TOWNSHIP OF UNION BOARD OF EDUCATION
Union, New Jersey

Policy

FILE CODE: 5141.5
X Monitored
X Mandated
X Other Reasons

STUDENT SUICIDE PREVENTION AND CRISIS INTERVENTION

The Township of Union Board of Education recognizes that depression, self-destruction or possible harm to others are problems of potentially increasing severity among children and adolescents. A student under severe stress cannot benefit fully from the educational program and may pose a threat to himself/herself or to others. In response to this serious problem, the Board of Education has determined that our schools must be prepared to meet this challenge.

The Board of Education encourages all school personnel to be alert to the warning signs of childhood and adolescent depression or potential suicide and the procedures to follow in the event he or she becomes aware or suspects the existence of such a condition. School personnel shall respond to those signs in accordance with procedures established by the Superintendent.

In accordance with N.J.A.C. 6A:16-11.1(b), "The district board of education shall develop and adopt policies and procedures for school district employees, volunteers, or interns with reasonable cause to suspect or believe that a student has attempted or completed suicide, to report the information to the Department of Human Services, Division of Mental Health and Addiction Services, in a form and manner prescribed by the Division of Mental Health and Addiction Services pursuant to N.J.S.A. 30:9A-24.a."

The Superintendent shall establish guidelines and procedures to deal with these types of behaviors of students. In-service training will be organized by the Director of Special Services of at least two hours of suicide prevention and awareness instruction as part of the 100-hour professional development five-year cycle to individual teaching members by licensed health care professionals with training and experience in mental health. The school psychologist, school counselor, student assistance counselor, school social worker, and/or school nurse will assist staff to identify and deal with these conditions in the school environment and in the suicide intervention procedures. (Please refer to Appendix X for a glossary of terms)

Adopted: January 28, 2014
Revised: April 3, 2017
Readopted: November 21, 2017
Readopted: June 18, 2019

STUDENT SUICIDE PREVENTION AND CRISIS INTERVENTION

RESPONSIBILITY

In accordance with Board Policy, the Superintendent has established the following procedures for the instruction of students and staff in suicide prevention, for the identification of and intervention with students at risk for suicide and for the appropriate response to a suicide completion or threat of harm to others.

PROCEDURES

1. INSTRUCTION
   Teachers shall be guided by the health curriculum approved by the Board of Education. Current thinking concerning suicide prevention curriculum is as follows: Instruction specific to suicide should be approached cautiously. Emphasis should be on educating students on various mental health problems (such as drugs, alcohol, dependency and depression), their common symptoms, and how and where to get help.

2. IDENTIFICATION
   a. School personnel must take seriously all suggestions, demonstrations, or communications of suicide. Any indication that a student may be in potential danger or pose a threat to others shall be reported immediately. Confidentiality is superseded by the presence of any type of suicidal behavior or threat to others.
   b. An Intervention committee (IC) shall be established in each school building and shall consist of the principal, school psychologist, school social worker, school counselor, student assistance counselor (SAC), school nurse, and/or teacher(s) (if they are the referring agent). This committee will assist in the identification of at risk students and intervention on their behalf. Each building principal will provide the Superintendent of Schools, Supervisor of School Counseling, Supervisor of Nursing, Director of Special Services, and the members of the IC team with the names of the members of the IC team at the beginning of the school year in September.
   c. The staff will be made aware of signs of suicide risk and instructed in the suicide intervention procedures through in-service training. Warning signs of suicide are listed in Appendix I.

3. INTERVENTIONS

A. LEVEL ONE: Observation of behaviors or warning signs that indicate a student may be at risk of engaging in a suicidal act or pose a threat to others.

The staff member who has reason to believe that a student has destructive tendencies to self or others shall immediately notify the principal who will assign a member of the IC to proceed as follows:

1) Keep the student under continuous adult supervision.
2) The school social worker, school psychologist or school nurse will interview the student to assess the level of suicidal behavior or risk. (See Appendix VI as a guideline).
3) In the case of students with IEPs, the student's case manager should be notified as soon as possible after school staff identifies the student has an IEP. If the student has an IEP, additional rules apply, which appear below in paragraph 9.
4) If the situation is evaluated as constituting a suicidal threat, the procedures listed under Section B: Level Two will be followed, otherwise, proceed to step 5.
5) Immediately, the IC member will contact the student's parents by phone to arrange for a conference. All aspects of the incident will be reviewed and appropriate interventions, i.e. referral to community mental health center/or to consulting Mental Health Professional. (See Appendix IX and Appendix XI) will be made. Authorization for the Release of Information will be obtained from the parent prior to the release of student information to individuals/agencies external to the school district.
6) An assessment by the School Social Worker, School Psychologist or School Nurse shall be performed. (See Appendix VIII)
7) The IC member who completes the assessment (Appendix VIII) will prepare and submit a Crisis/Suicide Intervention Report (see Appendix II) to the Superintendent, Director of Special Services, Principal and IC. An official file will be maintained by the Director of Special Services.
8) An IC member will follow up by checking with family, student, and/or treatment provider (notarized release must be on file before communicating to treatment provider) to ensure that adequate care has been offered.
9) After conducting a crisis assessment, if it is determined that a student with an IEP is a danger to self or others, additional rules apply. Even if not labeled as a suspension, any exclusion or removal from school for a student with disabilities is subject to the provisions of 20 U.S.C. Section 1415(k) and N.J.A.C. 6A:14-2.8, which set forth the procedures to be followed when disciplining students with disabilities. The federal and state regulations must be read together in order to determine discipline requirements. The district's discipline policy for students with disabilities is set forth in Policy #6171.4 and must be followed for any removal.

B. LEVEL TWO: Student has voiced or expressed intent in writing to engage in a suicidal act.

If after student contact, the IC member deems the situation to be sincere, the following steps will be implemented:

1) Keep the student under continuous adult supervision.
2) The IC member will immediately notify the Principal. The Principal will notify the Director of Special Services and the Superintendent. If the principal is not available, the IC member will contact the Director of Special Services and Superintendent directly.
3) The IC member will immediately contact the student's parent/guardian by phone and request that the parent/guardian come to school immediately for a conference. All aspects of the incident will be reviewed (see Appendix VII for a discussion guide), and the parent will be presented with a written determination stating the school's level of concern. Said determination shall require a signature of the parent or guardian. A School Psychologist, School Social Worker or School Nurse will conduct a student interview and determine the level of suicidal risk.
    a. If there does not appear to be imminent danger of bodily harm, screening by a mental health professional will be requested as well as referrals to community mental health centers and or consulting Mental Health Professionals (see Appendix IX and XI). Authorization for the Release of Information will be obtained from the parent prior to the release of student information to individuals/agencies external to the school district. If parent/guardian refuses to follow the recommendations of the IC member the Division of Child Protection and Permanency (DCPP, formerly DYFS) shall be contacted (See Appendix IX).
    b. If there appears to be imminent danger of bodily harm, parent/guardian consent for a mental health screening by a Licensed Mental Health professional shall be requested (see Appendix IX and Appendix XI). If it appears that consent is not forthcoming, the Division of Child Protection and Permanency (DCPP, formerly DYFS) will be contacted to provide for the safety of the student.
4) If the parent/guardian is unavailable, an IC member will remain with student until contact is made with the parent/guardian.
5) In the event a staff member is unavailable to remain for an extended period until the parent arrives, the Principal or his/her designee will make a determination in regard to further procedure.
6) An assessment by the School Social Worker, School Psychologist, or School Nurse shall be performed (See Appendix VIII) and this individual will prepare and submit a Crisis/Suicide Intervention Report (see Appendix II) to the Superintendent, Director of Special Services, Principal and IC members.
7) An IC member will follow up by checking with family, student, and treatment provider (notarized release must be on file before communicating to treatment provider) to ensure that adequate care has been afforded.
8) The Licensed Mental Health Professional Statement Form must be completed by a Licensed Mental Health Professional in order for the student to return to school.
9) Certified school personnel will monitor the student's school performance and behavior in relation to the specific treatment plan indicated in the Crisis/Suicide Intervention Report (Appendix II) and/or formulated by treatment provider. The Principal and Director of Special Services shall be informed of all follow-up contact by confidential memorandum.

C. LEVEL THREE A: Response to Suicide Attempted Outside of School

1) When any staff member hears of an attempted suicide outside the school setting he/she will notify the Principal (or designee) without delay.
2) The Principal or designee will:
   a. Immediately contact the parent/guardian to review all aspects of the incident and to arrange for appropriate follow up.
   b. Notify the Director of Special Services, the Superintendent, and IC.
   c. Together with members of the IC, a determination will be made on an appropriate plan of action in response to the incident. This will be completed via phone chain when the event occurs outside of school hours.
   d. Assign member of IC in consultation with the Director of Special Services to manage the case.
3) The IC member will:
   a. Assist the parent/guardian with appropriate referral and placement (see Appendix IX and XI). Authorization for the Release of Information will be obtained from the parent prior to the release of student information to individuals/agencies external to the school district.
   b. The School Psychologist, School Social Worker or School Nurse shall prepare and submit a Suicide Intervention Report (see Appendix II) to the Principal, Director of Special Services, Superintendent of Schools, and IC.
4) Procedures for student returning to school will then be followed. (See Section E).

