, such as e-mail or calls to classroom phones. Remember that information about the cause of death should be withheld until the family has been consulted.

Goals of Initial Meeting

Allow at least one hour to address the following goals:

- Introduce the Crisis Response Team members.
- Share accurate information about the death.
- Allow staff an opportunity to express their own reactions and grief. Identify anyone who may need additional support and refer them to appropriate resources.
- Provide appropriate faculty (e.g., homeroom teachers or advisors) with a scripted death notification statement for students. Arrange coverage for any staff who are unable to manage reading the statement.
- Prepare for student reactions and questions by providing handouts to staff on Talking About Suicide and Facts About Suicide and Mental Disorders in Adolescents.
- Explain plans for the day, including locations of crisis counseling rooms.
- Remind all staff of the important role they may play in identifying changes in behavior among the students they know and see every day, and discuss plan for handling students who are having difficulty.
- Brief staff about identifying and referring at-risk students as well as the need to keep records of those efforts.
- Apprise staff of any outside crisis responders or others who will be assisting.
- Remind staff of student dismissal protocol for funeral.
- Identify which Crisis Response Team member has been designated as the media spokesperson and instruct staff to refer all media inquiries to him or her.

End of the First Day

It can also be helpful for the Crisis Response Team Leader and/or the Team Coordinator to have an all-staff meeting at the end of the first day. This meeting provides an opportunity to take the following steps:

- Offer verbal appreciation of the staff.
- Review the day's challenges and successes.
- Debrief, share experiences, express concerns, and ask questions.
- Check in with staff to assess whether any of them need additional support, and refer accordingly.
- Disseminate information regarding the death and/or funeral arrangements.
- Discuss plans for the next day.
- Remind staff of the importance of self-care.
- Remind staff of the importance of documenting crisis response efforts for future planning and understanding.

From After a Suicide a Toolkit for Schools 2011, AFSP & SPRC

SAMPLE ANNOUNCEMENTS

Sample Announcements for Use with Students after a (Possible) Suicide

1. After the school's Suicide Response Team has been mobilized, it is critical for administration and/or crisis team members to prepare a statement about the death for release to faculty and students. The announcement should include the facts as they have been officially communicated to the school. Announcements should not overstate or assume facts not in evidence. If the official cause of death has not as yet been ruled suicide, avoid making that assumption. There are also many instances when family members insist that a death that may appear to be suicide was, in fact, accidental.

2. The Suicide Response Team should either visit all classrooms to give the announcement to staff or present the announcement at a meeting of all staff called by the building administrator as soon as possible following the death. If a meeting is held, the building administrator and a member of the Suicide Response Team could facilitate the meeting. The goals of such a meeting are to inform the faculty, acknowledge their grief and loss, and prepare them to respond to the needs of the students. Faculty will then read the announcement to their students in their homerooms (or other small group) so that students get the same information at the same time from someone they know.

3. The sample announcements in this section are straightforward and are designed for use with faculty, students, and parents, as appropriate. Directing your announcement to the grade level of the students is also important, especially in primary or middle schools. A written announcement should be sent home to parents with additional information about common student reactions to suicide and how to respond, as well as suicide prevention information.

Sample Announcements Day 1

Sample Announcement for When a Suicide Has Occurred, Morning, Day 1

This morning we heard the extremely sad news that _____ took his/her life lust night. I know we are all saddened by his/her death and send our condolences to his/her family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available, and students may attend with parental permission.

Sample Announcement for a Suspicious Death Not Declared Suicide: Morning, Day 1

This morning we heard the extremely sad news that _____ died last night from a gunshot wound. This is the only information we have officially received on the circumstances surrounding the event. I know we are all saddened by_____'s death and send our condolences to his/her family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available; students may attend with parental permission.

Sample Announcement, End of Day 1

At the end of the first day, another announcement to the whole school prior to dismissal can serve to join the whole school in their grieving in a simple, non-sensationalized way. In this case, it is appropriate for the building administrator to make an announcement similar to the following over the loud speaker:

Today has been a sad day for all of us. We encourage you to talk about _____'s death with your friends, your family. and whoever else gives you support. We will have special staff here for you tomorrow to help in dealing with our loss. Let us end the day by having the whole school offer a moment of silence for_____.

Sample Announcements Day 2

On the second day following the death, many schools have found it helpful to start the day with another homeroom announcement. This announcement can include additional verified information, re-emphasize the continuing availability of in-school resources, and provide information to facilitate grief. Here's a sample of how this announcement might be handled:

We know that _____'s death has been declared a suicide. Even though we might try to understand the reasons for his/her doing this, we can never really know what was going on that made him/her take his/her life. One thing that's important to remember is that there is never just one reason for a suicide. There are always many reasons or causes, and we will never be able to figure them all out.

Today we begin the process of returning to a normal schedule in school. This may be hard for some of us to do. Counselors are still available in school to help us deal with our feelings. If you feel the need to speak to a counselor, either alone or with a friend, tell a teacher, the principal, or the school nurse, and they will help make the arrangements.

We also have information about the visitation and funeral. The visitation will be held tomorrow evening at the Funeral Home from ____to____ p.m. There will be a funeral Mass _____ at _____ o'clock at _____ Church. In order to be excused from school to attend the funeral, you will need to be accompanied by a parent or relative, or have your parent's permission to attend. We also encourage you to ask your parents to go with you to the funeral home.

Reprinted from Underwood, M, & Dunne-Maxim, K. (1997). Managing sudden traumatic loss in the schools. Piscataway, N.J.: University of Medicine and Dentistry of New Jersey.

SAMPLE DEATH NOTIFICATION STATEMENT FOR STUDENTS

Use in small groups such as homerooms or advisories, not in assemblies or over loudspeakers.

OPTION 1 - WHEN THE DEATH HAS BEEN RULED A SUICIDE:

It is with great sadness that I have to tell you that one of our students, ____ has taken [his/her] own life. All of us want you to know that we are here to help you in any way we can.

A suicide death presents us with many questions that we may not be able to answer right away. Rumors may begin to circulate, and we ask that you not spread rumors you may hear. We'll do our best to give you accurate information as it becomes known to us.

Suicide is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking clearly about his or her problems and how to solve them. Sometimes these disorders are not identified or noticed; in other cases, a person with a disorder will show obvious symptoms or signs. One thing is certain: there are treatments that can help. Suicide should never, ever be an option.

Each of us will react to_'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known__very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction.

We have counselors available to help our school community deal with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, just let your teachers know.

Please remember that we are all here for you.

OPTION 2 - WHEN THE CAUSE OF DEATH IS UNCONFIRMED:

It is with great sadness that I have to tell you that one of our students, ____ has died. All of us want you to know that we are here to help you in any way we can.

The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask that you not spread rumors since they may turn out to be inaccurate and can be deeply hurtful and unfair to as well as [his/her] family and friends. We'll do our best to give you accurate information as it becomes known to us.

Each of us will react to_'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known__very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction. We have counselors available to help our school community deal with this sad loss. If you'd like to talk to a counselor, just let your teachers know.

Please remember that we are all here for you.

OPTION 3 - WHEN THE FAMILY HAS REQUESTED THAT THE CAUSE OF DEATH NOT BE DISCLOSED:

It is with great sadness that I have to tell you that one of our students,____, has died. All of us want you to know that we are here to help you in any way we can.

The family has requested that information about the cause of death not be shared at this time.

We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask that you not spread rumors since they may turn out to be inaccurate and can be deeply hurtful and unfair to as well as [his/her] family and friends. We'll do our best to give you accurate information as it becomes known to us.

Since the subject has been raised, we do want to take this opportunity to remind you that suicide, when it does occur, is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking dearly about his or her problems and how to solve them. Sometimes these disorders are not identified or noticed; in other cases, a person with a disorder will show obvious symptoms or signs. One thing is certain: there are treatments that can help. Suicide should never, ever be an option.

Each of us will react to_'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known__very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction. We have counselors available to help our school community deal with this sad loss. If you'd like to talk to a counselor, just let your teachers know.

Please remember that we are all here for you.

From After a Suicide a Toolkit for Schools 2011, AFSP & SPRC

TALKING ABOUT SUICIDE

Give accurate information about suicide.

Suicide is a complicated behavior. It is *not* caused by a single event such as a bad grade, and argument with parents, or the breakup of a relationship.

In most cases, suicide is caused by an underlying mental disorder like depression or substance abuse. Mental disorders affect the way people feel and prevent them from thinking clearly and rationally. Having a mental disorder is nothing to be ashamed of, and help is available.

Talking about suicide in a calm, straight-forward manner does not put ideas into kids' minds.

Examples of what to say:

- *"The cause of _____'s death was suicide. Suicide is most often caused by serious mental disorders like depression, combined with other complications."*
- *"_____ was likely struggling with a mental health issue like depression or anxiety, even though it may not have been obvious to other people."*
- *"There are treatments to help people who are having suicidal thoughts."*
- *"Since 90% of people who die by suicide have a mental disorder at the time of their death, it is likely that _____ suffered from a mental health disorder that affected [his/her] feelings, thoughts, and ability to think clearly and solve problems in a better way."*
- *"Mental disorders are not something to be ashamed of, and there are very good treatments to help the symptoms go away."*

Address blaming and scapegoating.

It is common to try to answer the question "why?" after a suicide death. Sometimes this turns into blaming others for the death.

Example of what to say:

- *"The reasons that someone dies by suicide are not simple, and are often related to mental disorders that get in the way of the person thinking clearly. Blaming others – or blaming the person who died – does not acknowledge the reality that the person was battling a mental health disorder."*

Do not focus on the method or graphic details.

Talking in graphic detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable youth.

If asked, it is okay to give basic facts about the method, but don't give graphic details or talk at length about it. The focus should be not on *how* someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.

Examples of what to say:

- *"It is tragic that he died by hanging. Let's talk about how _____'s death has affected you and ways for you to handle it."*
- *"How can we figure out the best ways to deal with our loss and grief?"*

Address anger.

Accept expressions of anger at the deceased and explain that these feelings are normal.

Example of what to say:

- *"It is okay to feel angry. These feelings are normal and it doesn't mean that you didn't care about _____. You can be angry at someone's behavior and still care deeply about that person."*

Address feelings of responsibility.

Reassure those who feel responsible or think they could have done something to save the deceased.

Examples of what to say:

- *"This death is not your fault."*
- *"We can't always predict someone else's behavior."*
- *"We can't control someone else's behavior."*

Encourage help-seeking.

Encourage students to seek help from a trusted adult if they or a friend are feeling depressed or suicidal.

Examples of what to say:

- *"We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried or depressed or had thoughts of suicide?"*
- *"There are effective treatments to help people who have mental health disorders or substance abuse problems. Suicide is never the answer."*
- *"This is an important time for all in our [school, team, etc.] community to support and look out for one another. If you are concerned about a friend, you need to be sure to tell a trusted adult."*

"After a Suicide: A Toolkit for Schools AFSP& SPRC

Talking Points for Students and Staff After a Suicide

TALKING POINT	WHAT TO SAY
Give accurate information about suicide. Suicide is a complicated behavior. Help students understand the complexities.	*Suicide is not caused by a single event, such as fighting with parents, or a bad grade, or the breakup of a relationship.* *In most cases, suicide is caused by mental health disorders like depression or substance abuse problems. Mental health disorders affect the way people feel and prevent them from thinking clearly and rationally. Having a mental health disorder is nothing to be ashamed of.* *There are effective treatments to help people who have mental health disorders or substance abuse problems. Suicide is never the answer.*
Address blaming and scapegoating. It is common to try to answer the question "why" by blaming others for the suicide.	*Blaming others for the suicide is wrong, and it's not fair. Doing that can hurt another person deeply.*
Do not talk about the method. Talking about the method can create images that are upsetting, and it may increase the risk of imitative behavior by vulnerable youth.	*Let's focus on talking about the feelings we are left with after_____'s death and figure out the best way to manage them.*
Address anger. Accept expression of anger at the deceased. Help students know these feelings are normal.	*It is okay to feel angry. These feelings are normal, and it doesn't mean that you didn't care about _____. You can be angry at someone's behavior and still care deeply about that person.*
Address feelings of responsibility. Help students understand that the only person responsible for the suicide is the deceased. Reassure those who have exaggerated feelings of responsibility, such as thinking they should have done something to save the deceased or seen the signs.	*This death is not your fault. We cannot always see the signs because a suicidal person may hide them well.* *We cannot always predict someone's behavior.*
Encourage help-seeking. Encourage students to seek help from a trusted adult if they or a friend are feeling depressed or suicidal.	*We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried, depressed, or had thoughts of suicide?*

From "Preventing Suicide: A High School Toolkit" SAMHSA

SAMPLE GRIEF DISCUSSION WITH STUDENTS

Share facts of the death:

"I have some very sad news to share today. Our teacher, Mrs._____died a few weeks ago due to complications from_____. I am feeling pretty sad and would like to take some time to talk to you about how you are and answer any questions you might have...

Share the information that you have directly and honestly.

- Ask students if they know what happened. Ask them how they found out. At this point allow them to share what they know or think without correcting them.
- Allow students to ask questions. Answer questions as best you can, knowing that it is okay to say "I don't know" when you don't have the answer.
- Talk to your class about how grief affects people and encourage them to share how they feel. One way to do this is to discuss what other types of losses or deaths the students in your class have experienced, and what helped them cope.
- Let students know that if they would like to write a letter and/or draw a picture to support the family that they could do so.
- Let students and families know that there are support counselors that they can speak with today who can help with on-going support as well.
- Discuss how difficult it may be for their classmate(s) to return to school, and how they may help. You can ask your class for ideas about how they would like others to treat them if they were returning to school after a death, pointing out differences in preferences such as:

    - Some grieving students might like to be left alone while others may want the circumstances discussed freely.
    - Some grieving students may want everyone to treat them the same way they treated them before. These students typically don't like people being "extra nice".
    - Other grieving students may say they don't want to be in the spotlight, but they may also feel like they don't want people acting like nothing happened.

Provide a way for your class to reach out to the grieving classmate and his or her family. One of the ways that students can reach out is by sending cards or pictures to the child and family, letting them know the class is thinking of them. If students in your class knew the person who died, they could share memories of that person.

