Youth Suicide Postvention: Support for Survivors and Recommendations for School Personnel

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Abstract

Suicide postvention is a concept related to the prevention of subsequent suicides, provision of mental health services, and the community response following a completed suicide. Many people including parents, school mates, friends, siblings, teammates and extended family are impacted in different ways by the loss of a family member or person of close connection, to suicide. In Alabama, suicide contributed to 667 lives lost in 2009 of which 76 (11.4%) were youth age 5-24 (D. Hodges, Alabama Injury Prevention Branch, personal communication, August 12, 2011). All suicides have one thing in common—the production of survivors, who grieve, attempt to understand and rationalize death by suicide, and to move forward in their lives. Despite robust data sources, it is estimated that for every suicide there are six survivors, a conservative estimate. This paper will provide an overview of postvention, characteristics of a survivor of suicide loss, general postvention program goals, school system preparation, support for families and peers in the wake of a youth suicide. For the purposes of this paper, youth is defined as a person between the ages of five and 24.

Background

Understanding Postvention

While death by suicide is final for the decedent, prevention risk is just beginning for the survivor of loss. Postvention, a term first coined by Shneidman at the first conference of the American Association of Suicidology (AAS), is used to describe "appropriate and helpful acts that come after a dire event" (1972). Andriessen (2009) offers yet another definition of postvention: "those activities developed by, with, or for suicide loss survivors in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior." Shneidman also contended "The largest public health problem was neither the prevention of the suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors of loss whose lives are forever altered" (1972, p. xi). The definition of "survivor" is complex and refers to the "behavior of someone else (not one's own suicide attempt), to the subsequent death and absence of that person, and to the subsequent impact on close others" (Andriessen, 2009). The survivor as discussed in this paper

describes a person who has lost a loved one to death by suicide, and should not be confused with an individual that has survived a suicide attempt. Nomenclature in the field of suicidology is important, therefore key terms warrant definition.

Historically, postvention services have been delivered using a passive model. This approach requires the bereaved to acquire resources in obscure ways (Campbell, 1997). For example, survivors may collect a pamphlet at a funeral home, see an advertisement for a survivor support group at a community event, or happen to locate a website when researching support for themselves or their family (Cerel & Campbell, 2008). In contrast, active models of postvention provide immediate and direct referrals for additional support to individuals impacted by the suicide loss. Friends, neighbors, co-workers, and distant family members are often overlooked, yet they are just as significantly impacted by the death as members of the immediate family (Campbell, Cataldie, McIntosh, & Miller, 2004). Postvention is thought to be an act provided to close relatives; however, the quality of the personal relationship would be an important factor to assess when addressing the sense of loss experienced by others (Chapman, 2007; McIntosh, 2003). Examples of active postvention include immediately providing survivors with a list of support groups they can attend and introducing the bereaved to others who have experienced suicide loss in hopes of strengthening the survivor's local support network. Specific group meetings and their meeting details can be easily found by searching the websites of the American Foundation for Suicide Prevention and/or the American Association of Suicidology. Given that school personnel are responsible not just for the intellectual development of youth, but their physical and emotional development, when a youth suicide occurs in a school, the emotional ripple effect it has must be actively addressed (Cerel & Campbell, 2008).

Characteristics of Survivors

Suicide postvention is a crisis intervention strategy describing actions taken after death by suicide "to help survivors such as family, friends, and co-workers cope with the loss of a loved one" (Suicide Prevention Resource Center [SPRC], 2008), dissuade social stigma associated with suicide, and disseminate fact-based information (Brock, 2002). Assistive efforts available after a death vary by type, location, and geographical distance of resources in given community. The sudden or unpredicted loss of a loved one to suicide triggers different emotions among survivors than does other means of death that are anticipatory, such as terminal cancer. Counseling professionals should know that survivors of suicide are at risk for complicated reactions and other mental health challenges, including direct suicide risk. The nature of such abrupt loss often generates a state of complicated grief for the survivor. Absence of preparation, the potential for self-blame, and guilt for not reading into behavioral cues conveyed by the decedent disrupt and can prolong the grief recovery cycle. The coping process is altered and the resources a survivor needs to move past the situation are varied and the specific needs of survivors are difficult to anticipate (Jordan & McIntosh, 2011).

