Guidelines for Suicide Prevention

Policy and Procedures

Second Edition

Connecticut State Department of Education

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State of Connecticut

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Preface

Suicide, the ultimate mental health crisis, is alarmingly common among children and youth. In addition to the tragedy of a life not lived, suicide has devastating consequences for the family and the community. It does not materialize in isolation and is often associated with an undiagnosed mental illness, such as depression. Other contributing factors can be victimization by peers, alcohol or substance abuse, poor social skills, failure and disappointment and personal-social stress. Schools can be the first line of defense by reducing the risk of suicide in the general population and by intervening when a child is in a state of crisis.

The imperative for schools to be attentive to this issue is so great that the Connecticut General Assembly passed An Act Concerning Child Abuse and the Prevention of Youth Suicide. This law requires schools to adopt a written policy and procedures for dealing with suicide prevention and suicide attempts. Policy and procedures are meaningless, however, unless staff members know about them, implement them effectively, and review and revise them as needed. The updating and revision of this guide should serve as an occasion for all school districts to ensure that these essentials are adequately addressed.

The updating of this document features some new material and shift in emphasis. First, it is proposed that suicide prevention should be coordinated with, rather than compete with, other prevention initiatives. Various guidelines and initiatives advise schools to form teams and develop plans for each of a number of mental health issues (e.g., attendance, child abuse, school climate, violence prevention). The proposed approach here is that these interrelated efforts should be coordinated by an inclusive team that has the overall mission of attending to students' personal, social and emotional well-being.

Also new to this revision is material about coordinating with resources that have emerged with the expansion of Connecticut's mental health system for children—in particular, the network of regional emergency mobile psychiatric services. While it is important for schools to have in-house expertise on suicide and other mental health issues, schools must collaborate with other agencies and with community providers to optimize the capacity to meet the substantial needs of children and families.

Finally, is it critical to ensure that the school resources are used to best advantage. An essential strategy for doing so is to include students and families in the planning, development, and evaluation of suicide prevention efforts.

Hopefully, these guidelines will contribute to the overall goal of helping students feel secure, supported and safe.

Acknowledgments

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I. INTRODUCTION

Suicide is clearly a serious concern. It is the third leading cause of death among children and adolescents nationally (National Institute of Mental Health, 2003), and among 15- to 24-year olds in Connecticut (Mueller, Hynes, Li, and Amadeo, 2003). Suicide rates among teenagers tripled from 1960 to 1990 (Hollinger, Offer, Barter and Bell, 1994), and remain high. Approximately one in five adolescents in the United States seriously considers suicide each year, five to eight percent make attempts, and more than two percent require medical attention for their attempts (Centers for Disease Control and Prevention, 1998; Grunbaum, Kann, Kinchen et. al, 2002). Yet, research is demonstrating that suicide can often be prevented.

School, as an institution that exposes children to frequent contact with caring adults, has a unique role to play in suicide prevention (U.S. Department of Health and Human Services, 2001). The school setting offers a significant opportunity to keep children safe from self-harm, not just by identifying warning signs and intervening when attempts occur, but by establishing positive school environments and providing programs and resources that are responsive to students' personal and social-emotional needs (Connecticut State Board of Education, February 2001).

In recognition of the serious threat posed by suicide and the important role schools assume in reducing suicide risk and responding to crisis situations, the Connecticut Legislature passed a law in 1989 requiring schools to establish policies and procedures to deal with youth suicide prevention and youth suicide attempts. Also in 1989, the State Department of Education (SDE) published guidelines to help school districts comply with this state law (Connecticut State Department of Education, 1990). This is a substantially revised updating of those guidelines.

The primary purpose of this document is to provide guidance to school districts as they review and, as needed, update and revise current policy and procedures. The emphasis is on administrative issues (e.g., What are essential components of policy and procedures? Who might be involved in the review and writing process?) rather than clinical issues (e.g., What are the most effective prevention strategies? How do mental health professionals conduct risk assessments?).

Because suicide prevention is such a vast and ever-expanding field of study, it is beyond the scope of this document to provide even a comprehensive overview. On the other hand, clinical considerations inevitably come into play, and school district policy and procedures must be founded upon the best of current-day research and practice. Therefore, these guidelines include some clinical guidance and resources on a highly selective basis. As a general rule, elaboration of clinical issues—material that is more relevant for a school district handbook or guide—has been extracted from the main text and placed in a box, table or appendix.

This document steers clear of suggesting that there is one "correct model" for a school district's policy and procedures. Given the diversity among populations, school district programs and services, and community resources, it is unrealistic to develop a one-size-fits-all model for statewide use. There is value, however, in learning from the best efforts of others. Therefore, samples of school district policies and procedures are provided in Appendix A.

II. YOUTH SUICIDE PREVENTION IN CONNECTICUT LAW

As enacted by Public Act 89-168,

> "Not later than July 1, 1990, each local and regional board of education shall adopt a written policy and procedures for dealing with youth suicide prevention and youth suicide attempts." (C.G.S. Section 10-220 (e))

The law also contained provisions for establishing school-based supports and providing professional development opportunities, which currently appear in state statute as follows:

> "Each board of education may establish a student assistance program to identify risk factors for youth suicide, procedures to intervene with such youth, referral services, and training for teachers and other school professionals and students who provide assistance in the program." (C.G.S. Section 10-220 (e))

> "Any candidate in a program of teacher preparation leading to professional certification shall be encouraged to complete a ... mental health component of such a program, which includes, but need not be limited to, youth suicide, child abuse, and alcohol and drug abuse." (C.G.S. Section 10-145a(c))

> "Each local or regional board of education shall provide an in-service training program for its teachers, administrators and pupil personnel who hold the initial educator, provisional educator or professional educator certificate. Such program shall provide such teachers, administrators and pupil personnel with information on ...health and mental health risk reduction education which includes, but need not be limited to, the prevention of risk-taking behavior by children and the relationship of such behavior to substance abuse, pregnancy, sexually transmitted diseases, including HIV-infection and AIDS, violence, child abuse, and youth suicide..." (C.G.S. Section 10-220a(a))

School districts need to ensure that they are continuing to meet the letter and intent of these statutory requirements. These guidelines have been updated to provide school districts with current information and resources as they review and, as necessary, update policies, procedures and practices.

III. Development of Policy and Procedures

The development and review/revision of school district policy and procedures related to youth suicide prevention is a complex and demanding activity best accomplished through collaboration between school district personnel, parents, students, community experts in suicide prevention education, and mental health professionals with expertise in intervention with students at risk.

Ideally, to ensure coordination and collaboration, this activity should be orchestrated by a multi-purpose committee, or council, that oversees health and mental health issues for the school district or community. Such a committee would assume responsibility for a broad range of related initiatives (e.g., school climate, violence prevention, crisis response and student safety, drug and alcohol prevention). To operate efficiently, it would expectedly establish task forces or teams to address specific issues, such as suicide prevention.

School district personnel who are recommended to serve on a task force to review and revise youth suicide prevention policy and procedures include:

- ✧ building administrators;
- ✧ central office administrators;
- ✧ teachers (e.g., classroom teacher, health educator, special educator);
- ✧ school mental health professionals (e.g., school counselor, school psychologist, school social worker); and
- ✧ school health professionals (e.g., medical advisor, nursing supervisor, nurses).

It is recommended that the task force include members of the school community, such as:

- ✧ parents;
- ✧ students;
- ✧ community health and mental health providers;
- ✧ representatives of child service provider agencies (child guidance clinics, community collaborators, emergency mobile services, youth service bureaus);
- ✧ experts from institutions of higher education;
- ✧ local law enforcement; and
- ✧ clergy.

If community experts are not available to meet on a regular basis, they should be encouraged to provide periodic consultation or to review and comment on materials developed by the committee. Even after the school district has developed or revised policy and procedures for youth suicide prevention, it is important for task force members from the community to continue to serve in an advisory role to ensure that the school district policy and procedures keep up with current research and practice, and to evaluate the effectiveness of school district prevention efforts.

An important caveat is that a task force as described above should deal with the general issue of suicide prevention (e.g., reviewing policy and procedures, developing programs, mobilizing resources), but should not be involved in responding to or investigating specific cases (as described in Section V) for reasons concerning student and family privacy rights.

The following section offers guidance about what is generally meant by "policy and procedures" to be developed by local and regional boards of education, in accordance with Connecticut law.

1 Definitions of Policy and Procedures

Definitions are intended to clarify what documents school districts should develop in order to fulfill mandates and address student and family needs in the area of suicide prevention. The rule of thumb offered here is that written policy and procedures on suicide prevention, developed in accordance with state law, should be thorough but not overly detailed, and written in a manner that will stand the test of time (i.e., not requiring frequent revisions as research and practice evolve).

