THE SCHOOL DISTRICT OF TORRINGTON, CONNECTICUT

SUICIDE PREVENTION POLICY, PROCEDURES AND GUIDELINES

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The Torrington School System recognizes that suicide has become one of the top three leading causes of death among young people. It further acknowledges the schools' role in providing an environment which is sensitive to societal changes which place youth at greater risk for suicide, and one which helps to foster positive youth development. Consequently, the Torrington School System recognizes its moral and ethical responsibility to take a proactive stance in preventing the problem of youth suicide by providing programs which are conducive to the positive development of youth, and by providing appropriate intervention and referral for those potentially suicidal youth who come to the attention of school personnel. At the same time, however, the Torrington School System recognizes that suicide is a complex issue which cannot be addressed by the school system alone. While the school may recognize potentially suicidal youth, it cannot provide the necessary, in-depth, clinical assessment and psychotherapy. The school system's role in dealing with youth who are at high risk for suicide is to try to identify and refer these youth to appropriate community agencies for more in-depth assessment and treatment. Therefore, any school employee who may have knowledge of a suicide threat or who observes student behavior which appears to be related to the possibility of suicide must take the proper steps, as specified in the following administrative procedures, to report this information to the designated school personnel, the student's family, and/or appropriate community agencies.

ADMINISTRATIVE GUIDELINES

DEFINITION OF TERMS

ADMINISTRATIVE REPRESENTATIVE:
Throughout this document, the term "administrative representative" shall be defined as personnel who hold appropriate certification for, and who are hired for, the position of School Counselor, School Psychologist, and/or School Social Worker.

RISK ASSESSMENT:
A risk assessment is defined as an evaluation of a student who may be at risk for suicide, and is conducted by a School Counselor, School Psychologist, or School Social Worker. This interview is designed to elicit information regarding the student's intent to kill him/herself, previous history of suicide attempts, the presence of a suicide plan and its level of lethality and availability, the presence of support systems, level of hopelessness and helplessness, mental status, and other relevant risk factors.

HIGH RISK:
A student who is defined as high risk for suicide is one who has made a suicide attempt, or has the intent to kill him/herself. He/she has thought about how he/she would do this, and may have a plan. He/she has access to the method described, but may not have everything in place. In addition, he/she may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. Support systems are often limited. This situation would necessitate parental contact and referral, as documented in the following procedures.

VERY LOW OR NO RISK:
A student who is defined as very low or no risk for suicide is one who has not seriously considered suicide and has no plan or method. He/she may be experiencing feelings of pain, but is willing to work to help to change the situation.
**PRIMARY PREVENTION OF SUICIDE**

The Torrington School System will undertake the following tasks in order to promote conditions that reduce the risk of possible youth suicide:

1. Conduct, and encourage others to conduct, activities designed to raise student, parent, staff, and community awareness about the problem of youth suicide.

2. Work collaboratively with community agencies for the purpose of fostering healthy youth development within the community and also facilitating appropriate student referrals.

3. Provide developmentally-based curricula to foster positive self-esteem, and the abilities to effectively cope with loss, to identify and utilize appropriate support systems, and to recognize and respond appropriately to the warning signs of suicide.

**SECONDARY PREVENTION OF SUICIDE**

**Identification:** While no one risk factor, in itself, proves suicidal intent, the presence of a combination of factors may indicate a need for further assistance. In order to promote good mental health, the Torrington School System agrees to respond to students who are experiencing stressful life conditions, and who are demonstrating an inability to cope with these stressors.

**Staff Actions:** Staff who have identified students who may need secondary prevention are expected to bring these students' names to the attention of the building Child Study/Collaborative Team as soon as possible by completing and submitting the appropriate building referral form. In response to this referral, the situation will be reviewed by the Child Study/Collaborative Team. Depending upon the circumstances, the team may recommend one, or some combination of the following options: monitoring the student, counseling for the student, consultation with the student's teachers and/or other staff, parental contact, referral to in-school resources, referral to out-of-school resources, initiation of a PPT referral, or other options as warranted by the circumstances. All communication between staff and team members regarding "at risk" students shall be treated confidentially.

**PROCEDURE FOR REPORTING STUDENTS AT HIGH RISK FOR SUICIDE**

**Identification:** High risk students include those who have made a suicide attempt, as well as those who are exhibiting the commonly recognized warning signs of suicide as listed in Appendix C (page Error! Bookmark not defined.) of this document. Staff are encouraged to be sensitive to other signs they believe may indicate a student is suicidal.

In order to facilitate such identification, the Torrington School System will provide training to all staff and students, at appropriate grade levels, in recognizing the warning signs for suicide. Special training in risk assessment and crisis intervention will be provided to School Counselors, School Psychologists, and School Social Workers, as needed. Special initiatives will be undertaken to inform parents of those warning signs. The Torrington School System will also seek to encourage students to recognize and
refer peers about whom they are concerned. Furthermore, the Torrington School System will work collaboratively with community agencies in an attempt to develop a formal written agreement for community-based intervention with high risk students.

**STAFF ACTIONS DURING SCHOOL HOURS**

1. All staff members who have reason to believe that a student appears to be at risk for suicide must report this information to an administrative representative immediately. This shall be reported to a building administrator as soon as possible. In the event that an administrative representative is not available, this information must immediately be reported to a building administrator, who will in turn contact the student's parent or guardian and share the staff member's concerns. If an administrator is not available, the staff member is to contact the parent by telephone immediately. (Please refer to the "Guidelines for Parent Contact Regarding Students at Risk for Suicide/Self Destructive Behavior" document in Appendix D, page 28.) This information will be communicated with an administrative representative as soon as possible.

2. In the event of a medical emergency, the student will immediately be referred to the School Nurse, or her designee, who will implement medical emergency procedures. The School Nurse will notify an administrative representative who will provide appropriate follow-up with the student and/or his/her family.

3. A student can be self-referred or referred by a friend, parent, neighbor, teacher, etc. When possible, at least two members of the counseling staff (herein defined as School Counselor, School Psychologist, and School Social Worker) will meet to coordinate an intervention plan. The referral information should be investigated as much as possible prior to interviewing the student. Whenever possible, this investigation should include consultation with the School Nurse, and interviewing the referring person about why they have concerns about the student: what behavior changes they have noticed, any other relevant information they may have. It might also include interviewing the staff person who knows the student best. This plan will always include a risk assessment interview with the student on the same day the referral is made, conducted by an appropriately trained, and certified/licensed professional (i.e., School Counselor, School Psychologist, or School Social Worker). When deciding which School Counselor, School Psychologist, or School Social Worker should conduct the interview, the following factors should be taken into account: (a). already existing relationships, (b). time and coverage constraints, (c). seriousness of presenting problem, and (d). experience of staff members. These factors need to be weighed by the team on a case by case basis. If a referral occurs after the student has left for the day, the parent or guardian will be informed of the concerns by phone and referred to a Mental Health Agency for assessment.

