This document was originally published as a ***Supplement*** to the ***Morbidity and Mortality Weekly Report***, August 19, 1988 / 37(S-6);1-12. These guidelines remain the current best practice guidelines for preventing and containing suicide clusters.

As a federal report, no changes have been made to this document. As such, the Center for Health and Learning would like to note that the term "committed" suicide is not recommended, based on extensive feedback from suicide loss survivors. Instead, "died by suicide" is recommended. This change took place after this supplement was issued in 1988.

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CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters

OUTLINE

I. A community should review these recommendations and develop its own response before the onset of a suicide cluster.

II. The response to the crisis should involve all concerned sectors of the community and should be coordinated by:
   - A. Coordinating Committee, which manages the day-to-day response to the crisis, and
   - B. Host Agency, whose responsibilities would include "housing" the plan, monitoring the incidence of suicide, and calling meetings of the Coordinating Committee when necessary.

III. The relevant community resources should be identified.

IV. The response plan should be implemented under either of the following two conditions:
   - A. When a suicide cluster occurs in the community, or
   - B. When one or more deaths from trauma occur in the community, especially among adolescents or young adults, which may potentially influence others to attempt or complete suicide.

V. If the response plan is to be implemented, the first step should be to contact and prepare those groups who will play key roles in the first days of the response.

VI. The response should be conducted in a manner that avoids glorification of the suicide victims and minimizes sensationalism.

VII. Persons who may be at high risk of suicide should be identified and have at least one screening interview with a trained counselor; these persons should be referred for further counseling or other services as needed.

VIII. A timely flow of accurate, appropriate information shouldbe provided to the media.

IX. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.

X. Long-term issues suggested by the nature of the suicide cluster should be addressed.

INTRODUCTION

Recent suicide clusters among teenagers and young adults have received national attention, and public concern about this issue is growing. Unfortunately, our understanding of the causes and means of preventing suicide clusters is far from complete. A suicide cluster may be defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community. A statistical analysis of national mortality data indicates that clusters of completed suicide occur predominantly among adolescents and young adults, and that such clusters account for approximately 1%-5% of all suicides in this age group (1). Suicide clusters are thought by many to occur through a process of "contagion," but this hypothesis has not yet been formally tested (2,3). Nevertheless, a great deal of anecdotal evidence suggests that, in any given suicide cluster, suicides occurring later in the cluster often appear to have been influenced by suicides occurring earlier in the cluster. Ecologic evidence also suggests that exposure of the general population to suicide through television may increase the risk of suicide for certain susceptible individuals (4,5), although this effect has not been found in all studies (6,7).

The Centers for Disease Control (CDC) has assisted several state and local health departments in investigating and responding to apparent clusters of suicide and suicide attempts. These clusters created a crisis atmosphere in the communities in which they occurred and engendered intense concern on the part of parents, students, school officials, and others. In the midst of these clusters of suicides or suicide attempts, community leaders were faced with the simultaneous tasks of trying to prevent the cluster from expanding and trying to manage the crisis that already existed. Potential opportunities for prevention were often missed during the early stages of response as community leaders searched for information on how best to respond to suicide clusters.

The recommendations contained in this report were developed to assist community leaders in public health, mental health, education, and other fields to develop a community response plan for suicide clusters or for situations that might develop into suicide clusters. A workshop for developing these recommendations was jointly sponsored by the New Jersey State Department of Health and CDC on November 16-17, 1987, in Newark, New Jersey.* Participants in that workshop included persons who had played key roles in community responses to nine different suicide clusters. They were from a variety of different sectors including education, medicine, local government, community mental health, local crisis centers, and state public health and mental health. Also participating in this workshop were representatives from the National Institute of Mental Health (NIMH), the Indian Health Service (IHS), the

American Association of Suicidology (AAS), and the Association of State and Territorial Health Officials (ASTHO).