Definitions are provided for policy and for administrative regulations. It is reasonable and recommended to regard administrative regulations, as described here, as meeting the legal requirement to develop written procedures. Administrative regulations need not include highly detailed instructions, recommendations concerning best practice, resource material, and the like. Such information can be incorporated into a guide or manual that can be regularly updated without formal board action. Examples of policies and procedures are provided in Appendix A.

▶ Policy

The four similar definitions that follow convey the typical nature and purpose of a school board policy.

1. School board policies are statements that set forth the purposes, and prescribe in general terms, the organization and program of a school system. They create a framework within which the superintendent and staff can discharge their assigned duties with positive direction. They describe desired outcomes, and may also give some indication of why and how much.

   Policies should:
   - ✧ define clearly the goals and objectives of the school system;
   - ✧ allow for the flexibility that is vital in day-to-day operations;
   - ✧ reflect the board's vision;
   - ✧ define roles and responsibilities; and
   - ✧ describe desired outcomes.

2. Policies are broad statements set forth by the school board to frame the district's course of action. They tell what is wanted, why the action is necessary and may describe a means of accomplishing it. They establish the responsibility of the appropriate administrator, usually the superintendent, but leave enough leeway for the development of detailed directions on how to put the policies into practice. The goals and plans that the board sets for the district—fiscal, administrative or curricular—should be accomplished through policy.

3. Policies are broad guidelines—philosophical statements that outline the direction that the board wants to take. Policy needs to be translated into action through administrative regulations, sometimes called procedures.

4. Policies are statements of intent adopted by the board of education. They serve as guides to the administration in the development and implementation of regulations for the operation of the district.

▶ Administrative Regulations or Procedures

Administrative regulations, which may serve as procedures, follow from and are consistent with policy. They specify required staff actions and designate the administrative arrangements under which the schools are to be operated. The purpose of administrative regulations is to fill in broad policy statements with the details that ensure that what the board wants done actually happens.

Regulations are practical. They describe arrangements and actions that can be reasonably implemented. They are specific to each district and must be formulated by personnel within the district to suit the particular needs of the district. Whereas policy should answer the questions of why and what; regulations should state precisely how often, exactly how many, where, by whom and when things are to be done. Most regulations will emanate from, and be approved by, the office of the superintendent.

Depending on the type of policy and the situation to which they are responding or the audience to which they are addressed, administrative regulations can be brief and flexible or long and prescriptive, or combinations of either. In any event, regulations provide the details needed for consistent application of board policy.

Depending upon the situation, administrative regulations may or may not require board adoption and/or approval (actually, more often not). However, given that Connecticut law requires board adoption of suicide prevention *procedures* as well as policies, administrative regulations that serve as procedures would require board approval.

Administrative regulations should describe required activities and actions in sufficient detail so that school district personnel can clearly determine whether district requirements have been met. In the case of suicide prevention, this might encompass such components as:

- ✧ Establishment of any committees or teams for the purpose of planning, program implementation, and/or crisis intervention;
- ✧ Professional development for staff;
- ✧ Intervention procedures: communication, response, documentation, etc.;
- ✧ Role of central office administration, building administrators and school mental health professionals in prevention and intervention efforts;
- ✧ Use of community resources for assistance, consultation, and referral; and
- ✧ Specification of any need for formal letters of agreement with other agencies.

▶ Guidelines

A school district might develop a separate guidelines document, or handbook, that serves as a comprehensive compilation of materials to inform and support professional practice. Guidelines can be continually revised to keep up with the current state of the art, and state and local resources. The following topics may be included in a district guide or handbook:

- ✧ risk factors
- ✧ elevated risk categories
- ✧ risk assessment procedures
- ✧ protective factors
- ✧ effective prevention programs
- ✧ intervention techniques
- ✧ resource materials for staff, parents, and students
- ✧ curriculum materials
- ✧ information resources
- ✧ referral sources

Alternatively, a school board or superintendent may choose to include detailed guidelines in their administrative regulations, or procedures, thereby making them subject to board review and approval. In opting to do so, however, the school district leadership must assume the responsibility of ensuring that the material is kept accurate and up-to-date, and routinely communicated to school personnel.

2 Policy and Procedures: Essential Content

According to state law, a school district will have a written policy and procedures for dealing with youth suicide prevention and youth suicide attempts. It is possible, however, that this material has not been reviewed for many years, or even since its initial development. If this is the case, school administrators and/or school mental health professionals with appropriate expertise should do an initial review to determine whether an update or

thorough revision is needed. If significant revision appears warranted, the school district should assign the task to an appropriately constituted group of professionals and stakeholders, as described at the beginning of this section. The section is intended to help make this determination, and to provide guidance in making revisions. Advisably, the initial review of existing policy and procedures, and any subsequent revision activities would be conducted under the auspices of a districtwide council or committee as described in the beginning of this section.

The school district policy should address the school district's philosophy related to youth suicide prevention and the essential commitments required of the school district, of school personnel and of other agencies that participate in some aspect of the youth suicide prevention program.

The philosophical basis for school policy related to youth suicide prevention emanates from an appreciation that suicide and other self-destructive behaviors have become critical problems for children and youth, for families, for school personnel and for the community. The policy may also recognize that students who are experiencing stress or depression are less available for learning and that students, who are engaging in self-destructive behaviors, including substance use and suicide attempts, are jeopardizing not only their health and well-being, but also their academic achievement. Finally, because a multitude of factors underlie many youth suicides, there are often opportunities to recognize in students the potential for suicide and to intervene in order to prevent self-destructive behavior and death.

In order for a youth suicide prevention program to be effective, the school district must make a commitment to address a number of important components, including:

- ✧ a learning environment that promotes the physical and mental health of students and staff;
- ✧ collaboration with families and with community providers in all aspects of youth suicide prevention;
- ✧ an educational program that is effective in reaching students, staff and parents;
- ✧ high-quality intervention services for students;
- ✧ interagency cooperation that enables school personnel to identify and access appropriate community resources for use in times of crisis;
- ✧ effective reintegration of high-risk youth into school following a crisis, hospitalization or residential treatment;
- ✧ leadership, planning, and support for students and school personnel to ensure appropriate responses to attempted or completed suicides; and
- ✧ regular evaluation and revision of the policy and procedures.

Most important, the district's policy and procedures should specify how school district personnel should respond whenever there is any suspicion that a student may be at risk for suicide. If assistance from community providers is an essential component of response

procedures, commitments from other agencies should be formalized through letters of agreement.

Four major components of a school district's policy and procedures for youth suicide prevention are outlined in the remaining sections of this document:

> Prevention Strategies
> Intervention Procedures
> Collaboration with Community Providers
> System Evaluation

Prevention strategies are needed to minimize the risk of suicide as well as the negative impact of other serious behavioral health issues. A comprehensive approach to suicide prevention includes (1) public awareness activities and educational programs to inform school personnel, students, parents and adults in the community about youth suicide and enable them to respond more effectively; and (2) programmatic efforts to promote students' resilience and healthy social-emotional development.

Intervention procedures are those actions that school district personnel take in order to prevent self-destructive behaviors by individual students who have been identified as being at high risk for suicide. These actions will vary depending on the stage of vulnerability or risk of an individual student, or the needs of a school community following a crisis.

Collaboration with community providers is an essential component of school district procedures. Given the limited resources available to school districts and primary role of the family in keeping children safe, school districts must formalize arrangements with community providers, and must clearly communicate to school personnel how to engage families and how to access community services.

System evaluation refers to the process of regular review and revision, as appropriate, of policy and procedures, and all other aspects of youth suicide prevention and intervention.

IV. PREVENTION STRATEGIES

Three general approaches to youth suicide prevention are:

1. Suicide prevention awareness and education for staff, parents and adults in the community;
2. Health/mental health promotion and prevention programs for all students; and
3. Prevention programs and services for groups of students and individual students at increased risk levels.

This wide range of approaches reflects the need to develop a continuum of interrelated prevention approaches that include (1) public awareness to ensure that the school community is knowledgeable about, and responsive to the issue of youth suicide, and (2) an array of services, programs, and other supports for students. The array of programs and services might encompass both universal supports (i.e., those designed to promote healthy development, resilience, and competence enhancement for all students) and targeted approaches to addressing the needs of at-risk students before their problems become serious.

In the field of public health, the term "prevention" has been applied across the continuum of prevention and intervention efforts. Recently, the terms primary prevention, secondary prevention, and tertiary prevention have been superseded by the more descriptive categories *universal prevention*, *selective prevention*, and *indicated prevention*, as delineated by the Institute of Medicine of the National Academies of Sciences (Goldsmith, Pellmar, Kleinman, and Bunney, 2002). Table 1 shows how these categories correspond to the previously used terms and to the sections that follow in these guidelines.