From KARA: Moving through Grief Toward Hope and Meaning. www.kara-grief.org

FACTS ABOUT SUICIDE AND MENTAL DISORDERS IN ADOLESCENTS

Suicide is not inexplicable and is not simply the result of stress or difficult life circumstances. The key suicide risk factor is an undiagnosed, untreated, or ineffectively treated mental disorder. Research shows that over 90 percent of people who die by suicide have a mental disorder at the time of their death.

In teens, the mental disorders most closely linked to suicide risk are major depressive disorder, bipolar disorder, generalized anxiety disorder, conduct disorder, substance use disorder, and eating disorders. While in some cases these disorders may be precipitated by environmental stressors, they can also occur as a result of changes in brain chemistry, even in the absence of an identifiable or obvious "reason."

Suicide is almost always complicated. In addition to the underlying disorders listed above, suicide risk can be affected by personality factors such as impulsivity, aggression, and hopelessness. Moreover, suicide risk can also be exacerbated by stressful life circumstances such as a history of childhood physical and/or sexual abuse; death, divorce, or other trauma in the family; persistent serious family conflict; traumatic breakups of romantic relationships; trouble with the law; school failures and other major disappointments; and bullying, harassment, or victimization by peers.

It is important to remember that the vast majority of teens who experience even very stressful life events do not become suicidal. In some cases, such experiences can be a catalyst for suicidal behavior in teens who are already struggling with depression or other mental health problems. In others, traumatic experiences (such as prolonged bullying) can precipitate depression, anxiety, abuse of alcohol or drugs, or another mental disorder, which can increase suicide risk. Conversely, existing mental disorders may also lead to stressful life experiences such as family conflict, social isolation, relationship breakups, or school failures, which may exacerbate the underlying illness and in turn increase suicide risk.

Warning Signs of Suicide

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has recently increased in frequency or intensity, and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or kill oneself
- Looking for ways to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated, or behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

What to Do in a Crisis

Take any threat or talk about suicide seriously. Start by telling the person that you are concerned. Don't be afraid to ask whether she or he is considering suicide or has a plan or method in mind. Resist the temptation to argue the person out of suicide by saying, "You have so much to live for" or "Your suicide will hurt your family and friends." Instead, seek professional help.

In an acute crisis:

- Call 911.
- Do not leave the person alone.
- If safe to do so, remove any firearms, alcohol, drugs, or sharp objects that could be used.
- Call the National Suicide Prevention Lifeline: 1-800-273-TALK (8255).
- Take the person to an emergency room or walk-in clinic at a psychiatric hospital.

Symptoms of Mental Disorders Associated with Suicide Risk

Most adults are not trained to recognize signs of serious mental disorders in teens, and symptoms are therefore often misinterpreted or attributed to normal adolescent mood swings, laziness, poor attitude, or immaturity. Diagnosis of a mental disorder should always be made by a qualified mental health professional.

The key symptoms of ***major depressive disorder*** in teens are sad, depressed, angry, or irritable mood and lack of interest or pleasure in activities the teen used to enjoy, lasting at least two weeks. Symptoms represent a clear change from the person's normal behavior and may include changes in appetite or sleep, feelings of worthlessness/guilt, inability to concentrate, slowed or agitated movement, recurrent thoughts of death or suicide, fatigue/loss of energy, and self-harm behavior.

Sometimes referred to as ***manic depression, bipolar disorder*** includes alternating episodes of depression and mania. Symptoms of mania last at least one week, cause clear social or academic problems, and include extreme distractibility, lack of need for sleep, unusually rapid speech or motor activity, excessive talking, and involvement in risky activities such as gambling or irresponsible sexual behavior.

The key characteristics of ***generalized anxiety*** include persistent worry (about tests or speaking in class) occurring on most days for a period of six months. Symptoms may include restlessness or feeling keyed up, irritability, being easily fatigued, muscle tension, difficulty concentrating, and sleep disturbances.

Teens with ***substance use disorder*** show a problematic pattern of drug or alcohol use over 12 months or more, leading to significant impairment or distress. Symptoms include taking larger amounts, over a longer period, than intended; continued use despite knowing that it is causing problems; increased irritability and anger; sleep disturbances; and family conflict over substance use.

Conduct disorder is a repetitive, persistent pattern in children or adolescents of violating the rights of others, rules, or social norms, occurring over 12 months. Symptoms include bullying or threatening others, physical fights, fire-setting, destroying property, breaking into houses/cars, physical cruelty to people or animals, lying, shoplifting, running away from home, and frequent truancy.

Anorexia nervosa and bulimia are ***eating disorders*** that are strongly linked to other mental disorders, especially depression and anxiety. Symptoms of anorexia nervosa include refusal to maintain body weight at a minimally normal level for age and height, intense fear of gaining weight, and a denial of low body weight. Symptoms of bulimia include repeated episodes of binge eating (at least twice a week for three months) combined with recurrent inappropriate behaviors to avoid gaining weight such as vomiting, misuse of laxatives, or excessive exercise.

Help Is Available

If there are concerns about a student's emotional or mental health, a referral should be made to an appropriate mental health professional for assessment, diagnosis, and possible treatment. Mental health resources that may be available include school counselors, community mental health agencies, emergency psychiatric screening centers, and children's mobile response programs. Pediatricians and primary care providers can also be a source of mental health referrals.

Some depressed teens show improvement in just four to six weeks with talk therapy alone. Most others experience a significant reduction of depressive symptoms with antidepressant medication. Medication is usually essential in treating severe depression and. other serious mental disorders, such as bipolar disorder and schizophrenia. Since 2004, an FDA warning has recommended close monitoring of youth taking antidepressants for worsening of symptoms, suicidal thoughts or behavior, and other changes. Risks of medication must be weighed against the risks of not effectively treating depression or other serious mental disorders.

Adapted with permission from More *Than Sad: Preventing Teen Suicide,* American Foundation for Suicide Prevention, http://www.morethansad.org.)

Additional Information

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AFSP & SPRC: After a Suicide a Toolkit for Schools 2011

MEMORIALIZATION

School communities often wish to memorialize a student who has died, reflecting a basic human desire to remember those we have lost. It can be challenging for schools to strike a balance between compassionately meeting the needs of distraught students while preserving the ability of the school to fulfill its primary purpose of education. In the case of suicide, schools must consider how to appropriately memorialize the student who died without risking suicide contagion among other students who may themselves be at risk.

KEY CONSIDERATIONS

It is very important that schools strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student's family and friends.

Nevertheless, because adolescents are especially vulnerable to the risk of suicide contagion, it's equally important to memorialize the student in a way that doesn't inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying mental health issues such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

Wherever possible, schools should both meet with the student's friends and coordinate with the family, in the interest of identifying a meaningful, safe approach to acknowledging the loss. This section includes several creative suggestions for memorializing students who have died by suicide.

Funerals and Memorial Services

All the recommendations made here focus on keeping the regular school schedule intact to the maximum extent possible for the benefit of the entire student body (including those who may not have known the deceased).

While at first glance schools may appear to provide an obvious setting for a funeral or memorial service because of their connection to the community and their ability to accommodate a large crowd, it is strongly advised that such services not be held on school grounds, to enable the school to focus instead on maintaining its regular schedule, structure, and routine. Additionally, using a room in the school for a funeral service can inextricably connect that space to the death, making it difficult for students to return there for regular classes or activities.

In situations where school personnel are able to collaborate with the family regarding the funeral or memorial service arrangements, it is also strongly advised that the service be held outside of school hours.

If the family does hold the service during school hours, it is recommended that school remain open and that school buses not be used to transport students to and from the service. Students should be permitted to leave school to attend the service only with appropriate parental permission (regular school protocols should be followed for dismissing students over the age of majority).

If possible, the school should coordinate with the family and funeral director to arrange for counselors to attend the service. A guide for funeral directors is available at http://www.sprc.org/sites/default/files/migrate/library/funeraldirectors.pdf. In all cases, the principal or another senior administrator should attend the funeral.

Schools should strongly encourage parents whose children express an interest in attending the funeral to attend with them. This provides not only emotional support but also an opportunity for parents to open a discussion with their children and remind them that help is available if they or a friend are in need.

Spontaneous Memorials

In the immediate aftermath of a suicide death, it is not unusual for students to create a spontaneous memorial by leaving flowers, cards, poems, pictures, stuffed animals, or other items in a place closely associated with the student, such as his or her locker or classroom seat, or at the site where the student died. Students may even come to school wearing t-shirts or buttons bearing photographs of the deceased student.

The school's goal should be to balance the students' need to grieve with the goal of limiting the risk of inadvertently glamorizing the death. In all cases, schools should have a consistent policy so that suicide deaths are handled in the same manner as any other deaths. A combination of time limits and straightforward communication can help to restore equilibrium and avoid glamorizing the death in ways that may increase the risk of contagion. Although it may in some cases be necessary to set limits for students, it is important to do so with compassion and sensitivity, offering creative suggestions whenever possible. For example, schools may wish to make poster board and markers available so that students can gather and write messages. It is advisable to set up the posters in an area that may be avoided by those who don't wish to participate (i.e., not in the cafeteria or at the front entrance). After a few days, the posters can be removed and offered to the family.

When a memorial is spontaneously created on school grounds, schools are advised to monitor it for messages that may be inappropriate (hostile or inflammatory) or that indicate students who may themselves be at risk. Schools can leave such memorials in place until after the funeral (or for up to approximately five days), after which the tribute objects may be offered to the family. It is generally not necessary to prohibit access to the site or to cordon it off, which would merely draw excessive attention to it.

It is recommended that schools discourage requests to create and distribute t-shirts and buttons bearing images of the deceased by explaining that, while these items may be comforting to some students, they may be quite upsetting to others. If students come to school wearing such items without first seeking permission, it is recommended that they be allowed to wear the items for that day only, and that it should be explained to them that repeatedly bringing images of the deceased student into the school can be disruptive and can glamorize suicide.

Since the emptiness of the deceased student's chair can be unsettling and evocative, after approximately five days (or after the funeral), seat assignments may be re-arranged to create a new environment. Teachers should explain in advance that the intention is to strike a compassionate balance between honoring the student who has died while at the same time returning the focus back to the classroom curriculum. The students can be involved in planning how to respectfully remove the desk; for example, they could read a statement that emphasizes their love for their friend and their commitment to work to eradicate suicide in his or her memory.

When a spontaneous memorial occurs off school grounds, the school's ability to exert influence is limited. It can, nevertheless, encourage responsible approach among the students by explaining that it is recommended that memorials be time-limited (again, approximately five days, or until after the funeral), at which point the memorial would be disassembled and the items offered to the family. Another approach is to suggest that the students participate in a (supervised) ceremony to disassemble the memorial, during which music could be played and students could be permitted to take part of it home; the rest of the items would then be offered to the family.

Students may also hold spontaneous gatherings or candlelight vigils. Schools should discourage gatherings that are large and unsupervised; when necessary, administrators may consider enlisting the cooperation of local police to monitor off-campus sites for safety. Counselors can also be enlisted to attend these gatherings to offer support, guidance, and supervision.

It is *not* recommended that flags be flown at half-staff (a decision generally made by local government authorities rather than the school administration in any event).

School Newspapers
Coverage of the student's death in the school newspaper may be seen as a kind of memorial; also, articles can be used to educate students about suicide warning signs and available resources. It is strongly recommended that any such coverage be reviewed by an adult to ensure that it conforms to the standards set forth in *Reporting on Suicide: Recommendations for the Media*, which was created by the nation's leading suicide prevention organizations.

Events
The student's classmates may wish to dedicate an event (such as a dance performance, poetry reading, or sporting event) to the memory of their friend. End-of-the-year activities may raise questions of whether to award a posthumous degree or prize, or include a video tribute to the deceased student during graduation. The guiding principle is that all deaths should be treated the same way. Schools may also wish to encourage the student's friends to consider creative suggestions, such as organizing a suicide prevention-awareness or fundraising event.

Often, the parents of the deceased student express an interest in holding an assembly or other event to address the student body and describe the intense pain the suicide death has caused to their family in the hopes that this will dissuade other students from taking their own lives. While it is surely understandable that bereaved parents would wish to prevent another suicide death, schools are strongly advised to explain that this is not an effective approach to suicide prevention and may in fact even be risky, because students who are suffering from depression or other mental health issues may hear the messaging very differently from the way it is intended, and may even become more likely to act on their suicidal thoughts. Instead, parents should be encouraged to work with the school to bring an appropriate educational program to the school, such as *S.O.S. Signs of Suicide*, a DVD that educates teens about the signs and symptoms of depression or others that are listed in the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry (available at http://www.sprc.org).

Yearbooks
Again, the guiding principle is that all deaths should be treated the same way. So if there is a history of dedicating the yearbook (or a page of the yearbook) to students who have died, that policy is equally applicable to a student who has died by suicide, provided that an adult makes final editorial decisions.

Whenever possible, the focus should be on mental health and/or suicide prevention. For example, underneath the student's picture it might say, "In your memory we will work to erase the stigma surrounding mental illness and suicide." The page might also include pictures of classmates engaging in a suicide prevention event such as an Out of the Darkness community walk (http://www.outofthedarkness.org).

Graduation
If there is a tradition of including a tribute to deceased students who would have graduated with the class, students who have died by suicide should likewise be included. For example, schools may wish to include a brief statement acknowledging and naming those students from the graduating class who have died. Final decisions about what to include in such tributes should be made by an adult.

Permanent Memorials and Scholarships
Some communities wish to establish a permanent memorial (sometimes physical, such as planting a tree or installing a bench or plaque; sometimes commemorative, such as a scholarship). Others are afraid to do so.

While there is no research to suggest that permanent memorials per se create a risk of contagion, they can prove to be upsetting reminders to bereaved students, and therefore disruptive to the school's goal of maintaining emotional regulation. Whenever possible, therefore, it is recommended that they be established off school grounds. Moreover, the school should bear in mind that once it plants a tree, puts up a plaque, installs a park bench, or establishes a named scholarship for one deceased student, it should be prepared to do so for others, which can become quite difficult to sustain over time.

