Suicide rates for adolescents have risen more than 300% since the 1950s, yet the rates for the population in general have remained relatively stable (King, 2001). In 1997, the suicide rate among 15- to 24-year-olds was 11.4 per 100,000 (King, 1997). Almost 86% of all suicides by youths under the age of 20 occur in 15- to 19-year-olds (National Center for Health Statistics, 1996) and estimates of completed youth suicides range from 7,000 to 9,000 a year. Even more alarming is the fact that, for every youth suicide, there are between 100 to 200 youth suicide attempts in this country (National Center for Health Statistics, 1992). Since a
A teacher in a typical U.S. high school classroom can expect to have at least one young man and two young women who attempted suicide in the last year (King, 2000), many states are requiring that schools include guidelines for suicide prevention, crisis management, and postvention in their written tragedy-response plans. In addition, a number of states require that all school faculty, administration, and staff participate in workshops that address the parameters of youth suicide and provide school personnel with information about risk factors and signs and symptoms as well as direction for the protocol to be followed when youth are identified as being at risk of self-harm.

Typically, school counselors are an integral part of school-based suicide prevention, crisis management, and postvention efforts, and the increased involvement with this segment of a school's population presents a number of legal and ethical challenges to counselors as well as other school faculty, administration, and staff. What are the ethical obligations of school counselors and other school personnel once a youth has been identified as potentially suicidal or has attempted or completed suicide? What are the roles of faculty, staff, and administrators and how do their roles differ from those of the school counselor and crisis team member? How do schools work with parents and guardians of minors to ensure that an appropriate constellation of services is provided for a suicidal youth? Can the school or school district be sued by families after an attempted or completed youth suicide?

The purpose of this article is to answer these questions by addressing "best practices" in the process of providing suicide prevention programs in schools. Best practices are the aspirational standards an ethical and well-informed school counselor should strive to attain in the process of planning and implementing school-based prevention, crisis management, and postvention efforts. They can be distinguished from minimally acceptable practices which, though meeting most legal standards, may not provide maximum protection to students and their families.

Since best practices, both legal and ethical, are always informed by awareness of the guidelines that theory and research provide, a brief overview of some of the literature available to school counselors on the topics of ethnic and gender differences, methods, risk factors, precipitants of acts of self-harm, myths, and the profile of a potentially suicidal adolescent is provided. This is followed by a description of best practices for creating and implementing prevention, crisis management, and postvention programs. The article concludes by highlighting the most important legal implications for school counselors' roles.
Background

The information needed by counselors prior to planning and implementing a suicide prevention, crisis management, and postvention program for a school or school district is extensive. Such information is available to counselors through a variety of resources. Ethnic and gender differences, methods, risk factors, precipitants of attempts and completions, myths, and the possible "profile" of a suicidal youth are the topics that must be studied by school counselors interested in reaching out to this at-risk population. These topics are briefly reviewed for the purpose of providing school counselors with the background needed to meet the legal and ethical challenges they will encounter when counseling potentially suicidal students. Counselors may use the articles and books cited in this section for further study.

Ethnic and Gender Differences

Some studies on youth suicide report that the suicide rate is higher among adolescent males than among females (although adolescent women attempt three to four times as often as adolescent men). Caucasian, adolescent males complete suicide more often than any other ethnic group (Canetto & Sakinofsky, 1998; Metha, Weber, & Webb, 1998; Popenhagen & Qualley, 1998).

Although a number of explanations have been proposed to account for the differences in rates among genders and races, no clear answers have been found. Some models used to explain racial differences in suicide have suggested that the extreme stress and discrimination that African Americans in the United States confront helps to create protective factors such as extended networks of social support, that lower the risk and keep the suicide rates for African American adolescents lower than those of Caucasian adolescents (Bush, 1976; Gibbs, 1988). Despite the overall pattern suggested by the data, during the period between 1980 and 2000, the suicide rates for African American adolescent males showed an increase of over 300% in the 10-14 age group and an increase of approximately 200% in the 15-19 age group (Metha et al.; Speaker & Petersen, 2000).