4. If the student is already in therapy, an administrative representative should contact the student's therapist as soon as possible for a recommendation as to how the school should proceed. If the threat appears serious, the involved administrative representative may contact the Emergency Psychiatric Service Coordinator or other designated staff at the Charlotte Hungerford Hospital Psychiatric Clinic (496-6350) for an opinion and recommendations. The hospital staff member should be given all the available information relating to the suicide threat and risk assessment, with the exception of the student's name. Identification of the student should be omitted until the parent agrees with the school's recommendation.
to sign an release of information form. On a temporary basis, verbal permission of the parent (documented in the file) is sufficient to allow school personnel to identify the student to the Charlotte Hungerford Hospital Mental Health Clinic. A permission to release information form must be signed by the parent(s) thereafter. However, if as judged in the best opinion of the intervention team, the child's right to be in a safe situation conflicts with the parents' right to confidentiality, the child's right to be safeguarded takes precedence.

5. Immediate contact with the student's parent or guardian will always be made if a student has made a suicide attempt or if there is suspicion that the student is at risk for suicide. If it is suspected that the threat is serious, appropriate recommendations will be made regarding referral and ensuring the student's immediate safety (i.e., advising the parent of warning signs, removing lethal objects from the home, supervising the student, etc.). If the involved administrative representatives deem it appropriate, and the student is eighteen or older, he/she may be dealt with directly. Teachers who initially reported observed warning signs may be asked to directly contact the student's parent/guardian so that first-party information is available. If, after the initial interview, the team does not suspect that the threat is serious, it may still be advisable to inform the parent that the interview has taken place and to actively seek additional information from the parent about whether the child has threatened or attempted suicide earlier or whether there are significant risk factors.

6. If it is felt that a parent's response is negligent, damaging to the child, or likely to cause a suicide attempt, DCF and/or the Police will be notified in cases where the student is under eighteen. In addition, a certified letter will be sent to the parents which clearly states the student's risk, summarizes contacts, and makes recommendations. If a student judged to be in immediate danger, is over eighteen and refuses help, or if the parent or emergency contact of a minor student in immediate danger cannot be located, the police will be contacted to see if they should take custody of the student and transport him/her to the hospital.

7. If it is determined that the threat of suicide might be carried out immediately, one of the staff members involved in the intervention, or a designee, will remain with the student at all times until he/she is released with his/her parent, DCF, or the police. Any potentially lethal objects will be removed from the student's possession. This will be done in the presence of two appropriate personnel when possible. The Administrator and School Nurse will be advised of the situation as soon as possible. If the object is potentially dangerous to others, an administrator and the School Nurse will be contacted immediately.

8. The administrative representative who functioned as the primary contact with the student will meet with the student on the next school day or the day of the student's return to school to provide follow-up and continued support. If the student was referred to a community agency or private mental health professional, follow-up contact will be made with the agency or mental health professional as well. It may also be advisable to follow up with parental contact.

9. Written documentation of actions taken will be maintained by each staff member involved in the evaluation process, using the form found in Appendix E (page 30). These records will be kept as strictly confidential material.
STAFF ACTIONS AFTER SCHOOL HOURS

1. In the event that a student calls or visits the home of a staff member after school hours and indicates a threat of suicide, that staff member must notify the parent or guardian immediately.

2. In the event that the family may not be available or helpful, the staff member receiving the call/visit should find out as much information from the student as possible, and, depending upon the seriousness of the situation, one of the following agencies will be contacted and provided with all the information the staff member has (the nature of the threat, where the student is, who else is around, who could be helpful, address, phone number, etc.):
   - The local police.
   - The DCF 24-hour Careline 1-800-842-2288, after 5 p.m. and weekends.
   - The Hospital Emergency Room.

3. Some situations are critical enough that the staff member should stay on the phone with the student to maintain contact. In that case the staff member should remain on the phone with the student and enlist the assistance of another person to contact the police if possible.

4. Information regarding after school hours contacts with potentially suicidal students or their parents must be shared with an administrative representative on the next school day.

PROCEDURES FOR RESPONDING TO COMPLETED SUICIDE OR SUDDEN DEATH OF A STUDENT OR STAFF MEMBER

Completed suicides may trigger other suicide attempts, which may cause a contagion effect. While there is no clear body of knowledge about how or why this occurs, most experts agree that it is better to keep students at school where adult support systems are available rather than to send students home where supervision may not be available. In order to minimize the risk of contagion, the Torrington School System will attempt to identify and monitor students who may be in a risk category, reduce the glamorization of the suicide, and implement carefully planned postvention activities. To this end, the following guidelines are to be followed:

1. Establishing Building and District Crisis Intervention Teams

   Each school shall form an ongoing Crisis Intervention Team. It is recommended that this team be composed of: the Principal, School Psychologist, School Social Worker, School Counselor, School Nurse, and a teacher. When appropriate, additional members of the community will be asked to participate (i.e., parents, clergy, mental health professionals, etc.). Each team must designate a team leader who has decision-making authority to coordinate assignments and communicate with the team members. The purpose of the building teams is to develop, implement, and coordinate specific crisis plans for the individual schools, as crises arise. The responsibilities of Crisis Team membership must take priority over other job assignments so that the team can convene quickly. Counseling professionals normally servicing other buildings may be utilized to provide additional direct and indirect support as needed. It may often be helpful to involve school mental health professionals from other buildings who are not emotionally involved with the crisis. The crisis team in each building should be governed by professional confidentiality as specified in the confidentiality guidelines.
When the crisis intervention team is asked to respond to a suicide or sudden death, its initial tasks should include the following:

a. Decide whether whole-school intervention is needed. With some situations (for example, a very new student, or one who had little contact with the general student body), it may be advisable to only deal with a smaller group of directly affected students initially. If it is decided to limit the intervention, feedback from all teachers must be elicited to determine if the death has had more of an impact on the general student body than initially anticipated. If so, the intervention should be expanded.

b. Prepare a written statement(s) of the facts of the death which will be shared with faculty, students, and parents. If it has not yet been resolved whether the death is a suicide, the uncertainty should be acknowledged and the term "apparent" suicide may be used. (Refer to Appendix J, page 36, for a sample statement.)

c. Plan faculty meeting.

d. Organize dissemination of information to affected student body. Plan to support teachers who are uncomfortable talking with their classes about the death.

e. Assign a team member to follow the deceased student/faculty member's schedule for the first day.

f. Plan for contact with friends of student.

g. Plan counseling/support groups (i.e., location, who will run groups, time, etc.).

h. Decide whether to involve outside consultants or members of other building crisis teams.

i. Discuss dealing with the media. Prepare a written statement that the designated secretary can use when responding to telephone inquiries from parents.

j. Decide who else should be notified and how this will be done (i.e., parents of close friends, colleagues, PTA, etc.).

k. Decide who will contact the deceased student's family.

l. Decide who will collect the deceased student's personal belongings.

m. Plan to assess, monitor, and support other "at risk" and "high risk" students, as this sudden death may increase their risk.

n. Plan regular meeting times during the crisis to monitor situation, support each other, and modify plans, as needed. During the initial stages of the crisis, these meetings may need to occur several times during the day.

