Bend-La Pine Schools

Suicide Prevention Protocol

A Guide to Youth Suicide Prevention, Intervention and Postvention for Bend-La Pine Schools

2023-2024

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Introduction

Purpose of Protocols and Procedures

The U.S. Surgeon General promotes the adoption of suicide prevention protocols by local school districts to protect school personnel and to increase the safety of at-risk youth and the entire school community. In 2019, the Oregon legislature passed Senate Bill 52, also known as “Adi’s Act”, which requires school districts to develop and implement a comprehensive student suicide prevention plan.

This document recognizes and builds on the skills and resources inherent in school systems. Schools are exceptionally resilient and resourceful organizations whose staff members may be called upon to deal with crises on any given day. Schools can be a source of support and stability for students and community members when a crisis occurs in their community. This document is intended to help school staff understand their role and to provide accessible tools.

School Boards and school personnel may choose to implement additional supportive measures to fit the specific needs of an individual school community. The purpose of these guidelines is to assist school administrators in their planning. The guidelines do not constitute legal advice, nor are they intended to do so.

Bend-La Pine Schools

- Recognizes that physical and mental health underpin all learning. Physical and mental health and wellness are integral components of student outcomes, both educationally and beyond graduation.
- Further recognizes that suicide is a leading cause of death among young people aged 10-24 in Oregon.
- Has an ethical responsibility to take a proactive approach in preventing deaths by suicide.
- Acknowledges the school’s role in providing a culture and environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience.

- Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components.
- Will publish its policy and plan on the district website and will revisit and refine the plan as needed.

Quick Notes: What Schools Need to Know

Take every suicidal behavior and warning sign seriously EVERY time. Take IMMEDIATE action.
Contact the School Screener and a building administrator to inform them of the situation.

- School staff are frequently considered the first line of contact in reaching suicidal students.
- While most school personnel are neither qualified nor expected to provide the in-depth assessment or counseling necessary for treating a suicidal student, they are responsible for taking reasonable and prudent actions to help at-risk students, such as notifying parents, making appropriate referrals, and securing outside assistance when needed.
- All school personnel need to know that protocols exist to refer at-risk students to trained professionals so that the burden of responsibility does not rest solely with the individual “on the scene.”
- Research has shown talking about suicide or asking someone if they are feeling suicidal will not put the idea in their head or cause them to kill themselves. See: Kalafat, J., & Elias, M. (1992). Adolescents' experience with and response to suicidal peers. Suicide and Life-Threatening Behavior, 22, 315-321.
- School Personnel, parents, caregivers, and students need to be confident that help is available if/when they raise concerns regarding suicidal behavior. Studies show that students often know, but do not tell adults, about suicidal peers because they do not know how they will respond or think they can’t help. Regardless of how comprehensive suicide prevention and intervention may be in a community, not all suicidal behavior can be prevented.
- Advanced planning is critical to providing an effective crisis response. Internal and external resources must be in place to address student issues and to normalize the learning environment for everyone.

Confidentiality

School employees are bound by laws of the Family Education Rights and Privacy Act of 1974; commonly known as FERPA. FERPA generally precludes schools from disclosing information without first obtaining consent, but there are exceptions, including health and safety emergencies and communication with district staff who have a legitimate educational interest. Further, there are situations when confidentiality must NOT BE MAINTAINED, meaning that staff have a legal obligation to share information.

If at any time, a student has shared information that indicates the student is in imminent risk of harm or danger to self or others, that information MUST BE shared immediately. The details regarding the student can be discussed with those who need to intervene to keep the student safe. This is in compliance with FERPA.

Definitions

AT-RISK

Risk for suicide exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention.

CRISIS RESPONSE AND SUPPORT TEAM

A group of people who work in collaboration with school administrators to address crisis preparedness, intervention, response, and recovery.

MENTAL HEALTH:

A state of mental health, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders. Mental health can be impacted by the home, school, social environment, early childhood adversity or trauma, physical health, and genes.

RISK SCREEN

An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated staff (e.g. school counselor, school psychologist, school social worker, nurse, or ASIST trained student success program coordinator). The Columbia-Suicide Severity Rating Scale (C-SSRS) is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, and other risk factors.

RISK FACTORS FOR SUICIDE

Characteristics or conditions that inrease the chance that a person may attempt to die by suicide. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological and/or social factors in the individual, family, and environment. The likelihood of an attempt is highest when factors are present or escalating, when protective factors and healthy coping techniques have diminished, and when the individual has access to lethal means.