Creative Suggestions

Some schools may resist allowing any kind of memorialization at all, damping down on any student desire to publicly acknowledge the death for fear of glamorizing suicide and risking suicide contagion. But simply prohibiting any and all memorialization is problematic in its own right–it is deeply stigmatizing to the student's family and friends, and can generate intense negative reactions, which can exacerbate an already difficult situation and undermine the school's efforts to protect the student body's emotional regulation.

Schools can play an important role in channeling the energy and passion of the students (and greater community) in a positive direction, balancing the community's need to grieve with the impact that the proposed activity will likely have on students, particularly those who were closest to the student who died.

It can be helpful for schools to proactively suggest a meeting with the student's close friends to talk about the type and timing of any memorialization. This can provide an important opportunity for the students to be heard and for the school to sensitively explain its rationale for permitting certain kinds of activities and not others. Schools may even wish to establish a standing committee composed of students, school administrators, and family members that can be convened on an as–needed basis.

It can also be helpful for schools to come equipped with specific, constructive suggestions for safe memorialization, such as:

- Holding a day of community service or creating a school–based community service program in honor of the deceased
- Putting together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (e.g., http:www.outofthedarkness.org), or holding a local fundraising event to support a local crisis hotline or other suicide prevention program
- Sponsoring a mental health awareness day
- Purchasing books on mental health for the school or local library
- Working with the administration to develop and implement a curriculum focused on effective problem–solving
- Volunteering at a community crisis hotline
- Raising funds to help the family defray their funeral expenses
- Making a book available in the school office for several weeks in which students can write messages to the family, share memories of the deceased, or offer condolences; the book can then be presented to the family on behalf of the school community

Additional Information

Centre for Suicide Prevention (Calgary). School Memorials After Suicide: Helpful or harmful? (2004). http://www.sprc.org/library_resources/items/school–memorials–after–suicide–helpful–or–harmful

Gould, M. et al. Media Contagion and Suicide Among the Young. American Behavioral Scientist 46:9 (May 2003) 1269–1284.

Jellinek, M. et al. When a Student Dies. Educational Leadership Association for Supervision and Curriculum Development (November 2007); 78–82.

National Association of School Psychologists. Memorial Activities at School: A List of "Do's" and "Don'ts" (2002). http://www.nasponline.org/resources/crisis_safety/memorialdo_donot.pdf

National School Board Association. Student Suicide Memorial Policy. School Board News.18 (March 24, 1998).

GUIDELINES FOR MEMORIAL ACTIVITIES FOLLOWING A SUICIDE

Because of the danger of "contagion" (increased suicide ideation, gestures, and attempts following a completed suicide), schools should be careful not to glorify or sensationalize the death in any way. For this reason, it is recommended that the suicide victim not be memorialized at school, as a memorial places the deceased in the position of a role model.

DO'S and DON'TS following a suicide (Brock, S. E. & Lieberman, R., 2008):

- DO something to prevent other suicides from happening.
- DO develop living memorials [e.g., Students Against Violence Everywhere Club (SAVE)] that help other students cope with feelings and problems.
- DO allow any student, with parental permission, to attend the funeral.
- DO encourage affected students, with parental permission, to go to the funeral.
- DO mention to school staff, affected families, and clergy the need to distance the person who committed suicide from survivors and to avoid glorifying the suicidal act.
- DON'T have a large school assembly to notify the school community members of a suicide.
- DON'T fly the flag at half-staff.
- DON'T have a moment of silence in all-school activities.
- DON'T have mass assemblies focusing on the suicide victim.
- DON'T make special arrangements to send all students from school to the funeral.
- DON'T have memorial or funeral services at school.
- DON'T put plaques in memory of the suicide victim.
- DON'T dedicate yearbooks, songs, or sporting events to the person who committed suicide.

This "hard-line" position against memorializing suicide victims can be very difficult for schools to follow and explain. Often, students may want a permanent memorial, especially if the suicide victim was popular. In some instances, parents also may request a memorial to honor their child. In such situations, it may be helpful to mention that this guideline is recommended by the American Association of Suicidology and explain why this ban on memorial is necessary (i.e., to prevent suicide "contagion").

WORKING WITH THE COMMUNITY

Because schools exist within the context of a larger community, it's very important that in the aftermath of a suicide or other death they establish and maintain open lines of communication with community partners such as the coroner/medical examiner, police department, mayor's office, funeral director, clergy, and mental health professionals.

KEY CONSIDERATIONS

The school is in a unique position to encourage open and constructive dialogue among important community partners, as well as with the family.

Even in those realms where the school may have limited authority (such as the funeral), a collaborative approach allows for the sharing of important information and coordination of strategies. For example, a school may be able to offer relevant information (such as the likely turnout at the funeral) and anticipate problems (such as the possibility that students may gather late at night at the place where the deceased died). A coordinated approach can be especially critical when the suicide death receives a great deal of media coverage and the entire community becomes involved.

Coroner/Medical Examiner

The coroner or medical examiner is the best starting point for confirming that the death has in fact been declared a suicide. (In some cases, it may also be necessary to contact the police department to verify the information). It is important that schools Get the Facts First and ascertain that all information is accurate before communicating with students.

However, given how quickly news and rumors spread {including through media coverage, e-mail, texting, and social networking sites), schools may not be able to wait for a final determination before they need to begin communicating with the students. In those cases, schools can say, "At this time, this is what we know..."

There may also be cases in which there is disagreement between the authorities and the family regarding the cause of death. For example, the death may have been declared a probable suicide but the family believes it to have been a homicide or an accident. Or the death may have been declared a suicide, but the family does not want this communicated, perhaps due to stigma, for fear of risking contagion, or because they simply do not (yet) believe or accept that it was suicide.

Schools have a responsibility to balance the need to be truthful with the school community while remaining sensitive to the family. They can take this opportunity to educate the community (including potentially vulnerable students) about the causes and complexity of suicide and to identify available mental health resources. For example, a school might say; "According to the medical examiner, the death has been declared a suicide. It can sometimes be difficult for us to be absolutely sure whether a death was intentional or not (for example, in the case of a drug overdose or a motor vehicle accident involving a single vehicle). While we may never know all of the details, we are deeply saddened, and want to take this opportunity to teach you some important information about suicide and where you can find help."

Of course, if a legal gag order is in effect, the school attorney should first research the applicable state law regarding discussing the cause of death before the school issues a statement.

Police Department

The police will likely be an important source of information about the death, particularly if there is an ongoing investigation (for example, if it has not yet been determined whether the death was suicide or homicide). The school will need to be in close communication with the police to determine (a) what they can and cannot say to the school community so as not to interfere with the investigation, and (b) whether there are certain students who must be interviewed by the police before the school can debrief or counsel them in any way.

There may also be situations in which the school has information that's relevant to the ability of the police to keep students safe. For example, the school may become aware that students have established a memorial off-campus and may even be engaging in dangerous behavior (such as gathering in large groups at the site of the

death at night or holding vigils at which alcohol is being consumed) and may need to enlist the cooperation of the police to keep the students safe. The school may also be in a unique position to brief the police (and even the family) about what to expect at the funeral or memorial service in terms of turnout and other safety concerns.

Mayor's Office and Local Government

A student suicide death may reveal an underlying community-wide problem such as drug or alcohol use, bullying, gang violence, or a possible community-wide suicide cluster. Because schools function within-not separate from--the surrounding community, local government entities such as the mayor's office can be helpful partners in promoting dialogue and presenting a united front in the interest of protecting the community's young people.

Funeral Director

The school and funeral home are complementary sources of information for the community. Schools are often in an excellent position to give the funeral director a heads-up about what to expect at the funeral in terms of the number and types of students likely to attend, and the possible need to have additional security present. The school can also provide information about local counseling and other resources to the funeral directors, with the request that the information be made available to attendees at the funeral.

Schools can ask the funeral director to provide (or recommend) materials that the school could provide to students to help them prepare for the funeral. Schools can also encourage the funeral director to talk to the family about the importance of scheduling the service outside of school hours, encouraging students' parents to attend, and providing counselors to meet with distraught students after the service (and the need for a quiet area in which to do so).

Clergy

Because the school may be in the best position to understand the risk of contagion, it can play an important role by encouraging a dialogue between the family and the clergy (or whomever will be officiating at the service) to help sensitize them to the issue. This dialogue may provide an opportunity to explain the importance of not inadvertently romanticizing either the student or the death in the eulogy, but instead emphasizing the connection between suicide and underlying mental health issues such as depression or anxiety, which can cause substantial psychological pain but may not be apparent to others (or may manifest as behavioral problems or substance abuse).

Of course, if the school has a religious affiliation, it will be important to include clergy who are on staff in any communications and outreach efforts to support the student body, and encourage them to be familiar with their faith's current understanding of the relationship between mental illness and suicide.

Mental Health and Medical Communities

Most schools have counselors on staff, and it is important that these individuals are linked to other mental health professionals in the community. In particular, 1t is advisable that the school establish an ongoing relationship with a community mental health center that can see students in the event of a psychiatric emergency. In the aftermath of a suicide death, schools will want to notify the center to ensure seamless referrals if students show signs of disuses. Schools will also want to publicize crisis hotline numbers such as Lifeline: 800-273-TALK (8255).

In addition, schools can encourage the local medical community, including primary care doctors and pediatricians, to screen for depression, substance abuse, and other relevant disorders in the youth they see.

Outside Trauma Responders

Working with schools in the aftermath of a suicide death can easily exhaust school crisis team members, which can interfere with their ability to effectively assist the students. Bringing in trained trauma responders from other school districts or local mental health or crisis centers to work alongside the school's crisis team members-and to provide care for the caregivers-can be quite helpful.

Community Organizations

Schools may also wish to network with their local chapter of the American Foundation for Suicide Prevention and with suicide bereavement support groups (see http://www.afsp.org).

Additional Information

SPAN USA and Suicide Prevention Resource Center (SPRC). Help at Hand: Supporting Survivors of Suicide loss. A guide for funeral directors. (2008). http://www.sprc./library/funeraldirectors.pdf

Suicide Prevention Resource Center (SPRC). After a suicide: Recommendations for religious services and other public memorial observances. (2004). http://www.sprc.org/library/aftersuicide.pdf

Suicide Prevention Resource Center (SPRC). Consensus Statement on Suicide and Suicide Prevention from an Interfaith Dialogue. (2009). http://www.sprc.org/library/Consensus_Statement.pdf

GUIDELINES FOR ANNIVERSARIES OF A DEATH

A revisiting of grief feelings can resurface on or near the anniversary date of a tragic loss. In some cultures, there is a memorial ceremony held about one year after a death. Faculty and staff, if reminded of the anniversary, can be prepared to monitor and support students at that time. Adults are not immune to this, and so staff members may also revisit the loss. The postvention team may consider a follow-up program on the anniversary date. The school should be prepared for grief and emotions associated with the death that may also occur on other occasions, such as:

- The birthday of the person who died
- Holidays
- Athletic or other events in which the deceased would have participated
- The start of a school year
- Proms
- Graduation

The following actions can help a school prepare for such an anniversary:

- Remind staff to be aware that students may experience emotional reactions
- Educate staff about the warning signs of suicide and how to recognize and respond to students who may be at risk or experience severe emotions
- Remind staff that they may also experience an emotional reaction on this date
- Have grief counselors or mental health professionals on call

Adapted from Kerr, M, Brent, D., McKain, B., & McCommons, P (2003). Postvention standards manual: A guide for a school's response in the aftermath of sudden death 4th ed.) Pittsburgh: University of Pittsburgh/Western Psychiatric Institute and Clinic

GUIDELINES FOR WORKING WITH THE MEDIA

The staff person responsible for working with the media should prepare a written statement for release to those media representatives who request it. The statement should include the following:

- A very brief statement acknowledging the death of the student that does not include details about the death
- An expression of the school's sympathy to the survivors of the deceased
- Information about the school's postvention policy and program

All other staff (including school board members) should:

- Refrain from making any comments to or responding to requests from the media
- Refer all requests from the media to the person responsible for working with the media

Media representatives should:

- *Not* be permitted to conduct interviews on the school grounds
- *Not be* allowed to attend parent and student group meetings in order to protect information shared by parents who are concerned about their children
- Be provided with a copy of SPRC's information sheet "At-a-Glance: Safe Reporting on Suicide," which can be found at http://www.sprc.org/library/at_a_glance.pdf

Adapted from Kerr, M, Brent, D., McKain, B., & McCommons, P. (2003). Postvention standards manual: A guide for a school's response in the aftermath of sudden death (4th ed.) Pittsburgh: University of Pittsburgh/Western Psychiatric Institute and Clinic.

SOCIAL MEDIA

The term social media refers to the various Internet and mobile communications tools (such as texting, Facebook, Twitter, YouTube, MySpace and others) that may be used to communicate information extremely rapidly, often to large numbers of people. In the emotionally charged atmosphere that can follow a suicide death, schools may be inclined to try to control or stifle such communications by students--a task that is virtually impossible in any event, since they generally take place outside of school hours and property. Schools can, however, utilize social media effectively to disseminate information and promote suicide prevention efforts.

KEY CONSIDERATIONS

Following a suicide death, students may immediately turn to social media for a variety of purposes, including transmitting news about the death (both accurate and rumored), calling for impromptu gatherings (both safe and unsafe), creating online memorials (both moving and risky), and posting messages (both appropriate and hostile) about the deceased.

Although schools may initially consider social media to be outside of its traditional jurisdiction, they can in fact collaborate with students and utilize these tools to disseminate important and accurate information to the school community, identify students who may be in need of additional support or further intervention, share resources for grief support and mental health care, and promote safe messages that emphasize suicide prevention and minimize the risk of suicide contagion.

Involve Students

It can be very beneficial for a designated member of the Crisis Response Team (ideally someone from the school's information technology department) to reach out to friends of the deceased and other key students to work collaboratively in this area. Working in partnership with student leaders will enhance the credibility and effectiveness of social media efforts, since the students themselves are in the best position to help identify the particular media favored by the student body, engage their peers in honoring their friend's life appropriately and safely, and inform school staff about online communications that may be worrisome.

Students who are recruited to help should be reassured that school staff are only interested in supporting a healthy response to their peer's death, not in thwarting communication. They should also be made aware that staff are available and prepared to intervene if any communications reveal cause for concern.