Family and Close Others

People who experience youth suicide, in particular those who discovered the decedent, are likely to experience a wide range of intense feelings. Kubler-Ross and Kessler (2007) indicated that people experience a cycle of grief related to any death process including denial, anger, bargaining, depression, and acceptance. According to Jackson and McIntosh (2011), it is not uncommon for survivors of suicide to experience complicated grief which can include shame, embarrassment,

isolation, unusual grieving patterns, and intrusive thoughts. Co-occurring problems such as acute and post-traumatic stress, depression, anxiety, social marginalization, family stress, and physiological and medical problems intensify the loss and grief process. In particular, survivors struggle with guilt because they may believe they were given warning from the decedent or were the last person to have contact with the decedent or both.

When suicide occurs, it is a traumatic event for survivors (Leenaars & Wenckstern, 1990) who often report receiving less social support than expected. The stigma attached to mental health and the taboo approach that cultures take with regard to issues of self-harm pressure some to view suicide as a sinful, selfish, or angry act. Just as those who die by suicide are not focused on the outcome their death will have on those left behind, survivors are not prepared for the negative association and stigmatization. Suicide survivors often need more care, comfort, and compassion than people who anticipated the death of a loved one, but the needs of survivors are often left unmet. When death occurs, it is culturally traditional to send flowers or a note of condolences to the immediate family or friends. Many times, observers or acquaintances do not understand or know the appropriate means by which to communicate their empathy towards a survivor of suicide; therefore, supportive acts such as sending cards, making phone calls, and being present at other supportive gatherings often do not take place. The absence of communal response leaves the survivor feeling further isolated and removed from potential support systems (Jordan &McIntosh, 2011; Granello & Granello, 2007).

Youth

While it is beyond the scope of this paper to present information related to specific race, gender, ethnic groups, and special youth populations, youth response to suicide should be considered. Useful articles for further investigation include Kaslow, Ivy, Berry-Mitchell, Franklin, Bethea (2009) and Silenzio, Pena, Duberstein, Cerel, and Knox (2007). It is important to recognize that youth respond to suicide in ways different than adults. Given that youth have a less developed cognitive capacity and coping skills to draw from, they often believe that they were responsible for the suicide in some way. Secrecy about a suicide can lead to additional psychosocial complications. Explaining the circumstances surrounding the death, and responding to questions with age-appropriate answers will thwart the potential for guilt and improve understanding (Cerel, Roberts, & Nilsen, 2005; Jordan & McIntosh, 2011).

Youth age four to eight years old may not talk directly about their feelings. Rather they act out their emotions through temper tantrums and anxiety when separated from certain adults. Youth age nine to 13 years old also commonly do not want to discuss their feelings directly but can respond to suicide with sleep disturbance or other difficult-to-manage behaviors. Youth age 14 to 18 may isolate and hide the information from their peers out of fear of being misunderstood or rejected (U.S. Department of Veterans Affairs, 2011a, 2011b, 2011c).

Cerel et al., (2005) found that high school students exposed to peer suicidal behavior were more likely to smoke cigarettes and marijuana, participate in high risk drinking, and engage in aggressive behaviors resulting in injury. Other studies have found youth to be at greater risk for depression, post-traumatic stress, suicidal ideation, relationship conflict, and traumatic grief and should be monitored to prevent these behaviors from emerging (Granello & Granello, 2007; Melhem, Day, Shear, Day, Reynolds, & Brent, 2004).