SELF-HARM

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm inrease the long-term risk of a future suicide attempt or accidental suicide.

SUICIDE

Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

SUICIDE ATTEMPT

A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of unresolved mindset, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, unresolved mindset is not reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.

SUICIDAL IDEATION

Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one's life is still considered suicidal ideation and will be taken seriously.

SUICIDE CLUSTER

Suicide clusters can be defined as a group of suicides or suicide related behaviors that occur close together in time and geographical areas than would be expected within a community.

SUICIDE CONTAGION

The process by which suicide deaths or suicide related behavior influences an increase in the suicidal behaviors of others. Often times this can be exacerbated by close family or friends who have died by suicide, language that continues to

stigmatize of suicide, and/or media coverage that does not meet best practices in preventing suicide.
https://www.cdc.gov/suicide/resources/suicide-clusters.html

POSTVENTION

Postvention refers to the community outreach and comprehensive response to those individuals and groups who were impacted by a suicide death in order to provide secondary prevention efforts with the goal to lower community risk. Overall goals of postvention includes: identify those at risk for suicide to help refer to care and/or resource-share, support those impacted by suicide and promote healing, promote help-seeking behaviors, de-stigmatize the conversation of suicide, and to safely speak of the suicide death by following best practice guidelines in order to do no harm.
https://www.ruralhealthinfo.org/toolkits/suicide/2/postvention

Groups at Increased Risk for Suicidal Behavior

BULLYING

Research has shown that bullying victimization and offending is an identifying risk factor to youth suicide. 16% of high school students in the United States reported they had been electronically bullied and 15% of high school students reported being bullied on school property in the last year.
https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

FAMILIAL FACTORS

Various familial factors have been linked to youth suicide, such as: Adverse Childhood Experiences, parental loss from divorce, abandonment, or death, as well as maltreatment. CDC data shows that roughly 3 to 4 high school students experienced at least on ACE during the pandemic resulting in these students reporting poor mental health and suicidal behavior.
https://www.cdc.gov/mmwr/volumes/71/wr/mm7141a2.htm

YOUTH LIVING WITH MENTAL AND/OR SUBSTANCE USE DISORDERS

Mental health conditions, in particular depression/dysthymia, attention-deficit hyperactivity disorder, eating disorders, intermittent explosive disorder, and conduct disorder are important risk factors for suicidal behavior among young people. An estimated one in four to five children have a diagnosable mental condition that will cause severe impairment, with the average onset of depression and dysthymia occurring between ages 11 and 14 years; therefore, school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk and enhance overall performance and improve long-term outcomes.

YOUTH WHO ENGAGE IN SELF-HARM OR HAVE ATTEMPTED SUICIDE

Risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Whether or not they report suicidal intent, one study found that 70 percent of adolescents admitted into inpatient psychiatric treatment who engage in self-harm report attempting suicide at least once in their life.

Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. One study found that as many as 88 percent of people who attempt suicide for the first time and are seen in the Emergency Department go on to attempt suicide again within two years. Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources, transportation, insurance, copays, parental consent, etc.

YOUTH IN OUT-OF-HOME SETTINGS

Youth involved in the juvenile justice or child welfare systems have a high prevalence of risk factors for suicide. As much as 60 to 70 percent of young people involved in the juvenile justice system meet criteria for at least one psychiatric disorder, and youth in juvenile justice residential programs are three times more likely to die by suicide than the general youth population. According to a study released in 2018, nearly a quarter of youth in foster care had a diagnosis of major depression in the last year. Additionally, a quarter of foster care youth reported attempting suicide by the time they were 17.5 years old.

YOUTH EXPERIENCING HOMELESSNESS

For unhoused youth, the rate of self-injury, suicidal ideation, and suicide attempts is over two times greater than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorder, and post-traumatic stress disorder. One study found that more than half of runaway and unhoused youth experience suicidal ideation.

RACIAL AND ETHNIC MINORITY YOUTH

AMERICAN INDIAN/ALASKA NATIVE (AI/AN) YOUTH

In 2017, the rate of suicide among AI/AN youth ages 15-19 was over 1.6 times that of the general youth population. Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see ihs.gov/suicideprevention.