Disseminate Information

- Schools may already have a website and/or an online presence (or page) on one or more social media sites; students can help identify others that are currently popular. These can be used to proactively communicate with students, teachers, and parents about:
- The funeral or memorial service (schools should of course check with the student's family before sharing information about the funeral)
- Where students can go for help or meet with counselors
- Mental illness and the causes of suicide
- Local mental health resources
- The National Suicide Prevention Lifeline number: 800-273-TALK (8255)
- National suicide prevention organizations such as the National Suicide Prevention Lifeline (http:llwww. suicidepreyentionlifeline.org), the American Foundation for Suicide Prevention (http:// afsp.org),

Schools should emphasize help-seeking and suicide prevention. More specific guidance for safe message content may be found at http://www.sprc.org/llbrazy/SafeMessagingfinaJ.pdf. Students can also be enlisted to post this information on their own online pages.

Online Memorial Pages

Online memorial pages and message boards have become common practice in the aftermath of a death.

Some schools (with the permission and support of the deceased student's family) may choose to establish a memorial page on the school website or on a social networking site. As with all memorialization following a suicide death, such pages should take care not to glamorize the death in ways that may lead other at-risk students to identify with the person who died. It is therefore vital that memorial pages utilize safe messaging, include resources, be monitored by an adult, and be time-limited.

It is recommended that online memorial pages remain active for up to 30 to 60 days after the death, at which time they should be taken down and replaced with a statement acknowledging the caring and supportive messages that had been posted and encouraging students who wish to further honor their friend to consider other creative suggestions.

If the student's friends create a memorial page of their own, it is important that school personnel communicate with the students to ensure that the page includes safe messaging and accurate information. School personnel should also join any student-initiated memorial pages so that they can monitor and respond as appropriate.

Monitor and Respond

To the extent possible, social media sites {including the deceased's wall or personal profile pages) should be monitored for:

- Rumors
- Information about upcoming or impromptu gatherings
- Derogatory messages about the deceased
- Messages that bully or victimize current students
- Comments indicating students who may themselves be at risk

Responses may include posting comments that dispel rumors, reinforce the connection between mental illness and suicide, and offer resources for mental health care. In some cases, the appropriate response may go beyond simply posting a comment, safe message, or resource information. It may extend to notifying parents and local law enforcement about the need for security at a late-night student gathering, for example.

In some cases, it may be necessary to take action against so-called trolls who may seek out memorial pages on social media sites and post deliberately offensive messages and pictures. Most sites have a report mechanism or comparable feature, which enables users to notify the site of the offensive material and request that it be removed. The administrator of the memorial page may also be able to block particular individuals from accessing the site. Because the available options vary from site to site and can evolve over time, schools are advised to contact the particular site for instructions.

The National Suicide Prevention Lifeline has developed an in-depth online postvention manual that details how to find various social media sites and other online groups, post resources, and reach out to parents. It also includes case examples and resource links and is available at

On occasion, schools may become aware of posted messages indicating that another student may be at risk of suicide. Messages of greatest concern may suggest hopelessness or refer to plans to join the deceased student. In those instances, it may be necessary to alert the student's family and/or contact the National Suicide Prevention Lifeline to request that a crisis center follow up with the student.

Additional Information

National Suicide Prevention Lifeline. Lifeline online postvention manual.
http://www.sprc.org/library/LifelineOnlinePostventionManual.pdf
Suicide Prevention Resource Center (SPRC). Safe and Effective Messaging for Suicide Prevention. (2006).
http://www.sprc.org/library/SafeMessagingfinal.pdf

SAMPLE MEDIA STATEMENT

To be provided to local media outlets either upon request or proactively.

School personnel were informed by the coroner's office that a _____ year-old student at _____ school has died. The cause of death was suicide. Our thoughts and support go out to [his/her] family and friends at this difficult time.

The school will be hosting a meeting for parents and others in the community at [date/time/location]. Members of the school's Crisis Response Team [or mental health professionals] will be present to provide information about common reactions following a suicide and how adults can help youths cope. They will also provide information about suicide and mental illness in adolescents, including risk factors and warning signs of suicide, and will address attendees' questions and concerns. A meeting announcement has been sent to parents, who can contact school administrators or counselors at [number] or [e-mail address] for more information.

Trained crisis counselors will be available to meet with students and staff starting tomorrow and continuing over the next few weeks as needed.

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has recently increased in frequency or intensity, and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or kill oneself
- Looking for ways to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated, or behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

Contra Costa Crisis Center Suicide and Crisis Hotline

1-800-833-2900

Text “HOPE” to 20121

Local Mental Health Resources:

Refer to Appendix B1, Resource List, SRVUSD Comprehensive Suicide Prevention Toolkit

Recommendations for Reporting on Suicide

Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion ("copycat" suicides), particularly among youth.

Media are strongly encouraged to refer to the document "Reporting on Suicide: Recommendations for the Media," which is available at http://www.afsp.org/media and http://reportingonsuicide.org/

Media Contact

Name_____ Title_____

School_____ Phone_____

E-Mail Address_____

AFSP & SPRC After a Suicide: A Toolkit for Schools 2011

KEY MESSAGES FOR MEDIA SPOKESPERSON

For use when fielding media inquiries.

Suicide/Mental Illness

- Depression is the leading cause of suicide in teenagers.
- About 6 percent of teenagers will develop depression yearly. Sadly, more than 80 percent of these kids will not have their illness properly diagnosed or treated, which can also lead to school absenteeism, failing grades, dropouts, crimes, and drug and alcohol abuse.
- Depression is among the most treatable of all mood disorders. More than three fourths of people with depression respond positively to treatment.
- The best way to prevent suicide is through early detection, diagnosis, and vigorous treatment of depression and other mental disorders, including addictions.

School's Response Messages

- We are heartbroken over the death of one of our students. Our hearts, thoughts, and prayers go out to [his/her] family and friends, and the entire community.
- We will be offering grief counseling for students, faculty and staff starting on [date] through [date].
- We will be hosting an informational meeting for parents and the community regarding suicide prevention on [date/time/location]. Experts will be on hand to answer questions.
- No 1V cameras or reporters will be allowed in the school or on school grounds.

School Response to Media

- Media are strongly encouraged to refer to the document "Reporting on Suicide: Recommendations for the Media," which is available at http://www.afsp.org/media and http://reportingonsuicide.org/
- Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion ("copycat" suicides), particularly among youth.
- Media coverage that details the location and manner of suicide with photos or video increases risk of contagion.
- Media should also avoid oversimplifying cause of suicide (e.g., "student took his own life after breakup with girlfriend"). This gives the audience a simplistic understanding of a very complicated issue.
- Instead, remind the public that more than 90 percent of people who die by suicide have an underlying mental disorder such as depression.
- Media should include links to or information about helpful resources such as local crisis hotlines or the National Suicide Prevention Lifeline 800-273-TALK (8255).

AFSP & SPRC: After a Suicide a Toolkit for Schools 2011

RECOMMENDATIONS FOR REPORTING ON SUICIDE©

Developed in collaboration with: American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project - University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, Substance Abuse and Mental Health Services Administration, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Sciences.

IMPORTANT POINTS FOR COVERING SUICIDE

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

Suicide Contagion or "Copycat Suicide" occurs when one or more suicides are reported in a way that contributes to another suicide.

References and additional information can be found at: www.ReportingOnSuicide.org.

INSTEAD OF THIS:	DO THIS:
• Big or sensationalistic headlines, or prominent placement (e.g., "Kurt Cobain Used Shotgun to Commit Suicide").	• Inform the audience without sensationalizing the suicide and minimize prominence (e.g., "Kurt Cobain Dead at 27").
• Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.	• Use school/work or family photo; include hotline logo or local crisis phone numbers.
• Describing recent suicides as an "epidemic," "skyrocketing," or other strong terms.	• Carefully investigate the most recent CDC data and use non-sensational words like "rise" or "higher."
• Describing a suicide as inexplicable or "without warning."	• Most, but not all, people who die by suicide exhibit warning signs. Include the "Warning Signs" and "What to Do" sidebar (from p. 2) in your article if possible.
• "John Doe left a suicide note saying...".	• "A note from the deceased was found and is being reviewed by the medical examiner."
• Investigating and reporting on suicide similar to reporting on crimes.	• Report on suicide as a public health issue.
• Quoting/interviewing police or first responders about the causes of suicide.	• Seek advice from suicide prevention experts.
• Referring to suicide as "successful," "unsuccessful" or a "failed attempt."	• Describe as "died by suicide" or "completed" or "killed him/herself."

AVOID MISINFORMATION AND OFFER HOPE

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.

SUGGESTIONS FOR ONLINE MEDIA, MESSAGE BOARDS, BLOGGERS & CITIZEN JOURNALISTS

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

MORE INFORMATION AND RESOURCES AT:

www.ReportingOnSuicide.org *or the following local resources:*

HELPFUL SIDE-BAR FOR STORIES

WARNING SIGNS OF SUICIDE

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated or recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.

WHAT TO DO

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone
- Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

THE NATIONAL SUICIDE PREVENTION LIFELINE

800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information and local resources.

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

APPENDIX A: Suicide Prevention Policies & Educational Standards

A1. SRVUSD BP 5141.52: Suicide Prevention

A2. SRVUSD AR 5141.52: Suicide Prevention

A3. California AB 2246

A4. Health Education Content Standards for California Public Schools:

Mental, Emotional, and Social Health

A4i. Grade Six

A4ii. Grades Seven and Eight

A4iii. High School (Grades Nine through Twelve)

SCHOOL BOARD POLICY

BP 5141.52 SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT
Adopted: 03.22.16 Danville, California

SUICIDE PREVENTION

The Board of Education recognizes that suicide is a major cause of death among youth and should be taken seriously. In order to attempt to reduce suicidal behavior and its impact on students and families, the Superintendent or designee shall develop preventive strategies and intervention procedures.

The Superintendent or designee may involve school health professionals, school counselors, administrators, other staff, parents/guardians, students, local health agencies and professionals, and community organizations in planning, implementing, and evaluating the district's strategies for suicide prevention and intervention.

Prevention and Instruction

Suicide prevention strategies may include, but not be limited to, efforts to promote a positive school climate that enhances students' feelings of connectedness with the school and is characterized by caring staff and harmonious interrelationships among students.

The district's comprehensive health education program shall promote the healthy mental, emotional, and social development of students including, but not limited to, the development of problem-solving skills, coping skills, and self-esteem. Suicide prevention instruction shall be incorporated into the health education curriculum in the secondary grades. Such instruction shall be aligned with state content standards and shall be designed to help students analyze signs of depression and self-destructive behaviors, including potential suicide, and to identify suicide prevention strategies.

The Superintendent or designee may offer parents/guardians education or information which describes the severity of the youth suicide problem, the district's suicide prevention curriculum, risk factors and warning signs of suicide, basic steps for helping suicidal youth, and/or school and community resources that can help youth in crisis.

Staff Development

Suicide prevention training for staff shall be designed to help staff identify and respond to students at risk of suicide. The training shall be offered under the direction of district counselor/psychologist and/or in cooperation with one or more community mental health agencies and may include information on:

1. Research identifying risk factors, such as previous suicide attempt(s), history of depression or mental illness, substance use problems, family history of suicide or violence, feelings of isolation, interpersonal conflicts, a recent severe stressor or loss, family instability, and other factors.
2. Warning signs that may indicate suicidal intentions, including changes in students' appearance, personality, or behavior.
3. Research-based instructional strategies for teaching the suicide prevention curriculum and promoting mental and emotional health.
4. School and community resources and services.
5. District procedures for intervening when a student attempts, threatens, or discloses the desire to commit suicide.

Intervention

Whenever a staff member suspects or has knowledge of a student's suicidal intentions, he/she shall promptly notify the principal or school counselor. The principal or counselor shall then notify the student's parents/guardians as soon as possible and may refer the student to mental health resources in the school or community.

Students shall be encouraged to notify a teacher, principal, counselor, or other adult when they are experiencing thoughts of suicide or when they suspect or have knowledge of another student's suicidal intentions.

Whenever schools establish a peer counseling system to provide support for students, peer counselors shall complete the suicide prevention curriculum, including identification of warning signs of suicidal behavior and referral of a suicidal student to appropriate adults.

The Superintendent or designee shall establish crisis intervention procedures to ensure student safety and appropriate communications in the event that a suicide occurs or an attempt is made on campus or at a school-sponsored activity.

Also see:
cf. 1020 – Youth Services
cf. 1220 – Citizen Advisory Committees
cf. 1400 – Relations Between Other Governmental Agencies and the Schools
cf. 4131 – Staff Development
cf. 4231 – Staff Development
cf. 4331 – Staff Development
cf. 5131 – Conduct
cf. 5131.6 – Alcohol and Other Drugs
cf. 5137 – Positive School Climate
cf. 5138 – Conflict Resolution/Peer Mediation
cf. 5141 – Health Care and Emergencies
cf. 5141.6 – School Health Services
cf. 5145.3 – Nondiscrimination/Harassment
cf. 5145.7 – Sexual Harassment
cf. 5145.9 – Hate-Motivated Behavior
cf. 6142.8 – Comprehensive Health Education
cf. 6164.2 – Guidance/Counseling Services

ADMINISTRATIVE REGULATION

AR 5141.52 SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT
Approved: 03.22.16 Danville, California

SUICIDE PREVENTION

Instruction

At appropriate secondary grades, the district's suicide prevention instruction shall be designed to help students:

1. Identify and analyze signs of depression and self-destructive behaviors and understand how feelings of depression, loss, isolation, inadequacy, and anxiety can lead to thoughts of suicide.
2. Identify alternatives to suicide and develop coping and resiliency skills.
3. Learn to listen, be honest, share feelings, and get help when communicating with friends who show signs of suicidal intent.
4. Identify trusted adults, school resources, and/or community crisis intervention resources where youth can get help and recognize that there is no stigma associated with seeking mental health, substance abuse, and/or suicide prevention services.