The imitation of suicide behavior, coined *contagion*, may occur following a death by suicide**.** Contagion, also referred to as cluster suicide, is a phenomenon whereby people who are already susceptible to suicide are influenced towards suicidal behavior through their knowledge of another person's suicidal act (AAS, 2012a; AAS, 2012b; Hawton &Williams, 2001; SPRC, 2008). The phenomena of suicide clusters are indeed unique to teenagers and young adults, and there is evidence of its existence primarily among youth for whom the underlying mechanism is peer modeling (Insel & Gould, 2008). Ways to reduce contagion include avoiding unnecessary inappropriate attention to the initial suicide, avoiding glorifying the act, and avoiding the portrayal of the decedent in a negative light. Minimizing the amount of details shared among peers is also useful in avoiding contagion after a suicide. Often there is a label, stigma, or negative frame placed around the individual who died from suicide. Stigma further perpetuates the myth that a formal discussion about suicide will encourage suicidal behaviors; this myth creates a gap between the survivors of loss and linkages with support resources.

School System Preparation

Suicide postvention in schools refers to "school activities occurring after a student has threatened, attempted, or completed suicide" (King, 2001, p.136). Schools are a place where youth spend the majority of their day and are a place where student safety and well-being are of utmost importance (Granello & Granello, 2007). Further, a high percentage of teens are acquainted with a suicidal peer, yet many are not equipped with appropriate response skills (Kalafat & Elias, 1992) and the help-seeking response differs by racial and ethnic factors (Goldston, Davis, Whitbeck, Murakami, Zayas, & Nagayama, 2008). When a death by suicide does take place, schools are encouraged to provide factual and truthful information to faculty, students, and staff.

Crisis planning and implementation

Schools systems often have a crisis plan in place, but the plan may or may not directly address suicide or specify a course of action, given the seriousness of the event. In a study with 1,200 educators conducted by Speaker and Petersen (2000), 20 percent of respondents reported active suicide prevention plans in place at their school, leaving 80 percent without a plan in place. Mr. Terry Talbott, a principal with 34-years of experience in a K-12 educational system explained “We had safety plans for natural disasters, and plans for notifying authorities if an intruder entered the building, but not a plan for addressing that crisis resulting from a student suicide.” Many school systems do not draft suicide prevention or postvention plans or policies in advance of youth crises. As a result, when a youth suicide occurs and school resources are unorganized, personnel are unsure of their role in this crisis intervention and everyone is placed in a reactive position when a timely response is critical (Jordan & McIntosh, 2011; Juhnke, Granello, & Granello, 2011). In the absence of a plan that is practiced and documented, personnel are ill-equipped to respond to the suicide event in a compassionate manner to effectively serve student survivors of the loss.

The issue of coping with problems as they arise is not a new phenomenon for school officials; even under the best of circumstances, potential student problems are not easily anticipated. However, the growing rate of media attention, prevalence of youth suicide, and schools as a natural partner in prevention should inform administrators that planning at the “early stages before crisis conditions develop is the best remedy for the administrator” (Gorton & Alston, 2012, p. 206). Some schools are reluctant to seek help when a death by suicide of a currently enrolled student takes place or when the tragedy is linked to recent alumni; as a result, the incident is not properly disclosed to other

students or the general community until the facts are revealed (Pirkis, Blood, Beautrais, Burgess, & Skehan, 2007).

Unfortunately, some schools are reactive rather than proactive, while postvention is the best prevention for subsequent suicides, postvention generally requires a loss of life to draw attention. Schools also fail to plan based on the common assumption that youth will disclose thoughts or actions about intended suicide self-harm to parents or caregivers; however, research indicates that youth keep these emotions suppressed and it may be a more distant self-other relationship (such as a teacher, coach, counselor, nurse, or classmate) that identifies potentially risky behaviors (Miller & McConaughy, 2005). Since youth spend a large amount of time in the school environment, many feel connected to their schools, believe teachers care about them, and develop positive student relationships which can reduce suicidal behaviors. Conversely, given the amount of time spent at school, youth may communicate their desire to die by suicide to several people in the school environment. When personnel and peers are not trained to detect risk factors, warning signs and appropriate intervention skills suicidal youth go undetected and without intervention (Capuzzi, 2009; Granello & Granello, 2007).