BLACK YOUTH

Among Black populations, suicide rates peak during adolescence and young adulthood, then decline. This is a different pattern than is seen in the overall U.S. population, where suicide rates peak in midlife. A particularly important risk factor associated with suicide behavior among Black youth is exposure to racism and trauma. Black youth who experience racism often feel alienated, rejected by society, ignored, marginalized, depressed, and anxious.

LATINO/A/X YOUTH

Suicide and suicide attempts are especially concerning among Latinx adolescent girls, who have the highest suicide rates among all adolescent groups nationwide. Statistics reveal that in the United States, 15.6% of Latinx adolescent girls have attempted suicide one or more times and 25% have thought about it. Risk factors include alienation - including disconnection from family or family origin, acculturative stress and family conflict, hopelessness and fatalism, discrimination, and racism.

ASIAN YOUTH

For Asian Americans and Pacific Islanders between the ages of 15 and 19, suicide was the leading cause of death in 2016, according to CDC data, accounting for 31.8 percent of all deaths. Asian youth may be susceptible to different risks than other racial/ethnic groups, such as ethnic and cultural socialization or orientation, poverty, education related stress, familialism, discrimination, and acculturation that can take root at a young age, affecting mental health outcomes.

LGBTQ+ (LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER OR QUESTIONING) YOUTH

The CDC finds that LGBTQ+ youth are 4.5 times more likely, and questioning youth are over twice as likely to consider attempting suicide as their heterosexual peers. One study found that 40 percent of transgender people attempted suicide

sometime in their lifetime — of those who attempted, 73 percent made their first attempt before the age of 18. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental health condition), these experiences can place them at increased risk. It is not their sexual orientation or gender identity that place LGBTQ+ youth at greater risk of suicidal behavior, but rather these societal and external factors: the way they can be treated, shunned, abused, or neglected, in connection with other individual factors such as mental health history.

YOUTH BEREAVED BY SUICIDE

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are nearly four times as likely to attempt suicide themselves.

YOUTH LIVING WITH MEDICAL CONDITIONS OR DISABILITIES

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive delays that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

Comprehensive Suicide Prevention Plan Components

Prevention

Bend-La Pine Suicide Prevention Trainings/Curricula/Resources

STAFF		
Prevention Effort	Description	Target Audience
QPR	Question, Persuade, Refer 1.5 hour training where participants learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. All building staff are trained every 3 years.	All Bend-La Pine staff, every 3 years, by building (or department, such as transportation)
ASIST	Applied Suicide Intervention Skills Training is a two-day course helping better understand ways that personal and societal attitudes affect views on suicide and interventions, provide guidance and suicide first aid to a person with thoughts of suicide that meet their individual safety needs, and identify the key elements of an effective suicide safety plan as well as the actions required to implement the plan. This suicide prevention protocol first responder training has a 5-year cycle.	Trained Risk Screeners: Licensed school counselors or social workers, Licensed school psychologists, clinically trained staff, school nurses
CALM	Counseling on Access to Lethal Means Suicide prevention first reponder training; allows greater competency in describing strategies for raising the topic of lethal means and explaining to stakeholders that reducing access to lethal means is an evidence based strategy for suicide prevention.	Licensed school mental health staff who safety plan with students: Licensed school counselors or social workers, Licensed school psychologists, clinically trained staff. 5 year cycle.

Connect Postvention	4-6 hour training designed to teach staff best practices on how schools can respond to a sudden death, which includes suicide, in order to prevent contagion and promote healing.	Crisis Response and Support Team, District Leadership
Sources of Strength Adult Advisor	A 4-6 hour training for admin and staff who are working with Peer Leaders in their school. The adults are trained to implement Sources of Strength to fidelity with the evidence-based program, which includes facilitating Peer Leader meetings and mentoring Peer Leaders through implementing school-wide safe messages of hope, help, and strength.	Any adults in the school buildings who work with small groups of students promoting student mental health school-wide.

Students		
Prevention Effort	Description	Target Audience
Teaching Curricula aligned with Oregon Standards Based Health Instruction	6th grade: Look, Listen, and Link; Wayfinder 7th grade: Red Flags; Wayfinder 8th grade: SOS; Wayfinder 9th grade: RESPONSE 3rd edition 10th grade: SOS High School Version Erika's Lighthouse can be field tested for grades 6-12.	Secondary Students
Sources of Strength	A best practice youth mental health promotion and suicide prevention program designed to harness the power of peer social networks to create healthy norms and culture,	Secondary Students

	ultimately preventing suicide, violence, bullying, and substance misuse.	
Student iPad apps for safety (9-12)	First Step Oregon: resource and tool for youth needing help for themselves or a friend. Resources include Youthline, Safe Oregon Tip Line and 988.	Students