Intervention

When a suicide attempt or threat is reported, the principal or designee shall:

1. Ensure the student's physical safety by one of the following, as appropriate:
   a. Securing immediate medical treatment if a suicide attempt has occurred
   b. Securing law enforcement and/or other emergency assistance if a suicidal act is being actively threatened
   c. Keeping the student under continuous adult supervision until the parent/guardian and/or appropriate support agent or agency can be contacted and has the opportunity to intervene
   2. Designate specific individuals to be promptly contacted, including the school counselor, psychologist, nurse, superintendent, and/or the student's parent/guardian, and, as necessary, local law enforcement or mental health agencies
3. Document the incident in writing as soon as feasible
4. Follow up with the parent/guardian and student in a timely manner to provide referrals to appropriate services as needed
5. Provide access to counselors or other appropriate personnel to listen to and support students and staff who are directly or indirectly involved with the incident at the school
6. Provide an opportunity for all who respond to the incident to debrief, evaluate the effectiveness of the strategies used, and make recommendations for future actions

In the event that a suicide occurs or is attempted on campus, the principal or designee shall follow the crisis intervention procedures contained in the school safety plan. After consultation with the Superintendent or designee and the student's parents/guardians about facts that may be divulged in accordance with the laws governing confidentiality of student record information, the principal or designee may provide students, parents/guardians, and staff with information, counseling, and/or referrals to community agencies as needed. School staff may receive assistance from school counselors or other mental health professionals in determining how best to discuss the suicide or attempted suicide with students.

Also see:
cf. 0450 – Comprehensive Safety Plan
cf. 1020 – Youth Services
cf. 1112 – Media Relations
cf. 5125 – Student Records
cf. 5131.6 – Alcohol and Other Drugs
cf. 5141 – Health Care and Emergencies
cf. 5141.6 – School Health Services
cf. 6142.8 – Comprehensive Health Education
cf. 6164.2 – Guidance/Counseling Services

ASSEMBLY BILL NO. 2246

CHAPTER 642

An act to add Article 2.5 (commencing with Section 215) to Chapter 2 of Part 1 of Division 1 of Title 1 of the Education Code, relating to pupil health.

[Approved by Governor: September 26, 2016. Filed with Secretary of State: September 26, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2246, O'Donnell. Pupil suicide prevention policies.

Existing law establishes a system of public elementary and secondary schools in this state and provides for the establishment of school districts and other local educational agencies to operate these schools and provide instruction to pupils. Existing law establishes the State Department of Education in state government and vests the department with specified powers and duties relating to the state's public school system.

This bill would require the governing board or body of a local educational agency, as defined, that serves pupils in grades 7 to 12, inclusive, to, before the beginning of the 2017–18 school year, adopt a policy on pupil suicide prevention, as specified, that specifically addresses the needs of high-risk groups. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. The bill would require the department to develop and maintain a model policy to serve as a guide for local educational agencies.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) According to the latest 2013 data from the federal Centers for Disease Control and Prevention, suicide is the second leading cause of death for youth and young adults 10 to 24 years of age, inclusive.
(b) As children and teens spend a significant amount of their young lives in school, the personnel who interact with them on a daily basis are in a prime position to recognize the warning signs of suicide and make the appropriate referrals for help.
(c) In a national survey conducted by the Jason Foundation, the number one person whom a pupil would turn to for helping a friend who might be suicidal was a teacher. It is imperative that when a young person comes to a teacher for help, the teacher has the knowledge, tools, and resources to respond.
(d) There are national hotlines available to help adults and lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth experiencing suicidal ideation, including the National Suicide Prevention Lifeline and the Trevor Project, respectively.
(e) According to the Family Acceptance Project, research has found that, for an LGBTQ youth, having at least one supportive adult can reduce the youth's risk of suicide.
(f) A model policy on suicide prevention created in consultation with suicide prevention experts and other stakeholders is available through the Trevor Project for adoption or adaptation, or both, by the State Department of Education and local educational agencies.

SECTION 2. Article 2.5 (commencing with Section 215) is added to Chapter 2 of Part 1 of Division 1 of Title 1 of the Education Code, to read:

Article 2.5. Pupil Suicide Prevention Policies

215. (a) (1) The governing board or body of a local educational agency that serves pupils in grades 7 to 12, inclusive, shall, before the beginning of the 2017–18 school year, adopt, at a regularly scheduled meeting, a policy on pupil suicide prevention in grades 7 to 12, inclusive. The policy shall be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts and shall, at a minimum, address procedures relating to suicide prevention, intervention, and postvention.

(2) The policy shall specifically address the needs of high-risk groups, including, but not limited to, all of the following:

(A) Youth bereaved by suicide.

(B) Youth with disabilities, mental illness, or substance use disorders.

(C) Youth experiencing homelessness or in out-of-home settings, such as foster care.

(D) Lesbian, gay, bisexual, transgender, or questioning youth.

(3) (A) The policy shall also address any training to be provided to teachers of pupils in grades 7 to 12, inclusive, on suicide awareness and prevention.

(B) Materials approved by a local educational agency for training shall include how to identify appropriate mental health services, both at the schoolsite and within the larger community, and when and how to refer youth and their families to those services.

(C) Materials approved for training may also include programs that can be completed through self-review of suitable suicide prevention materials.

(4) The policy shall be written to ensure that a school employee acts only within the authorization and scope of the employee's credential or license. Nothing in this section shall be construed as authorizing or encouraging a school employee to diagnose or treat mental illness unless the employee is specifically licensed and employed to do so.

(5) To assist local educational agencies in developing policies for pupil suicide prevention, the department shall develop and maintain a model policy in accordance with this section to serve as a guide for local educational agencies.

(b) For purposes of this section, "local educational agency" means a county office of education, school district, state special school, or charter school.

SECTION 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

HEALTH EDUCATION CONTENT STANDARDS FOR CALIFORNIA PUBLIC SCHOOLS

Content standards were designed to encourage the highest achievement of every student, by defining the knowledge, concepts, and skills that students should acquire at each grade level.

OVERARCHING CONTENT STANDARDS

The eight overarching health content standards for kindergarten through grade twelve are the following:

Standard 1: *Essential Health Concepts* – All students will comprehend essential concepts related to enhancing health.

Standard 2: *Analyzing Health Influences* – All students will demonstrate the ability to analyze internal and external influences that affect health.

Standard 3: *Accessing Valid Health Information* – All students will demonstrate the ability to access and analyze health information, products, and services.

Standard 4: *Interpersonal Communication* – All students will demonstrate the ability to use interpersonal communication skills to enhance health.

Standard 5: *Decision Making* – All students will demonstrate the ability to use decision-making skills to enhance health.

Standard 6: *Goal Setting* – All students will demonstrate the ability to use goal-setting skills to enhance health.

Standard 7: *Practicing Health-Enhancing Behaviors* – All students will demonstrate the ability to practice behaviors that reduce risk and promote health.

Standard 8: *Health Promotion* – All students will demonstrate the ability to promote and support personal, family, and community health.

CONTENT AREAS

The health education content standards are organized into six health content areas: Nutrition and Physical Activity; Growth, Development, and Sexual Health; Injury Prevention and Safety; Alcohol, Tobacco, and Other Drugs; Mental, Emotional, and Social Health; and Personal and Community Health.

Nutrition and Physical Activity

Nutrition encompasses healthy eating, which is associated with reduced risk of many diseases including the three leading causes of death in the United States: heart disease, cancer, and stroke. Healthy eating in childhood and adolescence is important for proper growth and development and can prevent obesity, type 2 diabetes, dental caries, and many other health problems. Physical activity is any body movement that is produced by skeletal muscles and that substantially increases energy expenditure.

Growth, Development, and Sexual Health

growth and development: the area of health education that focuses on the growth and development of the human body; keeping body systems healthy; developing habits that promote healthful development and aging; and choosing behaviors that reduce the risk of HIV/STD infection.

sexual health: the area of health education encompassing a broad scope of concepts and skills, including acquiring information about sexual development, reproductive health, interpersonal relationships, body image, and gender roles; recognizing habits that protect female and male reproductive health; and learning about pregnancy, childbirth, and the development of infants and children. It also includes skill development in areas such as communication, decision making, refusal techniques, and goal setting. Sexual health topics are grounded in the premise that sexuality is a natural, ongoing process that begins in infancy and continues through life.

Injury Prevention and Safety

The area of health education that focuses on safety practices to reduce the risk of unintentional injuries to self and others. This area includes protective factors to reduce violence and prevent gangs and weapons;† safety guidelines for weather or natural disasters, fires, and poisoning; bicycling and sport safety; motor vehicle safety; and helping others with basic first aid skills.

Alcohol, Tobacco, and Other Drugs
The area of health education that focuses on safe use of prescription and over-the-counter drugs, not drinking alcohol, avoiding tobacco and illegal drug use, and practicing protective factors.

Mental, Emotional, and Social Health
The area of health education that includes the ability to express needs, wants, and emotions in positive ways; to manage anger and conflict; and to deal with frustrations. This area involves practicing life skills, making responsible decisions, developing good character, following a plan to manage stress, and being resilient during difficult times.

Personal and Community Health
The area of health education that focuses on the priority a person assigns to being health literate, maintaining and improving health, preventing disease, and reducing risky health-related behaviors. This instructional area involves staying informed about environmental issues, initiatives to protect the environment, and being an advocate for the environment. Community health education focuses on knowledge of laws to protect health; recognizing consumer rights; choosing healthy forms of entertainment; analyzing ways in which messages are delivered through technology; making responsible choices about health care providers and products; and investigating public health needs.

MENTAL, EMOTIONAL, AND SOCIAL HEALTH STANDARDS – GRADE SIX

Standard 1: Essential Concepts

1.1.M Describe the signs, causes, and health effects of stress, loss, and depression.
1.2.M Summarize feelings and emotions associated with loss and grief.
1.3.M Discuss how emotions change during adolescence.
1.4.M Describe the importance of being aware of one's emotions.
1.5.M Describe the importance of being empathetic to individual differences, including people with disabilities and chronic diseases.
1.6.M Explain why getting help for mental, emotional, and social health problems is appropriate and necessary.
1.7.M Describe the importance of setting personal boundaries for privacy, safety, and expressions of emotions and opinions.
1.8.M Describe the similarities between types of violent behaviors (e.g., bullying, hazing, fighting, and verbal abuse).
1.9.M Discuss the harmful effects of violent behaviors.

Standard 2: Analyzing Influences

2.1.M Analyze the external and internal influences on mental, emotional, and social health.

Standard 3: Accessing Valid Information

3.1.M Identify sources of valid information and services for getting help with mental, emotional, and social health problems.
3.2.M Discuss the importance of getting help from a trusted adult when it is needed.

Standard 4: Interpersonal Communication

4.1.M Practice asking for help with mental, emotional, or social health problems from trusted adults.
4.2.M Describe how prejudice, discrimination, and bias can lead to violence.
4.3.M Demonstrate ways to communicate respect for diversity.
4.4.M Demonstrate the ability to use steps of conflict resolution.

Standard 5: Decision Making

5.1.M Apply a decision-making process to enhance health.
5.2.M Describe situations for which someone should seek help with stress, loss, and depression.
5.3.M Compare and contrast being angry and angry behavior, and discuss the consequences.

Standard 6: Goal Setting

6.1.M Make a plan to prevent and manage stress.
6.2.M Describe how personal goals can be affected if violence is used to solve problems.
6.3.M Make a personal commitment to avoid persons, places, or activities that encourage violence or delinquency.

Standard 7: Practicing Health-Enhancing Behaviors

7.1.M Carry out personal and social responsibilities appropriately.
7.2.M Practice strategies to manage stress.
7.3.M Practice appropriate ways to respect and include others who are different from oneself.
7.4.M Demonstrate how to use self-control when angry.

Standard 8: Health Promotion

8.1.M Encourage a school environment that is respectful of individual differences.
8.2.M Object appropriately to teasing or bullying of peers that is based on personal characteristics and perceived sexual orientation.

MENTAL, EMOTIONAL, AND SOCIAL HEALTH STANDARDS – GRADES SEVEN AND EIGHT

Standard 1: Essential Concepts

1.1.M Explain positive social behaviors (e.g., helping others, being respectful to others, cooperation, consideration).
1.2.M Identify a variety of nonviolent ways to respond when angry or upset.
1.3.M Identify qualities that contribute to a positive self-image.
1.4.M Describe how emotions change during adolescence.
1.5.M Recognize diversity among people, including disability, gender, race, sexual orientation, and body size.
1.6.M Describe the changing roles and responsibilities of adolescents as members of a family and community.
1.7.M Describe the benefits of having positive relationships with trusted adults.
1.8.M Analyze the harmful effects of using diet pills without physician supervision.
1.9.M Identify the signs of various eating disorders.
1.10.M Describe signs of depression, potential suicide, and other self-destructive behaviors.
1.11.M Describe common mental health conditions and why seeking professional help for these conditions is important.

Standard 2: Analyzing Influences

2.1.M Analyze internal and external influences on mental, emotional, and social health.
2.2.M Analyze techniques that are used to pressure someone to engage in or be a target of violent behavior.
2.3.M Analyze the influence of culture on family values and practices.

Standard 3: Accessing Valid Information

3.1.M Access accurate sources of information and services about mental, emotional, and social health.
3.2.M Describe situations for which adult help is needed, including intimidating and dangerous situations, and how to access help for oneself and others.
3.3.M Identify trusted adults to report to if people are in danger of hurting themselves or others.
3.4.M Analyze situations to determine whether they call for acts of caring among friends or require getting the help of trusted adults.

Standard 4: Interpersonal Communication

4.1.M Seek help from trusted adults for oneself or a friend with an emotional or social health problem.

Standard 5: Decision Making

5.1.M Apply decision-making processes to a variety of situations that impact mental, emotional, and social health.
5.2.M Monitor personal stressors and assess techniques for managing them.
5.3.M Describe healthy ways to express caring, friendship, affection, and love.
5.4.M Describe situations for which someone would seek help with stress, loss, an unrealistic body image, or depression.
5.5.M Analyze the importance of setting personal boundaries for privacy, safety, and expressions of emotions and opinions.

Standard 6: Goal Setting

6.1.M Develop achievable goals for handling stressors in healthy ways.

Standard 7: Practicing Health-Enhancing Behaviors

7.1.M Demonstrate effective coping mechanisms and strategies for managing stress.
7.2.M Practice respect for individual differences and diverse backgrounds.
7.3.M Participate in clubs, organizations, and activities in the school and community that offer opportunities for student and family involvement.
7.4.M Practice personal boundaries in a variety of situations.
7.5.M Demonstrate skills to avoid or escape from potentially violent situations, including dating.