There are many tools available for school professionals to evaluate programs when determining the type of policy, extent of training, and level of community capacity building that should be given to suicide crisis planning. The examples provided in Table 1 are not exhaustive, but will provide a basis for school procedural implementation, assessment, and discussion. A sample school-based postvention checklist is also provided (Table 2). School systems that ignore suicide prevention and postvention as a component of student success open themselves for potential litigation. School officials should be informed of legal obligations resulting from failure to plan and respond to youth suicide crises (Bartlett & Talbott, 2011; Berman, Jobes, and Silverman, 2006; Capuzzi, 2009). Table 3 provides a sample notification letter to proactively inform parents and to serve as evidence if litigation is pursued. It is just one of various forms available for school system consideration.

Schools with active crisis plans should take pride in their proactive efforts and publish them, select and train a crisis team that includes diverse faculty, staff, and school board members (King, 2001; New Hampshire National Alliance for Mental Illness, 2011) and make sure the plan is realistic should there be the need to execute it. The time between the death, release of information (within 24 hours of the suicide), and subsequent deterioration of peer emotional responses is a short and crucial window (King, 2001). As part of planning in advance, specific crisis response duties should be pre-assigned to personnel (such as media correspondence, communications dissemination with students, faculty and parents, and response from community mental health professionals) and the school must take time to identify natural partners, such as law enforcement, mental health professionals, media outlets, medical examiner, police, and clergy (Maples, Packman, Abney, Daugherty, Casey, & Pirtle, 2005; New Hampshire National Alliance for Mental Illness, 2011; Stack, 2003).

Enough emphasis cannot be placed on the importance of training school personnel to respond appropriately to suicide symptomology, to the school's crisis plan, and to intervene as needed (Roberts, Lepkowski, & Davidson, 1998; King, 2001). Should a death by suicide occur, teachers should announce the occurrence of the death during the first class meeting of the day and share with students that counseling services are available (Goldney & Berman, 1996). It is suggested that school personnel monitor the victim's classes and the school's emotional climate for several days to a week or weeks after the suicide for purposes of evaluating changes in peer behavior related to the

death (King, 2001). During the days immediately following a death by suicide, students, faculty (Poland, 1995), and staff should be made aware of designated discussion rooms in the building where counseling is available, if that is the case. Both individual and group counseling options should be provided to increase survivor comfort level and to best accommodate emotional needs and wishes regarding privacy. Specifically, school personnel should be cognizant that survivor-siblings attending the same school system may be in need of tailored assistance when coping with a loss of this magnitude. When approaching a sibling or other close youth, it is important to reduce psychological pain when intervening to prevent further suicidal behaviors (Miller & Eckert, 2009).

Inappropriate school responses

Even with the best of intentions and a crisis plan in place, well-intended school officials that are not trained mental health professionals need support during this time of stress and tragedy. Schools are dissuaded from discussing or releasing facts related to the topic of suicide or the death by suicide at a mass school assembly or over the intercom for fear of perpetuating suicide contagion, as previously discussed. For much the same reason, school officials should not allow for cancellation of regularly scheduled activities so that students may attend the planned funeral service. Schools should also dissuade perhaps well-intended others from authoring a memorial in the school yearbook or from dedicating a bench or tree as a reminder of the decedent, and refrain from allowing graduation speeches that reintroduce the incident. These activities are not advised as they may evoke emotional responses that are unpredictable and frame suicide as a positive option. Rather, the school should work toward communicating the message that other options to resolve emotional problems exist. This encourages other youth who may already be contemplating suicide to reconsider that choice (Capuzzi, 2009; Juhnke, Granello & Granello, 2011).

Survivor communication

The school plan should include verifying the facts of the death from several sources, such as law enforcement or, in some cases, the parents, family, or legal guardian of the deceased. Schools administrators are encouraged to contact the family in a concerned and conservative manner with the intent to apprise them of the school's intervention efforts, identify close friends of the decedent that are potentially at risk for suicide, and offer to assist with funeral arrangements. Initial contact between school officials and the family begins the process of community resource infusion and is perhaps the first time a family in crisis will learn about community mental health and other resources available to them. Therefore, well-prepared school personnel can engage the bereaved in active postvention methods and perhaps link them to early survivor support for positive self-care (Bartlett & Daughhetee, 2009; Chapman, 2007; McIntosh, 2003).