Table 1
Terms and SDE Guidelines Crosswalk

IOM* Category	Previous Term	SDE Guidelines Section and Subsection
UNIVERSAL PREVENTION (general population)	Primary Prevention	PREVENTION STRATEGIES: ✧ Suicide Prevention Awareness and Education for Staff, Parents, and Adults in the Community ✧ Health Prevention and Promotion Efforts for All Students
SELECTIVE PREVENTION (at-risk subgroups)	Secondary Prevention	PREVENTION STRATEGIES: ✧ Prevention Programs and Services for Sub-Groups of Students at Increased Risk
INDICATED PREVENTION (high-risk individuals)	Tertiary Prevention	INTERVENTION PROCEDURES: ✧ Identification ✧ Assessment ✧ Management and Referral ✧ Support Services and Monitoring ✧ Crisis Intervention and Post-Intervention Planning

** Institute of Medicine of the National Academies of Science (see Goldsmith, Pellmar, Kleinman, and Bunney, 2002).*

Many school districts already have in place one or more teams to promote behavioral health and provide support for at-risk students, for example, a student assistance team, student and staff support team, or child study team. The student assistance team (or the equivalent) should include a variety of school personnel. Importantly, the classroom teacher is a central member of the team, and collaborates with other team members in developing and implementing strategies to effectively intervene with individual students who are vulnerable to becoming at risk for suicide. Parents and guardians not only should be notified whenever a student is referred to the team for early intervention, they should be encouraged to participate as integral members of the team.

The size and characteristics of a school district will determine whether there are separate building-based teams, or a districtwide team. If a single team serves an entire district, this team might double as the group that develops and reviews school district policies and procedures. In school districts that work closely with other agencies, community mental health providers and parents through a local system of care (or "community collaborative"), a community resource team may serve, or support, this function.

Table 2

Prevention Matrix: Sample Programs and Services

School/Family/Community-Based Prevention Strategies

Universal Prevention	Selective Prevention	Indicated Prevention
General Population	**At-Risk Subgroups**	**High-Risk Individuals**
Information/Education ✧ Media Campaigns ✧ Mental Health Education Curriculum ✧ School Assemblies Competency/Skills Training ✧ Social Influence ✧ Normative Education ✧ Life/Social Skills Training - Assertiveness Training - Communication Skills - Decision Making - Anger/Stress Management School Management Changes ✧ School Policies ✧ Instructional Changes Parent Education ✧ Groups ✧ Lectures ✧ Curricula Parent Involvement Programs Parent Skills Training Family Skills Training Public Awareness Campaigns Information Clearinghouses Community Coalitions ✧ Community Task Forces ✧ Church-Sponsored Youth Groups Health Policy Change	Alternative Programs ✧ After-School Classes ✧ Mentoring ✧ Special Clubs/Groups - Children of Alcoholics - Gay-Straight Alliances ✧ Sports/Recreation ✧ Youth/Teen Clubs Competency/Skills Training ✧ Cultural Pride ✧ Tutoring Peer Leadership Peer Resistance Parent/Peer Groups Parenting Skills Training Family Skills Training Family Case Management Parent Support Groups Tutoring	Alternative Programs ✧ Advisor-Advisee Program ✧ Mentoring ✧ Delinquency Prevention Individual Counseling/Support Hotlines Peer Leadership/Resistance Parent-Peer Groups School Support Group Student Assistance Team Competency/Skills Training ✧ Cultural Pride ✧ Tutoring In-School Suspension Alternative Classes/Schools Family Skills Training Parent/Peer Groups for Troubled Youth Parent Self-Help Groups Structured Family Therapy ✧ Family Therapy/Counseling ✧ Family Case Management Skills Training ✧ Job Skills Training ✧ Job Apprenticeships

Adapted from Kleinman, Pellmar, Goldsmith, & Bunney (2002)

It should be noted that, while a variety of prevention programs and strategies are described in this section (e.g., social skills or suicide awareness curriculum for students, school-based screening, gatekeeper training for school personnel), the research to date does not clearly favor any one approach (Gould, Greenberg, Velting and Shaffer, 2003). Despite the accumulation of new research, the recommendations by O'Carroll, Potter, and Mercy (1994) to (1) use a variety of prevention strategies, (2) link programs with community mental health resources, and (3) evaluate suicide prevention efforts continue to be applicable.

1 Suicide Prevention Awareness and Education for Staff, Parents and Adults in the Community

A comprehensive approach to youth suicide prevention includes an educational component for adult members of the school community. School staff and parents are primary audiences for these efforts.

▶ Staff Development

Staff development programs involve all school personnel in efforts to create and maintain a healthy school climate and prepare school personnel for their roles in youth suicide prevention. School and community professionals who have clinical expertise in child and adolescent mental health should collaborate in planning and implementing such programs. Teachers and support service personnel may need preparation for collaborative responsibilities in classroom and student support programs.

Under Connecticut law (C.G.S. 10-22a), school districts must provide in-service training on youth suicide prevention for its certified teachers, administrators and pupil services personnel. While the statute does not specify the frequency of this training, it should be offered at least once a year, and its availability should be made known to all certified personnel as well as other interested school employees. All new staff should be oriented about their responsibilities regarding youth suicide prevention.

Staff development programs should provide factual information regarding:

- ✧ factors that may increase a student's risk for suicide;
- ✧ symptoms of stress, coping difficulties, depression and self-destructive behaviors;
- ✧ risk and protective factors;
- ✧ talking with (or, for school mental health professionals, assessing) students who are at risk; and
- ✧ accessing school and community resources.

Most important, in-service training should delineate the roles and functions of specific school personnel and the procedural guidelines and timelines to follow whenever a student is identified as vulnerable, at risk or in crisis. All teachers and administrators should have basic knowledge about know to respond to a situation where a student threatens suicide (see Box 1). *Gatekeeper training*—ensuring that school personnel know how to recognize that students are at risk and how to initiate a referral—is a common strategy.

Box 1

Recommended Actions for School Personnel When a Student Threatens Suicide

What to Do	What Not to Do
✧ Actively listen ✧ Ask direct questions ✧ Stay with the student ✧ Alert a school mental health professional or crisis intervention team member	✧ Deny the student's feelings ✧ Beat around the bush ✧ Leave the student alone ✧ Promise to keep secrets ✧ Try to handle the situation alone

* *Adapted from King (2001)*

Staff development might also address the issue of contagion effects, that is, the possibility that other students may be at heightened risk in the wake of a completed suicide. Teachers and other school personnel need to be extremely careful not to reinforce—either explicitly or implicitly—the tendency of students to glamorize suicide (e.g., through memorialization), or to regard it as a solution to problems.

▶ Parent and Community Awareness/Education

Parent and community involvement is essential for youth suicide prevention efforts to be fully effective. This can be achieved by including parents and community members in planning and management activities, through educational sessions on youth suicide prevention and other related issues, and by disseminating written material. Parent and community education should focus on:

- ✧ publicizing the school district's suicide prevention policy, procedures and programs;
- ✧ acknowledging the important role of parents, with an emphasis on prevention;
- ✧ informing adults about risk and protective factors, including a description of circumstances and social interactions that may contribute to suicidal thoughts and behaviors;

- ✧ stressing the importance of restricting access to lethal means of self-harm;[1]
- ✧ describing how parents and significant adults can help children and youth develop coping and communication skills, and enhance their self-esteem; and
- ✧ providing information on school and community resources.

Parent education sessions provide an excellent opportunity for participants to meet both school and community health and mental health professionals. It may be useful to provide time for parents to meet with these professionals, individually or in small groups, to discuss specific issues or questions.

Another important prevention strategy is to engage the media proactively about suicide coverage, both of prominent national figures—especially teen idols—and of local residents. Portraying suicide as a romantic or heroic act, or idealizing those who take their own lives can significantly heighten the risk of "suicide contagion." Media should be encouraged to adopt policies that acknowledge their responsibility for public safety. Common recommendations include not providing detailed descriptions of the circumstances of a suicide, and using such opportunities to publicize advances in treatment and knowledge or risk factors (American Foundation for Suicide Prevention, 2001). Parents and community experts can be helpful to school personnel in raising the issue with the local media.