Parents		
Prevention Effort	Description	Target Audience
Bend – La Pine Schools website	Mental Health Resource Page Curated links to local and national resources for suicide prevention and intervention, including crisis intervention information.	Parents

Intervention

Our School Community		
Intervention Effort	Description	Target Audience
Care Solace: 24/7/365 mental health care coordination service; 200+ languages spoken	Care Solace for BLS	Students, Families, Staff

Staff Response:

If a suicidal attempt, gesture, or ideation occurs or is recognized, staff will ensure the supervision of the student and report it to ASIST trained school staff member or a school administrator right away. If there is imminent danger, staff will call 911. Staff will use the C-SSRS: Screener with Triage for Schools (The Columbia-Suicide Severity Rating Scale) to screen for suicidal ideation and determine course of action, following the BLS Suicide Risk and Response Protocol.

Suicide Risk Concern Flowchart

Student Re-Entry

Developing a Re-Entry Plan

The re-entry process occurs after a student has been hospitalized for an attempt or has been out of school for a mental health crisis. Students who have made a suicide attempt are at a higher risk of re-attempting during the first 90 days after the attempt unless all members of the student's team (parents, caregivers, school staff, outside mental health professionals, etc.) work together utilizing evidence-based prevention protocols to monitor the student and establish a support system. It is critical to connect the student, their parents or caregivers, the student's mental health team, and the school counselor so that all pertinent information flows openly and a safety net is created.

The Re-Entry Meeting and/or School Safety Plan is scheduled by the designated school counselor or school based mental health staff with the student, parent, caregiver, nurse (if necessary) and administrator. The district Suicide Prevention Coordinator may be available to help, as needed, to complete the Safety Plan.

1. A re-entry meeting should occur when students are returning to school following a suicide attempt as a best practice approach contributing to student safety.
2. The Safety Plan should be completed upon the student's return to school, prior to attending classes. The team will agree which staff members need to be informed about the safety plan in order to keep the student safe at school.

Postvention

Bend – La Pine Suicide Crisis Response Protocol

Deschutes County Health Department Prevention and Promotion: Jessica Jacks, Caroline Suiter
District Director of Safety: Julianne Repman
District Director of Communication: Scott Maben
Executive Director Student Services & District Crisis Response Team Lead: Sean Reinhart

Definition of a crisis: The definition of crisis response is a course of action for dealing with an emergency situation. Intervention is designed to restore a school and community to baseline functioning and to help prevent or mitigate damaging psychological results following a disaster or crisis situation. It is important that during the immediate hours and days following a crisis, students and staff are helped to return to previous emotional equilibrium. If left unchecked, some emotional responses may become internalized and exhibit themselves in unusual behaviors. It is a team approach to assist in the healing process of students and staff following a traumatic event or incident.

District Protocols: In the event of any crisis in which a near death, suicide, or sudden death (in which the cause of death is unavailable) event occurs that impacts students, staff or part of the school community, please follow the following postvention response procedures.

Postvention of a suicide is to assure that focus on promoting healing and reducing risk is a priority, and is mandated by the State of Oregon, ORS 418.735. It is about engaging and building capacity for key service providers who will be involved in a response to a completed suicide. Individuals who know someone who has died by suicide are statistically at higher risk for dying by suicide. Providing individuals and communities with timely and appropriate postvention activities and interventions

not only offers support to help survivors of suicide of loss grieve and promote community healing but can also serve as a vehicle to reduce the risk for further suicide incidents. The District will activate a long term postvention plan that will include key service providers.

Notification: Once information has been verified, notification to community partners will take place immediately. (See Deschutes County Postvention plan)

Postvention planning will include:

- Understanding the risk of contagion and promoting strategies for reducing this risk.
- Understanding warning signs in persons who may be at risk after a suicide death help audiences understand best practices for effective suicide response.
- Helping the survivors of suicide loss deal with the loss and grief in an appropriate way.
- Addressing cultural factors that involve the survivors and students at high risk.
- Engaging with community partners to provide additional supports to students and families.
- Provide communication of a suicide in a safe and effective response after a suicide.
- Provide communication points that are appropriate and safe.
- Coordinate community meetings if deemed appropriate to educate community members about risk and warning signs.
- Coordinate community gatherings as a resource and opportunity for education, healing and concerted effort to strengthen protective factors and reduce risk factors.
- Coordinate with community partners such as clergy leaders to offer immediate support to the family, especially if restoration services are needed for the home.
- Be sensitive to staff and response team's need to grieve and need for assistance.
- Recognize the impact lasts for months and years.