These recommendations should not be considered explicit instructions to be followed by every community in the event of a suicide cluster. Rather, they are meant to provide community leaders with a conceptual framework for developing their own suicide-cluster-response plans, adapted to the particular needs, resources, and cultural characteristics of their communities. These recommendations will be revised periodically to reflect new knowledge in the field of suicide prevention and experience acquired in using this plan.

Certain elements of the proposed plan for the prevention and containment of suicide clusters are quite different from those of crisis-response plans for other community emergencies. These differences are primarily attributable to the potentially contagious nature of suicidal behavior and to the stigma and guilt often associated with suicide. Other elements of the proposed plan, however, are germane to crisis-response plans in general. Therefore, state and local health planners might consider whether the plan they develop from these recommendations should be integrated into existing guidelines for managing other emergencies or mental health crises.

I. A community should review these recommendations and develop its own response plan before the onset of a suicide cluster.

Comment: When a suicide cluster is occurring in a community--or when such a cluster seems about to occur--several steps in our recommended response plan should be taken right away. If such a timely reaction is to be possible, the response plan must necessarily already be developed, agreed upon, and understood by all the participants at the onset of the crisis. The recommended response requires a great deal of coordination among various sectors of the community. Such coordination is sometimes difficult to establish at the best of times and may be even more difficult to establish in the face of a crisis.

In the early days of an evolving suicide cluster there has typically been a great deal of confusion. There is often a sense of urgency in the community that something needs to be done to prevent additional suicides, but there has usually been little initial coordination of effort in this regard. Moreover, community members often disagree about precisely what should be done to prevent a cluster from expanding. In almost every case, communities ultimately develop some sort of plan for responding to the crisis in a coordinated manner, but opportunities for prevention are often missed in the crucial first hours of the response.

II. The response to the crisis should involve all concerned sectors of the community and should be coordinated as follows:

A. Individuals from concerned agencies--education, public health, mental health, local government, suicide crisis centers, and other appropriate agencies--should be designated to serve on a coordinating committee, which would be responsible for deciding when the response plan should be implemented and coordinating its implementation.
B. One agency should be designated as the "host" agency for the plan. The individual representing that agency would have the following responsibilities:
    1. Call the initial meeting of the coordinating committee before any crisis occurs so that these recommendations can be incorporated into a plan that reflects the particular resources and needs of the community (see Section III, below).
    2. Establish a notification mechanism by which the agency would be made aware of a potentially evolving suicide cluster (see Comment, below).
    3. Convene the coordinating committee when it appears that a suicide cluster is occurring, or when it is suspected that a cluster may occur due to the influence of one or more recent suicides or other traumatic deaths (see Section IV, below). At this initial meeting, the members of the coordinating committee could decide whether to implement the community response plan and how extensive the response needs to be.
    4. Maintain the suicide-cluster-response plan. The coordinating committee should meet periodically to assure that the plan remains operational.
    5. Revise the community plan periodically to reflect new knowledge in the field of suicide prevention, the community's experiences in using the plan, and changes in the community itself.

Comment: Every effort should be made to promote and implement the proposed plan as a community endeavor. During past suicide clusters, a single agency has often found itself "in the hot seat," that is, as the focal point of demands that something be done to contain the suicide cluster. No single agency, however, has the resources or expertise to adequately respond to an evolving suicide cluster. Moreover, the emergence of one agency as the sole focus for responding to an apparent suicide cluster has several unfortunate consequences. The agency and its representatives run the danger of becoming scapegoats for a community's fear and anger over the apparent cluster. Such a focus can potentially blind a community to other valuable resources for responding to the crisis and to basic community problems that may have engendered the crisis.

The concept of a "host" agency was developed because--even though the response will involve a variety of different agencies and community groups--one person must necessarily take responsibility for establishing a notification mechanism, maintaining the response plan, and calling meetings of the coordinating committee as outlined above. Which agency should serve as the host agency should be decided by each community. In past clusters, for example, a school district, a municipal government, a mental health association, and even a private, nonprofit mental health center have taken the lead in organizing their community's response. State or local public health or mental health agencies might also serve as host agencies for the plan. The role of host agency might also be rotated among the various agencies represented on the coordinating committee.