D. LEVEL THREE B: Response to Suicide Attempted on School Premises

1) If immediate medical services are required for physical injuries, the School Nurse and Principal shall ensure that emergency medical treatment is provided, either through the use of first aid techniques and/or by telephoning the local rescue squad. A staff member, designated by the Principal, shall accompany the child if transported by ambulance.
2) School staff member will immediately notify School Nurse and Principal. Principal or designee will immediately contact parent/guardian and request that he/she comes to school immediately.
3) The student shall be kept under close supervision until the parent/guardian or proper authorities arrive to take the child for immediate treatment.
4) The Principal will:
   a. Immediately contact the Superintendent, Director of Special Services, Intervention Committee, and police juvenile officer.
   b. Appoint in consultation with the Director of Special Services, an IC member who will meet with the child and be responsible for managing the case
   c. The Department of Human Services will be contacted in accordance with N.J.A.C. 6A:16-11.1(b), "The district board of education shall develop and adopt policies and procedures for school district employees, volunteers, or interns with reasonable cause to suspect or believe that a student has attempted or completed suicide, to report the information to the Department of Human Services, Division of Mental Health and Addiction Services, in a form and manner prescribed by the Division of Mental Health and Addiction Services pursuant to N.J.S.A. 30:9A-24.a."
5) The IC member will request consent of parent/guardian for a mental health evaluation. (See Appendix IX and Appendix XI).

6) If parent/guardian is not available or if parent/guardian refuses to follow the recommendations of the IC member, the Division of Child Protection and Permanency (DCPP, formerly DYFS) shall be contacted. (See Appendix IX)
7) Following the immediate crisis a faculty meeting will be called by the Principal at the earliest possible time to inform teachers of the event, offer them an opportunity to address their feelings and concerns, and to plan appropriate procedures for subsequent school days.
8) A School Social Worker, School Psychologist or School Nurse will prepare and submit a Crisis/Suicide Intervention Report to the Superintendent, Principal, Director of Special Services, and Intervention Committee (see Appendix II).
9) The nurse will file an accident report.
10) Procedures for student returning to school will then be followed. (See Section E).

E. Procedures for a Student Returning After a Suicide Attempt:

1) The designated IC member should be apprised of the situation by the attending Licensed Mental Health Professional.
2) Designated IC member will apprise the Principal and IC members of the situation.
3) Designated IC member should contact parents and treating therapist to discuss formulation of a treatment plan with respect to school attendance.
4) An information-sharing meeting will be held prior to the student's return to school, with members of the IC, the parents, and possibly the student. The Licensed Mental Health Professional Statement Form (Appendix XII) must be completed by a licensed Mental Health Professional and returned to the school in order for the child to return to school. The student's teacher(s) will be informed of the student's return as appropriate and in relation to the specific treatment plan indicated in the Crisis/Suicide Intervention Report (Appendix II) and/or formulated by treatment provider.
5) Certified school personnel will monitor the student's school performance and behavior in relation to treatment plan.
6) An IC member will maintain parental contact until the student is released from treatment.

F. RESPONSE TO A SUICIDE COMPLETION

1. Upon verification with the police that a suicide has been completed:
   a. The principal of the school affected will be in charge.
   b. The principal will give notice will be given immediately to the Superintendent, the Director of Special Services, and the IC and convene together as soon as possible to prepare for the subsequent steps in these procedures.
   c. The Principal will contact the family to express sympathy and to determine their wishes with respect to the acknowledgment of the death as a suicide and with respect to the disclosure of information concerning the death and the funeral arrangements. If news is received during the school day and there are siblings or other family members present in the schools, ask the student's family how and when to notify the family members and offer to have them escorted home. If appropriate at this time, offer information on counseling services.
   d. The principal will begin making preparations for the subsequent steps as outlined below (i.e., media release, faculty statement, counseling arrangements, etc.)

2. All contacts with the news media will be referred to the Superintendent or designee who will speak for the entire school during the suicide crisis.
   a. The faculty should be advised who the designated spokesperson is and that all media requests should be referred to this person.
   b. As soon as it is reasonably possible, the spokesperson shall meet the media as a group, but not at the building site affected by the suicide.
   c. The interviewing of students on school premises by the media shall be strictly forbidden.

3. In order to control rumors the Superintendent or designee will prepare a statement for the staff to ensure consistency in the reporting of all facts surrounding the suicide to students. In instances where the suicide is alleged, this fact should be clearly noted. Information on funeral arrangements will be included in accordance with the family's wishes.

4. The Principal shall call an emergency faculty and staff meeting as soon as is reasonably possible or early in the morning on the first school day following the suicide. Teacher notification will occur via the phone chain.
   a. Relevant facts and outline of staff procedures for the subsequent days should be disclosed.
   b. The written statement shall be distributed to assist the teachers in maintaining consistency in the reporting of facts to the students. Teachers will be given guidelines for discussing the situation in the classroom setting in a developmentally appropriate manner (see Appendix III and IV), and for identifying high-risk students (close friends, teammates, siblings, students who have exhibited suicidal behavior). Possible reactions to a suicide will also be reviewed (see Appendix V).
   c. Every effort shall be made to inform students in a small group setting such as homeroom or the mentor group. Large assemblies or the public address system will be avoided.
   d. Whenever possible, parents of elementary students should be told prior to students. A statement prepared by the Principal which informs parents of the death and of possible reactions of children will be read to each parent over the telephone. Parents would be instructed to give their children the same information.
   e. Emotional support of the staff will be provided.

5. The School Counselor, SAC, relevant teacher(s), and/or CST members shall compile a list of students who were close to the deceased student or who may be at risk. These students shall be identified, counseled, and closely observed.

6. Students shall be provided with factual information as soon as possible in a small group or classroom setting.
   a. Time shall be allotted in the daily schedule to enable students to express and discuss their feelings with school or mental health personnel regarding the incident. Homerooms, drop-in center, class periods, or mentor groups could be utilized.
   b. Students shall have the opportunity to visit a counselor as needed during the initial crisis period (3-5 days).
   c. Community resources such as clergy, juvenile officer, and mental health agencies shall be used to assist school personnel in counseling the students.

7. Over-focusing on a suicide can have deleterious effects, including copycat attempts by children. A regular school routine should be followed as soon as possible. Under no circumstances shall the suicide be memorialized through such things as assemblies or yearbook dedications. On the day of the funeral school will remain open; grief may be recognized through a moment of silence. The flag will not be lowered. Students will be allowed to attend the funeral with parental permission. It will be recommended that, if possible, parents attend the service with their children. Principal or an official school representative will attend.

8. An after-school faculty meeting on the first school day following the suicide will be called;
   a. To debrief the events of the day.
   b. To provide emotional support for all staff after a full day of dealing with their responses and those of the students.
   c. To review the characteristics of high-risk students and compile an additional list based on staff observations of student reactions during the day.

9. The Principal will maintain communication with parents through such means as written messages, and/or small group meetings. The following information would be helpful for parents to know:
   a. Pertinent facts surrounding suicide and subsequent steps taken by school.
   b. A review of school/community resources parents may wish to utilize.
   c. A description of their children's special needs during this time including the developmental understanding of death (Appendix III) and possible reactions to a suicide (Appendix V).

10. The Principal will prepare a report evaluating the district's response to the crisis situation. The IC will meet to discuss the report and make appropriate changes to the procedures.

G. FOR ALL TRAUMATIC EVENTS/CRISIS MANAGEMENT AND INTERVENTION, as appropriate, the Township of Union Emergency Plan for Faculty and Students will be followed and the Memorandum of Agreement Between Education and Law Enforcement Officials will be adhered to. In the event a student poses a threat to others the individual(s) who are the subject(s) of the threat and their parent/guardians must be notified and informed.

APPENDIX I

WARNING SIGNS OF SUICIDE

A. Suicidal Indicators

1. Suicidal threat or other statement indicating desire of intention to die.

   - May be direct verbal statement or indirect through joking, creative writing assignment, art work
   - Acting out, violent behavior often with suicidal or homicidal threats
   - Wish to die/intense preoccupation with death

2. Previous attempts even if superficial

3. Depression

   - Withdrawal from friends and activities
   - Loss of joy in life and bleak outlook for future
   - Changes in sleeping and eating habits
   - Risk-taking or reckless behavior
   - Preoccupation with death
   - Increased somatic complaints
   - Concentration problems with schoolwork
   - Frequent mood changes
   - Uncharacteristic emotional or rebellious outbursts
   - Low self-esteem or lack of confidence in abilities and in decision-making capabilities
   - Significant weight loss or gain
   - Decreased attention to physical appearance
   - Hyperactivity
   - Chronic fatigue
   - Feelings of worthlessness, inferiority, or guilt

4. Marked or sudden changes in behavior

   - Behavior symptomatic of depression
   - School problems
   - Substance abuse
   - Psychosomatic ailments
   - Constant accidents

5. Final arrangements
   - Giving away of valued articles
   - Sudden lifting of severe depression
   - More characteristic of older children and adolescent

APPENDIX I (continued)

B. Risk Factors

1. Relationship to School
   - Sense of not belonging in a school
   - Alienation from peers
   - Sense of having restricted future because of poor performance in school

2. School Environment
   - Recent transitions imposed by system
   - Lack of specialized programs
   - Alienation and rejection of certain students
   - Too much attention given to suicide threats or attempts

3. Family
   - Low level of family support
   - Suicidal behavior in family
   - Instability
   - Communication problems
   - Dysfunctional or disturbed structure
   - Crisis not tolerated
   - History of physical, mental, emotional, or sexual abuse

C. Common Stresses or Precipitating Events
   - Increased arguments with friends
   - Breakup with boyfriend or girlfriend
   - Trouble with sibling
   - Loss of friend
   - Divorce
   - Change in parents' finances
   - Injury or illness
   - Trouble with teacher
   - Failing grade
   - Change of school
   - Getting into trouble, being afraid
   - Disappointments, rejection, failure
   - Anxiety over impending change
   - Recent example of suicide

D. General "Types" of Teenagers More at Risk:
   - Impulsive, aggressive teenager with troubled relationship and a history of failure in school or work
   - Perfectionist, rigid teenager who is successful, but has very distorted or negative view of self
   - Depressed teenager
   - Youth Living with mental and/or substance use disorder
   - Youth who engage in self-harm or have attempted suicide
   - Youth in out of home settings
   - Youth experiencing homelessness
   - Youth bereaved by suicide
   - Youth living with mental conditions and disabilities

APPENDIX I (continued)

SOURCES

American Foundation for Suicide Prevention, the American School Counselor Association, & the National Association of School Psychologists (2014). Model School District Policy on Suicide Model Language, Commentary, and Resources. Retrieved from http://www.thetrevorproject.org/pages/modelschoolpolicy.