The literature on youth suicide continues to document the fact that Native Americans also have high adolescent suicide rates in the United States. There is considerable variability across tribes. The Navajos, for example have suicide rates close to the national average of 11 to 13
per 100,000 of the population; some Apache groups have rates as high as 43 per 100,000 (Berlin, 1987). The high suicide rates in the Native American population have been associated with factors such as alcoholism and substance abuse, unemployment, availability of firearms, and child abuse and neglect (Berman & Jobes, 1991). In general, less traditional tribes have higher rates of suicide than do more traditional tribes (Wyche, Obolensky, & Glood, 1990). Suicide rates for both Asian-American and Hispanic-American adolescents continue to be lower than those for African-American and Native-American youth even though the 1980-1994 time period bore witness to much higher rates than previously recorded (Metha et al, 1998).

Methods

The use of firearms outranks all other methods of completed suicides; firearms are used by both genders. Studies in the United States show that availability of guns increases the risk of adolescent suicide (Brent et al., 1993; King, 2000). The second most common method is hanging and the third most common is gassing. Males use firearms and hanging more often than do females, but females use gassing and ingestion more often than do males for completed suicides (Berman & Jobes, 1991). The most common method used by suicide attempters is ingestion or overdose of medicine.

Risk Factors

As noted by Garland and Zigler (1993) and Shaffer and Craft (1999), the search for the etiology of suicide spans many areas of study. Studies of counselor awareness of risk factors continue to take place (King, 2000). Examples of risk factors that have been studied include neurotransmitter imbalances and genetic predictors, psychiatric disorders, poor self-efficacy and problem-solving skills, sexual or physical abuse, concerns over sexual identity or orientation, availability of firearms, substance abuse, violent rock music, divorce in families, unemployment and labor strikes, loss, disability, giftedness, and, interestingly, phases of the moon. It is important for school counselors to note that almost all adolescent suicide victims have experienced some form of psychiatric illness. The most prevalent psychiatric disorders among adolescents who have completed suicide appear to be affective disorders, conduct disorders or antisocial personality disorders, and substance abuse disorders (Shaffer, 1988: Shaffer & Craft). Among affective disorders, particular attention should
be paid to bipolar illness and depressive disorder with comorbidity such as attention deficit disorder, conduct disorder, or substance abuse disorders (Rohde, Lewinsohn, & Seeley, 1991).

The suicide of a family member or a close friend of the family can also be a risk factor for youth suicide. Prior attempts also escalate risk and are still the best single predictors (Shaffer, Garland, Gould, Fisher, & Trautman, 1988). An adolescent experiencing a physical illness that is chronic or terminal can also be at higher risk (Capuzzi, 1994). Many researchers have studied cognitive and coping-style factors (e.g., generalized feelings of hopelessness and poor interpersonal problem-solving skills) as risk factors for youth suicide (Garland & Zigler, 1993). High neuroticism and low extraversion, high impulsiveness, low self-esteem, giftedness, disability, and an external locus of control have also been studied and can be used to predict risk (Beautrais, Joyce, & Mulder, 1999).

Precipitants

Often, attempted or completed suicide is precipitated by what, to the adolescent, is interpreted as a shameful or humiliating experience (e.g., failure at school or work, or interpersonal conflict with a romantic partner or parent). Mounting evidence indicates that adolescents who do not cope well with major and minor life events and who do not have family and peer support are more likely to have suicidal ideation (Mazza & Reynolds, 1998). The humiliation and frustration experienced by some adolescents struggling with conflicts connected with their sexual orientation may precipitate suicidal behavior (Harry, 1989; McFarland, 1998), although being gay or lesbian in and of itself may not be a risk factor for suicide (Blumenthal, 1991). Hoberman and Garfinkel (1988) found the most common precipitant of suicide in a sample of 229 youth suicides to be an argument with a boyfriend, a girlfriend, or a parent (19%), followed by school problems (14%). Other humiliating experiences such as corporal punishment and abuse also serve as precipitants; the experience of sexual or physical assault seems to be a particularly significant risk factor for adolescent women (Hoberman & Garfinkel).