School community collaboration

There are many community entities that can serve as helpful resources to the school, family members, and other survivors. Partnerships and contacts with community resources such as law enforcement should take place as part of the school's comprehensive crisis intervention planning process. For example, school officials may want to communicate with the local medical examiner about the facts of the death by suicide; while this information may be necessary to decrease speculation about a recent death, the facts may point to gaps in the school crisis plan and serve as a learning tool (Juhnke, Granello & Granello, 2011). A proactive school system should have a pre-determined list of community mental health providers; those providers should be notified that

survivors will be referred to them by the school for support services. The lack of connection between the local school system and community mental health resources may delay response time of perhaps the most critical starting point to the healing process. Further, in the postvention planning process, school leadership is advised to include community mental health providers and organizations to collaborate as partners. An ideal outcome is for those counselors who are not part of the suicide loss to respond and support students and school personnel who are affected by the loss (SPRC, 2011).

School relations with media

In crisis situations, it is critical that schools be proactive in their communication, including having a plan in place. After the occurrence of death by suicide, rumors of the event may become exaggerated and spiral out of control; as a result, it is imperative that accurate postvention information be accessible. A systematic and cautious approach that provides for dissemination of information related to suicide is ideal. Information distributed should not glorify the behavior, but be provided in a kind and caring way.

A significant point to emphasize with media and parents is that no one thing or person is to blame for the suicide event and that help is available; rather, the cause of suicide is considered to be multifactorial by experts. There is no one event (such as a break up, a defeat, etc.) that causes suicide; suicidality is caused by neurological, biological, cognitive, contextual, emotional, and other factors. In light of the fact that school personnel are often intimidated when interfacing with media, it is recommended that school leadership prepare information such as email messages, blogs, news releases, and parent letters in advance for inclusion in the postvention plan. Media releases should include these four key elements: (1) general facts regarding the suicide incident, (2) that the crisis incident is over, and if true, that safety has been restored, (3) messaging that does not glamorize the event, and (4) where students should go for class or counseling (Juhnke, Granello & Granello, 2011). As mentioned previously, one person should serve as the primary point of contact for all media inquiries; school personnel need to know who the school media representative is and direct all media requests for information to the designee specified in the postvention plan (Heath & Sheen, 2005). This process will reduce reported misinformation, preserve school integrity, and protect the privacy of the decedent's family. There are many resources for schools related to interaction with the media including guidelines that the American Foundation for Suicide Prevention and the American Association of Suicidology have developed and post on their websites for school leaders.

Conclusion

Suicide is an act that school systems must be prepared for and respond to. In the wake of a youth suicide, postvention resources and programs should support the needs of students to grieve and display emotion, as well as address issues related to suicide contagion early in the process. Good postvention can be the best prevention in that collective effort; postvention may detect and deter the onset of subsequent survivor or cluster suicides. Having a postvention plan of action ready to implement may facilitate the healthy adaptation of youth, families, and communities to suicide loss and serve to prevent suicides. It is important to note that a comprehensive school-based effort will include ongoing preventive, interventive, and tertiary training and evaluation for faculty, staff, administrators, and the community—all of whom are impacted by the loss of a youth to suicide. Intuitively, postvention makes sense; however, no known systematic evaluation of postvention processes or procedures to respond to deaths by suicide in schools, organizations, or community

settings exist. Given the paucity of research school-based postvention effectiveness further investigation is necessary.