Davis, JM (1988). Suicide and the Schools: Intervention and Prevention. In J. Sandoval (Ed.), Crisis Counseling, Intervention, and Prevention in the Schools. Hillsdale, N.J.: Lawrence Erlbaum

Miller, DN (2010) Child and Adolescent Suicidal Behavior: School-Based Prevention, Assessment, and Intervention. NY: The Guilford Press

Peterson, S. & Straub R.L. (1992). School Crisis Survival Guide.

Poland, S. (1989). Suicide Intervention in the Schools. N.Y.: The Guilford Press

The Center for Applied Research in Education, West Nyack, N.Y.

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APPENDIX II

CONFIDENTIAL

CRISIS/SUICIDE INTERVENTION REPORT

Name _____ Date _____ Grade _____

Address _____ Phone (Home) _____

_____ Phone (Work) _____

Parent/Guardian _____

Details of Incident: _____

_____

_____

_____

Parent/Guardian Notification _____

When reasonable cause to suspect or believe that a student has attempted or completed suicide is present – the Department of Human Services, Division of Mental Health and Addiction Services must be notified. Refer to NJAC 6A:16-11.1(b)

Interventions: _____

Follow-Up _____

_____

SUBMITTED BY: _____ DATE _____

Name Title

REPORTS SENT TO:

_____ Superintendent

_____ Director of Special Services

_____ Principal

_____ Intervention Committee Members

APPENDIX III

DEVELOPMENTAL UNDERSTANDING OF DEATH

Perceptions of Death

- Understanding at the developmental age, not the chronological age
- More mature understanding of an impersonal death; when personally affected, tend to regress
- Even if intellectual understanding is advanced, emotional ability to cope may not be

Ages 3 to 5

- Death is temporary, reversible and caused magically or by own bad thoughts, wishes, or actions
- Believe own bad wishes and actions may cause own death
- Graphic pictures of life after death
- Life like needs (food, etc.) attributed to death
- Concrete, literal thinkers so need careful explanations
- Hurt and angry at abandonment
- Pain is caused by separation; may re-experience grief when understand finality of death at older age
- Anxious that others may abandon
- Guilty because believe might have caused death

Ages 6 to 8

- Developing the concept of living versus non-living
- Preoccupation or fascination with life and death, decomposition and decay
- Frequently personify death as person to be fought off; only the weak and old lose the fight and die
- Dead people can see, hear, eat
- Interested in rituals and details so may ask many questions concerning death and funerals.

Ages 9 to 12

- Death understood as final and irreversible; pain is not just separation but knowledge of forever
- Death affects only the old
- Death as a matter of luck, possibly to escape
- Begin to consider possibilities after death so religious beliefs may provide comfort
- Fears about physical consequences of death and process of dying
- May experience guilt if had wished for the deceased's death because believe own behavior causes reactions

Adolescence

- Death is now universal and personal as well as final and irreversible (mature concept)
- However, belief in immortality of youth and will distance selves from the possibility
- Abstract thinkers will view death as remote and spiritual

APPENDIX III (continued)

SOURCES

Bauers, J. and Hatch T. (2005) The ASCA National Model: A Framework For School Counseling Programs, 2nd Ed., American Counseling Association.

Dudley, J. (2003) When Grief Visits Schools: Organizing A Successful Response. NY Educational Media Corp.

Petersen, S. & Straub, R.L. (1992). School Crisis Survival Guide.

The Center for Applied Research in Education, West Nyack, N.Y.

Wilson, P.G.R. (1988). Helping Children Cope With Death. In J. Sandoval (Ed.), Crisis Counseling, Intervention, and Prevention in the Schools. Lawrence Erlbaum, Hillsdale, N.J.

APPENDIX IV

GUIDELINES FOR CLASSROOM TEACHERS
Related to Suicide

1. The following are points to keep in mind:
   a. Suicide is the result of complex interaction of many factors in a person's life. There is no one cause. Avoid speculating on possible causes or attributing blame.
   b. Students will react in a variety of different ways. There is no "right way to feel" or "right way to mourn." Each person will have a unique response involving various different feelings that change over time.
   c. Mourning is a process that takes time varying in length for each individual.

2. Each first period or homeroom teacher should inform students of the death using the outline provided by the administration. If they are unable to do so or are absent, the Child Study Team and school counselor(s) should give assistance. The instructor should share basic facts to dispel rumors, but not dwell on details.

3. The teacher should share his/her own feelings of loss and grief, but not in any way convey the message that suicide is admirable or a viable way of dealing with problems.

4. Specific classes affected may wish to consider a commemorative response such as condolence letters to the family (which would be screened by administration before sending) or a fund raising project for a specific activity such as a mental health project. Plaques or trees are not recommended.

5. The classroom teacher should encourage students to seek out appropriate school personnel to discuss their reactions and feelings. The students should be excused from class to do so. The students should be provided a hallway pass/monitor (a "buddy" or school staff member).

6. During the next several days students should be allowed to leave class to attend counseling groups.

7. Students will be assisted by following the regular classroom activities. Structured activities are helpful in containing any contagion effect. It is advisable that stressful activities such as major examinations be rescheduled for later dates. If you have any questions about an activity, ask an Intervention Committee member.

SOURCE

Underwood, M.M. & Dunne-Mann, K. (1992). Managing Student Violent Loss in Schools. Piscataway: New Jersey State Department of Education & New Jersey State Department of Human Resources.

APPENDIX V

POSSIBLE REACTIONS TO A SUICIDE

Specific to a Suicide:

- Intense grief, but grief reactions vary
- Anger that may lead to scapegoating and blaming
- Denial
- Intensified anxiety
- Exaggerated feeling of responsibility for death

Normal Reactions to Traumatic Stress Situations:

- Forgetfulness
- Sleep and appetite disturbances
- Loss of concentration
- Irritability, anger
- Preservation (i.e., going over and over the last contact with the deceased)
- Numbed feelings
- Diminished interest

Immediate upon hearing news:

- Flight
- Avoidance by creating distractions
- Giggling
- Immobilization

APPENDIX VI

SUGGESTED QUESTIONS FOR CHILDREN

1. It seems things haven't been going so well for you lately. Your parents and/or teachers have said _____.
   Most children your age would feel upset about that. Have you felt upset or maybe you had some sad or angry feelings you've had trouble talking out?

2. Do you feel things can get better or are you worried (afraid or concerned) things will just stay the same or get worse?

3. Has anyone that you know attempted to kill himself or herself? Do you know why?

4. Have you thought about how you might make yourself die? Do you have a plan? Do you have the means available? Do you have access to these means?

5. Have you ever tried to kill yourself before? (If yes,) how far have you gone towards reaching an attempt?

6. What has made you feel so awful?

7. Who is there for you?

APPENDIX VII

SUGGESTED QUESTIONS FOR PARENTS

1. Has any serious change occurred in your child's or your family's life recently (last year)?
2. How did your child respond?
3. Has your child had any accidents or illnesses without a recognizable physical basis?
4. Has your child experienced a loss recently?
5. Has your child experienced difficulty in any areas of his/her life?
6. Has your child been very self-critical or have you or his/her teachers been very critical lately?
7. Has your child made any unusual statements to you or to others about death or dying? Any unusual questions or jokes about death or dying?
8. Have there been any changes you've noticed in your child's mood or behavior over the last few months?
9. Has your child ever threatened or attempted suicide before?
10. Have any of his/her friends or family, including you, ever threatened or attempted suicide?
11. How have these last few months been for you?
12. How have you reacted to your child (anger, despair, empathy)?