Myths

One of the biggest problems connected with youth suicide is the fact that parents, teachers, mental health professionals, and the adolescent
population itself are not made aware of a variety of myths and misconceptions associated with this topic. Since subsequent discussion of best practices for prevention, crisis management, and postvention in this article is based on prior awareness of this topic, the reader is referred to Capuzzi and Gross (2000) for a more complete discussion of the following myths:

- Suicide is hereditary
- Suicide happens with no warning
- Adolescents from affluent families attempt or complete suicide more often than adolescents from poor families
- Once an adolescent is suicidal, he or she is suicidal forever
- If an adolescent attempts suicide and survives, he or she will never make an additional attempt
- Adolescents who attempt or complete suicide always leave notes
- Most adolescent suicides happen late at night or during the pre-dawn hours
- Never use the word suicide when talking to adolescents because using the word gives some adolescents the idea
- Every adolescent who attempts suicide is depressed.

The Profile

The suicidal profile has been analyzed from the perspectives of both the practicing counselor or mental health practitioner and that of the empirically based researcher. Although no constellation of traits and characteristics has been identified as predictive of suicidal attempts, a number of experts (Beautrais et al., 1999; Capuzzi, 1994; Capuzzi & Golden, 1988; Capuzzi & Gross, 2000; Curran, 1987; Davis; 1983; Hafen & Frandsen, 1986; Hussain & Vandiver, 1984; Johnson & Maile, 1987; Mazza & Reynolds, 1998) believe that about 90 percent of the adolescents who complete suicide (and lethal first attempts can result in completions) give cues to those around them in advance. Whether these cues are limited or numerous will depend on the adolescent, since each adolescent has a unique familial and social history. It is important for school counselors and other school personnel to recognize the signs and
symptoms to facilitate prevention efforts. One of the essential components of the best practices discussed in a subsequent section of this article is teaching the profile of the suicidal or potentially suicidal youth so that referral and intervention can take place. Behavioral verbal, and cognitive cues and personality traits are the four areas around which counselors can make observations to base their assessments of the extent of suicidal ideation and risk. They are presented below in abridged form. The reader is referred to Capuzzi and Gross (2000) for more extensive description and discussion.

Behaviors

A number of common behaviors can be noted by counselors and other practitioners as possible cues: lack of concern about personal welfare; changes in social patterns; a decline in school achievement; altered patterns of sleeping and eating; attempts to put personal affairs in order or to make amends; use or abuse of alcohol or drugs; unusual interest in how others are feeling; preoccupation with death and violence themes; sudden improvement after a period of depression; and sudden or increased promiscuity.

Verbal Cues

As noted by Schneidman, Farbverow, and Litman (1976), verbal statements can provide cues to self-destructive intentions. Such statements should be assessed and considered in relation to factors such as behavioral signs, changes in thinking patterns, motivations, and personality traits. There is no "universal" language or "style" for communicating suicidal intention. Some adolescents will openly and directly say something like "I am going to commit suicide" or "I am thinking of taking my life." Others will be far less direct and make statements such as "I'm going home," "I wonder what death is like," "I'm tired," "She'll be sorry for how she has treated me," or "Someday I'll show everyone just how serious I am about some of the things I've said."

Thinking Patterns and Motivations

In addition to behavioral and verbal cues, thinking patterns and motivations of suicidal adolescents can also be assessed and evaluated. For such an assessment to occur, it is necessary to encourage
self-disclosure to learn about changes in an adolescent's cognitive set and distortions of logic and problem-solving ability. As noted by Velkoff and Huberty (1988), the motivations of suicidal adolescents can be understood more readily when suicide is viewed as fulfilling one of three primary functions: (a) an avoidance function that protects the individual from the pain perceived to be associated with a relationship or set of circumstances; (b) a control function that enables an adolescent to believe he or she has gained control of someone or something thought to be out of control, hopeless or disastrous; and (c) a communication function that lets others know that something is wrong or that too much pain or too many injuries have been accumulated.

Personality Traits

As previously noted, it would be ideal if the research on the profile of the suicidal youth provided practitioners with such a succinct profile of personality traits that youth at risk for suicide could be identified far in advance of any suicidal risk. Adolescents who fit the profile could then be assisted through individual and group counseling or other means. Although no consensus has yet been reached on the "usual," "typical," or "average" constellation of personality traits of the suicidal adolescent, researchers have agreed on a number of characteristics that seem to be common to many suicidal youth. Among these are low self-esteem, hopelessness/helplessness, isolation, high stress, need to act out, need to achieve, poor communication skills, other directedness, guilt, depression, and poor problem-solving skills.