BLS Sudden Death Postvention Response Procedures

🔲 School administrator or other is notified of suspected or known student/staff death by sudden death. The building administrator notifies the Director of Safety.

🔲Director of Safety or designated personnel confirms the cause of death through law enforcement and Deschutes County Health Services Postvention Response Lead.
(If death occurs on campus, refer to BLP Emergency Operation Plan: Health and Medical Annex for immediate response)

🔲Director of Safety notifies the Superintendent, level leader, and the District Crisis Response Lead of confirmed death.

🔲District Crisis Response lead notifies members of district response team (student services and communications) and activates crisis response.

🔲 District Crisis Response Team Lead contacts building Principal/Administrator to discuss the response, estimate level of need or response resources required, determines what information is to be shared, and offers general guidance about the postvention response.

🔲School Administrator or designee mobilizes the Crisis Response and Support Team.
BLS CRST intake form

🔲School Administrator or designee communicates with the family to offer condolences and determines their wishes for communication about the death.

🔲The communications office prepares any media statements if applicable.

🔲 District crisis response lead or designee, school administrator/leadership, district communications, deschutes county postvention lead meet to plan response logistics and considerations for:

- potentially at-risk students and staff, e.g., those knowledgeable about or connected to the deceased.
- gather input on concerns from teachers and staff
- determine list of folks and other impacted school staff that need to be notified of death (i.e transportation, behavioral health partner, SBHC staff)

...and develop safe messaging scripts for:

- Stand up staff meeting and/or email
- Parent letter and community members
- Script for staff to read to students in class
- Messaging for secretaries and front office staff
- Talking points for staff to discuss with students

🔲Staff and family letters are sent out at designated time. Once the staff letter is sent, all school principals and all school counselors are sent a copy of the staff letter for situational awareness.

🔲Administrator holds all-staff or stand-up meeting as soon as possible and distributes scripts and other resources for teachers/staff to use.

🔲Building teachers/staff, as directed by the administrator, notify students, and distributes any needed notifications or resource handouts.

🔲The district communications team monitors media information, including social media.

🔲Crisis response activities are held during the school day.
BLS Crisis Response and Support Team Manual Resources

🔲The principal/administrator holds end-of-day meeting with the crisis response team, provides communication with staff, and determines any follow-up resources or coordination needed to support students or staff.

🔲The principal/administrator communicates needs for follow up to the District Response Lead and crisis team response lead (if applicable).

🔲The crisis response team lead documents the date of death and identifies school needs (e.g. internal/external communications, on-site supports, follow-up intervals etc.) for the 3-month and prior to the 1 year and future anniversaries to promote awareness and sensitivity to students and staff potentially impacted.

Bend LaPine Schools Crisis Response Team 2023-2024	
Name, Role	**Contact**
Scott Bojanowski, Asst. Director of Safety	541-355-1011
Sean Reinhart, District Crisis Response and Support Team Lead	541-355-1060
Scott Maben, Director of Communications	541-355-1006

Memorialization

- **Memorials:** BLS Executive Director of Student Services and the School Principal will address the content and timing of memorializing the event. Immediate issues, such as how to formally convey condolences to family survivors on behalf of the school, are appropriately addressed after receiving input from the school community. BLS Policy on memorials can be viewed here.
    - Spontaneous memorials may be created by students. These memorials often are set up by a locker and/or school rock or such. Often memorials are set up at the site where the death occurred. The school's goals should be to balance the students' needs to grieve with the goal of limiting the risk of inadvertently glamorizing the death. **In all cases, memorializing will be considered equally** and the following items should be considered:
        - Location: Areas to avoid are generally locations such as cafeteria and entry ways - so that those who don't wish to participate don't have to. Oftentimes lockers are the key area for such memorialization but should not be cordon off which would merely draw excessive attention to it. Also consider students whose lockers are nearby, suggesting moving to a temporary locker elsewhere if needed. Preferably located close to the counselor office.
        - Emptiness of the deceased student's chair can be unsettling and evocative, after approximately 5 days (or after the funeral), at that point it is suggested to set up a new seating arrangement to create a new environment. Teachers should always explain in advance that the intention is to strike a balance between

compassionately honoring the student who has died while at the same time returning the focus back to the classroom curriculum.