APPENDIX VIII

CRISIS/SUICIDE EVALUATION

To be completed by School Psychologist, School Social Worker or School Nurse

Name _____ Age_____ Date _____

1. Suicide Potential
   a. Non-suicidal
   b. Suicidal ideation
   c. Suicide threat
   d. Mild attempt (believes would not have killed self)
   e. Serious attempt (believes would have been fatal)

2. Suicide Plan
   a. Lethal potential of plan
   b. Availability of means
   c. Sophistication

3. Past Attempts
   a. Self
   b. Others

4. Affects and Behaviors
   a. Anxiety
   b. Anger
   c. Sadness
   d. Weight loss
   e. Running away
   f. Depression
   g. Hopeless resignation
   h. Temper tantrums
   i. Psychomotor increase or decrease
   j. Transformed rage
   k. Fire setting
   l. Defiance
   m. Trouble sleeping
   n. Social withdrawal
   o. Drug addiction
   p. Alcoholism

5. Family Behavior
   a. Drug, alcohol, child abuse
   b. Recent deaths or separations
   c. Parents have coping plan

6. Precipitating Events
   a. Loss or threat of loss
   b. Health problems
   c. Social disgrace
   d. School problems
   e. Loss of reason to live

APPENDIX VIII (continued

7. Response from Support Network

8. Concept of Death

9. Cognitive Functioning, Reality Testing, and Affect Regulation

10. Impulse Control

Signature:_____

Print Name: _____

Title: _____

Date: _____

APPENDIX IX

(SCHOOL LETTERHEAD)

DATE

Parent/Guardian of _____

The Intervention Committee of _____School has recently met regarding concerns for your son/daughter. It has been brought to the attention of the Intervention Committee that your son/daughter has voiced or written intent to engage in a suicidal act/harm to self or others. In accordance with N.J.A.C. 6A:16-11.1(b), "The district board of education shall develop and adopt policies and procedures for school district employees, volunteers, or interns with reasonable cause to suspect or believe that a student has attempted or completed suicide, to report the information to the Department of Human Services, Division of Mental Health and Addiction Services, in a form and manner prescribed by the Division of Mental Health and Addiction Services pursuant to N.J.S.A. 30:9A-24.a."

Due to the seriousness of the situation, it is the request of the Intervention Committee that your son/daughter be evaluated by a Licensed Mental Health Professional as described by the list of following professionals (Source: The New Jersey Division of Consumer Affairs; www.njconsumeraffairs.gov):

Psychiatrist (M.D.) – A physician who specializes in the prevention, assessment, diagnosis, and treatment of mental illness. A psychiatrist must receive additional training and serve a supervised residency in his or her specialty. He or she may also have additional training in a psychiatric specialty, such as child psychiatry or neuropsychiatry. Psychiatrists can prescribe medication; which psychologists cannot do. Persons requiring licensure for Psychiatry conduct is within the scope of practice set forth through the New Jersey State Board of Medical Examiners.

Licensed Clinical Psychologist (PhD, and/or Psy.D) – Has received the degree PhD and Psy.D in psychology from a recognized educational institution. "Licensed practicing psychologist" means a professional person who renders professional psychological services to individuals or in groups, whether in the general public or in organizations, either public or private, for a fee, monetary or otherwise. "Professional psychological services" means the application of psychological principles and procedures in the assessment, counseling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations. Persons requiring licensure include all those whose conduct is within the scope of practice set forth in N.J.A.C. 13:42-1.1 and whose practice is not otherwise exempt pursuant to N.J.S.A. 45:14B-6, and 45:14B-8, N.J.A.C. 13:42-1.4 and 1.5 through the New Jersey Board of Psychological Examiners.

Licensed Clinical Social Worker (LCSW) – Professionals who are trained in the application of social work methods and values in the Assessment and psychotherapeutic counseling of individuals, families and groups. These professionals have completed two years of full-time clinical work totaling 1,920 hours of face-to-face client contact within any three consecutive year period subsequent to earning a master's degree in social work under direct supervision pursuant to the standards set forth in N.J.A.C. 13:44G-8.1. They are individuals whom obtained licensure to practice social work in the State of New Jersey. Clinical social work services include, but are not limited to, clinical assessment, clinical consultation, psychotherapeutic counseling, client centered advocacy, and clinical supervision of individuals pursuant to the standards set forth in N.J.A.C. 13:44G-8.1 through the New Jersey Board of Social Work

APPENDIX IX (continued)

Licensed Professional Counselor (LPC) – State-licensed mental health professionals whose scope of practice includes, but is not limited to, counseling, counseling interventions, appraisal and assessment, consulting, referral, and research activities, as defined in N.J.A.C. 13:34-10.2. Professional Counselor Licensing Act, P.L. 1993, c.340 (N.J.S.A. 45:8B-34 et seq.) (the "Act") as amended and supplemented by P.L. 1997, c.155, and regulate the profession of counseling, as defined in N.J.A.C. 13:34-10.2, within the State of New Jersey.

The Licensed Mental Health Professional Statement Form must be completed by a Licensed Mental Health Professional in order for the student to return to school. The form must be submitted to the building Principal from the Licensed Mental Health Professional before your child is permitted to return to school. (The recommendation in the clearance letter for treatment or follow-up care are at the sole discretion of that professional and are not required for re-entry into school. The Township of Union Public Schools will not be financial responsible for any recommendations made by the mental health professional.) Please understand that this is a recommendation made out of caring and concern for your son/daughter.

_____ _____

School Principal Intervention Committee Member

Please check the appropriate sentence below and sign.

☐ I understand the above recommendation and will follow through with a Licensed Mental Health Professional evaluation.

☐ I, _____, understand the recommendation for a Mental Health Professional evaluation, however I do not feel that it is necessary at this time. I hereby confirm that I have been fully apprised of the matter of my child's voiced or written intent to engage in a suicidal act or harm to self or others. I was: (a) Advised as to the seriousness of the matter; (b) Offered resources. However, I elect to decline the recommendations for the Mental Health Professional Evaluation. I accept full responsibility and understand that the Division of Child Protection and Permanency (DCPP, formerly DYFS) will be contacted concerning the situation

_____ _____

Date Parent/Guardian Signature

Remove_____ Date _____
Intervention Committee Member

Remove_____ Date _____
Intervention Committee Member

METHOD OF DELIVERY: _____Provided at Conference _____Mailed to Home

APPENDIX X

GLOSSARY OF TERMS

DEFINITIONS

Intervention Committee (IC): A building-based committee consisting of the principal, school counselor, school nurse, Student Assistance Counselor (SAC), School Social Worker, School Psychologist and/or teachers (if they are the referring agent). This committee will identify at-risk students and plan interventions in their behalf.

Suicidal Indicators: Verbal or non-verbal signs that a student may be at risk to engage in suicidal behaviors.

Mental Health Professional: As defined by the following professionals (Source: the New Jersey Division of Consumer Affairs; www.njconsumeraffairs.gov):

Psychiatrist (M.D.) – A physician who specializes in the prevention, assessment, diagnosis, and treatment of mental illness. A psychiatrist must receive additional training and serve a supervised residency in his or her specialty. He or she may also have additional training in a psychiatric specialty, such as child psychiatry or neuropsychiatry. Psychiatrists can prescribe medication; which psychologists cannot do. Persons requiring licensure for Psychiatry conduct is within the scope of practice set forth through the New Jersey State Board of Medical Examiners.

Licensed Clinical Psychologist (PhD, and/or Psy.D) – Has received the degree PhD and Psy.D in psychology from a recognized educational institution. "Licensed practicing psychologist" means a professional person who renders professional psychological services to individuals or in groups, whether in the general public or in organizations, either public or private, for a fee, monetary or otherwise. "Professional psychological services" means the application of psychological principles and procedures in the assessment, counseling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations. Persons requiring licensure include all those whose conduct is within the scope of practice set forth in N.J.A.C. 13:42-1.1 and whose practice is not otherwise exempt pursuant to N.J.S.A. 45:14B-6, and 45:14B-8, N.J.A.C. 13:42-1.4 and 1.5 through the New Jersey Board of Psychological Examiners.

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Licensed Professional Counselor (LPC) – State-licensed mental health professionals whose scope of practice includes, but is not limited to, counseling, counseling interventions, appraisal and assessment, consulting, referral, and research activities, as defined in N.J.A.C. 13:34-10.2. Professional Counselor Licensing Act, P.L. 1993, c.340 (N.J.S.A. 45:8B-34 et seq.) (the "Act") as

amended and supplemented by P.L. 1997, c.155, and regulate the profession of counseling, as defined in N.J.A.C. 13:34-10.2, within the State of New Jersey

APPENDIX XI

RESOURCE LIST*

FAMILY CENTER AT MONTCLAIR* 973-857-5333
Mental Health *Union Township Board of Education Approved

Counseling Centers for Human Development 908-276-0590
*Union Township Board of Education Approved

CARRIER COUNSELING CENTER 908-281-1000
Adolescent/Adult Mental health/Substance Abuse

COOPERATIVE COUNSELING 908-731-7100
Mental Health

FAMILY RESOURCE CENTER 908-276-2244
Mental Health Counseling

GANNON COUNSELING 908-964-4233
Substance Abuse Counseling

HIGH FOCUS TREATMENT CENTER 800-877-FOCUS
Adolescent/Adult Substance Abuse

MOUNT CARMEL GUILD 908-497-3968
Mental Health/Substance Abuse

PROCEED (SPANISH) 908-351-7727
Substance Abuse Counseling

RESOLVE 908-322-9180
Mental Health/Substance Abuse

SUMMIT OAKS 908-522-7000
Mental Health/Substance Abuse

SUMMIT PSYCHIATRIC & COUNSELING 908-277-1550
Mental Health Counseling

SUMMIT PSYCHOLOGICAL SERVICES 908-273-5558
Mental Health/Substance Abuse

TRINITAS HOSPITAL 908-994-7131
Psychiatric Emergency Room

YOUTH & FAMILY COUNSELING SERVICES Mental Health Counseling	908-233-204
Atlantic Health Systems - Overlook	888-247-1400

*Current telephone numbers as of date Board of Education policy approved. If parent/guardian is unable to contact an any of the resources listed contact the Director of Special Services.