Best Practices

At the end of the introduction to this article, four questions were posed that relate to the legal and ethical challenges in counseling suicidal students. The first three of these questions (What are the ethical obligations of school counselors and other school personnel once a youth has been identified as potentially suicidal or attempted or completed suicide?, What are the roles of faculty, staff, and administrators, and how do their roles differ from those of the school counselor or crisis team member?, and How do schools work with parents and guardians to ensure that an appropriate constellation of services is provided for a suicidal youth?) are addressed through brief descriptions of school preparedness for prevention, crisis management, and postvention.
Prevention

Since a growing number of legal opinions have indicated that unanticipated acts of violence in schools (and suicide is an act of violence) can be predicted (Hermann & Remley, 2000), courts, in the future, probably will expect schools to have prevention programs in place. If they do not, courts may hold the schools accountable for suicides. A number of steps must be taken to facilitate a successful school-community prevention effort. Communication with administrators, faculty/staff in-service, preparation of crisis teams, providing for individual and group counseling options, parent education, and classroom presentations are necessary to fulfill ethical obligations and to delineate roles.

Communication with administrators. There is a compelling need for prevention, crisis management, and postvention programs for the adolescent suicide problem to be implemented in elementary, middle, and high schools throughout the country (Metha et al., 1998; Zenere & Lazarus, 1997). One of the biggest mistakes made by counselors, educators, and coordinators' of counseling/student services is to initiate suicide prevention programs without first obtaining the commitment and support of administrators and others in supervisory positions. Building principals and superintendents must be supportive; otherwise efforts may not be effective.

In addition to the groundwork that must be done on the building level, it is also important to effect advance communication and planning on the district level. The superintendent, assistant superintendent, curriculum director, staff development director, student services coordinator, research and program evaluation specialist, must all commit their support to intervention efforts.

Faculty/staff in-service. Since teachers and other faculty and staff usually learn of a student's suicidal preoccupation prior to the situation being brought to the attention of the school counselor or another member of the crisis team (assuming such a team exists), all faculty and staff (e.g., teachers, aides, secretaries, administrators, custodians, bus drivers, food service personnel, librarians, school social workers) must be included in building or district level in-service on the topic of youth suicide. All should be taught the background information previously delineated so that they can make referrals to the school counselor. It is imperative that all adults in schools be educated about both youth suicide and building and district policies and protocols for prevention, crisis management, and
postvention. They must be cautioned against attempting to provide personal counseling; their roles are to recognize risk and facilitate referrals. A growing number of publications provide excellent guidelines for elements of prevention programming focused on school faculty and staff (Davidson & Range, 1999; Metha et al., 1998; Zenere & Lazarus, 1997).

Preparation of crisis teams. Most schools have crisis teams composed of faculty, staff, and parents connected with a particular building. These teams often exist in conjunction with a program for the prevention and intervention efforts necessary to cope with the drug problem among young people in today's schools. With education beyond that which is provided during faculty/staff in-service programs discussed previously as well as additional supervision and evaluation of clinical skills, a crisis team can be taught how to facilitate prevention efforts in a school as well as how to respond to a student already experiencing a suicidal crisis or in need of postvention efforts.

Individual and group counseling options. Prior to providing students with any information about suicide and suicide prevention efforts in a school, arrangements must be made for the individual and group counseling services that will be needed by those who seek assistance for themselves or their friends. School counselors rarely have the opportunity to provide the counseling needed by students identified as potentially suicidal because of other responsibilities as well as very high student-to-counselor ratios. Unless such counseling options are available, any effort at prevention, crisis management, or postvention will be doomed to failure.

If the school district cannot make a commitment to providing counseling, then arrangements for referral to community agencies and private practitioners must be made. It is important to provide adolescents and their families with a variety of referral possibilities along with information on fee schedules. There may be some question about whether the school district will be liable for the cost of such counseling if the referral is made by the school. (This issue should be explored by whatever legal counsel is retained by the district.) The dilemma, of course, is that unless counseling takes place when a suicidal adolescent has been identified, the probability is high that an attempt or a completion will take place. If the school is aware of a teenager's suicidal preoccupation and does not act in the best interests of such a teenager, families may later bring suit against the district.