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Table 1: Postvention Resources

School Resources

After a Suicide: A Toolkit for Schools (SPRC/AFSP): www.sprc.org/afterasuicideforschools.asp

Archived: Research to Practice webinar: Responding After a Suicide: Best Practices for Schools (SPRC): www.sprc.org/traininginstitute/disc_series/index.asp

Mental Health America of Wisconsin: Components of School-Based Prevention, Intervention, and Postvention Model: www.mhawisconsin.org/schoolbasedmodel.aspx

'Postvention' category in SPRC online Library: www.library.sprc.org/browse.php?catid=40

School Suicide Postvention Accreditation Program (AAS): www.suicidology.org/web/guest/certification-programs/school-professionals

School Safety and Crisis Resources (NASP): www.nasponline.org/resources/crisis_safety/index.aspx

List-servers and Chat Addresses

1000 Deaths	www.1000deaths.com/lists.html
Survivor Support	www/afsp.org/support/support.html

Meeting of Hearts	www.meetingofhearts.com
Bereaved by Suicide	www.bereavedbysuicide.com
Suicide Survivors Organization	www.suicidesurvivors.org
Alliance of Hope for Suicide Survivors	www.forsuicidesurvivors.com
Survivors of Suicide	www.survivorsofsuicide.com
Surivors Road2 Healing	www.road2healing.com
Sibling Survivors	www.siblingsurvivors.com
Parents of Survivors	http://www.pos-ffos.com/

Table 2: Checklist for Components of a School Suicide Postvention Program

Consider checking off the following components that are currently in place in your school system, and take notice of the components that might need to be implemented.

Currently, does your school (or district):

1. _____**Contact the police, coroner's office, or local hospital to verify the death and get the facts?**

It is essential that the suicide be officially confirmed before the postvention protocol is implemented. A determination of suicide mU.S.t be made by a medical examiner or coroner.

2. _____**Inform the school superintendent & administrators of schools where siblings are enrolled?**

Does the school have a process or routine to coordinate and track this process? Does the school have a documentation process for this?

3. _____**Contact the family of the deceased student to express condolences?**

Does the school outline applicable guidelines for confidentiality in this situation? Does the school have a process for who to confer with prior to making this call (e.g. FERPA/HIPPA coordinator, etc.)?

4. _____**Notify and activate the school's crisis response team?**

Does the school use a telephone tree or other approach that allows for direct communication with the crisis response team?

5. _____**Schedule a time and place to notify faculty members and staff?**

Does the school set up a meeting before the start of the school day, if possible? Does the school prepare school staff for possible student reactions? Does the school include support staff (kitchen

staff, bus drivers, custodians, substitute teachers)? Does the school allow time for staff to ask questions and express feelings? Does the school remind staff of the possibility of contagion? Does the school ask staff to identify concern about individual students?

6. _____**Activate procedures for responding to the media?**

Does the school announce how media representatives will be interacted with? Does the school remind staff members not to the press, spread rumors, or repeat stories? Are all inquires directed to the designated spokesperson?

7. _____**Contact community support services, local mental health agencies, other school counselors, and clergy to arrange for crisis intervention assistance?**

Is the school prepared to identify and refer students who are most likely to be at high risk because of their close physical and emotional contact with the deceased student?

8. _____**Announce the death to students through a prearranged system?**

Does the school make the announcement in person and in small groups or in classroom settings?

9. _____**Use caution in allowing students to leave school unattended?**

Does the school make every effort to maintain a routine schedule? Does the school use a reliable system to track student presence and location?

10. _____**Provide written information for parents/guardians as soon as possible so they can be prepared and available to provide support for their children?**

Does the notification include information about how the school is responding to the crisis and resources available to them for specific concerns?

11. _____**Have crisis teams available in the deceased student's classes?**

Do teams follow the deceased student's schedule to observe reactions of students and to follow up as necessary?

12. _____**Establish support stations and counseling rooms and publicize their availability for students?**

Does the school document who attends and the time of attendance so that follow up may be provided?

13. _____**Make sure administrators and staff are visible in hallways and during lunch to monitor students and provide a calming presence for the school?**

Does the school identify which staff and administrators will coordinate and complete this task? Does the school give guidance on how those who complete this task will collaborate, exchange and document their efforts?

14. _____**Provide secretaries or others who answer phones with a prepared script to field telephone calls or answer inquiries from people who show up at school?**

Does the school train the staff in this process? How is this process tracked? How are concerns that secretaries have about inquiries communicated to school administrators or other appropriate staff and personnel?