Adopted:	January 28, 2014
Revised:	April 3, 2017
Readopted	November 21, 2017

BLACKLINE

TOWNSHIP OF UNION BOARD OF EDUCATION
Union, New Jersey

Policy

FILE CODE: 5141.5
X Monitored
X Mandated
X Other Reasons

STUDENT SUICIDE PREVENTION AND CRISIS INTERVENTION

The Township of Union Board of Education recognizes that depression, self-destruction or possible harm to others are problems of potentially increasing severity among children and adolescents. A student under severe stress cannot benefit fully from the educational program and may pose a threat to himself/herself or to others. In response to this serious problem, the Board of Education has determined that our schools must be prepared to meet this challenge.

The Board of Education encourages all school personnel to be alert to the warning signs of childhood and adolescent depression or potential suicide and the procedures to follow in the event he or she becomes aware or suspects the existence of such a condition. School personnel shall respond to those signs in accordance with procedures established by the Superintendent.

In accordance with N.J.A.C. 6A:16-11.1(b), "The district board of education shall develop and adopt policies and procedures for school district employees, volunteers, or interns with reasonable cause to suspect or believe that a student has attempted or completed suicide, to report the information to the Department of Human Services, Division of Mental Health and Addiction Services, in a form and manner prescribed by the Division of Mental Health and Addiction Services pursuant to N.J.S.A. 30:9A-24.a."

The Superintendent shall establish guidelines and procedures to deal with these types of behaviors of students. In-service training will be organized by the Director of Special Services of at least two hours of suicide prevention and awareness instruction as part of the 100-hour professional development five-year cycle to individual teaching members by licensed health care professionals with training and experience in mental health. The school psychologist, school counselor, student assistance counselor, school social worker, and/or school nurse will assist staff to identify and deal with these conditions in the school environment and in the suicide intervention procedures. (Please refer to Appendix X for a glossary of terms)

Adopted: January 28, 2014
Revised: April 3, 2017
Readopted: November 21, 2017
Readopted: June 18, 2019

STUDENT SUICIDE PREVENTION AND CRISIS INTERVENTION

RESPONSIBILITY

In accordance with Board Policy, the Superintendent has established the following procedures for the instruction of students and staff in suicide prevention, for the identification of and intervention with students at risk for suicide and for the appropriate response to a suicide completion or threat of harm to others.

PROCEDURES

1. INSTRUCTION

   Teachers shall be guided by the health curriculum approved by the Board of Education. Current thinking concerning suicide prevention curriculum is as follows: Instruction specific to suicide should be approached cautiously. Emphasis should be on educating students on various mental health problems (such as drugs, alcohol, dependency and depression), their common symptoms, and how and where to get help.

2. IDENTIFICATION

   a. School personnel must take seriously all suggestions, demonstrations, or communications of suicide. Any indication that a student may be in potential danger or pose a threat to others shall be reported immediately. Confidentiality is superseded by the presence of any type of suicidal behavior or threat to others.
   b. An Intervention committee (IC) shall be established in each school building and shall consist of the principal, school psychologist, school social worker, school counselor, student assistance counselor (SAC), school nurse, and/or teacher(s) (if they are the referring agent). This committee will assist in the identification of at risk students and intervention on their behalf. Each building principal will provide the Superintendent of Schools, Supervisor of School Counseling, Supervisor of Nursing, Director of Special Services, and the members of the IC team with the names of the members of the IC team at the beginning of the school year in September.
   c. The staff will be made aware of signs of suicide risk and instructed in the suicide intervention procedures through in-service training. Warning signs of suicide are listed in Appendix I.

3. INTERVENTIONS

A. LEVEL ONE: Observation of behaviors or warning signs that indicate a student may be at risk of engaging in a suicidal act or pose a threat to others.

The staff member who has reason to believe that a student has destructive tendencies to self or others shall immediately notify the principal who will assign a member of the IC to proceed as follows:

1) Keep the student under continuous adult supervision.
2) The school social worker, school psychologist or school nurse will interview the student to assess the level of suicidal behavior or risk. (See Appendix VI as a guideline).
3) In the case of students with IEPs, the student's case manager should be notified as soon as possible after school staff identifies the student has an IEP. If the student has an IEP, additional rules apply, which appear below in paragraph 9.
4) If the situation is evaluated as constituting a suicidal threat, the procedures listed under Section B: Level Two will be followed, otherwise, proceed to step 5.
5) Immediately, the IC member will contact the student's parents by phone to arrange for a conference. All aspects of the incident will be reviewed and appropriate interventions, i.e. referral to community mental health center/or to consulting Mental Health Professional. (See Appendix IX and Appendix XI) will be made. Authorization for the Release of Information will be obtained from the parent prior to the release of student information to individuals/agencies external to the school district.
6) An assessment by the School Social Worker, School Psychologist or School Nurse shall be performed. (See Appendix VIII)
7) The IC member who completes the assessment (Appendix VIII) will prepare and submit a Crisis/Suicide Intervention Report (see Appendix II) to the Superintendent, Director of Special Services, Principal and IC. An official file will be maintained by the Director of Special Services.
8) An IC member will follow up by checking with family, student, and/or treatment provider (notarized release must be on file before communicating to treatment provider) to ensure that adequate care has been offered.
9) After conducting a crisis assessment, if it is determined that a student with an IEP is a danger to self or others, additional rules apply. Even if not labeled as a suspension, any exclusion or removal from school for a student with disabilities is subject to the provisions of 20 U.S.C. Section 1415(k) and N.J.A.C. 6A:14-2.8, which set forth the procedures to be followed when disciplining students with disabilities. The federal and state regulations must be read together in order to determine discipline requirements. The district's discipline policy for students with disabilities is set forth in Policy #6171.4 and must be followed for any removal.

B. LEVEL TWO: Student has voiced or expressed intent in writing to engage in a suicidal act.

If after student contact, the IC member deems the situation to be sincere, the following steps will be implemented:

1) Keep the student under continuous adult supervision.
2) The IC member will immediately notify the Principal. The Principal will notify the Director of Special Services and the Superintendent. If the principal is not available, the IC member will contact the Director of Special Services and Superintendent directly.
3) The IC member will immediately contact the student's parent/guardian by phone and request that the parent/guardian come to school immediately for a conference. All aspects of the incident will be reviewed (see Appendix VII for a discussion guide), and the parent will be presented with a written determination stating the school's level of concern. Said determination shall require a signature of the parent or guardian. A School Psychologist, School Social Worker or School Nurse will conduct a student interview and determine the level of suicidal risk.
    a. If there does not appear to be imminent danger of bodily harm, screening by a mental health professional will be requested as well as referrals to community mental health centers and or consulting Mental Health Professionals (see Appendix IX and XI). Authorization for the Release of Information will be obtained from the parent prior to the release of student information to individuals/agencies external to the school district. If parent/guardian refuses to follow the recommendations of the IC member the Division of Child Protection and Permanency (DCPP, formerly DYFS) shall be contacted (See Appendix IX).
    b. If there appears to be imminent danger of bodily harm, parent/guardian consent for a mental health screening by a Licensed Mental Health professional shall be requested (see Appendix IX and Appendix XI). If it appears that consent is not forthcoming, the Division of Child Protection and Permanency (DCPP, formerly DYFS) will be contacted to provide for the safety of the student.
4) If the parent/guardian is unavailable, an IC member will remain with student until contact is made with the parent/guardian.
5) In the event a staff member is unavailable to remain for an extended period until the parent arrives, the Principal or his/her designee will make a determination in regard to further procedure.
6) An assessment by the School Social Worker, School Psychologist, or School Nurse shall be performed (See Appendix VIII) and this individual will prepare and submit a Crisis/Suicide Intervention Report (see Appendix II) to the Superintendent, Director of Special Services, Principal and IC members.
7) An IC member will follow up by checking with family, student, and treatment provider (notarized release must be on file before communicating to treatment provider) to ensure that adequate care has been afforded.
8) The Licensed Mental Health Professional Statement Form must be completed by a Licensed Mental Health Professional in order for the student to return to school.
9) Certified school personnel will monitor the student's school performance and behavior in relation to the specific treatment plan indicated in the Crisis/Suicide Intervention Report (Appendix II) and/or formulated by treatment provider. The Principal and Director of Special Services shall be informed of all follow-up contact by confidential memorandum.

C. LEVEL THREE A: Response to Suicide Attempted Outside of School

1) When any staff member hears of an attempted suicide outside the school setting he/she will notify the Principal (or designee) without delay.
2) The Principal or designee will:
   a. Immediately contact the parent/guardian to review all aspects of the incident and to arrange for appropriate follow up.
   b. Notify the Director of Special Services, the Superintendent, and IC.
   c. Together with members of the IC, a determination will be made on an appropriate plan of action in response to the incident. This will be completed via phone chain when the event occurs outside of school hours.
   d. Assign member of IC in consultation with the Director of Special Services to manage the case.
3) The IC member will:
   a. Assist the parent/guardian with appropriate referral and placement (see Appendix IX and XI). Authorization for the Release of Information will be obtained from the parent prior to the release of student information to individuals/agencies external to the school district.
   b. The School Psychologist, School Social Worker or School Nurse shall prepare and submit a Suicide Intervention Report (see Appendix II) to the Principal, Director of Special Services, Superintendent of Schools, and IC.
4) Procedures for student returning to school will then be followed. (See Section E).