A district Crisis Intervention Team shall be formed by the Superintendent, representatives of each building team, and must include at least one School Psychologist, School Social Worker, School Counselor, School Nurse, and represent all three school levels. Similar to the building teams, a team leader should be appointed to coordinate plans and communicate with the
Superintendent. The purpose of the district team is to plan and coordinate crisis plans for the entire school district and to facilitate district-wide communication.

When deemed appropriate by the involved building team, the Community Response Team will be included in the team to provide guidance and consultation and to direct services as needed.

2. **Disseminating Information to Faculty and Students**

One of the first issues following a sudden death or suicide is effective communication with students, faculty, and parents. It is critical that the death be addressed openly and directly. Any attempt to delay informing the students of the facts will only encourage rumors. It is impossible to keep the suicide of a student or teacher a secret, even if the family requests this. The impact of the loss can be compounded if the information is not presented honestly, with empathy, and in a timely manner. The following steps should be taken:

   a. The first staff member who hears of the death will contact the building Principal.

   b. The building Principal will notify the Superintendent and Crisis Team members.

   c. The building Principal shall attempt to verify the information from the police, medical examiner, family members, or other reliable sources.

If the crisis occurs **after school hours or during school vacations**, the following steps should be taken:

   a. The Principal or designee will telephone all Crisis Intervention Team members as soon as possible to inform them of the known facts and to schedule a meeting prior to the beginning of the school day in order to review procedures, develop a specific plan, and delegate specific responsibilities, as outlined above (refer to page 8).

   b. Crisis Intervention Team members will contact all building staff immediately to share the information regarding the death. This will allow staff time to deal with their own feelings first, so they are better able to help the students the next day. As the staff members are being notified about the death, the contact person should be sensitive to whether any of them might need special support due to their relationship with the deceased. During the call, the staff members are informed that there is a meeting before school the next day. This meeting will take place following the initial meeting of the Crisis Intervention Team.

   c. Designated team members will inform the parents or guardians of those students who were closest to the deceased student. (Refer to "Parental Contact" section (4) of these procedures, page 12.)

   d. Designated Crisis Team members will notify Crisis Team leaders from other buildings, whose team members may be needed the next day to assist the Crisis Team at the school of the deceased student/faculty member. It is also important to notify the crisis

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team members from other buildings in consideration of the siblings
and friends of the deceased student.

If the school is informed of the crisis during school hours:

a. The building Crisis Intervention Team should be convened
   immediately to review procedures, develop a plan and delegate
   responsibilities, as outlined above (refer to page 8).

b. Those students who were closest to the deceased should be informed
   individually by a team member, with follow-up parent contact.
   They should be given the option of returning to class, continuing
   to meet with support personnel, or going home (if accompanied by a
   parent or guardian).

c. Faculty should always be notified prior to the general student
   body, ideally at a meeting at the end of the day so they are
   prepared to deal with their students' grief and confusion. THE
   USE OF A LOUDSPEAKER OR LARGE ASSEMBLIES TO DISSEMINATE
   THIS INFORMATION SHOULD BE AVOIDED. When it is not
   possible to wait for a faculty meeting at the end of the day,
   members of the crisis team should go to each classroom
   individually to inform the teachers of the death, to inform staff
   of the time and location for the initial faculty meeting, and to
   provide them with a written statement which they can share with
   students. The statement should include the basic facts of the
   death and known funeral arrangements (without disclosing a precise
   description and details of the suicide method), recognition of the
   sorrow and distress the news will cause, and information about the
   resources available to help students cope with their grief.
   Faculty should be encouraged to follow up with classroom
   discussions to allow students an opportunity to share feelings in
   a small group setting.

An emergency faculty meeting should always take place as soon as possible
(either at the end of the day, or before the beginning of classes) after the
news of the sudden death of a student or faculty member. It should include
the following components:

- Distribute a written statement of facts which teachers can read to
  their students. Dispel any rumors or misinformation. Announce
  any scheduled arrangements (i.e., funeral, memorial services,
  etc.) and policy regarding student attendance.

- Allow, encourage, and support staff to react, ask questions, and
  express their feelings. Point out that understanding their own
  feelings will make it easier to deal with student feelings. Point
  out the availability of support services for staff, as well as
  students.

- Anticipate student reactions. Review "normal" stages of grief and
  specific developmental issues students may face.

- Inform faculty of what actions have been taken so far.

- Announce crisis intervention team member roles, available support
  services for students (who, when, and where), and contact persons
  for responding to outside requests for information (from police,
  media, parents, etc.).
• Review plan to inform students of the death and review "Guidelines for Talking to Students About Suicide or Sudden Death" (Appendix F, page 31). Stress availability of crisis team members to assist and support staff members who are uncomfortable leading class discussions.

• Address how particularly affected classes will be handled (i.e., crisis team member following the deceased student's schedule, etc.).

• Review concept of "contagion." It should be explained to the teachers that the purpose of trying to identify and give services to other high risk students is to prevent another death. Discuss the need to monitor possible and known "at risk" and "high risk" students more carefully. Ask faculty members for a list of students they feel may be "high risk" (by virtue of their relationship with the deceased or other risk factors) and require special monitoring or intervention. Review suicide warning signs (Appendix C, page 26) and procedures for reporting high risk students (page 4).

• Review plan for school day. Announce after-school faculty meeting schedule during crisis period. In subsequent faculty meetings, and in initial meetings which occur after students have been informed:
  • Continue to support staff and encourage discussion of their feelings.
  • Review the day's events, identify problems that have arisen and problem-solve.
  • Identify "at risk" and "high risk" students; develop a plan for monitoring and supporting them.

3. **Contact with Family of the Deceased and Personal Possessions of the Deceased**

The Principal, members of counseling staff (School Psychologist, School Social Worker, Guidance Counselor), and/or faculty members who had a close relationship with the victim should visit the bereaved family. Prior to this, all school records of the deceased should be gathered and reviewed by the Principal. This provides an opportunity to offer condolences and support and to obtain information or messages the family may wish to have passed on to their child's friends. The family can also assist in identifying friends and siblings in other schools who may need assistance.

Families usually feel isolated and stigmatized. They often need reassurance that they are not being blamed. They may take comfort in knowing that the school has a procedure to help other children and teachers with their grief and will often want to cooperate in this process. The family needs to know what the school is doing during the postvention process. The visit to the family can be a time to offer assistance in retrieving their child's belongings from school. They may wish to have the opportunity to do this in private or have someone else do it for them. This meeting will also provide the opportunity to make them aware of community agencies and resources for support.
Consultation should be made with the deceased student's family regarding media contact. The parameters which the school district has established should be explained. Assurance should be made that confidential information is being protected. Stating the exact plan for dealing with the media is important, so that there is no possibility of misunderstanding the school's position. An offer should be made to help them in any way in dealing with the media, even to the extent of offering to issue a statement through the school.