Standard 8: Health Promotion

8.1.M Promote a positive and respectful school environment.
8.2.M Object appropriately to teasing of peers and community members that is based on perceived personal characteristics or sexual orientation.

MENTAL, EMOTIONAL, AND SOCIAL HEALTH STANDARDS – HIGH SCHOOL (GRADES NINE THROUGH TWELVE)

Standard 1: Essential Concepts

1.1.M Describe the benefits of having positive relationships with trusted adults.
1.2.M Analyze the qualities of healthy peer and family relationships.
1.3.M Describe healthy ways to express caring, friendship, affection, and love.
1.4.M Describe qualities that contribute to a positive self-image.
1.5.M Describe how social environments affect health and well-being.
1.6.M Describe the importance of recognizing signs of disordered eating and other common mental health conditions.
1.7.M Analyze signs of depression, potential suicide, and other self-destructive behaviors.
1.8.M Explain how witnesses and bystanders can help prevent violence by reporting dangerous situations.
1.9.M Classify personal stressors at home, in school, and with peers.
1.10.M Identify warning signs for suicide.
1.11.M Identify loss and grief.

Standard 2: Analyzing Influences

2.1.M Analyze the internal and external issues related to seeking mental health assistance.

Standard 3: Accessing Valid Information

3.1.M Access school and community resources to help with mental, emotional, and social health concerns.
3.2.M Evaluate the benefits of professional services for people with mental, emotional, or social health conditions.

Standard 4: Interpersonal Communication

4.1.M Seek help from trusted adults for oneself or a friend with an emotional or social health problem.
4.2.M Discuss healthy ways to respond when you or someone you know is grieving.

Standard 5: Decision Making

5.1.M Monitor personal stressors and assess techniques for managing them.
5.2.M Compare various coping mechanisms for managing stress.
5.3.M Analyze situations when it is important to seek help with stress, loss, an unrealistic body image, and depression.

Standard 6: Goal Setting

6.1.M Evaluate how preventing and managing stress and getting help for mental and social problems can help a person achieve short- and long-term goals.
6.2.M Set a goal to reduce life stressors in a health-enhancing way.

Standard 7: Practicing Health-Enhancing Behaviors

7.1.M Assess personal patterns of response to stress and use of resources.
7.2.M Practice effective coping mechanisms and strategies for managing stress.
7.3.M Discuss suicide-prevention strategies.
7.4.M Practice respect for individual differences and diverse backgrounds.
7.5.M Participate in clubs, organizations, and activities in the school and in the community that offer opportunities for student and family involvement.
7.6.M Practice setting personal boundaries in a variety of situations.

Standard 8: Health Promotion

8.1.M Support the needs and rights of others regarding mental and social health.
8.2.M Promote a positive and respectful environment at school and in the community.
8.3.M Object appropriately to teasing of peers and community members that is based on perceived personal characteristics and sexual orientation.

APPENDIX B: Student and Parent Handouts & Resources

B1. Mental Health Resources List

B2. Student Mental Health Handout

B3. Parent Handouts

- When Your Child Expresses Suicidal Thoughts or Behaviors
- What to Do and Available Services/Resources
- Self-Care Advice for Parents with a Child in Crisis

Mental Health Resources

Online Resources

American Academy of Child and Adolescent Psychiatry www.aacap.org

American Foundation for Suicide Prevention www.afsp.org

American Psychological Association www.apa.org

Anxiety and Depression Association of America www.adaa.org

Building Bridges Initiative www.buildingbridges4youth.org

Depression and Bipolar Support Alliance http://www.dbsalliance.org

Depression Toolkit University of Michigan Depression Center http://www.depressiontoolkit.org

Help Guide Mental & Emotional Health Management Resources 44.4 www.helpguide.org

Kids Health www.kidshealth.org

Mental Health America www.mentalhealthamerica.net

National Alliance on Mental Illness www.nami.org

Substance Abuse and Mental Health Services Admin (SAMHSA) www.samhsa.gov

Suicide Prevention Lifeline www.suicidepreventionlifeline.org

Suicide Prevention Resource Center www.sprc.org

Hot Lines

California Youth Crisis Line 800-843-5200

Contra Costa County Crisis Center

Crisis and Suicide Hotline: 800-833-2900

Crisis Text Line, Text "HOPE" to 20121

Grief Hotline: 800-837-1818

Crisis Text Line, Text "HELP" to 741-741

LGBT National Youth Talk-line 800-246-7743

LGBT National Hotline 800-843-4564

National Alliance of Mental Illness (NAMI) 800-950-6264 or Text "NAMI" to 741-741

National Child Abuse Hotline 800-422-4453

National Runaway Switchboard 800-786-2929

National Sexual Assault Hotline 800-656-4673

National Suicide Prevention Lifeline 800-273-8255 (TALK)

SAMHSA National Helpline 800-662-4357

Trevor Project Lifeline 866-488-7386 or Text "TREVOR" to 202-304-1200

Youth Support Line 888-977-3399

Community Mental Health Resources

(Additional resources available at http://www.srvusd.net/suicideprevention)

Counseling Centers/Agencies

Axis Community Health Center 925-201-6250 www.axishealth.org

Community Counseling Center – CSUEB 510-885-3007

Contra Costa County Mental Health 925-521-5700 http://cchealth.org

Discovery Counseling Center 925-837-0505 www.discoveryctr.net

JFK Counseling 925-798-9240

Kaiser Mental Health 925-295-4145

Oasis Center 925-944-1800 http://oasiscenterinc.org

Crisis Centers

Contra Costa County Crisis Center 925-939-1916 www.crisis-center.org

Contra Costa Regional Medical Center 925-370-5000; Psychiatric Emergency Services 925-646-2800

Tri Valley Haven 800-884-8119 www.trivalleyhaven.org

Book Resources for Parents: Mental Health and Resilience

Beardslee, William. Out of the Darkened Room: When a Parent is Depressed: Protecting the Children and Strengthening the Family. 2002.

Rapee, Ronald et al. Helping your anxious child: A step by step guide. 2000.

Manassis, Katharina & Levac, Anne Marie. Helping your teenager beat depression: A problem-solving approach for families. 2004.

Lezine, DeQuincy and Brent, David. Eight Stories Up: An Adolescent Chooses Hope over Suicide. 2008.

Bourne, Edward. The Anxiety & Phobia Workbook. 2005.

Riera, Michael. Uncommon Sense for Parents with Teenagers. 2004.

Phelan, Thomas. Surviving Your Adolescents: How to Manage and Let Go of Your 13-18 year olds. 1998.

Sachs, Brad. The Good Enough Child: How to Have an Imperfect Family and Be Totally Satisfied. 2001.

Apter, Terri. The Confident Child: Raising Children to Believe in Themselves. 1997.

Book Resources for Teens: Mental Health and Resilience

Hipp, Earl. Fighting Invisible Tigers: A Stress Management Guide for Teens. 2008

Fox, Annie. Too Stressed to Think? A Teen Guide to Staying Sane When Life Makes You Crazy. 2005

Seaward, Brian. Hot Stones and Funny Bones: Teens Helping Teens Cope with Stress and Anger. 2002.

Espeland, Pamela. Life Lists for Teens: Tips, Steps, Hints, and How-To's for Growing Up, Getting Along, Learning, and Having Fun. 2003.

Covey, Sean. The 7 Habits of Highly Effective Teens. 1998.

Student Mental Health Handout

School can be an exciting time, filled with new experiences, but at times you might feel as though it's more of a struggle. This handout is meant to help you as you work through a tough time.

Life can be stressful. Between friend drama, packed schedules, classes, clubs, relationships, sports, jobs, parental expectations, figuring out who you are, uncertainty over things, and not enough sleep, life can occasionally get you down and feel overwhelming. And that's normal.

What's not normal is struggling through each day, feeling like things will only get worse. Maybe you feel like you've lost control, that nothing matters, or that you're alone. These feelings may indicate a condition that requires professional help, such as depression, anxiety or other mental health conditions.

Not everyone experiences mental health conditions in the same way, but everyone struggling with their mental health deserves help. Depression is among the most common conditions experienced. It is a complex medical illness that significantly interferes with an individual's ability to function, enjoy life, and feel like themselves.

A number of factors may contribute to a person becoming depressed; genetic predisposition and stressful life events can certainly play a role, but sometimes depression can occur without an obvious cause. This means that anyone can become depressed, even those who seemingly have every reason to be happy.

Depression commonly affects your thoughts, your emotions, your behaviors, and your overall physical health. Experiencing any one of these symptoms on its own does not constitute depression; a diagnosis of depression requires several of these symptoms to occur for at least two weeks. Here are some of the most common symptoms that point to the presence of depression:

Feelings:
- Sadness
- Hopelessness
- Guilt
- Moodiness
- Angry outbursts
- Loss of interest in friends, family, and favorite activities

Thoughts:
- Trouble concentrating
- Difficulty making decisions
- Trouble remembering
- Thoughts of harming oneself
- Delusions and/or hallucinations can also occur in cases of severe depression

Behaviors:
- Withdrawing from people
- Substance abuse
- Missing work, school, or other commitments
- Attempts to harm oneself (e.g., cutting)

(Symptoms of depression, continued)

Physical problems:

- Tiredness or lack of energy
- Unexplained aches and pains
- Changes in appetite
- Weight loss or gain
- Changes in sleep – sleeping too little or too much

If you are experiencing symptoms of depression, it's important to **talk to a trusted adult** (parent, teacher, counselor, coach, or clergy) or doctor so that you can get the help you need. **Depression does not go away on its own, but with the appropriate help it can be treated!** Studies show that more than 80% of people with depression can feel better with talk therapy (counseling) and/or medication.

Maybe you've noticed that your friend hasn't been acting like themselves lately and you're worried about whether or not they're really "fine" after all. If you think a friend may be depressed, show them you care by reaching out. Give yourself time to talk in a private, comfortable place. Honestly share what you've noticed (changes in behavior, things they've said or done) and ask them how they are feeling. Let them know that you're asking them because you care, because you want them to feel better, and because there is help. Let them know that there is hope and help available, and support them to get the help they need. If you don't feel comfortable asking your friend, share your concerns with a trusted adult who can.

Talking about mental health can be difficult, but reaching out and getting help for depression is one of the most courageous, important things you can do for yourself or for a friend. **It might even save a life.**

Resources

At home or outside school:

- Talk to a parent or older relative
- Call your pediatrician or physician
- Talk to someone at your church

At your school site:

- Talk to a trusted adult, teacher, or guidance counselor

24/7 Confidential Helplines:

- Contra Costa County Crisis Center, Crisis and Suicide Hotline: 800-833-2900
- Contra Costa County Crisis Center, Crisis Text Line: Text "HOPE" to 20121
- California Youth Crisis Line: 800-843-5200
- Trevor Lifeline for LGBTQ Youth: 866-488-7386
- National Suicide Prevention Lifeline: 800-273-8255
- Crisis Text Line: Text "HELP" to 741-741

If someone is in immediate danger, **call 911**.

Getting help does not mean that you have failed, it means you've allowed others to show they care.

Parent Handouts
When Your Child Expresses Suicidal Thoughts or Behaviors

This paper is designed to support you with the information you need as you and your child work together toward wellness.

You are not alone. It is not uncommon for adolescents to consider suicide as a possible solution to their difficulties. The reasons for this are many and varied. What is most important, for you and your child, is knowing there is help available. With support, recovery is possible.

If you think that your child may be contemplating suicide, you can best help him/her by paying attention, listening, and acknowledging what they are saying or doing. Remain calm and get them to the help they need. It is not uncommon for someone in their emotional state to resist seeking help. There can be many reasons for this: stigmatization, fear of being restrained or locked up, etc. They may plead that you do nothing. They are in crisis and may be incapable of making a rational decision. They may say they are fine and they did not mean what they said or did. Or they may be feeling their situation is hopeless and nothing can help. Whatever may be occurring for them, they will look to you for support. Assure them that help is available.

This is a life and death situation. Accepting any reason for not getting help is too dangerous. Though you and/or your child may fear what will result from acknowledging these suicidal thoughts or actions, the risk of not seeking help is too great.

Attached are Warning Signs and Risk Factors that a suicidal person may be experiencing. This is included to help you identify specific behaviors you may have been noticing. Though someone has expressed suicidal ideation, no one person will show all these behaviors. They may not show any of the specific behaviors listed; even so, it is important for them to seek help.

Seeking Assistance:
There are differing situations where your child's distress may become apparent. Your child may reveal their suicidal thoughts to you, a friend, or a trusted adult. Whoever becomes aware of your child's distress must immediately seek assistance. In seeking assistance, your child's safety is the first consideration. The child should never be left alone during this crisis. If your child has a physician or therapist, call to alert them of the situation. Alternatively, the Contra Costa County Crisis Center Crisis and Suicide Hotline can be called at 1-800-833-2900 or text "HOPE" to 20121 (see Mental Health Resources list provided for additional hotlines and information).

Parent Handouts
What to Do and Available Services/Resources

If your child needs to be transported to an emergency room (ER), there are three ways this can occur:

1. **Calling 911**
   Call 911 when the child is in immediate danger of self-harm. If there is a specific cultural or language need, mention this during the 911 call. If your child is transported to an ER, the law enforcement officer will often handcuff them for both your child's and the officer's safety. It is important to remind your child that this is being done for their safety, not because they are a criminal.
2. **Transporting Your Own Child**
   Transporting your child to the ER yourself is not recommended. Driving while helping a child in crisis is not safe. For the safety of you and your child, have a second adult with you. Do not take your child to an Urgent Care facility. Urgent Care does not have the capacity to deal with an emotional/psychological crisis and will transport your child to an ER via ambulance.

Getting Help: What to Expect
When your child's distress is first identified:
If 911 determines that your child is in immediate danger, they will be transported to Emergency Care. The law enforcement officer may initiate a 72-hour hold for a psychiatric evaluation, called a California Welfare and Institution Code (WIC)5585 for minors or WIC5150 for adults. To place a person on a hold it must be determined that they may harm themselves or others, or that they are gravely disabled (lack the ability to care for themselves).