Parent education. Parents of students in a school in which a suicide prevention program is to be initiated should be involved in the school's efforts to educate, identify, and assist young people in this respect.
Parents have a right to understand why the school is taking such steps and what the components of a school-wide effort will be. Evening or late afternoon parent education efforts can be constructive and engender additional support for a school or school district. Parents have the same information needs as faculty and staff with respect to the topic of adolescent suicide.

Classroom presentations. Debate continues surrounding the safety of adolescent suicide prevention programs that contain an educational component presented to adolescents. This debate is similar to the one that emerged years ago when schools initiated staff development and classroom presentations on the topic of physical and sexual abuse. In conjunction with this debate, a number of advocates of education and discussion efforts are focused on students in a school-wide suicide prevention effort (Capuzzi, 1988, 1994; Capuzzi & Golden, 1988; Curran, 1987; Ross, 1980; Sudak, Ford, & Rushforth, 1984; Zenere & Lazarus, 1997). These advocates recommend providing an appropriate forum in which adolescents can receive accurate information, ask questions, and learn about how to obtain help for themselves and their friends. They believe that doing so does not precipitate suicidal preoccupation or attempts (Capuzzi; Capuzzi & Gross, 2000).

A carefully prepared and well-presented classroom presentation made by a counselor or member of the school's crisis team is essential. Such a presentation should include both information on causes, myths, and symptoms as well as information about how to obtain help through the school. Under no circumstances should media be used in which adolescents are shown a suicide plan.

On the elementary level, school faculty should not present programs on the topic of suicide prevention. Their efforts are better focused on developmental counseling and classroom presentations directed at helping children develop resiliency and overcome traits (e.g., low self-esteem or poor communication skills) that may put them at risk for suicidal behavior at a later time. Although these efforts should be continued through secondary education, middle and high school students are better served through presentations that address adolescent suicide directly.

Crisis Management

School counselors often receive student referrals from other adults in the building when the student is thought to be experiencing a suicidal crisis. The principles delineated below are shared for the purpose of providing succinct guidelines for a suicide-risk assessment so that
steps can be taken to prevent a possible attempt. Any assessment, phone call, or step taken in this context should be documented in case notes.

Remember the meaning of the term crisis management. When thinking of crisis management, it is important to understand the meaning of the word crisis as well as the word management. The word crisis means that the situation is not usual, normal, or average; circumstances are such that a suicidal adolescent is highly stressed and in considerable emotional discomfort. The word management means that the professional involved must be prepared to apply skills that are different than those required for preventive or postvention counseling. An adolescent in crisis must be assessed, directed, monitored, and guided for the purpose of preventing an act of self-destruction.

Be calm and supportive. A calm, supportive manner on the part of the intervener conveys respect for the perceptions and internal pain of an adolescent preoccupied with suicidal thoughts. Remember that such an adolescent usually feels hopeless and highly stressed. The demeanor and attitude of the helping person are pivotal in the process of offering assistance.

Be nonjudgmental. Statements such as "You can't be thinking of suicide, it is against the teachings of your church," or "I had a similar problem when I was your age and I didn't consider suicide" are totally inappropriate during a crisis situation. An adolescent's perception of a situation is, at least temporarily, reality and that reality must be respected.

Encourage self-disclosure. The very act of talking about painful emotions and difficult circumstances is the first step in what can become a long-term healing process. A professional helper may be the first person with whom such a suicidal adolescent has shared and trusted in months or even years, and it may be difficult for the adolescent to confide simply because of lack of experience with communicating thoughts and feelings. It is important to support and encourage self-disclosure so that an assessment of lethality can be made early in the intervention process.

Acknowledge the reality of suicide as a choice but do not "normalize" suicide as a choice. It is important for professionals to let adolescents know that they are not alone and isolated with respect to suicidal preoccupation. It is also important to communicate the idea that suicide is a choice, a problem-solving option, not a good choice, and that there are better choices and options.

Actively listen and positively reinforce. It is important, during the
Do not attempt in-depth counseling. Although it is very important for a suicidal adolescent to begin to overcome feelings of despair and to develop a sense of control as soon as possible, the emotional turmoil and stress experienced during a crisis usually makes in-depth counseling impossible.