2 Health Promotion and Prevention Programs for all Students

Central to the goal of suicide prevention are systemic efforts to provide a positive school environment and promote positive behavioral health for all students. These concerns are not incidental to the school's educational mission, since mental health and personal-social problems can present significant barriers to learning. Development of social skills, emotional intelligence and coping strategies—key strategies in reducing students' susceptibility to suicide and other risky behaviors—has been shown by research to have a positive impact on educational performance. Similarly, the effective schools literature identifies a safe and supportive school climate as one of the key variables that account for high academic achievement. The impact of behavioral health and school environment upon educational performance is elaborated upon in the Connecticut State Board of Education's position statements on Student Support Services and Creating a Healthy School Environment. Position statements are available online at: http://www.state.ct.us/sde/board/statements.htm

A comprehensive social-emotional learning curriculum and related educational programs that emphasize the maintenance of physical and mental health can play an important part in youth suicide prevention. Effective educational programs for students have developmentally appropriate goals, objectives and learning activities. Social-emotional

[1] While keeping firearms and other lethal means of self-harm out of the reach of children and youth does not provide absolute assurance of safety, findings from the Harvard Injury Control Research Center (Miller, Azrael, and Hemenway, 2002) indicate that restricted access to lethal means is correlated with significantly lower suicide rates.

learning programs may cover a broad range of important social skills (e.g., social problem-solving, self-awareness, stress management, relationship skills, responsible decision making) that prepare students for life and enable them to cope with personal-social challenges. Social and emotional learning programs can also engage students in the effort to establish and maintain a healthy, supportive school climate, and provide them with opportunities to feel competent and successful. The Collaborative for Academic, Social, and Emotional Learning (2003) has produced an authoritative guide that can help school personnel select appropriate, empirically supported programs and curricula for this purpose.

A school district may consider implementing a curriculum specific to suicide awareness, which typically involves teaching youth to recognize when peers are at risk for self-destructive or suicidal behaviors, and advising students to take action to protect peers from harm (i.e., by being supportive and telling a responsible adult). Instruction of this sort should be incorporated into the personal health and safety component of the school district's health education curriculum, and subjected to periodic review. Given the sensitive nature of the student-to-student and student-staff interactions this involves, and the varied research findings to date, it is important for school personnel to be familiar with the clinical literature and attentive to recommended practices (see Box 2).

Box 2

Implementation of a Suicide Awareness/Prevention Curriculum

A significant concern in offering suicide awareness and prevention programs in schools is that introducing the topic "may put ideas in students' heads." Research studies from the late 1980s and early 1990s revealed instances in which suicide risk was *heightened* by such programs (Gould, Greenberg, Velting, & Shaffer, 2003). A recent evaluation of Signs of Suicide (SOS), a school-based suicide prevention program (Aseltine & DeMartino, 2004), has demonstrated that it increases help-seeking behavior by students and does not raise the level of suicide risk as a result of increased attention. What distinguishes the SOS program from predecessors is that it combines a self-screening measure, administered confidentially in the classroom, with an educational program on suicide and depression. It is reasonable to conclude that the manner in which suicide prevention programs are designed and implemented will determine their effectiveness. In this sensitive area, the essential, overriding principle is "do no harm." Programs and services that directly address suicide prevention should only be conducted by professionals with considerable expertise in this area. Teachers and other school personnel play an important role in bringing students who they are concerned about to the attention of mental health professionals, but they should not try to determine the level of risk or provide clinical interventions. In designing a program to identify students in immediate need of intervention, it is also essential that the school have sufficient skilled mental health personnel available to respond promptly to all requests for help.

3 Prevention Programs and Services for Groups of Students and Individual Students at Elevated Risk Levels

Schools need to offer a range of programs and services that provide support for, and enhance the resilience of, students who are at elevated risk for suicide (e.g., students are subjected to bullying or harassment, close friends of a recently-deceased peer, struggling with sexual identity issues, experiencing significant stress at home, or showing signs of depression). Examples of programs and services for students who are identified as at elevated risk on the basis of particular characteristics are listed in the "selective prevention" category in Table 2.

Neither the risk status nor the prevention programs for these students should be regarded as specific to suicide alone. Many of the warning signs of suicides are also indicators that a child is at increased risk for drug and alcohol abuse, truancy, risky sexual behavior, and other anti-social or self-harmful behavior. Schools cannot, and should not, design prevention programs for each behavioral health concern in a separate and categorical manner. This is a major reason why it is advisable for a school committee or team with broad responsibilities for behavioral health issues to oversee the development and coordination of school-based suicide prevention policies, plans and programs.

V. Intervention Procedures

In responding to an immediate threat of suicide, schools require the expertise of personnel who are appropriately qualified and trained to provide intervention services (i.e., certified school mental health professionals or licensed mental health professionals). Collaboration among school personnel and collaboration with expert clinicians in the community are essential for effective planning and response.

Many school districts already have in place a committee or team, or can establish a subset of an existing team, that develops early intervention strategies for students who are vulnerable to becoming at risk for suicide, as described in the previous section. Separate from this "selective prevention" function, schools need to identify a clinical intervention team that responds to situations where a student is at imminent risk of self-harm. The clinical intervention team should include the building principal, and school health and mental health professionals who are appropriately qualified and trained to assess the health or mental health status of children and adolescents (typically, the school social worker, school nurse, school psychologist and school counselor). The principal provides administrative support and assumes decision-making responsibility consistent with school district policy and procedures, while support services personnel address the health and/or mental health needs of the student and contribute clinical judgment. The clinical intervention team members confer with the classroom teacher and other appropriate school personnel as indicated in the assessment and intervention process. The Connecticut Technical High School System policy and procedures in Appendix A illustrate how critical information is processed and decisions are made in the event that a student is in crisis.

If a school district does not have support personnel who are appropriately qualified and trained to assess the status of a student who may be at risk for suicide, the district should develop formal working relationships with community agencies or clinicians who can provide clinical services such as consultation, student assessment, initial crisis management and facilitation of referral to appropriate community resources. To ensure that school personnel can provide high quality intervention services, school districts, should include relevant qualifications and clinical competencies in the job descriptions for school health and mental health professionals, and consider these qualifications and competencies when making hiring decisions and providing professional development.

The intervention process for youth suicide prevention in schools includes five major areas of responsibility:

1. Identification;
2. Assessment;
3. Management and Referral;
4. Support Services and Monitoring; and
5. Crisis Intervention and Post-Intervention Planning.

The first four intervention responsibilities address the needs of individual students who appear to be at risk for suicide. The fifth area of responsibility addresses the needs of the school community following an attempted or completed suicide.

1 Identification

Identification of students who are seriously at risk of self-harm is the first step in the intervention process. All school personnel should be prepared through the educational program to recognize those students who exhibit risk factors for suicide (see Appendix B). Whenever a staff member becomes concerned that a student may be at risk for suicide, or is unsure whether observed behavior of a student constitutes a warning sign, that staff member should immediately inform a member of the clinical intervention team. A student who has a concern about a peer should also be directed to a clinical intervention team member. A time frame for each step of the identification process should be indicated in the procedures. Procedures should also specify appropriate staff action in the absence of all designated team members.

It is important to recognize that identification is distinct from assessment and management. Classroom teachers in particular have a critical role to play in the identification process. Once a student is identified as possibly at risk for suicide, or already in crisis, further assessment and intervention becomes the responsibility of school mental health professionals who are appropriately qualified and trained, and duly authorized within their job descriptions to carry out such responsibilities.

2 Assessment

When students are identified as possibly at risk for suicide, the clinical intervention team should be responsible for assessing the student's health and mental health status and the level of risk or lethality involved. When a referral is made to the team, team members should immediately confer in order to:

- ✧ share relevant data about the student and/or situation;
- ✧ develop a preliminary assessment plan; and
- ✧ identify specific responsibilities of team members in the assessment process.

The clinical intervention team members should also confer with other key personnel, such as a teacher or coach who has a special relationship with the student. In an emergency, normal emergency medical procedures should be followed and any assessment or team conference is postponed until the emergency is managed.

3 Management and Referral

When a student is identified as at risk for suicide, the clinical intervention team uses the assessment data to determine an appropriate sequence of actions and to assign management responsibilities. Management plans will vary depending on the assessment of lethality and other health needs of the student, as well as resources in the school and community. For all students at risk for suicide, management plans should include:

- ✧ informing and conferring with the parent/guardian;
- ✧ collaborating with the family to access mental health services or make a referral to an appropriate community resource for further assessment and intervention;
- ✧ developing an initial plan for school support; and
- ✧ developing a plan for ongoing communication with the family and community providers.

The following management plan considerations would be appropriate to address in a school district's guidelines or handbook.

Box 3

Management Plan Considerations

A school district's management plan should include standard responses and time frame for addressing various common circumstances, such as the following:

- ✧ medical emergency (physical or psychiatric);
- ✧ high risk for suicide;
- ✧ low risk for suicide;
- ✧ short-term developmental or situational crisis with no current risk for suicide; and
- ✧ potential need for special education.