D. LEVEL THREE B: Response to Suicide Attempted on School Premises

1) If immediate medical services are required for physical injuries, the School Nurse and Principal shall ensure that emergency medical treatment is provided, either through the use of first aid techniques and/or by telephoning the local rescue squad. A staff member, designated by the Principal, shall accompany the child if transported by ambulance.
2) School staff member will immediately notify School Nurse and Principal. Principal or designee will immediately contact parent/guardian and request that he/she comes to school immediately.
3) The student shall be kept under close supervision until the parent/guardian or proper authorities arrive to take the child for immediate treatment.
4) The Principal will:
   a. Immediately contact the Superintendent, Director of Special Services, Intervention Committee, and police juvenile officer.
   b. Appoint in consultation with the Director of Special Services, an IC member who will meet with the child and be responsible for managing the case
   c. The Department of Human Services will be contacted in accordance with N.J.A.C. 6A:16-11.1(b), "The district board of education shall develop and adopt policies and procedures for school district employees, volunteers, or interns with reasonable cause to suspect or believe that a student has attempted or completed suicide, to report the information to the Department of Human Services, Division of Mental Health and Addiction Services, in a form and manner prescribed by the Division of Mental Health and Addiction Services pursuant to N.J.S.A. 30:9A-24.a."
5) The IC member will request consent of parent/guardian for a mental health evaluation. (See Appendix IX and Appendix XI).

6) If parent/guardian is not available or if parent/guardian refuses to follow the recommendations of the IC member, the Division of Child Protection and Permanency (DCPP, formerly DYFS) shall be contacted. (See Appendix IX)
7) Following the immediate crisis a faculty meeting will be called by the Principal at the earliest possible time to inform teachers of the event, offer them an opportunity to address their feelings and concerns, and to plan appropriate procedures for subsequent school days.
8) A School Social Worker, School Psychologist or School Nurse will prepare and submit a Crisis/Suicide Intervention Report to the Superintendent, Principal, Director of Special Services, and Intervention Committee (see Appendix II).
9) The nurse will file an accident report.
10) Procedures for student returning to school will then be followed. (See Section E).

E. Procedures for a Student Returning After a Suicide Attempt:

1) The designated IC member should be apprised of the situation by the attending Licensed Mental Health Professional.
2) Designated IC member will apprise the Principal and IC members of the situation.
3) Designated IC member should contact parents and treating therapist to discuss formulation of a treatment plan with respect to school attendance.
4) An information-sharing meeting will be held prior to the student's return to school, with members of the IC, the parents, and possibly the student. The Licensed Mental Health Professional Statement Form (Appendix XII) must be completed by a licensed Mental Health Professional and returned to the school in order for the child to return to school. The student's teacher(s) will be informed of the student's return as appropriate and in relation to the specific treatment plan indicated in the Crisis/Suicide Intervention Report (Appendix II) and/or formulated by treatment provider.
5) Certified school personnel will monitor the student's school performance and behavior in relation to treatment plan.
6) An IC member will maintain parental contact until the student is released from treatment.

F. RESPONSE TO A SUICIDE COMPLETION

1. Upon verification with the police that a suicide has been completed:
   a. The principal of the school affected will be in charge.
   b. The principal will give notice will be given immediately to the Superintendent, the Director of Special Services, and the IC and convene together as soon as possible to prepare for the subsequent steps in these procedures.
   c. The Principal will contact the family to express sympathy and to determine their wishes with respect to the acknowledgment of the death as a suicide and with respect to the disclosure of information concerning the death and the funeral arrangements. If news is received during the school day and there are siblings or other family members present in the schools, ask the student's family how and when to notify the family members and offer to have them escorted home. If appropriate at this time, offer information on counseling services.
   d. The principal will begin making preparations for the subsequent steps as outlined below (i.e., media release, faculty statement, counseling arrangements, etc.)

2. All contacts with the news media will be referred to the Superintendent or designee who will speak for the entire school during the suicide crisis.
   a. The faculty should be advised who the designated spokesperson is and that all media requests should be referred to this person.
   b. As soon as it is reasonably possible, the spokesperson shall meet the media as a group, but not at the building site affected by the suicide.
   c. The interviewing of students on school premises by the media shall be strictly forbidden.

3. In order to control rumors the Superintendent or designee will prepare a statement for the staff to ensure consistency in the reporting of all facts surrounding the suicide to students. In instances where the suicide is alleged, this fact should be clearly noted. Information on funeral arrangements will be included in accordance with the family's wishes.

4. The Principal shall call an emergency faculty and staff meeting as soon as is reasonably possible or early in the morning on the first school day following the suicide. Teacher notification will occur via the phone chain.
   a. Relevant facts and outline of staff procedures for the subsequent days should be disclosed.
   b. The written statement shall be distributed to assist the teachers in maintaining consistency in the reporting of facts to the students. Teachers will be given guidelines for discussing the situation in the classroom setting in a developmentally appropriate manner (see Appendix III and IV), and for identifying high-risk students (close friends, teammates, siblings, students who have exhibited suicidal behavior). Possible reactions to a suicide will also be reviewed (see Appendix V).
   c. Every effort shall be made to inform students in a small group setting such as homeroom or the mentor group. Large assemblies or the public address system will be avoided.
   d. Whenever possible, parents of elementary students should be told prior to students. A statement prepared by the Principal which informs parents of the death and of possible reactions of children will be read to each parent over the telephone. Parents would be instructed to give their children the same information.
   e. Emotional support of the staff will be provided.

5. The School Counselor, SAC, relevant teacher(s), and/or CST members shall compile a list of students who were close to the deceased student or who may be at risk. These students shall be identified, counseled, and closely observed.

6. Students shall be provided with factual information as soon as possible in a small group or classroom setting.
   a. Time shall be allotted in the daily schedule to enable students to express and discuss their feelings with school or mental health personnel regarding the incident. Homerooms, drop-in center, class periods, or mentor groups could be utilized.
   b. Students shall have the opportunity to visit a counselor as needed during the initial crisis period (3-5 days).
   c. Community resources such as clergy, juvenile officer, and mental health agencies shall be used to assist school personnel in counseling the students.

7. Over-focusing on a suicide can have deleterious effects, including copycat attempts by children. A regular school routine should be followed as soon as possible. Under no circumstances shall the suicide be memorialized through such things as assemblies or yearbook dedications. On the day of the funeral school will remain open; grief may be recognized through a moment of silence. The flag will not be lowered. Students will be allowed to attend the funeral with parental permission. It will be recommended that, if possible, parents attend the service with their children. Principal or an official school representative will attend.

8. An after-school faculty meeting on the first school day following the suicide will be called;
   a. To debrief the events of the day.
   b. To provide emotional support for all staff after a full day of dealing with their responses and those of the students.
   c. To review the characteristics of high-risk students and compile an additional list based on staff observations of student reactions during the day.

9. The Principal will maintain communication with parents through such means as written messages, and/or small group meetings. The following information would be helpful for parents to know:
   a. Pertinent facts surrounding suicide and subsequent steps taken by school.
   b. A review of school/community resources parents may wish to utilize.
   c. A description of their children's special needs during this time including the developmental understanding of death (Appendix III) and possible reactions to a suicide (Appendix V).

10. The Principal will prepare a report evaluating the district's response to the crisis situation. The IC will meet to discuss the report and make appropriate changes to the procedures.

G. FOR ALL TRAUMATIC EVENTS/CRISIS MANAGEMENT AND INTERVENTION, as appropriate, the Township of Union Emergency Plan for Faculty and Students will be followed and the Memorandum of Agreement Between Education and Law Enforcement Officials will be adhered to. In the event a student poses a threat to others the individual(s) who are the subject(s) of the threat and their parent/guardians must be notified and informed.

APPENDIX I

WARNING SIGNS OF SUICIDE

A. Suicidal Indicators

1. Suicidal threat or other statement indicating desire of intention to die.

   - May be direct verbal statement or indirect through joking, creative writing assignment, art work
   - Acting out, violent behavior often with suicidal or homicidal threats
   - Wish to die/intense preoccupation with death

2. Previous attempts even if superficial

3. Depression

   - Withdrawal from friends and activities
   - Loss of joy in life and bleak outlook for future
   - Changes in sleeping and eating habits
   - Risk-taking or reckless behavior
   - Preoccupation with death
   - Increased somatic complaints
   - Concentration problems with schoolwork
   - Frequent mood changes
   - Uncharacteristic emotional or rebellious outbursts
   - Low self-esteem or lack of confidence in abilities and in decision-making capabilities
   - Significant weight loss or gain
   - Decreased attention to physical appearance
   - Hyperactivity
   - Chronic fatigue
   - Feelings of worthlessness, inferiority, or guilt

4. Marked or sudden changes in behavior

   - Behavior symptomatic of depression
   - School problems
   - Substance abuse
   - Psychosomatic ailments
   - Constant accidents

5. Final arrangements
   - Giving away of valued articles
   - Sudden lifting of severe depression
   - More characteristic of older children and adolescent

APPENDIX I (continued)

B. Risk Factors

1. Relationship to School
   - Sense of not belonging in a school
   - Alienation from peers
   - Sense of having restricted future because of poor performance in school

2. School Environment
   - Recent transitions imposed by system
   - Lack of specialized programs
   - Alienation and rejection of certain students
   - Too much attention given to suicide threats or attempts

3. Family
   - Low level of family support
   - Suicidal behavior in family
   - Instability
   - Communication problems
   - Dysfunctional or disturbed structure
   - Crisis not tolerated
   - History of physical, mental, emotional, or sexual abuse

C. Common Stresses or Precipitating Events
   - Increased arguments with friends
   - Breakup with boyfriend or girlfriend
   - Trouble with sibling
   - Loss of friend
   - Divorce
   - Change in parents' finances
   - Injury or illness
   - Trouble with teacher
   - Failing grade
   - Change of school
   - Getting into trouble, being afraid
   - Disappointments, rejection, failure
   - Anxiety over impending change
   - Recent example of suicide

D. General "Types" of Teenagers More at Risk:
   - Impulsive, aggressive teenager with troubled relationship and a history of failure in school or work
   - Perfectionist, rigid teenager who is successful, but has very distorted or negative view of self
   - Depressed teenager
   - Youth Living with mental and/or substance use disorder
   - Youth who engage in self-harm or have attempted suicide
   - Youth in out of home settings
   - Youth experiencing homelessness
   - Youth bereaved by suicide
   - Youth living with mental conditions and disabilities

APPENDIX I (continued)

SOURCES

American Foundation for Suicide Prevention, the American School Counselor Association, & the National Association of School Psychologists (2014). Model School District Policy on Suicide Model Language, Commentary, and Resources. Retrieved from http://www.thetrevorproject.org/pages/modelschoolpolicy.