Developing a plan to begin lessening the sense of crisis an adolescent may be experiencing is extremely important, however, and should be accomplished as soon as possible. Crisis management necessitates the development of a plan to lessen the crisis; this plan should be shared with the adolescent so that it is clear that circumstances will improve. In-depth counseling cannot really take place during the height of a suicidal crisis.

Do not do an assessment alone. It is a good idea to enlist the assistance of another professional, with expertise in crisis management, when an adolescent thought to be at risk for suicide is brought to a school counselor's attention. School counselors should ask a colleague to come into the office and assist with assessment. It is always a good idea to have the support of a colleague who understands the dynamics of a suicidal crisis; in addition, the observations made by two professionals are more likely to be more comprehensive. Since suicidal adolescents may present a situation that, if misjudged or mismanaged, could result in a subsequent attempt or completion, it is in the best interests of both the professional and the client for professionals to work collaboratively whenever possible. It should also be noted that liability questions are less likely to become issues and professional judgment is less likely to be questioned if assessment of the severity of a suicidal crisis and associated recommendations for crisis management have been made on a collaborative basis.

Ask questions to assess lethality. A number of dimensions must be explored to assess lethality. This assessment can be accomplished through an interview format (a crisis situation is not conducive to the administration of a written appraisal instrument). Readers are referred to Capuzzi and Gross (2000) for a complete description of the assessment process and a list and explanation of the questions. It is important to understand that the role of the school counselor and crisis team is to determine if a student is potentially suicidal. Once this determination has been made, the student should be reassessed by the agency identified
by the school district to make the final decision about the degree of risk for a suicide attempt or completion.

Make crisis management decisions. If, as a result of an assessment made by at least two professionals, the adolescent is thought to be potentially suicidal, the student should be seen by an outside agency. Under no circumstances should the student be left alone or asked to return home or meet with a mental health counselor without being accompanied by a parent or guardian.

Notify parents. Parents of minors must be notified and asked for assistance when an adolescent is determined to be at risk for a suicide attempt. Often, adolescents may attempt to elicit a promise of confidentiality from a school counselor who learns about suicidal intent. Such confidentiality is not possible or required (Remley & Herlihy, 2001); the welfare of the adolescent is the most important consideration.

Sometimes parents do not believe that their child is suicidal. At times, parents may be adamant in their demands that the school or mental health professional withdraw their involvement. Although some professionals worry about liability issues in such circumstances, liability is higher if such an adolescent is allowed to leave unmonitored with no provision for follow-up assistance. Schools should confer with legal counsel to understand liability issues and to make sure that the best practices are followed in such circumstances. It may be necessary to refer the student to protective services for children and families when parents or guardians refuse to cooperate.

Consider hospitalization. Hospitalization can be the option of choice during a suicidal crisis, if the parents are not cooperating, when the risk is high. An adolescent who has not been sleeping or eating, for example, may be totally exhausted or highly agitated. The care and safety that can be offered in a psychiatric unit of a hospital is often needed until the adolescent can experience a lowered level of stress, obtain food and rest, and realize that others consider the circumstances painful and worthy of attention. The protocol in the school and school district's written tragedy response plan should be followed in such circumstances. School counselors and crisis team members should not take it upon themselves to transport a student to the psychiatric unit of a local hospital; this should be facilitated by the staff of the agency the school collaborates with when such circumstances arise.

Refuse to allow the youth to return to school without an assessment by a mental health counselor, psychologist, psychiatrist, or other qualified professional. An increasing number of school districts are adopting this
policy. Although it could be argued that preventing a suicidal youth from returning to school might exacerbate suicidal ideation and intent, this policy increases the probability that the youth will receive mental health counseling and provides the school with support in the process of preventing the youth from engaging in self harm. Acquiring a release from a third party for a student's return also provides an element of protection in the event that an attempt or completion takes place at a later time and the family files a law suit.

Postvention

When an adolescent has attempted or completed a suicide, it is imperative, particularly in a school setting, for the counselors to be aware of the impact of such an event on the "system." Usually within just a few hours, the fact that an adolescent has attempted or completed suicide has been chronicled through the peer group. This could present a problem to the faculty and staff in a given school building since not answering questions raised by students can engender the sharing of misinformation or rumors. The following guidelines should prove helpful to school counselors in the process of planning and implementing postvention efforts:

• The principal of the building in which a student has attempted or completed suicide (even though such an incident most likely occurred off the school campus) should organize a telephone network to notify all faculty and staff that a mandatory meeting will take place prior to school the next morning. The principal should share information and answer questions about what happened during such a meeting. In the case of a suicide completion, it is recommended that the principal provide all faculty and staff with an announcement that can be read in each class rather than over a public address system, so that everyone in the school receives the same information. The announcement should confirm the loss and emphasize the services the school and community will be providing during the day and subsequent days. Details about the circumstances or the family of the deceased should not be given so that confidentiality is maintained in that regard.