4. Parental Contact

The sudden death of any youngster will evoke much emotion, confusion, and a sense of urgency. With this in mind, the school will also have to respond to the needs and concerns of parents of students. Accurate information to dispel any myths surrounding a crisis will be critical, as will support and advice to parents concerning how to handle their son or daughter.

In an effort to allay parents' fears and anxieties, the following steps will be implemented:

   a. Identify close friends of the victim or students who appear extremely distraught. Students will be assigned to members of the crisis team who will then contact their parents. Parents will be informed of the facts of the death, the effect it is having on their child, typical reactions, and warning signs to be aware of. Permission will be obtained for a crisis team member to meet with students on an individual basis to determine whether further assessment is warranted.

   b. There will be a follow-up contact with parents of high risk students. Staff will reinforce the need to be sensitive to their child's reactions and to encourage them to seek a professional evaluation if their child continues to display magnified or atypical signs. A list of warning signs and local mental health agencies will be provided (see Appendices C and G, pg. Error! Bookmark not defined. and 33).

   c. If the crisis team deems it appropriate, a letter will be sent to all parents by the Principal notifying them of the death and circumstances surrounding it, and funeral arrangements (see Appendix H, page 34). Parents will also be invited to an evening informational session which will delineate the school's actions and response to the crisis. A mental health professional will also provide a presentation addressing the impact this has on youth and behaviors parents should be aware of. A parent information packet will be distributed which may include guidelines for talking to your child about death, etc. (see Appendix I, page 35).

   d. Following a death, faculty will be asked to maintain a list of students who appear to be having difficulty coping. The list will be forwarded to the crisis team who will follow the same procedure outlined in step "a" for those students not initially seen. Consideration should be given to students who are absent during this time period.

   e. As soon as possible after the death of a student, the crisis team will convene to formulate a statement which will be conveyed to parents calling in reference to the death (see Appendix J, pg.36). The statement may include acknowledgement of the death, actions of the school, a list of community resources, and any other information deemed appropriate. The secretary will then use this
statement in responding to all parents calling for confirmation of the death or other information.

5. **Working with the Media**

The objectives of developing a process for working with the media in the event of a crisis (i.e., suicide or sudden death) are:

- To minimize sensationalization or glorification of a suicide in/by the media.
- To avoid confusion or exacerbation of the crisis.
- To prevent unnecessary disruption of the school's operation by the media.
- To use the media as a constructive part of the community partnership.

One person will be designated as media spokesperson. That person will be the building Principal or his/her designee. Secretaries will refer all inquiries from the media directly to the spokesperson. The spokesperson's responsibilities include:

- Keeping the Superintendent informed.
- Answering all media inquiries.
- Preventing disruption of the school process by anyone, including the media.
- If appropriate, calling a press conference.

The spokesperson should be prepared to discuss the following information, as deemed appropriate by the Crisis Intervention Team (refer to Appendix K, page 37):

- Feelings of sympathy/regret.
- A brief statement regarding information shared with students and staff about the crisis.
- Any part of the public record.
- Postvention/intervention plans.
- Available school/community resources.
- Positive comments regarding the victim/victim's family.
- The family's wishes/arrangements.
- Other school operations (i.e., schedule changes, etc.).

Information which is **inappropriate and should not be shared** includes:

- Confidential information.
- Victim motivation.
• Means of suicide.
• Personal information regarding the family.
• Details regarding the suicide or crisis.
• Anything you wouldn't want said about yourself.

6. **Provision of Individual and Group Counseling**

In the days immediately after a sudden death, two things should be simultaneously occurring:

1) **The maintenance of a calm, supportive atmosphere** -- The predictability of the school routine is often reassuring during a time of stress. Thus it is important that the school remain open and maintain, as far as possible, a normal schedule with some reduction in academic expectations.

2) **The provision of special counseling initiatives** -- A flexible approach should be adopted which provides maximum opportunity for students to discuss their reactions. Besides encouraging the use of existing counseling resources, special outreach and screening measures should be initiated to identify and support the "at risk" student.

The **locations** utilized for counseling should be appropriate for groups, as well as individual counseling. They should be private, free from interruption, and conducive to the counseling process. Large rooms, such as cafeterias or auditoriums should be avoided as they do not lend themselves to counseling. If a large room is used and becomes too full it could lead to emotional contagion that becomes too difficult to control and increases the risk. Smaller areas in which the students may informally congregate or sit quietly should be made available as well, with a crisis team member always close by. Since people grieve in different ways, as long as it is not destructive, students should be permitted to choose what is the most comfortable situation for them.

The postvention counseling approach focuses on emotional and behavioral reactions that interfere with a healthy grieving process and with survivors' ability to cope with the crisis. **Guidelines for postvention counseling** follow:

- Validate, explain, encourage, and normalize the expression of many conflicting feelings such as: shock, fear, sadness, guilt, anger at others or at the victim, blame, denial, and anxiety. Assure students that these painful feelings can and will be alleviated through discussion, counseling, and emotional support, and will become less intense over time.
- Reassure that there is no "right way" to feel after a death.
- Do not try to cheer the students up. They will need to experience the pain in order to progress through their own grief.
- Help to clarify the facts of the death as they are understood. Ask students to repeat information they have heard and correct errors.
• Encourage reality testing of the common misconception that someone other than the victim is to blame for the suicide. The suicide was the choice of the victim.

• Do not speculate why the victim chose to die or who is to blame. Acknowledge survivors' desire to know "why", yet impress on them that the only one who really knows the answer is now dead.

• Do not describe the suicide in positive terms or glamorize the act. The focus needs to be placed upon ways to get attention from significant others without threatening or attempting suicide.

• Ask survivors to describe their memories about the deceased and to talk about the last time they saw the victim. These memories may be happy, sad or angry. Ask them what they wished they had said or would have said if they had known that this would be the last time they saw him or her.

• Encourage discussion of other recent losses and description of their experiences at funerals and what might be expected at this one. Rehearse condolence messages to the family. This may be a new experience and can cause anxiety.

• Acknowledge that suicidal thoughts are common but do not have to be acted upon. Problem-solve other alternatives.

• Encourage students to talk to their parents and friends about their feelings and thoughts regarding the death. Ask them to discuss positive experiences with seeking help, and to list whom they can turn to for support. Direct students to available sources of assistance.

• Release grieving students from school only with their parents' knowledge and approval, and in the care of a responsible adult. Do not permit students to leave the school to go home to an empty house. They are much better off being with their friends and caring adults. Contact parents of students who have left school without parental permission immediately.

7. Screening the "At Risk" Student

Students who were close friends of the victim, a relative of the victim, students with a history of suicidal behavior/ideation, or those students who have recently dealt with another suicide are considered to be particularly vulnerable.

A crisis center(s) will be established in the deceased student's school, staffed by the crisis team and appropriate community professionals. Faculty will be instructed to inform students of the crisis center. Students who are considered to be "at risk" will be accompanied to the crisis center. Crisis team personnel will individually assess students deemed to be "at risk."