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Miller, DN (2010) Child and Adolescent Suicidal Behavior: School-Based Prevention, Assessment, and Intervention. NY: The Guilford Press

Peterson, S. & Straub R.L. (1992). School Crisis Survival Guide.

Poland, S. (1989). Suicide Intervention in the Schools. N.Y.: The Guilford Press

The Center for Applied Research in Education, West Nyack, N.Y.

Adopted: January 28, 2014
Revised: April 3, 2017
Readopted: November 21, 2017

APPENDIX II

CONFIDENTIAL

CRISIS/SUICIDE INTERVENTION REPORT

Name _____ Date _____ Grade _____

Address _____ Phone (Home) _____

_____ Phone (Work) _____

Parent/Guardian _____

Details of Incident: _____

_____

_____

_____

Parent/Guardian Notification _____

When reasonable cause to suspect or believe that a student has attempted or completed suicide is present – the Department of Human Services, Division of Mental Health and Addiction Services must be notified. Refer to NJAC 6A:16-11.1(b)

Interventions: _____

Follow-Up _____

_____

SUBMITTED BY: _____ DATE _____

Name Title

REPORTS SENT TO:

_____ Superintendent

_____ Director of Special Services

_____ Principal

_____ Intervention Committee Members

APPENDIX III

DEVELOPMENTAL UNDERSTANDING OF DEATH

Perceptions of Death

- Understanding at the developmental age, not the chronological age
- More mature understanding of an impersonal death; when personally affected, tend to regress
- Even if intellectual understanding is advanced, emotional ability to cope may not be

Ages 3 to 5

- Death is temporary, reversible and caused magically or by own bad thoughts, wishes, or actions
- Believe own bad wishes and actions may cause own death
- Graphic pictures of life after death
- Life like needs (food, etc.) attributed to death
- Concrete, literal thinkers so need careful explanations
- Hurt and angry at abandonment
- Pain is caused by separation; may re-experience grief when understand finality of death at older age
- Anxious that others may abandon
- Guilty because believe might have caused death

Ages 6 to 8

- Developing the concept of living versus non-living
- Preoccupation or fascination with life and death, decomposition and decay
- Frequently personify death as person to be fought off; only the weak and old lose the fight and die
- Dead people can see, hear, eat
- Interested in rituals and details so may ask many questions concerning death and funerals.

Ages 9 to 12

- Death understood as final and irreversible; pain is not just separation but knowledge of forever
- Death affects only the old
- Death as a matter of luck, possibly to escape
- Begin to consider possibilities after death so religious beliefs may provide comfort
- Fears about physical consequences of death and process of dying
- May experience guilt if had wished for the deceased's death because believe own behavior causes reactions

Adolescence

- Death is now universal and personal as well as final and irreversible (mature concept)
- However, belief in immortality of youth and will distance selves from the possibility
- Abstract thinkers will view death as remote and spiritual

APPENDIX III (continued)

SOURCES

Bauers, J. and Hatch T. (2005) The ASCA National Model: A Framework For School Counseling Programs, 2nd Ed., American Counseling Association.

Dudley, J. (2003) When Grief Visits Schools: Organizing A Successful Response. NY Educational Media Corp.

Petersen, S. & Straub, R.L. (1992). School Crisis Survival Guide.

The Center for Applied Research in Education, West Nyack, N.Y.

Wilson, P.G.R. (1988). Helping Children Cope With Death. In J. Sandoval (Ed.), Crisis Counseling, Intervention, and Prevention in the Schools. Lawrence Erlbaum, Hillsdale, N.J.

APPENDIX IV

GUIDELINES FOR CLASSROOM TEACHERS
Related to Suicide

1. The following are points to keep in mind:
   a. Suicide is the result of complex interaction of many factors in a person's life. There is no one cause. Avoid speculating on possible causes or attributing blame.
   b. Students will react in a variety of different ways. There is no "right way to feel" or "right way to mourn." Each person will have a unique response involving various different feelings that change over time.
   c. Mourning is a process that takes time varying in length for each individual.

2. Each first period or homeroom teacher should inform students of the death using the outline provided by the administration. If they are unable to do so or are absent, the Child Study Team and school counselor(s) should give assistance. The instructor should share basic facts to dispel rumors, but not dwell on details.

3. The teacher should share his/her own feelings of loss and grief, but not in any way convey the message that suicide is admirable or a viable way of dealing with problems.

4. Specific classes affected may wish to consider a commemorative response such as condolence letters to the family (which would be screened by administration before sending) or a fund raising project for a specific activity such as a mental health project. Plaques or trees are not recommended.

5. The classroom teacher should encourage students to seek out appropriate school personnel to discuss their reactions and feelings. The students should be excused from class to do so. The students should be provided a hallway pass/monitor (a "buddy" or school staff member).

6. During the next several days students should be allowed to leave class to attend counseling groups.

7. Students will be assisted by following the regular classroom activities. Structured activities are helpful in containing any contagion effect. It is advisable that stressful activities such as major examinations be rescheduled for later dates. If you have any questions about an activity, ask an Intervention Committee member.

SOURCE

Underwood, M.M. & Dunne-Mann, K. (1992). Managing Student Violent Loss in Schools. Piscataway: New Jersey State Department of Education & New Jersey State Department of Human Resources.

APPENDIX V

POSSIBLE REACTIONS TO A SUICIDE

Specific to a Suicide:

- Intense grief, but grief reactions vary
- Anger that may lead to scapegoating and blaming
- Denial
- Intensified anxiety
- Exaggerated feeling of responsibility for death

Normal Reactions to Traumatic Stress Situations:

- Forgetfulness
- Sleep and appetite disturbances
- Loss of concentration
- Irritability, anger
- Preservation (i.e., going over and over the last contact with the deceased)
- Numbed feelings
- Diminished interest

Immediate upon hearing news:

- Flight
- Avoidance by creating distractions
- Giggling
- Immobilization

APPENDIX VI

SUGGESTED QUESTIONS FOR CHILDREN

1. It seems things haven't been going so well for you lately. Your parents and/or teachers have said _____. Most children your age would feel upset about that. Have you felt upset or maybe you had some sad or angry feelings you've had trouble talking out?

2. Do you feel things can get better or are you worried (afraid or concerned) things will just stay the same or get worse?

3. Has anyone that you know attempted to kill himself or herself? Do you know why?

4. Have you thought about how you might make yourself die? Do you have a plan? Do you have the means available? Do you have access to these means?

5. Have you ever tried to kill yourself before? (If yes,) how far have you gone towards reaching an attempt?

6. What has made you feel so awful?

7. Who is there for you?

APPENDIX VII

SUGGESTED QUESTIONS FOR PARENTS

1. Has any serious change occurred in your child's or your family's life recently (last year)?
2. How did your child respond?
3. Has your child had any accidents or illnesses without a recognizable physical basis?
4. Has your child experienced a loss recently?
5. Has your child experienced difficulty in any areas of his/her life?
6. Has your child been very self-critical or have you or his/her teachers been very critical lately?
7. Has your child made any unusual statements to you or to others about death or dying? Any unusual questions or jokes about death or dying?
8. Have there been any changes you've noticed in your child's mood or behavior over the last few months?
9. Has your child ever threatened or attempted suicide before?
10. Have any of his/her friends or family, including you, ever threatened or attempted suicide?
11. How have these last few months been for you?
12. How have you reacted to your child (anger, despair, empathy)?