• Faculty and staff should be instructed to answer student questions that spontaneously arise.

• Faculty and staff should be told to excuse students from class if they are upset and need to spend time in the office of the building counselor or another member of the crisis team.
• Parents who are upset by the suicidal incident should be directed to a designated individual to have questions answered. Parents should also be provided with options for counseling, whether this counseling is provided by school personnel or referred to members of the mental health community.

• At times, newspaper and television journalists contact the school for information about both the attempt or the completion and the school's response to the "aftermath." It is important to direct all such inquiries to a designated individual to avoid the problems created by inconsistency or sharing inaccurate information.

• Be alert to delayed or enhanced grief responses on the part of students prior to the anniversary of a suicide completion. Often students will need opportunity to participate in a support group with peers or individual counseling prior to and, perhaps, beyond the anniversary date.

• Do not conduct a memorial service on the school campus after a suicide because doing so may provide reinforcement to other students preoccupied with suicidal ideation. This means that it is unwise to conduct an on-campus memorial service after a death for any reason--it is difficult to explain why a student who has suicided is not being remembered when another student, faculty or staff has been memorialized previously. Excuse students to attend the off campus memorial or funeral. Do the same thing for deaths for other reasons.

• Early in the sequence of events, one or two individuals from the school should contact the family and ask if there is any support it might need that the school can provide. It is a good idea to offer such assistance periodically, since so many families are left alone with their grief once the memorial or funeral has taken place.

Additional Considerations

The fourth question posed in the beginning of this article is Can the school or school district be sued by families after an attempted or completed suicide? In a pertinent review of the results of school violence litigation against educators, Hermann and Remley (2000) noted that, even though school personnel are expected to exert reasonable care to prevent harm to students, courts have been reluctant to hold educators liable for injuries related to-violence or self-harm. Usually state law claims fail because so much of today's school violence (and suicide attempts and completions are components of school violence)
results from what can be termed spontaneous acts of violence. This statement should not, however, lull school personnel into a false sense of security, since a growing number of legal opinions have indicated that an unanticipated act of violence can be predictable and thus actionable under state law. Counselors, teachers, administrators, and other members of school staffs can protect themselves by writing and implementing prevention, crisis-management, and postvention policies and procedures for protecting youth from self-harm.

These policy and procedural documents should mandate in-service for school personnel so that all adults in the school environment recognize risk factors, myths, and possible behavioral, verbal, cognitive, and personality indicators as well as role responsibilities and limitations. Best practices are more likely to be followed if schools take a proactive rather than a reactive stance to this growing epidemic in our nation's schools.

Concluding Comments

Because of the legal and ethical considerations delineated in this article, counselors and other school personnel who are interested in learning how to identify potentially suicidal youth must obtain more extensive information than that provided here. In addition, since school counselors may need to provide follow-up supportive counseling once a suicidal youth returns to school, school counselors should obtain supervision from professionals who are experienced in working with suicidal youth after a suicidal crisis or a suicide attempt. Generally, prevention, crisis management, and postvention activities should not be attempted by anyone who has not completed a 2-year CACREP accredited or CACREP equivalent graduate program. Membership in the American Association of Suicidology or the American Foundation of Suicidology, participation in workshops and conferences focused on the topic of youth suicide, and consistent reading of the Journal of Suicide and Life Threatening Behavior and other books and journals is imperative so that best practices are followed in a way that ensures that legal and ethical standards are integrated into the prevention, crisis management, and postvention efforts of school counselors.

A youth who becomes suicidal is communicating the fact that he or she is experiencing difficulty with issues such as problem-solving, managing stress, and expressing feelings. It is important for school counselors to respond in constructive, safe, informed ways, because the future of their communities is dependent upon individuals who are positive, functional, and able to cope with the complex demands of life.
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