Crisis team staff members will contact the parents of "at risk" students to offer assistance and to provide information and support for the parents of these students. "Procedures for Reporting a Student At Risk for Suicide" should be followed (refer to page 4 of these guidelines).
"At risk" students will be monitored by crisis team members after the initial crisis phase is over. Family and school communication should be encouraged and documented throughout this period.

Crisis team members may develop an on-going support group to meet with "at risk" students.

8. **Support for School Personnel**

Staff members will need to ventilate feelings about the suicide/death. They will be working through their own reactions while trying to assist their students through the crisis. Time should be scheduled before school and during the school day for faculty to talk to support staff or community professionals brought in to help with the crisis. These professionals should be available in the faculty lounge, staff cafeteria, or wherever faculty congregate in order to facilitate discussion.

Crisis team and/or support staff should be "on call" to assist teachers or give them a break during the school day as needed. Staff should be made aware of this service and encouraged to use it as appropriate. Faculty should be apprised that they, too, may be very likely to go through the grief process.

Staff members who have recently dealt with the deceased should be encouraged to seek out someone to talk with. Issues of "not having seen what was coming," missing warning signs, disciplinary referrals, and other interactions may make a staff member feel particularly vulnerable.

A faculty meeting should be held at the end of the school day to give the staff an opportunity to talk as a group about their own reactions, and how they managed in dealing with their students, and to discuss plans for the up-coming day.

Crisis team members should consider a short debriefing session at the end of the day to bring closure to the day's events, and to provide mutual support.

9. **Memorials and the Funeral**

It is critical to maintain a balance between support of the grieving process and avoidance of glamorizing or sensationalizing a completed suicide. Maintaining this balance is a particularly delicate issue as the school decides on appropriate commemorative activities following a completed suicide.

In the case of a suicide, some memorial activities are questionable and potentially dangerous, even if they are customary. **DO NOT DEDICATE AN ATHLETIC EVENT, DANCE OR OTHER SCHOOL ACTIVITY TO THE DECEASED STUDENT, FLY THE FLAG AT HALF-MAST, OR ESTABLISH ANY KIND OF PERMANENT MEMORIAL SUCH AS A PLAQUE, TREE, YEAR BOOK DEDICATION, SCHOLARSHIP FUND.** These kinds of memorials have the potential for becoming a constant invitation to consider suicide, and may give students the message that suicide will, in fact, give them the recognition they were unable to obtain in life. Memorial assemblies can be too intense and difficult to manage. Discussions should be held in small groups where student reactions can be monitored by crisis team members. It is critical to understand the need of grieving students and faculty to find a way to honor the memory of a deceased friend as an important part of the grief process.

The challenge lies in finding ways to channel energies into constructive projects that help the living, and do not glorify death. For example, funds may be collected and offered to the family to assist with funeral expenses or
donated to a community agency such as a crisis center or suicide prevention program. In cases where the death is not due to suicide, a crisis intervention team liaison should meet with the family of the deceased to determine an appropriate memorial.

Funeral arrangements should be announced as they are known. All students wishing to attend the funeral service should be encouraged to do so, with written parental permission. It is strongly suggested that parents accompany their children to the funeral service and be available to discuss and share the experience with them.

Many students will be anxious about the funeral and will benefit from this topic being covered during counseling sessions to help them prepare for the emotional impact. The school and teachers should NOT assume responsibility for transporting students to the funeral home, church, or cemetery. A funeral service held after regular school hours minimizes the disruption of the regular school schedule. IF THE FUNERAL IS HELD DURING SCHOOL HOURS, THE SCHOOL SHOULD STAY OPEN for those students who choose not to attend.

It is critical to maintain as normal a routine as possible. At least one administrator and several crisis team members should be assigned to attend the funeral. They should watch and help the unattended high risk students. They should also be available to support any students or staff who might be having particular difficulty. If the funeral is during school hours, some team members must remain in the buildings to help those students unable to attend. Provision should also be made for other faculty who wish to attend.
APPENDIX B - SUICIDE RISK FACTORS

The following life crises, behaviors and circumstances have been identified by experts as potential risk factors for suicide. No one can say with certainty which specific life conditions and personality traits may combine to result in suicide. Nor can we say why one person commits suicide and another with similar circumstances does not. Staff should become familiar with these risk factors and make referrals to the principal or his/her designee when they are observed.

FAMILY FACTORS

Suicide of a family member (especially of a parent or sibling).
Loss of a parent through death or divorce.
Family alcoholism or other drug dependency.
Absence of meaningful relationships and attachment within the family.
Destructive, violent parent-child interactions.
Physical, emotional or sexual abuse.
Chronically depressed, mentally ill or suicidal parent.
Highly rigid and perfectionistic standards set for child.
Frequent (though not necessarily intended) communications that the child is unwanted or expendable.
Periods of unusual family stress due to factors such as illness, unemployment, disabilities, etc.

ENVIRONMENTAL FACTORS

Suicide of someone the youth has known or identified with.
Frequent mobility, especially during early to late adolescence.
Religious conflicts where the youth feels caught in the middle.
Incarceration for a criminal offense, especially if youth was intoxicated when placed in jail.
Loss of any significant relationship.
Chronic high levels of stress in life.
Loss of identity or status or repeated failures to achieve desired status.
Social isolation and failure to develop peer attachments.
Fears that one has contracted or been exposed to AIDS.
Accumulating failures or rejections.

BEHAVIORAL FACTORS

Past history of suicide gestures or attempts.
Running away - especially from abusive or alcoholic family.
Alcohol and other drug abuse.
Eating disorders.
School failure or chronic under-achievement.
Chronic or unexpected disciplinary crises at home or school.
Aggression or rage that shows up in violent outburst or behavior (often how boys show depression).
Fascination with death, violence, satanism.
Legal problems.
Self-risking behaviors such as reckless driving, overt sexual promiscuity or potentially harmful risk-taking.

PERSONAL FACTORS

Frequent periods of feeling down.
Frequent feelings of powerlessness.
Learning disabled.
Gifted.
Poor impulse control, especially involving aggression or risk-taking.  
Unwillingness to seek or accept help for problems.  
Desire for revenge or to punish another.  
Confusion/conflict over sexual identity.  
Alienation from traditional social institutions and values.  
Compulsively perfectionistic; highly self-critical.  
Seems to lack inner resources and skills to solve problems, deal with frustration.  
Poor social skills; low sense of self-esteem.  
Desires to be re-united with someone who is dead.  
Highly defensive and avoidance reactions to problems.  
Strong feelings of shame or guilt that persist over time.  
Unresolved feelings of grief.  
Tendency to develop "tunnel vision" about problems.  
Perceives that he/she can only get attention in negative ways.

PSYCHIATRIC FACTORS

Affective disorder diagnoses.  
Conduct disorder diagnoses.  
Depression diagnoses.  
Substance abuse diagnoses.