If an ambulance is called for transport to the ER you may or may not be allowed in the vehicle with your child. If you are not allowed in the ambulance be sure to find out which facility they will be taken to. Youth in crisis are transported to the nearest hospital emergency room. Local police will send or take your child to the County Regional Medical Center located in Martinez. The ER staff will conduct a full physical and psychological assessment. Be aware that, if your child is agitated, the hospital staff may opt not to calm your child with medication so as not to mask any symptoms. A guard may be placed outside your child's door in the ER; again, this is done for their safety. You may be able to sit with your child while in the ER; however, at times you will be asked to leave in order for the physician to speak in private with your child. Depending on the outcome of this assessment they could either be admitted, released or transported to an in-patient facility.

If it is determined that your child is not in immediate danger and is released. the attending physician should review with you discharge plans, including immediate steps to take to ensure continuing care for your child. You should follow up immediately with the child's primary care doctor or therapist. It is vital that you seek follow up care for your child (see Mental Health Resources list).

Other parents who have experienced their child's crisis situation strongly recommend bringing a notebook to record information from healthcare providers, instructions, and observations. This is vital due to the stress you are experiencing and the quantity of new information. Do not hesitate to ask questions.

It is also important that you find support for yourself. (See attached Self Care Advice for Parents with a Child in Crisis). Expand your compassion circle to include supportive family and friends. Your child will also benefit from knowing there are those who support them just like they would be supported if they had a physical illness.

When your child is hospitalized:
Once the attending doctor determines that your child is medically stable they will be transported to a psychiatric care facility. Provisions exist for transfer of patients to other facilities when requested, when resources in the hospital are not available, and when specialized services not available at Contra Costa Regional Medical Center (CCRMC) are needed. The bed capacity of the department includes 19 beds, with 6 available for cardiac monitoring. Once hospitalized, parents of minors have access to their child's medical records unless it is determined the child's safety will be compromised if this information is released. Parents can always provide information about their child.

Several things are done in a psychiatric unit for your child's safety:
The unit will be locked. There are restrictions on possessions, including clothing (no belts, straps, shoelaces, etc.), sharp objects, cigarette lighters, and other possibly dangerous objects. You may bring your child some of their favorite possessions (quilts, pillows, pictures, food, etc.). Often the hospital staff provides a list of acceptable items you can provide that will give comfort to your child.

Stabilizing your child requires a variety of services:
An assessment is conducted by the professional team, usually consisting of a psychiatrist, psychologist, nurse, and social worker. Treatment may consist of a combination of talk therapy, mindfulness-based meditation, group support, medication, etc. Family may be included in support or therapy sessions. In order to understand the treatments that are recommended and to begin to process your child's care plan, it is important that you work with the care team. You should keep your child's care team informed of any effects of treatments that you notice. Treatments and medications (dose, frequency, type) may be adjusted depending on their effects.

Supporting your child during their hospital stay:
Your visiting hours will be limited. Often you may visit only in the evenings on weekdays and from midday to the evening on weekends. Telephone and email contact is allowed.

Your child has been through an exhausting experience and is working hard to get well. They may feel frightened and excessively tired. At this point your child is safe and your non-invasive support can be most helpful. It is important that your child knows people do care. You and trusted friends and family can bring some lightness into this serious situation by providing supportive comments and conversations that do not focus on the crisis, in spite of how worried you are. Ask the staff how you can best support your child, understanding that the answer may be to just let your child be. Your child may just need to have down time when they are around you. It is also important that you are open---minded and compassionate towards others who are in the hospital. Remember that they are hurting and in crisis as well.

When your child transitions out of the hospital:

When your child is ready to leave the hospital environment, you will create a Discharge Plan with a discharge planner and your child's care team. It is important that you understand the goals of this plan. For your child's safety, care should not end with their hospital release. Depending on the setting that will most enhance your child's recovery, it may be recommended that your child transition to a residential home or a day program before returning home.

Often, subsequent suicide attempts occur shortly after leaving a treatment facility or ER. Vital to your child's safety is means reduction, which is "reducing a suicidal person's access to highly lethal means" (Harvard School of Public Health Means Matter, http://www.hsph.harvard.edu/means-matter/). Reducing access includes removing firearms and alcohol; monitoring medications; and limiting the quantity of potentially poisonous substances present in the home. See "Recommendations for Families" for more information: http://www.hsph.harvard.edu/means-matter/recommendations/families/.

When your child returns home they must have an immediate follow up with their psychiatrist/psychologist. Accompany them to the first appointment for support and to guarantee that they attend. Encouraging ongoing attendance at therapy sessions is a must.

In order for your child to return to school the attached Health Plan form must be filled out by your psychiatrist or psychologist. This form will allow the school psychologist or counselor to communicate with your child's care provider. A meeting will then be arranged so that you and your child can make a School Re-Entry Plan with the school psychologist or counselor. This plan ensures that when your child returns to school, they do so in a manner and at a pace that will potentiate their ongoing success and well-being.

It is also important for you and your child to create a Safety Plan with the school psychologist or counselor. This is a personal plan about how to deal with a subsequent crisis, including a list of individuals and resources your child will contact in a crisis. (See the SRVUSD Personal Safety Plan).

Key to the recovery of your child is vigilance. By listening and providing encouragement and understanding your child can feel hopeful. Your continued support adds value to medical services and helps your child continue on the path of recovery.

Self-Care Advice for Parents with a Child in Crisis

The importance of caring for yourself:
Caring for a child or teen in crisis is stressful and can be physically and emotionally draining. There can be much uncertainty and fear. You might feel guilty or selfish acknowledging your own fatigue. Taking care of your own health and psyche will allow you to be more fully present for your child and other loved ones. You will also be modeling health-seeking behavior. Remember the lesson from any airplane flight you have taken; put on your oxygen mask first before helping a child put theirs on. Self-care is not optional. Some practical suggestions for self-care include:

- Reach out to supportive family and friends, religious or spiritual sources of support and solace. People care. Talking about your experiences, reactions, and feelings can be very healing.
- Recognize that you may be "burning the candle at both ends". Plan for and allow yourself to "crash" at some point and get rest.
- Be patient with yourself; you may be distracted and not able to function as efficiently as usual.
- Let others do their part – accept help when offered.
- Keep up your own good health with exercise and healthy meals; avoid numbing the pain with excess alcohol, caffeine, or drugs.
- Participate in stress-relieving process, whether individually or in a group; for instance, Mindfulness Meditation, caregiver support groups or supports provided by NAMI Contra Costa County.
- Keep a journal. Write in it if you can't sleep.
- Go for walks (exercise) – but don't overdo it.

APPENDIX C: Kara Resources on Grief and Self-Care

C1. A Few Thoughts for Teachers and Parents

C2. Grief and Mourning in Children and Teens

C3. 10 Basic Principles for Grieving for Children and Teens

C4. Ways to Support Children in Coping with Trauma or Loss

C5. Comforting a Grieving Individual

C6. Grief Discussion with Students after a Suicide

C7. Useful Grief Insights for Teachers: A Script

C8. Sample Letter to Parents after a Death

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A Few Thoughts for Teachers and Parents

By Lynn Bennett Blackburn

You are faced with the challenge of helping your class and your children cope with the loss of a classmate. The goal of addressing the student's death with them is to give the children some understanding of what they are experiencing, to give them labels for their feelings, and to let them know they are not alone in having these feelings. The goal is to help them grieve, not to make the grief go away. There are several things to consider:

Be honest about your feelings. Share what you are feeling through simple statements coupled with comments about what you do to express and cope with these feelings. Encouraging the children to share and express what they feel is more effective when you model this behavior.

Be honest with the limits of your knowledge. The death of a classmate may raise questions about why it happened, what it feels like to die, and what happens after death. For many of these you will have no answers. It is important to ask what they think, for. often such questions represent other worries or concerns that you can address. Sometimes it will be best to encourage the child to share the question with parents. A simple "I don't know, but I wonder about that, too" may be the most helpful and truthful answer you can give.

Be honest with yourself. Recognize that you are grieving, too. Be an advocate regarding the time you need to deal with this loss. You may need someone to fill in for you while you attend the funeral, visit the family, talk with your children. You'll probably need a few minutes alone, too. If you are uncomfortable with certain topics or aspects of approaching this situation, ask others-- the social worker, school psychologist or counselor. You don't have to do it all and you don't have to do it alone.

Provide opportunities for feeling expression. Grieving is often a mixture of anger and sadness.

Allow time for tears. Let the children know that crying is a normal reaction to losing someone or something we value; that saying good-bye to a friend can be very sad. Children often view crying as a sign of weakness or immaturity. They may need help to see tears as something positive for adults as well as children.

Finding constructive outlets for anger may be your greatest challenge. It is important to help the children define the source --at whom and about what they are angry. Anger can be released through verbal activities such as role-playing or writing down what you wish you could say or do to the subject of the anger. Physical outlets, such as throwing bean bags at a target, throwing a ball at a wall, or working with clay (pounding, pulling, squeezing) can help release the energy that anger creates.

For older children, anger may be channeled into a class project related to the cause of their friend's death. A sense of meaning can be attached to the tragedy through fund raising to support community action such as fire safety, water safety, groups against drunk driving or informational campaigns to increase peer and public awareness such as helmet use.

Maintain class and home routine and rules. Children gain security from structure and routine. While brief interruptions may occur to accommodate a funeral or memorial service, returning to routine provides the comforting reassurance that life will go on.

Don't rush. Some classes have come to school to find a dead schoolmate's desk removed and all evidence of the child hidden away. Let your class decide what to do with the empty desk and other things owned by the class. Making things disappear does not make the death easier. Rather, it gives the children a feeling that they don't really matter.

Add feeling-related ideas to your regular curriculum. The need to express feelings will not end with the funeral. It is important, over the months that follow, to continue to provide opportunities for feeling expression. Art and writing projects can be built around feeling themes – things that make you happy, what you do when you feel sad, drawing or writing about a memorable day. Stories about coping with death, plus losses such as divorce or moving can be incorporated into reading activities.

Recognize and affirm your privileged position. This is a time when you can have a very positive influence on your children. How you help them handle this grief will, in some large or small way, help them in the future. Giving them permission to feel and share those feelings, to cry, to love and to care may be the greatest single gift you ever give them.

About the Author: Lynn Bennett Blackburn has a doctorate in child clinical psychology. She is a Pediatric Neuropsychologist in the Division of Pediatric Neurology at the University of Minnesota. Her work involves assessing children with neurological disorders and learning problems, then working with their families and school staff to help staff and parents better understand and respond to each child's special needs.

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Moving through grief toward hope and meaning

Grief and Mourning in Children and Teens

Compiled by Kara

Developmental Stages and Grief: Children and Teens

Developmental Age:	Infancy – Birth to 18 months
Primary Developmental Challenge:	Basic trust vs. mistrust
Ability Being Developed:	Hope
Child's Beliefs about Death:	No concept of death, limited concept of time.
Grief Reactions:	General distress, shock, despair, protest, sleeplessness. May show increased needs for holding, touching. May show increased reluctance to be separated from nurturer.
Needs:	Routines maintained, nurturing from a consistently available caregiver, reassurance, love, secure environment. Meet increased attachment needs for eye contact, facial expressions, touching, rocking, singing.

Developmental Age:	Toddlerhood – Infancy to 3 years
Primary Developmental Challenge:	Autonomy vs. shame/doubt
Ability Being Developed:	Will and self-control
Child's Beliefs about Death:	Death seen as temporary separation; any separation from parent may create anxiety. Repeated explanations do not increase child's understanding, because cognitive ability to understand death is limited. Confuse fantasy/ reality. On an unconscious and non-verbal level, child may assume what happens is under their control & is therefore "their fault."
Grief Reactions:	May relieve anxiety through fantasy or distressed behaviors (regression, aggression, clinging.) May feel guilty. May fear being left alone. May regress to earlier stages, needs. May not understand sadness around him or may seem unaffected. Confusion, agitation at night, nightmares. Repeated questions are common.
Needs:	Reassure child he will be cared for by maintaining routines, nurturing from a consistently available caregiver, reassurance, love, and a secure environment. Simple, honest words, concrete explanations, repetition, & patience help the child distinguish between fantasy & reality. Assure child he did not cause it to happen & it is not his fault. Offer the opportunity for inclusion in family rituals such as funeral, and provide a supportive adult to honor the child's wishes if the child

	changes his mind or wants to leave. Help child acknowledge own feelings-anger, sadness, etc.; Accept regressive behavior.
Developmental Age:	Early Childhood
Primary Developmental Challenge:	Initiative vs. guilt
Ability Being Developed:	Purpose and direction
Child's Beliefs about Death:	May still be quite similar to that of a toddler in that death is not understood as permanent. Some 4 and *5* year olds may have the beginnings of an understanding, as experience over time with the concrete reality of the deceased not reappearing begins to have meaning. Cognitive ability to understand death is still limited, however.
Grief Reactions:	May regress and "act younger." May cling to adult caregiver, show or even verbalize anxiety that the adult may die or become ill. May tell everyone and anyone about the death. Confusion, agitation at night, nightmares are possible. Repeated questions about the death or the deceased are common. In general, children cycle through their emotions much more rapidly than adults-smiling one minute, crying the next, angry the next, giggling a minute later. Emotions may seem amplified. Frustrations that would have been minor before the loss may result in more frequent major meltdowns that last longer than expected. At other times the child may say "I'm happy," or may seem unaffected.
Needs:	Same as above for toddler, plus increased dialog about the deceased and opportunity to participate in the ways to remember the deceased. Helpful to continue to hear stories about the deceased, see pictures of them, and hear about their relationship with them. Give the child age-appropriate, brief information, and then attune to his questions and curiosities, providing frequent opportunities to talk briefly, and answering questions honestly.
Developmental Age:	Middle Childhood – 5 years to puberty
Primary Developmental Challenge:	Industry vs. inferiority
Ability Being Developed:	Competency
Child's Beliefs about Death:	By 5-7 years old, child begins to see death as final & universal for others; neither believes nor denies that he himself will die; may believe he can escape by being good/ trying hard. Death is often perceived as external: a person, a spirit. By 7-11, children perceive the irreversibility, permanence, inevitability of death, and perceive their *own* mortality; they have vivid ideas about what occurs after death, and may be concerned with consequences following death.
Grief Reactions:	May act like nothing happened or deny that things are different. Tend to show grief through play or behaviors instead of talking about it: numbness, shock, sorrow, confusion, fears, anxiety, anger, embarrassment, happiness & humor, in short cycles. May desire to conform to peers and present a façade of coping. May act younger than his age. Want to understand: may want lots of information, may become

an expert in the disease that caused a death, for example. Peer relationships are increasingly important. Some children find support from their friends, others try to hide the fact that they've experienced a death.