Guidelines should also delineate appropriate actions to help ensure that the family of a student who is at high risk for suicide follows through with a referral or treatment plan. The first and foremost role of school personnel is to provide information to enable the family to secure needed services (see Appendix C). School personnel may need to provide further assistance to help a family contend with complicating obstacles such as barriers to access, insurance glitches, language differences or lack of resources in a region. In rare instances where a family is seriously non-compliant with referral recommendations and places a child at imminent risk of harm, school personnel may need to consider whether a referral to DCF is warranted (see Connecticut State Department of Education, 2000).

Other issues to address in guidelines include:

- ✧ consultation with community service providers;
- ✧ re-entry into school following hospitalization, residential treatment or crisis-
- ✧ documentation;
- ✧ confidentiality; and
- ✧ release of information between school personnel and community service providers.

In developing procedures and guidelines, the school district should take into account variability in staffing; qualifications and training of school health and mental health professionals; and access to community consultants, emergency services and treatment centers. When a student is at any level of risk for suicide, a referral to a community provider should always be made and the community provider should assume the primary responsibility for treatment. Appropriately qualified and trained school health and school mental health professionals should collaborate with the community service providers in the implementation and evaluation of the treatment plan.

4 Support Services and Monitoring

When a student is identified as at risk for suicide, the clinical intervention team, in collaboration with the community provider, may determine that one or more of the following school-based services is appropriate:

- ✧ support group;
- ✧ individual counseling;
- ✧ group counseling; and/or
- ✧ joint school and community-based support program.

These support services for students who are at risk for suicide do not constitute mental health treatment, but may complement a mental health treatment plan.

School districts may already have support services and support programs available for students, or may need to explore alternative methods to provide such services. Staff members and community experts who are appropriately qualified and trained should be identified to facilitate, supervise and evaluate school-based support programs and services. Continuing education, consultation and supervision should be made available to staff members who assume these clinical responsibilities.

When students are involved in peer support groups or other peer assistance activities, the district must ensure that the roles assumed by students are developmentally appropriate, accompanied by adequate professional supervision and support, and that clear boundaries are established for peer facilitators. Students should never attempt to provide counseling services.

5 Crisis Intervention and Post-Intervention Planning

In addition to interventions for individual students, school districts should develop a crisis intervention plan to implement in the event of a suicide or other crisis that widely affects students and staff. This should include a "post-intervention plan" in the event of a suicide.

A situation that has broad impact upon the school environment should be managed by a school-based crisis response team. The crisis response team will typically need to meet on multiple occasions to develop and update a crisis intervention and post-intervention plan. The team will also need to evaluate the effectiveness of the plan after a crisis response. Also, after dealing with a demanding and stressful crisis, it is advisable for the team to debrief—to review their actions and personal reactions—with the assistance of a trained facilitator.

Crisis intervention and post-intervention plans should address the following:

- ✧ parent/family communications;
- ✧ parent authority to release information;
- ✧ communications with staff and students;
- ✧ specific programs and support services;
- ✧ use of community experts;
- ✧ monitoring and support of the student's peers who are also known to be at risk;
- ✧ communication with the media; and
- ✧ documentation.

When the situation does not have a far-reaching impact on the school environment (which is more likely in the event of an attempted, rather than a completed, suicide), intervention efforts may be assumed by the clinical intervention team. Responsibilities may include communication with the family and with community service providers, and prompting school staff to be alert for risk factors for suicide. School mental health professionals may want to refer to an article by Spirito and Overholser (2003) for guidance on evaluating and providing support to adolescents and their families following a suicide attempt.

VI. Collaboration with Community Providers

As described in the previous section, students who are identified as being at risk for suicide should be referred to community providers. The respective roles of school personnel and of community providers may vary with the expertise and availability of school personnel, and the extent and nature of available community services. Basically, however, a community provider must assume primary responsibility for the student's ongoing treatment. The role of school personnel is to ensure that a treatment plan and services continue to be in place for a student who is at risk.

Private mental health providers or physicians, as identified by the student's family, are the first community resources to consider. The private provider can make a determination about the need to access a local emergency room. In the event of a medical emergency where a family provider cannot be reached immediately, the school's crisis intervention team may need to determine whether a student is at such imminent risk (e.g., requiring medical attention, physical restraint, or constant surveillance) that transport to an emergency room is necessary.

Authorized school personnel may, with parental notification and permission, refer students to the emergency mobile psychiatric service (EMPS) for their region. EMPS teams of trained professionals can assist school personnel in assessing a child's mental health status during a crisis situation (e.g., child presents with suicidal ideation, serious psychiatric symptoms, or severe anxiety related to trauma). EMPS teams can also help school personnel develop and coordinate appropriate plans for crisis intervention. The regional EMPS does *not*, however, function as a community provider that assumes ongoing responsibility for treatment or "certifies" students as being medically cleared to return to school. EMPS contact information can be found in the KidCare Resource Directory on the Department of Children and Family's website (http://www.state.ct.us/dcf/).

Families in need of ongoing mental health services may be referred to community resources, such as child guidance clinics or other service providers (see Appendix C for Resources). Also, INFOLINE provides referral information on a statewide basis. Some schools have a resource readily available in the form of a school-based health center, which has a mental health provider on staff. Since a school-based health center has the same "outside agency" status as a child guidance clinic, however, proper consent must be obtained for evaluation and treatment. Similarly, when consulting with community providers, school personnel should be careful not to disclose confidential student information without parent consent.

Youth service bureaus may be ideal community partners with which schools can collaborate to design and offer prevention programs, provide individual and group counseling for students, and disseminate information to parents and other community members about youth suicide (see Appendix C).

VII. System Evaluation

System evaluation refers to the process of regular review and revision of policy and procedures, and all other aspects of youth suicide prevention and intervention. The evaluation component of a youth suicide prevention program is essential in order to determine whether the plans and actions implemented for each part of the education and intervention components are effective, and the information—resource and contact information in particular—is up-to-date. Regularly evaluating program components and making revisions as needed ensure the continuation of a responsive, coordinated support system. Evaluation also enhances the potential for achieving youth suicide prevention. Administrators, teachers, concerned parents, school mental health professionals, and others with expertise in research and evaluation should periodically participate in the evaluation and revision process.

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Appendix A

Sample School District Policies and Procedures

Connecticut Association of Boards of Education (CABE)

CABE has provided local education agencies with sample policies and administrative regulations on youth suicide prevention and intervention to address the legal requirement referenced in Section II.1

Pages A-3 through A-22

Connecticut Technical High School System

The Connecticut Technical High School System revised its policy and procedures in 1996.

On-line document only
http://www.state.ct.us/sde/deps/Student/PsychSocial/CTHSS_suicide_prevention.pdf

EASTCONN

EASTCONN, the regional educational service center that serves the northeast corner of the state, has developed a manual that would fulfill the requirement for a local educational agency to adopt procedures for dealing with youth suicide prevention and youth suicide attempts.

Available on request

The above materials have been reprinted with permission. The authors are gratefully acknowledged for their outstanding work.

[1] Sample policies and/or administrative regulations are distributed for demonstration purposes only. Unless so noted, contents do not necessarily reflect official policies of the Connecticut Association of Boards of Education, Inc.

Sample Policies and Administrative Regulations
Connecticut Association of Boards of Education[2]

Policy Sample #1

5141.5

Students

Suicide Prevention and Intervention

The Board of Education recognizes that suicide is a complex issue and that, while the school may recognize a potentially suicidal youth, it cannot make a clinical assessment of risk and provide in-depth counseling. Instead, the Board directs school staff to refer students who may be at risk of attempting suicide to an appropriate service for assessment and counseling.

The Board of Education recognizes the need for youth suicide prevention procedures and will establish program(s) to identify risk factors for youth suicide, procedures to intervene with such youth, referral services and training for teachers, other school professionals and students to provide assistance in these programs.

Any school employee who may have knowledge of a suicide threat must take the proper steps to report this information to the building principal or his/her designee who will, in turn, notify the appropriate school officials, the student's family and appropriate resource services.

Legal Reference: Connecticut General Statutes

10-221(e) Boards of education to prescribe rules.

Policy adopted: [date]

[2] Sample policies and/or administrative regulations are distributed for demonstration purposes only. Unless so noted, contents do not necessarily reflect official policies of the Connecticut Association of Boards of Education, Inc.

5141.5

Students

Suicide Prevention and Intervention

The _____ Board of Education recognizes that suicide is among the three leading causes of death among young people and, consequently, is a concern to this school system and the community it serves. It is the policy of the Board of Education to actively respond in any situation where a student verbally or behaviorally indicates an intent to attempt suicide or to do physical harm to himself/herself.