Source: Final Report to the General Assembly of the Connecticut Task Force on Youth Suicide Prevention, February 10, 1989

SUPPLEMENTAL INFORMATION FOR APPENDIX B

The following supplement is designed to provide more in-depth information concerning some of the more important risk factors for suicide as listed in Appendix A.

1. PREVIOUS SUICIDE ATTEMPTS - Even if these attempts were not deemed to be very serious, and even if they occurred in the past and were not followed by therapy or counseling, they indicate increased risk for further attempts.

2. SEXUALITY CONFLICTS - Gay and lesbian youths have a higher incidence of suicide than heterosexual youths; this is true even if the young person has not outwardly defined him/herself as homosexual but is still struggling with sexual identity issues.

3. EXPOSURE TO AIDS - The knowledge that one's sexual partner has contracted or been exposed to AIDS may result in a higher risk for suicide even if this person has not taken the AIDS test but believes him-/herself to be in danger of contracting it.

4. LOW SELF-ESTEEM AND SOCIAL SKILLS - Students who are continually being rejected by others (or have that perception) may become self-rejecting, self-hating and self-harming.

5. SERIOUS RISK-TAKING - A disregard for one's personal safety, whether expressed through unnecessary risks taken in athletics or recreational activities or through daredevil driving while drunk, may indicate an ambiguity about wanting to live.
6. **ALCOHOL/DRUG ABUSE** - Many troubled students initially use alcohol/drugs to "medicate" their pain, only to discover that, over time, this use increases their depression and problems. 50-80% of suicidal teens are alcohol/drug involved.

7. **SEXUAL, PHYSICAL, EMOTIONAL ABUSE** - The self-blame, quiet shame, and self-hatred experienced as a result of abuse, as well as the "loss" of the parent as a trusted adult, increase risk for suicide even if the abuse occurred years earlier.

8. **SUICIDE OF A FAMILY MEMBER** - especially a parent, increases risk for the child even if the suicide has been kept a "secret" and especially if no counseling was ever provided to survivors.

9. **TEENS WITH CHRONIC SERIOUS PROBLEMS** - within their families, their school-work, their peer relationships or their community may respond by acting negatively, getting into even more difficulty with their parent, the law or school officials, leading to the perception that there is "no way out."

10. **LEARNING DISABLED OR GIFTED STUDENTS** - who experience feelings of alienation and being different from their peers may become increasingly discouraged and hopeless about things ever getting better.

11. **FAMILY ALCOHOLISM** - may result in feelings of guilt, shame, isolation, and inability to control one's life or meet parental expectations; this is especially aggravated by the "code of silence" children learn, leading to feelings of hopelessness, helplessness and alienation.

12. **COMPULSIVE ACHIEVERS** - or perfectionists who are chronically unable to meet their own or parental standards or who interpret lower achievement levels as failure may become so self-rejecting and self-loathing as to become self-harming.

13. **RUNNING AWAY** - Suicide screenings of runaway young people have shown that over 50% of them have thought about suicide as an answer to their problems. There is also a high correlation between running away and family abuse and alcoholism.

14. **SCHOOL PROBLEMS - ACADEMIC OR BEHAVIORAL** - Many young people experience school as a place where they feel like a failure. A negative cycle may develop in which the young person does poorly at school because of low self-esteem, lower ability levels or preoccupation with personal or family problems; the school problems put more pressure on the young person, adding to already-present feelings of worthlessness and hopelessness, which in turn result in further school problems, etc. etc.

15. **LOSS** - of any kind, whether due to death, divorce, failure to achieve a goal, breaking up with a girlfriend or boyfriend, moving, going off to college, etc., often results in feelings of grief, embarrassment, isolation, alienation, insecurity, and aloneness. Without an adequate support system these feelings may become overwhelming for the young person.

16. **FASCINATION WITH DEATH, VIOLENCE, SATANISM** - is often expressed through music, clothing, posters in their rooms and behavior. This fascination may indicate that the young person is pre-occupied with thoughts of death and self-harm. If such a fascination becomes a pre-occupation, that is, the young person's life begins to change significantly, the potential for suicide must be seriously considered.
17. **PSYCHIATRIC DISORDERS** - Certain psychiatric diagnoses, specifically clinical depression, conduct disorders and certain affective disorders, have been identified by the National Institute of Mental Health researchers as risk factors for suicide.

APPENDIX C - WARNING SIGNS

It is important to note that adolescence is often a time of change and mood swings. When considering possible warning signs of suicide, you should look for the pattern (several related signs), the duration (2 or more weeks of a given pattern), the intensity, and the presence of a particular crisis event. You should measure these against what is perceived to be normal for a given adolescent.

Most importantly, you should trust your instincts. When in doubt, seek help. Any young person exhibiting some combination of these signs is probably in need of some type of help.

Many of the risk factors listed in Appendix A are, in hindsight, seen as early warning signs for suicide following a completed suicide. Observation of the following signals of severe emotional distress or overt suicide warning signs, especially when combined with two or more risk factors from Appendix A, must be reported to the principal or his/her designee as soon as possible.

EARLY WARNING SIGNS

Difficulty coping with any of the risk factors in Appendix A. Sudden or unexpected changes in school behavior such as:

- Attendance
- Declining academic performance
- Changed peer relationships
- Sudden failure to complete work
- Loss of interest; inability to concentrate
- Disciplinary crisis, especially involving violence or aggression
- Communicating about death or suicide through writing, art work, class discussion, etc.

- Increased frequency and/or quantity of alcohol and other drug use.
- Sudden changes in appearance - especially neglect of appearance.
- Gradual withdrawal from friends, school, family; loss of interest in activities.
- Sudden or increasingly negative changes in personality and attitude.
- Depression (may be expressed as sadness or angry acting out).
- Sleep disturbances (inability to sleep or sleeping to "escape").
- Eating disturbances (loss of appetite, sudden weight gain or loss, eating disorders).
- Restlessness and agitation (especially if perceived as uncontrollable).
- Over-reaction to criticism; overly self-critical.
- Overwhelming feelings of failure, worthlessness.
- Failure or inability to derive pleasure from one's life, friends, activities.
- Exaggerated or long-term apathy and disinterest.
- Inability to recover from a loss; ongoing and overwhelming feelings of grief.
- Excessive frequency and intensity of mood swings (especially if perceived as uncontrollable).
- Persistent nightmares.
- Frequent expressions of hostility, anger, rage (especially if perceived as uncontrollable).
- Pessimism about life, about one's future.
- Persistent physical complaints (especially if no physiological basis can be found) such as headaches, stomachaches, nausea, anxiety reactions.
- Difficulties in concentration, completing tasks, making decisions (especially if perceived as uncontrollable).
- Delusions or hallucinations; loss of touch with reality.
LATE WARNING SIGNS

Threatening to commit suicide.
Openly talking about death, not being around, not being wanted or needed.
Dropping out of activities; increasing isolation and withdrawal.
Feelings of helplessness, inability to change or control one's life.
Feelings of extreme humiliation, loss of status.
Radical personality or behavioral change.
Sudden or increasingly dangerous risk-taking behavior.
Increasing feelings of aloneness, despair; perception that no one can help.
Increasing loss of control over behavior.
Making final arrangements; giving things away, putting one's life in order.
Sudden and inexplicable improvement in behavior, appearance.