Needs: Simple, honest answers & information; ample reassurance. Models for mourning. Acknowledgment of their feelings, allowing a child to express or withhold, as needed. Support the child's unique style of coping. Safe place, people & time to talk, share their experience. Assistance in remembering the person who died. Support in showing grief in his own unique way. Limits & rules, upheld firmly but with kindness. Reassurance about future & clarity that they are not responsible for it, nor for the death. Choices, inclusion. Respect of their "need to know," as information returns some sense of control. Respect child's increasing need for peer relationships. Physical outlets, play, expressive art, reading; memory book can be helpful. Do not require children to be "brave," "grown-up," "in-control," or to comfort others.

Developmental Age: Adolescence

Primary Developmental Challenge: Identity vs. identity confusion

Ability Being Developed: Individuation

<u>Three Developmental Stages within Adolescence</u>

Early Adolescence – 11 to 14 years
Challenge: Reunion vs. abandonment/separation from parents
Ability Being Developed: Emotional separation from parents
Middle Adolescence – 14 to 17 years
Challenge: Independence vs. dependence
Ability Being Developed: Mastery/control
Late Adolescence – 17 to 21 years
Challenge: Closeness vs. distance
Ability Being Developed: Intimacy vs. commitment

Child's Beliefs about Death: Recognize their own mortality but may act as though it could never happen to them. Attitudes towards death becoming similar to adults'.

Grief Reactions: <u>*Physical*</u>*:* May feel fatigued, sleep more, gain/lose weight, have headaches, get ill more easily, be accident-prone, restless. May be attracted to alcohol, smoking, drugs, excessive risk-taking.
<u>*Mental*</u>*:* May experience trouble concentrating in school, forgetfulness, lack of motivation, "negative" attitude, "no one understands". May need to ask "why?" or say "if only," mourning what might have been.
<u>*Emotional*</u>: Sad, irritable, worried, angry, anxious, fearful, relieved, guilty, lonely, mood swings, crying spells, frustration, revenge. Watch for depression, hopelessness, helplessness. May fill emptiness with intimacy, sex.
<u>*Spirit*</u>: May experience loss of direction, future, meaning, faith
<u>*Relational*</u>: Feeling isolated, less cooperative, withdrawing, or getting very busy, perfectionistic, and social. May lash out or show moods more readily. Friendships may change a lot as the teen wants others to reach out or leave him alone. May have difficulty with others' reactions

	& what is said about the death, as well as with the everyday content of peer's conversations, which may suddenly seem trivial compared to the death. Can be left feeling isolated in a crowd.
Needs:	Balanced, healthy food, water, adequate sleep, exercise, medical check-ups. Professional assistance if alcohol, drug, promiscuity, or eating issues develop. Recognition of the importance of their peer relationships.
	Understanding, patience, and assistance of teachers & parents needed if grades suffer, if additional help or time are required for assignments, or if teen needs to step out of classroom during a grief burst.
	Respect the teen's need to work through the loss independently. Be available but not intrusive: "I'm here if you want to talk or if you need me." They will be most likely to talk to listeners who make themselves available but don't force talking, who respect the teen's need for privacy, and give the teen a clear sense that they have choices about when & with whom they feel comfortable expressing grief emotions. Teens benefit from opportunities & support for self-expression, and need tolerance of conflicting feelings, and push/pull relationship with adults. Even when they protest, they need adults to look after their safety, as well as set and enforce limits.
	Even when adults are monolithic in their grief, teens need fun, recreation, and time with peers. They also need inclusion, choices in memorializing the deceased.

The above material was prepared by Liz Powell, adapted from the work of Erik Erikson, J. William Worden, Charles A. Corr, Clyde M. Nabe & Donna M Corr, the Kara community, and hundreds of children and teens served by Kara since 1993. It includes material adapted by Sue Shaffer from the work of John Bowlby, Earl Grollman, Claudia Jewett, Elizabeth Kubler-Ross, Margaret Nagy, J. W. Worden, Alan Wolfolt, and Valerie Young.

Kara
Grief support for children, teens, and adults

10 Basic Principles of Grieving for Children and Teens

Children are concrete in their thinking
•
Children generalize from the specific to the general
•
Children are repetitive in their grief
•
Children are physical in their grief
Children grieve cyclically
•
Children need choices
•
Children grieve as part of a family
•
Children's feelings are their allies
•
Children's grief is intertwined with normal developmental tasks
•
There are Key Tasks of Mourning in Children and Teens

1. **Children are concrete in their thinking:**
In order to lessen their confusion, use the words "death" and "dying." Describe death concretely. Answer their questions simply and honestly without using euphemisms such as "passed on," "went to sleep," etc. You don't have to add a large number of details. Children will ask if they want to know more. You can see if they are listening because they want to, or if it is for your benefit (they seem agitated, fidgety, and give you little or no eye contact).

2. **Children generalize from the specific to the general:**
If someone died in a hospital, children think that hospitals are for the dying. If someone died in their sleep, children are afraid to go to sleep. If one person died, "someone (or everyone) else will die," or "I will die." They will learn to accommodate new truths on their own if they are allowed to express themselves and try things out (e.g., going to sleep and waking up alive).

3. **Children are repetitive in their grief:**
Children may ask questions repetitively. The answers often do not resolve their searching. The searching itself is a part of their grief work. Their questions are indicative of their confusion and uncertainty. Listen and support their searching by answering repetitively and/or telling the story over and over again.

4. **Children are physical in their grief:**
The older children are, the more capable they are of expressing themselves in words. Younger children simply ARE their feelings. What they do with their bodies speaks their feelings. Grief is a physical experience for all ages, but most especially for younger children. Watch their bodies and understand their play as their language of grief. Reflect their play verbally and physically so that they will feel that they are "being heard." For example, "You are bouncing, bouncing, bouncing on those pillows. Your face is red and you are yelling loudly."

5. **Children grieve cyclically:**
Their grief work goes in cycles throughout their childhood and their lives. Each time they reach a new developmental level, they reintegrate the important events of their lives, using their newly acquired processes and skills. Example: a one year old, upon losing his mother, will become absorbed in the death again when her language skills develop and as she is able to use words for the expressions of her feelings. She may re-experience the grief again as an adolescent, using her newly acquired cognitive skills of abstract thinking.

6. **Children need choices:**
Death is a disruption in children's lives that is quite frightening. Their lives will probably seem undependable, unstable, confusing, and out of control. These topsy-turvy feelings can be appeased if children have some say in what they do or don't do to memorialize the person who has died, and to express their feelings about the death.

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Grief support for children, teens, and adults

Let children and teens teach you about their grief.

7. **Children grieve as part of a family:**
When a family member dies, it will affect the way the family functions as a whole. All the relationships within the family may shift, adjusting to this change in the family structure. Children will grieve for the person who died, as well as the environment in the family that existed before the death. Children may grieve over the changed behavior of family and friends. It is helpful if each family member is encouraged to grieve in his/her own way, with support for individual differences.

8. **Children's feelings are their allies:**
Feelings help children pay attention to their loss. Through this attention comes their own understanding about the death that they grieve. It is important not to shield children from their emotions; offering them the option to stay or leave will allow them to feel included, and will give them permission to be with the feelings.

9. **Children's grief is intertwined with normal developmental tasks:**
It can be impossible to determine which behaviors are part of developmental phases and which are grief-related (e.g., "Is it adolescence or is it grief?").

10. **Key Tasks of Mourning in Children and Teens:**
    a. Understand the death and try to make sense of what happened.
    b. Express emotional and other strong responses to the loss.
    c. Commemorate the person that's been lost.
    d. Learn how to go on living and loving.

Let children and teens
teach you about their grief.

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Moving through grief toward hope and meaning

Ways to Support Children in Coping with Trauma or Loss

1. Take time to listen to their concerns; help them to feel safe; encourage expression of their feelings.
2. Acknowledge that trauma and loss are hard to handle for everyone.
3. Smile and hug often; use creative ways to help them express complex feelings.
4. Encourage them through their challenges with "I believe in you" messages.
5. Give age appropriate information about the critical event that is honest and direct.
6. Listen to their experience and respond without judgment.
7. Partner with children; help them decide how they want to deal with difficult "adult" things like funerals and remembrance anniversaries.
8. Let children know about YOUR difficult feelings and vulnerability.
9. Honor their uniqueness and individuality.
10. Affirm that all ways of experiencing grief are "normal."
11. Encourage them to take time for themselves and ask for what they need.
12. Let them know that you are available to talk or just to hang out, as they wish.

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Comforting a Grieving Individual

Many people feel inadequate about what to say to a friend or family member who is grieving. This guide to comforting a grieving individual covers both (1) words that offer comfort, and (2) words that, while well intentioned, may harm or stifle the bereaved, making the journey through grief more difficult.

Saying nothing or pretending the death didn't happen also hurts the individual in the long run. It is important for this person to hear words of comfort from you and especially from friends, family members, or colleagues to whom he/she is close.

Words that Do Comfort	Words that May Not Comfort
I'm sorry.	Now she's in a better place.
I'm thinking of you.	Time will heal you.
I care and want to help.	Think of all you have to be thankful for.
You are so important to me.	Just be happy that he's out of his pain.
I'm here for you.	He lived a long life.
If I were in your shoes, I think I'd feel that way too.	Be strong. You are holding up so well.
One of my favorite memories of _____ (use the name of the person or pet) is …	Keep busy.
It seems so natural to cry at a time like this.	Try not to think about it.
I don't know what to say but I know this must be very difficult for you.	He wouldn't have wanted you to be sad.
Do you feel like talking for a while?	This is a blessing.
How do you feel today?	Now you have an angel in heaven.
	You shouldn't feel that way.
	Stop acting like a baby.
	You need to be strong.

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Grief Discussion with Students after a Suicide

Before the meeting with students:

- Review "Talking About Suicide" (AFSP Toolkit, Pages 15-16)

Meeting Guidelines

- Before having the discussion with students, students are asked to respect one another and that not a lot of detailed information will be shared about the person who died.
- Share the information that you have directly and honestly.

Read "Sample Death Notification Statement for Students" (AFSP Toolkit, Pages 17-18)

- Allow students to ask questions. Answer questions as best as you can, knowing that it is okay to say "I don't know" when you don't have the answer.
- Talk to your class about how grief affects people and encourage them to share how they feel. One way to do this is to discuss what other types of losses or deaths the students in your class have experienced, and what helped them cope.
- Psycho-educate students on the facts about suicide (i.e., brain illness, warning signs, symptoms) and resources to support themselves and others – "Facts about Suicide and Mental Disorders in Adolescents" (AFSP Toolkit, Pages 26-28) is a great resource.
- Let students know that if they would like to write a letter and/or draw a picture to support the family that they could do so.
- Let students and families know that there are support counselors that they can speak with today who can help with on-going support as well.

Recommended: Share "Helping Students Cope" (AFSP Toolkit, Pages 29-31) with teachers, counselors, and administrators who will be supporting the students and parents.

Kara
Moving through grief toward hope and meaning

Useful Grief Insights for Teachers: A Script

Scene: You are faced with the challenge of helping your students cope with the loss of a classmate. The goal is to help them grieve, not to make the grief go away.

Action: Tell a story of a death you believe the children will understand (a pet, a tree, a bird, etc.) or use one of the activities from the enclosed notebook.

Setting the scene:

- *Be honest with yourself.* Recognize that you are grieving too. You don't have to do it all. For example, "I miss Sally, too."
- *Be honest about your feelings.* Share what you are feeling with your students, share with them through simple statements and comments about what you do to express and cope. For example, "I sometimes feel better after drawing a picture."
- *Be honest with the limits of your knowledge.* The death may raise questions about what it feels like to die and what happens after death. You won't be able to answer many of their questions. Ask what they think so you can hear what their actual worries or concerns are.
- *Provide opportunities for feeling expression.* When we grieve, it is often a mixture of anger and sadness. Allow time for their tears. Let the children know that crying is a normal reaction to the death of a classmate and of a loved one.
- *Maintain class and home routine and rules.* Students need structure and routine. Even with the interruption of a funeral or memorial service, your return to routine will provide reassurance to the students that life does go on.
- *Don't rush.* If a classmate has died, let your students decide what to do with the empty desk and the other things owned by the child who died. The idea is not to make the child disappear, it doesn't make it easier for the children. Rather, it gives children a sense that the child didn't really matter.
- *Add feeling-related activities to your regular curriculum.* Many children are kinesthetic learners. The need to express feelings about the loss will continue for all your students. In particular, the kinesthetic student is particularly comforted by art and writing projects built around feeling themes. Stories about coping with death and loss can be incorporated into the classroom reading activities. It is important to continue to provide opportunities for feeling expression.
- *Honor and affirm your privileged position.* This is a time you have a very healing influence on your students. Showing them how to handle grief in even these small ways will help them in the future.

Finale: Giving permission to feel and to share feelings may be the single most important gift you ever give to them.

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Sample Letter to Parents after a Death

Dear parents,

A very sad thing has happened in our school community. Last night, we lost _____. This loss was sudden and unexpected, and we are all profoundly saddened by his death.

We have shared this information with your children today and had discussions with all the students in their homeroom. Bereavement counselors, teachers, and other support staff have been and will continue to be available to students, teachers, and parents. Please contact the school if you have any questions or concerns.

As a parent, you may want to talk to your child about death because it impacts each person in different ways. How children and teens react will depend on the relationship they had with the person who died, their age, and their prior experience with death.

Your child may:

- Appear unaffected
- Ask questions about the death repeatedly
- Be angry or aggressive
- Be withdrawn or moody
- Be sad or depressed
- Become afraid
- Have difficulty sleeping or eating

We suggest that you listen to your children. If they want to talk, answer their questions simply, honestly and be prepared to answer the same questions repeatedly.

Our thoughts are with (family name).

Sincerely,

Principal XXXX

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