APPENDIX VIII

CRISIS/SUICIDE EVALUATION

To be completed by School Psychologist, School Social Worker or School Nurse

Name _____ Age_____ Date _____

1. Suicide Potential
   a. Non-suicidal
   b. Suicidal ideation
   c. Suicide threat
   d. Mild attempt (believes would not have killed self)
   e. Serious attempt (believes would have been fatal)

2. Suicide Plan
   a. Lethal potential of plan
   b. Availability of means
   c. Sophistication

3. Past Attempts
   a. Self
   b. Others

4. Affects and Behaviors

a. Anxiety	g. Hopeless resignation	l. Defiance
b. Anger	h. Temper tantrums	m. Trouble sleeping
c. Sadness	i. Psychomotor increase or decrease	n. Social withdrawal
d. Weight loss		o. Drug addiction
e. Running away	j. Transformed rage	p. Alcoholism
f. Depression	k. Fire setting	

5. Family Behavior
   a. Drug, alcohol, child abuse
   b. Recent deaths or separations
   c. Parents have coping plan

6. Precipitating Events
   a. Loss or threat of loss
   b. Health problems
   c. Social disgrace
   d. School problems
   e. Loss of reason to live

APPENDIX VIII (continued

7. Response from Support Network

8. Concept of Death

9. Cognitive Functioning, Reality Testing, and Affect Regulation

10. Impulse Control

Signature:_____

Print Name: _____

Title: _____

Date: _____

APPENDIX IX

(SCHOOL LETTERHEAD)

DATE

Parent/Guardian of _____

The Intervention Committee of _____School has recently met regarding concerns for your son/daughter. It has been brought to the attention of the Intervention Committee that your son/daughter has voiced or written intent to engage in a suicidal act/harm to self or others. In accordance with N.J.A.C. 6A:16-11.1(b), "The district board of education shall develop and adopt policies and procedures for school district employees, volunteers, or interns with reasonable cause to suspect or believe that a student has attempted or completed suicide, to report the information to the Department of Human Services, Division of Mental Health and Addiction Services, in a form and manner prescribed by the Division of Mental Health and Addiction Services pursuant to N.J.S.A. 30:9A-24.a."

Due to the seriousness of the situation, it is the request of the Intervention Committee that your son/daughter be evaluated by a Licensed Mental Health Professional as described by the list of following professionals (Source: The New Jersey Division of Consumer Affairs; www.njconsumeraffairs.gov):

Psychiatrist (M.D.) – A physician who specializes in the prevention, assessment, diagnosis, and treatment of mental illness. A psychiatrist must receive additional training and serve a supervised residency in his or her specialty. He or she may also have additional training in a psychiatric specialty, such as child psychiatry or neuropsychiatry. Psychiatrists can prescribe medication; which psychologists cannot do. Persons requiring licensure for Psychiatry conduct is within the scope of practice set forth through the New Jersey State Board of Medical Examiners.

Licensed Clinical Psychologist (PhD, and/or Psy.D) – Has received the degree PhD and Psy.D in psychology from a recognized educational institution. "Licensed practicing psychologist" means a professional person who renders professional psychological services to individuals or in groups, whether in the general public or in organizations, either public or private, for a fee, monetary or otherwise. "Professional psychological services" means the application of psychological principles and procedures in the assessment, counseling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations. Persons requiring licensure include all those whose conduct is within the scope of practice set forth in N.J.A.C. 13:42-1.1 and whose practice is not otherwise exempt pursuant to N.J.S.A. 45:14B-6, and 45:14B-8, N.J.A.C. 13:42-1.4 and 1.5 through the New Jersey Board of Psychological Examiners.

Licensed Clinical Social Worker (LCSW) – Professionals who are trained in the application of social work methods and values in the Assessment and psychotherapeutic counseling of individuals, families and groups. These professionals have completed two years of full-time clinical work totaling 1,920 hours of face-to-face client contact within any three consecutive year period subsequent to earning a master's degree in social work under direct supervision pursuant to the standards set forth in N.J.A.C. 13:44G-8.1. They are individuals whom obtained licensure to practice social work in the State of New Jersey. Clinical social work services include, but are not limited to, clinical assessment, clinical consultation, psychotherapeutic counseling, client centered advocacy, and clinical supervision of individuals pursuant to the standards set forth in N.J.A.C. 13:44G-8.1 through the New Jersey Board of Social Work

APPENDIX IX (continued)

Licensed Professional Counselor (LPC) – State-licensed mental health professionals whose scope of practice includes, but is not limited to, counseling, counseling interventions, appraisal and assessment, consulting, referral, and research activities, as defined in N.J.A.C. 13:34-10.2. Professional Counselor Licensing Act, P.L. 1993, c.340 (N.J.S.A. 45:8B-34 et seq.) (the "Act") as amended and supplemented by P.L. 1997, c.155, and regulate the profession of counseling, as defined in N.J.A.C. 13:34-10.2, within the State of New Jersey.

The Licensed Mental Health Professional Statement Form must be completed by a Licensed Mental Health Professional in order for the student to return to school. The form must be submitted to the building Principal from the Licensed Mental Health Professional before your child is permitted to return to school. (The recommendation in the clearance letter for treatment or follow-up care are at the sole discretion of that professional and are not required for re-entry into school. The Township of Union Public Schools will not be financial responsible for any recommendations made by the mental health professional.) Please understand that this is a recommendation made out of caring and concern for your son/daughter.

_____ _____

School Principal Intervention Committee Member

Please check the appropriate sentence below and sign.

☐ I understand the above recommendation and will follow through with a Licensed Mental Health Professional evaluation.

☐ I, _____, understand the recommendation for a Mental Health Professional evaluation, however I do not feel that it is necessary at this time. I hereby confirm that I have been fully apprised of the matter of my child's voiced or written intent to engage in a suicidal act or harm to self or others. I was: (a) Advised as to the seriousness of the matter; (b) Offered resources. However, I elect to decline the recommendations for the Mental Health Professional Evaluation. I accept full responsibility and understand that the Division of Child Protection and Permanency (DCPP, formerly DYFS) will be contacted concerning the situation

_____ _____

Date Parent/Guardian Signature

Remove_____ Date _____
Intervention Committee Member

Remove_____ Date _____
Intervention Committee Member

METHOD OF DELIVERY: _____Provided at Conference _____Mailed to Home

APPENDIX X

GLOSSARY OF TERMS

DEFINITIONS

Intervention Committee (IC): A building-based committee consisting of the principal, school counselor, school nurse, Student Assistance Counselor (SAC), School Social Worker, School Psychologist and/or teachers (if they are the referring agent). This committee will identify at-risk students and plan interventions in their behalf.

Suicidal Indicators: Verbal or non-verbal signs that a student may be at risk to engage in suicidal behaviors.

Mental Health Professional: As defined by the following professionals (Source: the New Jersey Division of Consumer Affairs; www.njconsumeraffairs.gov):

Psychiatrist (M.D.) – A physician who specializes in the prevention, assessment, diagnosis, and treatment of mental illness. A psychiatrist must receive additional training and serve a supervised residency in his or her specialty. He or she may also have additional training in a psychiatric specialty, such as child psychiatry or neuropsychiatry. Psychiatrists can prescribe medication; which psychologists cannot do. Persons requiring licensure for Psychiatry conduct is within the scope of practice set forth through the New Jersey State Board of Medical Examiners.

Licensed Clinical Psychologist (PhD, and/or Psy.D) – Has received the degree PhD and Psy.D in psychology from a recognized educational institution. "Licensed practicing psychologist" means a professional person who renders professional psychological services to individuals or in groups, whether in the general public or in organizations, either public or private, for a fee, monetary or otherwise. "Professional psychological services" means the application of psychological principles and procedures in the assessment, counseling or psychotherapy of individuals for the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations. Persons requiring licensure include all those whose conduct is within the scope of practice set forth in N.J.A.C. 13:42-1.1 and whose practice is not otherwise exempt pursuant to N.J.S.A. 45:14B-6, and 45:14B-8, N.J.A.C. 13:42-1.4 and 1.5 through the New Jersey Board of Psychological Examiners.

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Licensed Professional Counselor (LPC) – State-licensed mental health professionals whose scope of practice includes, but is not limited to, counseling, counseling interventions, appraisal and assessment, consulting, referral, and research activities, as defined in N.J.A.C. 13:34-10.2. Professional Counselor Licensing Act, P.L. 1993, c.340 (N.J.S.A. 45:8B-34 et seq.) (the "Act") as

amended and supplemented by P.L. 1997, c.155, and regulate the profession of counseling, as defined in N.J.A.C. 13:34-10.2, within the State of New Jersey

APPENDIX XI

RESOURCE LIST*

FAMILY CENTER AT MONTCLAIR* 973-857-5333
Mental Health *Union Township Board of Education Approved

~~**JERSEY BEHAVIORAL CARE** 908-291-2727~~
~~*Union Township Board of Education Approved~~

Counseling Centers for Human Development 908-276-0590
*Union Township Board of Education Approved

CARRIER COUNSELING CENTER 908-281-1000
Adolescent/Adult Mental health/Substance Abuse

COOPERATIVE COUNSELING 908-731-7100
Mental Health

FAMILY RESOURCE CENTER 908-276-2244
Mental Health Counseling

GANNON COUNSELING 908-964-4233
Substance Abuse Counseling

HIGH FOCUS TREATMENT CENTER 800-877-FOCUS
Adolescent/Adult Substance Abuse

MOUNT CARMEL GUILD 908-497-3968
Mental Health/Substance Abuse

PROCEED (SPANISH) 908-351-7727
Substance Abuse Counseling

RESOLVE 908-322-9180
Mental Health/Substance Abuse

SUMMIT OAKS 908-522-7000
Mental Health/Substance Abuse

SUMMIT PSYCHIATRIC & COUNSELING 908-277-1550
Mental Health Counseling

SUMMIT PSYCHOLOGICAL SERVICES 908-273-5558
Mental Health/Substance Abuse

TRINITAS HOSPITAL 908-994-7131
Psychiatric Emergency Room

YOUTH & FAMILY COUNSELING SERVICES Mental Health Counseling	908-233-204
Atlantic Health Systems - Overlook	888-247-1400

*Current telephone numbers as of date Board of Education policy approved. If parent/guardian is unable to contact an any of the resources listed contact the Director of Special Services.

Adopted:	January 28, 2014
Revised:	April 3, 2017
Readopted	November 21, 2017