15. _____**Use a prearranged strategy to monitor and assist students who may be at increased risk for suicide?**

Does the school provide additional support serves and education about suicide bereavement? Does the school follow up with students identified at increased risk? Does the school make sure all students have access to suicide hotline numbers? Does the school give special attention to student sin peer groups, friends, teams, romantic partners, and others who may be at higher risk?

16. _____**Conduct daily debriefing with faculty and staff during the initial crisis and postvention periods?**

In the event of a student suicide, is there a plan in place for how the system or district will respond to the other students, school personnel, media, and community at large?

17. _____**Reschedule any immediate stressful academic exercises or tests, but try to stay with the general school schedule as much as possible?**

Does the school keep the facility open and follow regular school routines to the greatest extent possible? Does the school convey the message that while we all grieve, life must go on?

18. _____**_ Provide information about the funeral to students and parents?**

Does the school work with family and ask, if possible, if the funeral can be held after school hours? If this is not possible, does the school allow the students to attend the funeral with parental permission and announce the policy regarding school absences for funeral attendance?

19. _____**Offer ongoing grief counseling for students and staff?**

Does the school train staff on this kind of counseling activity? Does the school bring in professionals from the community to assist? Does the school have a list of community resources to give students and staff to obtain support outside of school hours?

20. _____**Follow up with students identified as at risk, and maintain follow up for as long as possible?**

Does the school have a process on how to share and collaborate in this circumstance? Who will decide when this process is complete (e.g. the students are no longer at risk)? Does the school have a documentation process?

21. _____**Carefully monitor memorial activities or events?**

Does the school select commemorative activities so as to avoid glamorizing the event?

22. _____**Follow prearranged protocol for emptying the student's locker and returning personal items to the family?**

In the event of a student suicide, is there a plan in place for how the system or district will respond to the other students, school personnel, media, and community at large?

23. _____**Determine how diplomas, athletic letters, and other awards will be given posthumously?**

Has the school confirmed the process through the school system?

24. _____**Provide support for the crisis response team members?**

Does the school evaluate the needs of the crisis response team? How are decisions made regarding what supports may be needed, how to implement them, pay for them, etc.? Who facilitates and coordinates this process?

25. _____**Document activities as dictated by school protocols?**

Does the school have written protocols regarding what needs to be documented? By whom? Who the information is shared with? How the information is stored or integrated into the continual development of the postvention protocol?

Adapted from: Juhnke, G. A., Granello, D. H., & Granello, P. F. (2011). *Suicide, self-injury, and violence in the schools: Assessment, Prevention, and intervention strategies.* Hoboken, NJ: John Wiley & Sons.

Table 3: Sample Suicide Risk Notification and Agreement Form

_____

Name of the student (or person) who may be at risk for suicide

I acknowledge that the school employee who has signed this form has told me that he or she believes that the individual listed above may be at risk for suicide. I understand that this belief is based on specific information regarding this individual. I further understand that this employee is not in a position to make a determination as to whether the individual listed above is at risk for suicide.

I agree to care for the individual listed above until he or she can be evaluated by a qualified professional to determine whether the individual is at risk. I will share the evaluation results with the school administration or designee. I further agree to ensure that the individual listed above is provided the mental health care he or she needs after the evaluation is completed, and based on the recommendations of the evaluator.

I understand that if an emergency arises, I should take the individual listed above to a hospital emergency room for emergency mental health treatment.

_____

Printed Name of Parent or Guardian of Student (or Person)

_____ _____

Signature of Parent or Guardian of Student (or Person) Date

_____

Printed Name of School Employee

_____ _____

Signature of School Employee Date

_____

Printed Name of School Employee Witness

_____ _____

Signature of School Employee Witness Date

Source: Modified by Mary L. Bartlett, LPC, PhD. with permission, from original form developed by Theodore P. Remley, Jr., JD, PhD., Old Dominion University, Norfolk, Virginia.