The Board of Education recognizes the need for youth suicide prevention procedures and will establish program(s) to identify risk factors for youth suicide, procedures to intervene with such youth, referral services and training for teachers, other school professionals and students to provide assistance in these programs.

It is also recognized by the Board that suicide is a complex issue, and that, while school staff members may recognize potentially suicidal youth, they cannot make clinical assessment of risk and provide in depth counseling, but must refer the youth to an appropriate agency for such assessment and counseling.

Therefore, any school employee who may have knowledge of a suicide threat or intent will report this information to the school principal or his/her designee, who will, in turn, mobilize the crisis intervention team as described in the district's Guide to Crisis Intervention Procedures. The student's family will be notified, and an appropriate referral will be made. At no time during this process is the student to be left alone.

Legal Reference: Connecticut General Statutes

10-221(e) Boards of education to prescribe rules.

Policy adopted: [date]

5141.5(a)

Students

Suicide Prevention/Intervention

Guidelines

All school district professionals have a responsibility to share with principal observations of student behavior which appear to be related to the possibility of suicide.

The Principal, in turn, has a responsibility to follow the guidelines attached to the Board policy and regulation on suicide. If circumstances of a particular situation indicate that actions other than those described would serve the best interests of a given student and the school system, the Principal may consult with the designated student school system, the Principal may consult with the designated Student Assistance Team (SAT), Planning and Placement Team (PPT) and/or other appropriate personnel to make such a decision and shall make appropriate documentation of the circumstances and the resulting decision.

For the elementary schools, the term Student Assistance Teams should be replaced with Pupil Personnel Services Designee or school nurse.

Special Issues in Using Procedures

1. **Communication**

   The building Principal shall maintain communication with the Superintendent of Schools about all suicide attempts and shall call on the Central Office for advice on how to proceed if any situation warrants. In turn the Superintendent will keep the Board informed about suicide related issues as appropriate. All communications must be kept confidential as appropriate.

2. **Documentation**

   All actions taken by school personnel should be carefully documented. Such records should express facts, observable behaviors and actions. They should be placed in the student's supplementary file. Following an attempt or completed suicide, a daily log might be helpful.

3. **Contagion**

   Sometimes a suicide attempt or completed suicide will trigger other suicide attempts. There is no clear body of knowledge about how or why this occurs and what unique circumstances cause it. The best preventive measure against the contagion effect seems to involve careful identification and monitoring of students who may be in a risk category, efforts to reduce glamorization of the suicide and carefully planned follow-up activities.

Students

Suicide Prevention/Intervention

Guidelines (continued)

4. Principal

Shall be understood to mean Principal or Principal's designee.

5. Anniversary Dates

The week, month or year anniversary of the death may trigger a delayed grief reaction or suicide attempts modeled after the first. School personnel should be sensitive to this and intensify monitoring of students at these times.

6. Support

While Student Assistance Team members will probably be sensitive to each other's needs for support, it can also be helpful to have an outside professional available during and following crisis periods to "debrief" the team and offer support to individual members as needed.

7. Suicide at School

Most experts agree it is better to keep students at school where adult support systems are available than to send them home, where no adult supervisors might be available to them. Students should only be released to their parents or other responsible adults should they ask to leave school early.

Students at Risk for Suicide

1. General Procedures During School Hours

School staff who have identified a student who exhibits the signs as noted in Appendix A or who have other reason to believe the student is at risk for suicide must immediately bring the student's name to the attention of the principal or his/her designee. This must be done even if the student has confided in the staff person and asked the staff person to keep their discussion confidential. In such cases, the staff person would explain that he/she cannot keep confidentiality in these circumstances.

Students

Suicide Prevention/Intervention

Students at Risk for Suicide (continued)

Appropriate staff member(s) gather background information prior to contacting the student unless there appears to be imminent risk of self harm. This background check should be done on the same day as the referral and may include:

A. Further discussion with the person who made the referral.

B. Contact with other staff members to get data on recent student performance. At the earliest possible moment following the collection of information, contact with the student will be made to determine the seriousness of the situation.

C. **Critical Situation**

The student has the intent to kill himself/herself, a specific plan for how he/she will do it and immediate access to the method; in addition, he/she exhibits feelings of loneliness, hopelessness, helplessness and the inability to tolerate any more pain.

(1) A staff member will stay with the student to offer support. In addition, he/she will explain to the student that someone will be contacting parent(s) because of deep concern.

(2) A staff member will notify the parent(s) and request that they come to the school immediately. The following points should be covered in the meeting with the parents:

(a) The seriousness of the situation.
(b) The need for immediate outside professional help.
(c) The need for continued monitoring.
(d) A request for parent(s) to sign a release of information form for communication between the school and the facility to which the student will be taken, the student's therapist and other individuals as appropriate.

(3) If the parent(s) cannot be contacted or if they refuse to come to the school and the team determines that a medical emergency exists, normal procedures will be followed for such emergencies. The principal will explain that the school may be required to file a medical neglect report with the Department of Children and Families. In addition, the principal may inform the parents

Students

Suicide Prevention/Intervention

Students at Risk for Suicide (continued)

that the student will not be accepted back into school until a formal mental health evaluation has taken place.

This exclusion will be done in compliance with state regulations and only if it is deemed to be in the best interest of the student.

(4) As a follow-up, a staff member will contact the family to discuss the family's plans to provide professional help and support to the student. Permission for communication between school and therapist will be requested. A plan of action for in-school support of the student will be discussed at the next Student Assistance Team meeting. The team will continue to monitor the student.

D. **Potential Situation**

The student has some intent to kill himself/herself and has thought about how he/she would do it. He/she has access to the method but does not have everything in place. Although the student may exhibit feelings of hopelessness, helplessness and unbearable pain, he/she shows some willingness to accept help. The following action will be taken, the order to be determined by the specific situation:

(1) A staff member will explain to the student that parent(s) will be contacted in order to arrange for professional help and to develop an appropriate support system. The staff member will offer to speak to those people on the student's behalf.

(2) The Principal or designee will ask the student to sign an agreement not to harm himself/herself.

(3) Following the meeting with the student the principal or designee will:

(a) Convene the Student Assistance Team to plan a course of action.
(b) Contact the student's parent(s) to inform them of the seriousness of the situation and to request a meeting that day.
(c) Obtain further information from the parent(s) concerning the student's mental health history including therapy and previous suicidal attempts or threats. If the student is currently being seen by a

Students

Suicide Prevention/Intervention

Students at Risk for Suicide (continued)

mental health professional, the principal will ask for parental permission to speak with that professional.

(d) Communicate the need for suicidal risk evaluation.

(4) If the parent refuses to come to school, the principal will explain that the school may be required to file a medical neglect report with DCF.

(5) As follow up a team member will contact the family to discuss their plans to provide professional help to the student. The team will meet to develop a plan for in school support.

E. **General Procedures After School Hours**

If a staff member has become aware of a potentially suicidal student during after school hours, he/she should consider and decide the following actions:

1. Contact the parents.
2. Contact the police.
3. Contact student's therapist.
4. Contact 24-hour crisis center.
5. Contact the principal.

Students Who Have Attempted Suicide

1. In School Attempt

A. The staff person who becomes aware of the attempt will remain with the student and will immediately send for the nurse and Principal.
B. The nurse and Principal will follow school medical emergency procedures to get immediate medical help for the student.
C. The parents will be contacted.
D. The Principal will refer to the Crisis Intervention Plan and Media guidelines to determine a course of action.

Students

Suicide Prevention/Intervention

Students at Risk for Suicide (continued)

2. Out of School Attempt

A. The Staff person who receives the information concerning an attempted suicide will immediately contact the school Principal who will verify the information and actions taken by the parents.

B. The Principal will determine if the situation warrants informing the full faculty.

C. If the attempted suicide is causing visible distress among students, staff may be asked to follow "Guidelines For Talking to Students About Suicide/Sudden Death." An after school meeting may be held to identify others at risk with students and discuss concerns.

D. The Principal in conjunction with the Student Assistance Team will develop a plan to monitor and support high risk students.

E. A team member will be assigned to follow up and monitor the student upon his/her return to school.

F. If appropriate, information will be shared with the Principal of the sibling's school.

Legal Reference: Connecticut General Statutes

10-221(e) Boards of education to prescribe rules.

Regulation approved:

Students

Suicide Prevention/Intervention

The district recognizes suicide as a leading cause of death among young people and therefore a major concern of the community and there crisis intervention team in each school building. The following guidelines, addressing suicide intervention and prevention, are clarification of district efforts to provide immediate support for a student in crisis.

When a staff member in the _____ Public School System is confronted with a situation in which a student expresses suicidal thoughts, or it appears that an attempt at suicide is possible, the following actions will take place:

1. The staff member will immediately refer the student to the Crisis Intervention Team's (C.I.T.) building administrator.