PRECIPITATING EVENTS - OFTEN ONE EVENT WILL SEEM TO TRIGGER A SUICIDE OR SUICIDE ATTEMPT. The most common of these seem to be:

Loss of a close relationship through death or divorce.
Breaking up with boyfriend/girlfriend.
Suicide of a friend, family member or someone youth has known or identified with.
Unexpected loss of status with peers or failure to achieve such status.
Serious fight with parents or close peer.
Being arrested for a crime (especially if incarcerated).
Sudden or unexpected failure or setback.
Recent traumatic event such as moving, a car accident, a major loss or disciplinary crisis that makes facing the future seem impossible.
Anniversary of someone else's suicide or death.
Fear of a major change in life status such as graduation, moving.
Actual major life change such as going to college, staying behind while friends go to college.

Source: Final Report to the General Assembly of the Connecticut Task Force on Youth Suicide Prevention, February 10, 1989
APPENDIX D - GUIDELINES FOR PARENT CONTACT

 REGARDING STUDENTS AT RISK FOR SUICIDE/
SELF-DESTRUCTIVE BEHAVIOR

1. State that you are concerned and explain the reasons for your concern in specific, objective terms. Give examples. Ask the parents if they have noticed any changes at home before you tell them your most serious concern. This will help to engage them. For example:

I'm very concerned about Scott/Samantha. I've noticed some real changes in him/her. He/She has stopped handing in his/her homework and his/her grades have been dropping. He/She also seems more withdrawn and often seems to be daydreaming in class. Have you noticed anything different? - The reason why I felt that I had to contact you today is that I overheard Scott/Samantha telling some of his/her friends that he/she felt that he/she had nothing to look forward to and that his/her life really just "sucks." He/She also wrote a story in class the other day that was all about death. When I put all of these things together, I got really concerned that Scott/Samantha might be thinking about killing him/herself and felt that you needed to know right away.

2. Be as empathetic as possible, but do NOT minimize your concerns. Explain to parent/guardian that what you have observed are often warning signs that a youngster may be considering suicide, and, at the very least, most certainly is reaching out for help. Review other warning signs with parents in order to focus their attention to areas supporting your concerns (see attached list of warning signs):

A loss of interest in school, declining grades, withdrawal, and daydreaming are often signs of depression. When I heard Scott/Samantha talking about life so pessimistically - feeling that he/she has nothing to look forward to - combined with that story he/she wrote, I really became frightened. I'm worried that his/her depression may be so severe that he/she feels the only way out may be death. When kids talk about wanting to die or seeing no purpose to life, we really must take them seriously. It's just too dangerous not to. Perhaps you've seen some other warning signs at home? Have you noticed any changes in Scott/Samantha's eating habits? Is he/she sleeping more or less than usual? Is he/she still in touch with his/her friends? . . .

3. Refer the parent for an evaluation. If it is before 5:00 p.m. on a weekday, refer them to the Emergency Psychiatric Service at Charlotte - Hungerford Hospital (496-6350). If it is after hours, refer them to an Emergency Room:

I really think that it's important for you to have Scott/Samantha evaluated as soon as possible to make sure he/she is safe. (If before 5:00 p.m.): We're fortunate enough to have an emergency psychiatric service right here in town at the hospital. The person who would evaluate Scott/Samantha specializes in working with children and teenagers who are experiencing a crisis and who may be suicidal. Please call to make an appointment. Their phone number is 496-6350. If you become concerned in the evening or over the weekend, I'd really suggest that you take Scott/Samantha to the Emergency Room.
4. Inform the parent/guardian that you will contact a Pupil Personnel Specialist as soon as possible to advise the specialist of your concerns and conversation. Explain that the counselor will be available for any further questions or assistance.

Together we can make a difference and save lives!
APPENDIX E - SUICIDE INTERVENTION FORM

(Confidential - for use by Administrator/Administrative Representative only)

School ______________________________ Principal __________ Date __________

Student's Name __________________________ DOB _________ Age _______ Sex __

Parent's Name ______________________________

Address ____________________________________________________________ Phone: (H) _______ (W) _______

Parent's Name (non-custodial if divorced) ________________________________________________

Address ____________________________________________ Phone: __________________

Student referred by ________________________________________________________________

Assessed by ________________________________

Staff consulted ________________________________

1. State reason for referral:

2. Describe level of possible suicide risk and indicators below:
   (i.e. risk factors, warning signs, behaviors, feelings, plan, method, etc.):

3. Describe actions taken, recommendations, and follow-up:

<table>
<thead>
<tr>
<th>Action</th>
<th>Date/Time</th>
<th>Person Responsible</th>
</tr>
</thead>
</table>

Suicide Prevention Policy
Approved 9/2/92;
Admin. Regulations Rec'd 9/2/92; 5/4/94
APPENDIX F - GUIDELINES FOR TALKING TO STUDENTS ABOUT SUICIDE OR SUDDEN DEATH

1. Prepare students for the serious and tragic nature of the information you are about to tell them. Explain that you anticipate that this news will upset many of them and that you and other staff are there to help them get through this.

2. Inform students of the known facts of the situation and what actions are being taken as a result, including funeral arrangements, if known, (i.e., informing all classes, availability of counseling in school, etc.).

3. Encourage and respond to any questions and reactions. Convey a sense of acceptance of all feelings expressed. Avoid being judgmental, or making value judgments about anyone's feelings. Pay special attention to the following:
   - Dispel any rumors or unconfirmed information.
   - Emphasize that we all react differently to tragedies and must respect one another's feelings and reactions.
   - Point out that disbelief, grief, anger, guilt, fear, and sadness are all common reactions to such news.

4. Explain that some people's feelings will be stronger than others and that individual assistance is available for those who wish to discuss their feelings further. Give students information regarding available support (who and where). If students' reactions seem particularly intense or you feel unable to respond adequately, strongly encourage them to seek assistance from one of the designated counseling centers, and offer to accompany them after class.

5. If students have questions you are unable to answer or if you feel uncomfortable in the discussion, request assistance from one of the crisis team members.

6. Allow students who do not want to participate in the discussion to study quietly in the room or seek assistance from one of the designated counselors. Don't assume that lack of a visible reaction means that the student has no reaction.

7. Encourage students to be supportive of each other. Emphasize the importance of seeking help and encouraging their friends to seek help from adults if their feelings seem particularly intense or persistent.

8. Reassure students that they are not responsible for what happened. Discourage guilt and unrealistic regrets. Focus the discussion on what they can learn from this in order to avoid similar tragedies in the future.

9. Stress that the feelings that the students now have are temporary and will diminish with time. Demonstrate a sense of assurance that things will get better.