- It is recommended that schools discourage requests to create and distribute t-shirts, buttons that bear image of the deceased, this includes numbers on helmets or on jerseys.
- Cross cultural considerations should be accepted and responders need to accommodate requests to the best of their ability.
- Students may hold spontaneous gatherings or candlelight service. Schools should discourage these gatherings unless they are well supervised by staff and crisis team members. This would be a great role for any community clergy members who are part of the crisis team.
- Timing: Schools can leave such memorials in place until after the funeral or memorial service, up to approximately 5 school days. Items should then be removed and offered to the family after the Crisis Team has read all items for appropriateness and to consider students at risk.
- Avoid flying the flag at half-staff.

- **Permanent Memorials and Scholarships:** Some families and/or communities wish to establish a permanent memorial, sometimes physical, such as planting a tree or installing a bench or plaque; sometimes commemorative, such as a scholarship. It is highly recommended that all memorials be established off school grounds. As difficult as this can be, schools can plan an important role in channeling the energy and passion of the students and greater community in a positive direction, balancing the need to grieve with the impact that the proposed activity will likely have on students, particularly those who were closest to the student or staff member who died.

- **Safe memorialization ideas:**

    - Holding a day of community service or creating a school-based community service program in honor of the deceased (great suggestion for athletic teams or other extracurricular groups)
    - Putting together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations; i.e., out of the darkness walks, or holding a local fundraising event to support a local crisis hotline or other suicide prevention program
    - Sponsoring a mental health awareness day
    - Purchasing books on mental health for the school or local library

- **Funerals and Memorial Services:** Encourage services to occur at a location outside of the school if possible. Encourage services to occur at a time when parents and caregivers can accompany youth. Do not close school for a memorial service and it is encouraged to have additional counselors or crisis team members attend if possible.

- **School Newspapers and Yearbooks:** The guiding principle is that all deaths should be treated the same way. So if there is a history of dedicating the yearbook (or a page of the yearbooks) to students who have died, that policy is equally applicable to a student who has died by suicide, provided that the final decisions are made by a school administrator.
    - Coverage of the student's death in a school newspaper may be seen as a kind of memorial; also articles can be used to educate students about suicide warnings signs and available resources. All articles should be reviewed by a school administrator with the considerations of safe messaging practices. (see safe messaging document)

- **Events:** The student's family or classmates may wish to dedicate an event (such as a dance, performance, concert, or sporting event) to the deceased.

The recommendation is that all deaths should be treated the same way. It is also highly recommended to not use the aftermath of a completed suicide as a time to promote suicide prevention. Having speakers present to students about suicide actually puts high risk students at a higher risk of acting on their own suicidal thoughts.

- **Graduation:** Many times parents of deceased children would like an empty chair for their child placed amongst the graduation class, or a portrait placed, or a jersey, or some kind of tribute. The recommendation is to include the name of the deceased in the graduation program, along with the dates of his/her life. During the opening remarks by the administrator, a brief statement can be made acknowledging students who have died. Again, all deaths should be treated the same way. Empty chairs and portraits and tributes should not be part of the graduation ceremony. If it is customary to hang student collages during a celebratory event it is acceptable to hang one of a deceased student as long as no reference to suicide or cause of death.

Resources

After a Suicide Toolkit, 2nd Edition:

This second edition of After a Suicide: A Toolkit for Schools was written in 2018 by the American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC), Education Development Center (EDC).

Recommended Local Mental Health Resources

Recursos Recomendados De Salud Mental

Bend - La Pine Schools Student Mental Health Resources

Care Solace Mental Health Care Coordination Service for Bend-La Pine Students, Staff, and their Families

Acknowledgements

About this Guide

In 2009, Deschutes County received a Garrett Lee Smith Memorial Act Youth Suicide Prevention Grant award from the Oregon Health Authority. The funding required the Deschutes County Children & Families Commission and Health Services to work in partnership with the community and four high schools to implement a comprehensive approach to suicide prevention in schools and to bring awareness to the community. This guide is the result of that partnership and can be applied to any school district seeking to proactively address suicide. Information for this guide was derived from resources that uphold evidence based approaches. For more information please contact the Deschutes County Prevention Coordinator at 541-322-7420.

Acknowledgments

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Deschutes County Suicide Prevention Program
Bend-La Pine Schools Student Services Team

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