2. In the event the staff member perceives that a student has taken action which creates a medical emergency, the school nurse will be notified immediately and emergency medical procedures will be followed.

3. The building administrator will coordinate the efforts of all team members and seek the intervention of the department of student services worker -- either the school counselor, social worker, or psychologist.

4. The counselor and/or another C.I.T. member will meet with the student immediately for the purpose of establishing sequential facts or events leading to the crisis. At no time during this process is the student to be left alone.

5. If the student is not found to be suicidal, the parents will be notified of the referral and of all conclusions reached. Follow-up contact with the student and the parents or guardians will maintained until such time as it is determined that all threats of suicide has passed. A written report of all contacts with the student and the parent or guardian will be kept. The C.I.T. Chairperson will coordinate follow-up and documentation.

6. If the student is found to be suicidal, immediate contact will be made with a parent or guardian and a conference will be held the same day.

7. During the conference, the parent or guardian will be advised that an immediate mental health intervention is needed. Community resources will be identified and suggestions to parents will be provided.

Suicide Prevention/Intervention (continued)

8. Under no circumstances is a student allowed to go home alone. The student must be released only to a parent, guardian, or other responsible adult.

9. If reasonable attempt to reach the parent, guardian, or other responsible adult in whose custody the student may be released are not successful, the case will be treated as a medical emergency and arrangements will be made to the transport the student to an area hospital emergency room or mental health facility.

10. If the student requires medical attention, he/she will be transported immediately to an area hospital. Parents will be informed to meet the student at the hospital.

11. The Crisis Intervention Team Report will be completed by the most appropriate C.I.T. Chairperson will assign this responsibility.

12. Follow-up contact will be in accordance with the C.I.T. recommendations. A report will be written indicating those activities performed to follow through and ensure the safety and well-being of the student.

13. A copy of all reports will be submitted to the parents, the principal, and the Director of Student Services.

Failure on the part of the family to take seriously and provide for the safety of the student in case of potential suicide will be considered emotional neglect and reported to the Department of Children and Families.

If as a result of suicidal activity a need exists for changes in the student's program, the school's planning and placement team will convene and consult with the student's mental health professional, the parent(s) or guardian, appropriate outside facility staff merges and, if feasible, the student to plan the student's educational program. When necessary, the Emergency Supervision Plan will be implemented.

The school counselor or C.I.T. member assigned to the case will maintain contact with the student's mental health professionals to support programming needs and follow-up procedures.

Management of Suicide in the Schools

If a suicide by a student or staff member occurs, the Superintendent of Schools shall be notified immediately.

Students

Suicide Prevention/Intervention

Management of Suicide in the Schools (continued)

1. Communication

A. All requests for information will be directed to the Building Principal.

B. The Building Principal will assemble administrative staff to plan and implement an Action Plan. The Director of Pupil Services will participate in this meeting and coordinate resources, if necessary.

2. Action Plan

A. Assemble staff prior to the opening of school to provide accurate information and to present the plans for the school day. The building principal will try to anticipate sensitive situations and inform all staff, permanent and itinerant, accordingly.

B. A building-level C.I.T meeting will be called in order to assist the staff and students in dealing with the general school situation and any individual problems which may arise. Members of the team will assist the building staff in developing and implementing the Action Plan within the building.

C. The Crisis Team should identify those students who have the greatest potential for suicide and/or reaction this incident and interview them to assess their needs. The Team should implement a monitoring plan for those students, if needed.

D. The Action Plan should include provisions for group discussions as well as individual sessions with students and staff.

3. Students

Following a suicide, the atmosphere in school can be a critical factor in preventing additional suicides. Some students will be affected more than others, and the impact might surface in different ways. Students should be allowed to discuss their feelings of loss without embarrassment but should not be discuss their feelings of lost without embarrassment but should not be forced to participate in such discussions. Any discussions of a suicide should be tailored to the age, maturity and needs of the student(s) involved.

Additional guidelines for talking to students about suicide/sudden death are in the Appendix of this Guide.

Regulation approved:

Students

Suicide Prevention/Intervention

A Guide to Crisis Intervention - Introduction

Students in the _____ Public School District, at times, face enormous psychological distress. The Crisis Intervention Committee has identified and developed Crisis Intervention Procedures in order to assist each student faced with a crisis in the most expeditious manner possible. A crisis is defined by Gerald Coplan in Principles of Preventive Psychiatry as the loss of ordinary balance between problems and resources available to respond to them. A crisis may be, but not limited to, the following: suicide, substance abuse, child abuse, severe emotional distress, etc.

Crisis Intervention as used in this regulation/guide is not therapy nor sympathetic friendship but an act of immediate and direct intervention at a crucial moment. The goal of Crisis Intervention is to restore the individual student to the pre-crisis level by being active, directive and supportive. While the traditional steps in Crisis Intervention include: assessment of the students problem; planning and intervention; providing intervention; resolution of the crisis and follow up planning, a critical success factor is the attitude of the intervenor at the time of contact with the student.

It is important to realize that these procedures while providing structure may not apply to every situation deemed a crisis. Each building administrator as a team member maintains the authority to initiate all steps necessary in a given situation to insure the safety and well being of each student.

Included also in this procedural guide is a description of "Warning Signs" which have been developed to assist staff in identifying possible negative behaviors which might constitute a crisis situation.

The guide will be updated regularly and used as a basis for providing district-wide in-service.

Elementary and Secondary Level

While there are inherent similarities among students at the elementary and secondary level there are also differences. The purpose of the Crisis Intervention Team (C.I.T.) at each level is to recognize those differences and thereby make quick and informed decisions for intervention in a crisis situation.

Students

Suicide Prevention/Intervention

Elementary and Secondary Level (continued)

1. At the elementary level the crisis intervention team will normally consist of:

    A. Building administrator,

    B. Classroom teacher,

    C. School social worker,

    D. School nurse, and

    E. Parent.

2. At the secondary level the crisis intervention team will normally consist of a:

    A. Building administrator,

    B. Director of guidance,

    C. School counselor,

    D. Social worker,

    E. School nurse,

    F. Classroom teacher, and

    G. Parent.

The differences in crisis intervention team membership at the elementary and secondary level is exclusively the result of district wide staffing patterns and in no way diminishes the teams effectiveness.

In some instances, it is obvious that the referral source of a student in crisis may be another staff member, a parent, or a concerned citizen.

Students

Suicide Prevention/Intervention

Specific Task of the Crisis Intervention Team (C.I.T.)

When a crisis situation is brought to the attention of a C.I.T. member, (Note: a "crisis" is when the student is no longer able to balance problems with resources) the primary objective of the C.I.T. member is to provide quick and precise intervention and support to the student.

1. **Building Administrator**

   Coordinates efforts of all team members; consults with classroom teacher; guidance & counseling staff, school social worker and school nurse if necessary and if available initiates parental contact personally or through the most appropriate C.I.T. member; contacts police, hospital, Division of Children and Youth Services, other agencies when appropriate; schedules future meetings (conference, planning and placement team or C.I.T.), if necessary; contacts the Director of Pupil Personnel Services for consultation; contacts a district consultant for assistance when appropriate; complete and forwards to the Director of Pupil Personnel Services the Crisis Intervention Report Form when necessary.

2. **Classroom Teacher**

   Immediately notifies building administrator of the crisis situation; removes student from class if necessary or allows student to remain in classroom depending upon the situation; assist with coordination of team efforts when requested.

3. **Director of Guidance**

   Immediately informs team members; coordinates internal interventions and special services if appropriate; schedules future meetings when necessary; assists with coordination of all team efforts when requested.

4. **Guidance Counselor**

   Immediately informs the Director and Building Administrator; insures that the student is safe and remains with the student; explains to the student what happens when a crisis occurs and what the C.I.T. members will do; provides follow up with student, parent and/or community resources as requested.

5. **School Nurse**

   Assesses physical condition of the student; provides medical information and advice; participates in meetings concerning the student.

Students

Suicide Prevention/Intervention

Specific Task of the (C.I.T.) (continued)

6. School Social Worker

Consults with team regarding internal interventions; provides temporary intervention/support to student and/or team members; acts as liaison with external resources.

7. Parent

Immediately available to provide support to son/daughter and school staff when contacted; attends emergency school meetings to hear and discuss concerns; secures intervention for son/daughter.

Types of Crisis

A suicide threat; sexual or physical abuse; death of a family member, peer or teacher; acute alcohol or drug reaction; hospitalization or illness; an acute emotional or mental disorder in family member; reactions to moving; incarceration - jail; rape; crisis situation in school - fighting, sexual abuse, drug reaction; catastrophic situations within school - fire, suicide of teacher/student; marital difficulties - divorce; sudden termination of a boyfriend/girlfriend relationship; overt bizarre behavior; violence in family; isolation/withdrawal/lack of connection in school.