10. In cases of suicide, avoid glamorizing the death and the deceased. Stress that this was a tragic and unnecessary act, and does not reflect a healthy way to resolve problems.
11. In **cases of suicide**, avoid focusing on the details or circumstances that led up to the person's death. Emphasize that suicide is a permanent solution to a temporary problem and focus discussion on how the person might have gotten help to avoid this tragic ending. Stress that suicide is not a "normal" or healthy reaction to life's problems.

12. Allow as much time as students seem to need for the discussion. Try to move the discussion toward how students can help one another express sympathy for the family and help to prevent (in the case of suicide) similar tragedies. Discuss ways in which students can express their feelings and concerns (i.e., cards, a class letter, donation to a suicide prevention center). **In cases of suicide**, discourage any permanent memorials or public dedications (i.e., yearbook dedications, plaques, scholarship funds, trees, etc.) because these types of memorials will glorify the suicide and therefore have the potential for becoming a constant invitation to others to consider suicide. Students who are insistent about memorializing the deceased in an unacceptable way should be referred to a crisis team member.

13. End the class by reminding students of the counseling and support services that are available in school and in the community.

14. Inform a crisis team member of students who are having strong reactions or appear to be at risk.
APPENDIX G - COMMUNITY RESOURCES

CHARLOTTE HUNGERFORD HOSPITAL PSYCHIATRIC CLINIC
540 Litchfield Street
Torrington, CT 06790
496-6350 - Ask for Emergency Psychiatric Services if you are concerned that the student may be suicidal or in immediate danger.

CHILD AND FAMILY SERVICES NORTHWEST
564 Prospect Street
Torrington, CT 06790
482-8561

CATHOLIC FAMILY SERVICES
132 Grove Street
Torrington, CT 06790
482-5558

HOUSATONIC MENTAL HEALTH CENTER
71 Spencer Street
Winsted, CT 06098
379-3337
OR
Lakeville, CT 06039
435-2529

WHEELER CLINIC
91 Northwest Drive
Plainville, CT 06062
747-6801
Dear Parent,

The School staff was deeply saddened to learn of the sudden death of one of our students. The tragic circumstances of __________'s death are shocking and difficult to accept.

We have asked the Crisis Team to help students cope with this loss. Classroom discussions are being conducted in response to this death and team members are available for additional support to our student body.

For your information, __________ 's funeral will be held on at _________. Your child may be excused from school to attend the funeral with written parental permission. All students attending the funeral must provide their own transportation. We encourage you to accompany your child in order to provide him/her with needed emotional support.

A parent information packet is enclosed to assist you in helping your child accept this sudden death. Included in the packet is a list of community agencies which are available for help to you and your child.

If you have any other concerns regarding this matter, please feel free to call the school.

Sincerely,

Principal

**************************************************

Dear Parent,

In response to the recent death of a member of our student body, the __________ School will be sponsoring an informational meeting on (date) at (time) in (location).

An expert from a local mental health agency will address the incident, its aftermath and the effects on our children and the community at large. There will also be an opportunity to express any concerns and to have any questions answered.

If you have any questions, please contact ____________________.

Sincerely,

Principal
APPENDIX I - PARENT GUIDELINES FOR TALKING TO CHILDREN ABOUT SUICIDE OR SUDDEN DEATH

1. Prepare your child for the serious nature of the information you are about to share.

2. Ask your child what he or she may have already heard regarding the suicide or sudden death.

3. Inform your child of the known facts and respond to questions in order to dispel rumors and misinformation.

4. Encourage your child to react, discuss, and share feelings. Listen attentively.

5. Convey a sense of acceptance for all the feelings expressed. Avoid judgmental or value statements about his or her feelings.

6. Be aware that reactions may range from no reaction at all to sadness, anger, guilt, fear, and disbelief.

7. Reassure your child that he or she is not responsible for what happened. Discourage unrealistic "hindsight" regrets (i.e., "There's probably nothing that you could have done to prevent this."). Focus on how your child might use what he or she knows now in future situations.

8. Stress that the feelings they now have will diminish in time. Display your own sense of assurance that things will get better.

9. In cases of suicide, avoid glamorizing the death or dead person. Stress that this was a tragic and unnecessary event.

10. In cases of suicide, avoid focusing on the details or circumstances that led up to the person's death. Stress that suicide is a permanent solution to a temporary problem. Discuss how the person might have gotten help to avoid this tragic ending. Stress that suicide is not a "normal" reaction to life's setbacks.

11. Let your child know that you are available to him or her should he or she wish to speak with you further about the death and their feelings and reactions to it.

12. If your child's reaction seems particularly intense or you feel unable to respond to him or her adequately, strongly encourage him or her to seek assistance from the available school personnel. Feel free to contact the school staff or community counseling agencies to discuss your concerns regarding your child's reaction.
APPENDIX J - SAMPLE SECRETARY'S STATEMENT

On (day) at (time), (name) died. The cause of death has been determined to be suicide/ self-inflicted/has not been determined, etc. Members of our Crisis Team are assisting faculty members in leading classroom discussions as well as providing support to students experiencing extreme distress.

Crisis Team members are in the process of identifying students who were close to the victim as well as those students who might need further support and intervention. Once these students are identified, their parents will be notified and appropriate recommendations made.

School personnel will continue to be available to respond to the grief of our students. However, if you feel your child is unable to cope with this tragedy, we can refer you to some outside agencies which can provide counseling to you and your child. (Secretary lists agencies listed in Appendix G, page 32.)

If a parent is calling about funeral arrangements, the secretary can provide the available information.
The following information should be included in a media statement:

1. What happened.

2. Who has been informed:
   - Initial school contact (i.e., superintendent, principal),
   - Crisis Team meetings,
   - Crisis Team functions,
   - Teachers,
   - Students.

3. Support services offered:
   - To whom,
   - Where,
   - When.

4. School schedule/changes/review of policies, etc.

The following information should be included as appropriate:

1. Crisis postvention plan (i.e., group counseling, individual counseling, teacher meetings, crisis team support, involvement of other crisis teams and/or community agencies, etc.)

2. Special counseling initiatives for those students and staff demonstrating need.

3. Community resources:
   - Who,
   - What,
   - Where,
   - When.

4. Parent/kin messages/wishes (if appropriate).

5. Services/arrangements:
   - Where,
   - When,
   - School policy regarding release time.

6. Special messages.

Sample Statement:

The principal of ______ School has been informed that ______ was found dead last night. The details surrounding the death are being investigated by ______. The school crisis team convened at 7:00 a.m. today, followed by a faculty meeting during which the teachers were informed of the situation. Teachers will discuss the tragedy with their students during homeroom period. Support services being offered by ______ School include:
APPENDIX L - REFERENCES

The following references were utilized in the development of this policy:


Catskill Central School District. Dealing with Crisis: A District Wide Program.


Hogan, Michael F. CDC Recommendations for Community Planning for Suicide Prevention, State of Connecticut Department of Mental Health, 1990.

Indiana State Board of Health. Youth Suicide: A School Approach for the Prevention of Youth Suicide in Indiana.


Regional Youth Substance Abuse Project. Suicide Prevention Policy, 1990.