General Symptoms - Personality Profile

1. Behavioral

Patterns of work, play, leisure, exercise, diet (eating and drinking habits), sexual behavior, sleeping habits, use of drugs and tobacco; presence of any of the following: suicidal, homicidal, or aggressive acts.

2. Affective

Feelings about any of the above behaviors; presence of feelings such as anxiety, anger, joy, depression, etc.; appropriateness of affect to life circumstances. Are feelings expressed or hidden?

Students

Suicide Prevention/Intervention

General Symptoms - Personality Profile (continued)

3. Somatic

General physical functioning, health. Presence or absence of tics, headaches, stomach difficulties, and any other somatic complaints; general state of relaxation/tension; sensitivity of vision, touch, taste, sight, hearing.

4. Interpersonal

Nature of relationships with family, friends, neighbors, and co-workers; interpersonal strengths and difficulties; number of friends, frequency of contact with friends and acquaintances; role taken with various intimates (passive, aggressive, withdrawn); basic interpersonal style (congenial, suspicious, manipulative, exploitative, submissive, dependent).

5. Cognitive

Current day and night dream; mental pictures about past or future; self image; life goals and reasons or their presence or any of the following; catastrophizing, overgeneralizing, delusions, hallucinations, irrational self-talk, rationalizations, paranoid ideation; general (positive/negative) attitude towards life.

Specific Behavioral Clues Exhibited in School

Frequent alcohol use; frequent drug use; withdrawal/isolation (e.g. hiding in lavatories, skipping classes) sexual promiscuity; aggressive acting out (e.g. fighting); sudden dropping out of school-related activities (e.g. clubs, sports); Drastic decline in school performance; Risk-taking behaviors (e.g. driving fast, hanging out of windows, jumping off objects, stair platforms etc.); Chronic tardiness to school; Excessive absenteeism; always completing assignments after the due date; frequent somatic complaints/frequent visits to the nurse's office; frequent injuries/accidents; frequent crying; unusual outbursts of temper; inability to concentrate (e.g. falling asleep in class); giving away possessions; verbal threats of suicide; frequent verbal expressions of negative self-worth; Getting one's life in order (e.g. paying debts, sudden turning in of back assignments, sudden make-up of tests not necessarily coinciding with the end of a marking period); talking about "going away"/"leaving"/"not coming back;" excessive fascination with death; unusual gain or loss of weight; pathological/excessive denial of feelings or problems.

Legal Reference: Connecticut General Statutes
10-221(e) Boards of education to prescribe rules.

Regulation approved:

Suicide Prevention/Intervention

Risk Assessment Checklist

1. Has the person recently withdrawn from therapeutic help?
2. Has the person been abusing drugs or alcohol recently?
3. Is there a history of suicide in the person's family?
4. Is the person exhibiting marked hostility to those around him or her?
5. Has the person's life become disorganized recently?
6. Does the person drop in and out of schools?
7. Has the person become unusually depressed or anxious recently?
8. Has a friend committed suicide recently?
9. Has the person threatened suicide, or spoken about it with friends or teachers.
10. Is the person preoccupied with themes of death or dying?
11. Has the person made previous suicide attempts?
12. Does the person have trouble holding onto friends?
13. Does the person have a "plan" for suicide, and has the person made preliminary arrangements?
14. Has the person made "final arrangements" (given away possessions, said "Goodbye")?

If you believe someone may be thinking of suicide, get help for that person by immediately contacting people designated in the district plan on crisis intervention. Do not wait!

SUICIDE INTERVENTION FORM

(Confidential - for Administrator/SAT use 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: (h)** _____ **(w)**_____

Student referred by _____

Recorded by _____

1. **State reason for referral.**

   _____

   _____

   _____

   _____

2. **List behavioral or verbal indicators if possible suicide risk (refer to Appendix A and B) in this student.**

   _____

   _____

   _____

   _____

3. **Describe level of possible suicide risk as assessed by** _____

4. Describe indicators that resulted in given risk assessment rating.

Behaviors: _____

_____

Feelings:_____

_____

Suicide Plan and Method: _____

_____

5. Describe Actions Taken:

ACTION	DATE/TIME	PERSON RESPONSIBLE

6. Follow-up: Describe follow-up recommendations and actions.

RECOMMENDATION	ACTION	DATE	PERSON RESPONSIBLE

Appendix B

Risk Factors and Protective Factors

Certain factors or conditions are known to be associated with an elevated degree of risk for suicidal behavior—not in crisis and requiring immediate attention, but in need of supports and ongoing monitoring. Such individuals are more likely than students in general to engage in various risky behaviors, including drug and alcohol use, unsafe sex, truancy and criminal activity. Just as it is important to identify individuals who are at risk, knowledge of protective factors or conditions is essential to suicide prevention. The impact of risk factors is countered, to some degree, by the presence of protective factors.

RISK FACTORS

Biopsychosocial

- ✧ Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders (e.g., borderline, antisocial)
- ✧ Alcohol and drug use
- ✧ Feelings of hopelessness
- ✧ Impulsive and/or aggressive tendencies
- ✧ History of trauma or abuse
- ✧ Some major physical illnesses
- ✧ Previous suicide attempt
- ✧ Family history of suicide

Environmental

- ✧ Relational or social loss
- ✧ Easy access to lethal means (e.g., guns)
- ✧ Local clusters of suicide that have a contagious influence

Sociocultural

- ✧ Sense of isolation (especially for female adolescents) and lack of social support
- ✧ Stigma associated with help-seeking behavior
- ✧ Barriers to accessing mental health care and substance abuse treatment
- ✧ Certain cultural and religious beliefs (e.g., that suicide is a noble resolution of a personal dilemma)
- ✧ Exposure to and influence of others who have died by suicide, including media influence

PROTECTIVE FACTORS

- ✧ Effective clinical services for mental, physical and substance use disorders
- ✧ Easy access to various clinical intervention and support for help-seeking
- ✧ Restricted access to highly lethal means of suicide
- ✧ Strong connections to family and community
- ✧ Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- ✧ Resiliency, self esteem, optimism, and empathy
- ✧ Cultural and religious beliefs that discourage suicide and support self-preservation

SUICIDE CRISIS INDICATORS

A suicide crisis is a time-limited occurrence in which an individual is in immediate danger of suicide. Indicators of a suicide crisis, sometimes referred to as warning signs, help identify individuals in immediate need of attention.

- ✧ Suicidal statements or suicide notes
- ✧ Ominous utterances (speaking of going away, or of others being better off without them)
- ✧ Marked changes in behavior (e.g., trouble sleeping or eating, loss of interest in usual activities, neglect of self-care)
- ✧ Intense affective state in combination with depression
- ✧ Preoccupation with death, afterlife and violence in the context of sad or negative feelings
- ✧ Precipitating event (e.g., marked reaction to loss of loved one)
- ✧ Statements of hopelessness
- ✧ Deteriorating functioning in school, at work, or socially
- ✧ Telltale actions (e.g., buying a gun, putting one's affairs in order)
- ✧ Increased use of alcohol or drugs
- ✧ Other self-destructive behavior (e.g., loss of control, rage explosions)
- ✧ Recent incarceration

Appendix C

Community Resources

The **Department of Children and Families** website has a **Connecticut Community KidCare** Resource Directory:

http://www.state.ct.us/dcf/KidCare_Directory/kidcare_index.htm

From this page, you can access contact information for:

- ✧ Child Guidance Clinics
- ✧ Family Advocacy
- ✧ Emergency Mobile Psychiatric Services (under Regional Services)
- ✧ Community Collaboratives (under Regional Services)

INFOLINE / 2-1-1 (or 1-800-203-1234)

INFOLINE is a 24 hour a day information and referral service for all kinds of social services, including suicide prevention. INFOLINE also staffs a speaker's bureau that can train staff or education students about suicide prevention.

Youth Service Bureaus contact information can be found on the Connecticut Youth Services Association website:

http://www.ctnonprofits.org/pages/humanservices/cysa.asp

Connecticut State
Department of Education

Division of Teaching and Learning Programs and Services
George A. Coleman
Associate Commissioner
Deborah Koval
Publications and Web Content Coordinator

Bureau of Health and Nutrition Services
and Child/Family/School Partnerships
Charlene Russell-Tucker
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School Health Services
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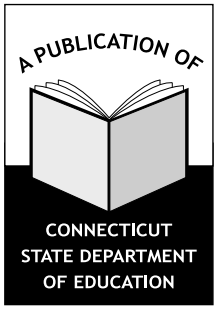
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