The notification mechanism by which the host agency would be made aware of a potentially evolving suicide cluster would vary from community to community. In small communities, one death of a teenager by suicide might be unusual, and information about the death would be quickly transmitted to a county-level host agency. In some large communities, however, there are many suicides each year among young persons. Clearly, a more formal system would be needed in such a county to notify the host agency when an unusual number of suicides had occurred in a particular high school or municipality.

Determining whether to implement the response plan is not an all-or-nothing decision. Indeed, an important function of the coordinating committee is to decide to what extent the plan will be implemented. In situations in which it is feared that a cluster of suicides may be about to start, for example, the implementation of the plan might be quite subtle and limited, whereas in the event of a full-blown community crisis the implementation should be more extensive.

III. The relevant community resources should be identified. In addition to the agencies represented on the coordinating committee, the community should also seek to identify and enlist help from other community resources, including (but not limited to):

A. hospitals and emergency departments
B. emergency medical services
C. local academic resources
D. clergy
E. parents groups (e.g., PTA)
F. suicide crisis centers/hotlines
G. survivor groups
H. students
I. police

J. media
K. representatives of education, public health, mental health, and local government, if not already represented on the coordinating committee

Comment: The roles of each of the above groups should be defined as clearly as possible in the response plan before any crisis occurs. These roles should be agreed upon and reviewed by persons representing those groups. Most of those involved in the response will already know how to perform their particular duties. However, appropriate training for the staff of these groups should be provided as necessary (8). For example, if it is deemed desirable to conduct surveillance for suicide attempts through hospital emergency departments, officials at the state or local public health department might help design the system and train the emergency department staff. Other potential resources for training and counseling include state and local mental health agencies, mental health and other professional associations, and suicide crisis centers.

It is particularly important that representatives of the local media be included in developing the plan. In at least one community faced with a suicide cluster, the media collaborated in preparing voluntary guidelines for reporting suicide clusters. Although frequently perceived to be part of the problem, the media can be part of the solution. If representatives of the media are included in developing the plan, it is far more likely that their legitimate need for information can be satisfied without the sensationalism and confusion that has often been associated with suicide clusters.

The following example representing a composite of several actual suicide clusters illustrates the need for inclusion of and cooperation among many community organizations. Suppose that two high school students from the same school commit suicide in separate incidents on a weekend during the regular school year. The coordinating committee decides that these two deaths may increase the risk of suicide or attempted suicide among other students. The responsibilities of some of the relevant community resources might be as follows: School officials might be responsible for announcing the deaths to the students in an appropriate manner (discussed below, Section VI). School counselors and teachers might assist in identifying any students whom they think are at high risk; students in the school might also help in this regard. The local mental health agency might provide counselors to work with troubled students, as well as supply training and support for the teachers. Emergency departments of community hospitals might set up a suicide-attempt surveillance system that would increase the sensitivity with which suicide attempters were identified and would ensure proper referral of the attempters for counseling. Hotlines might help identify potential suicide attempters, and police might assist in locating such persons when appropriate. Police may also help by identifying and maintaining contact with such high-risk persons as high school dropouts and those

with a history of delinquency. Local government or public health authorities might help coordinate these various efforts, if so designated by the coordinating committee.

IV. The response plan should be implemented under either of the following two conditions:

A. When a suicide cluster occurs in the community; that is, when suicides or attempted suicides occur closer together in space and time than is considered by members of the coordinating committee to be usual for their community;
   - OR

B. When one or more deaths from trauma occur in the community (especially among adolescents or young adults) which the members of the coordinating committee think may potentially influence others to attempt or complete suicide.

Comment: It is difficult to define a "suicide cluster" explicitly. Clearly, both the number and the degree of "closeness" of cases of suicide in time and space that would constitute a suicide cluster vary depending on the size of the community and on its background incidence of suicide. But when a community considers that it is facing a cluster of suicides, it is essentially irrelevant whether the incident cases of suicide meet some predefined statistical test of significance. With the suddenly heightened awareness of and concern about suicide in such a community, steps should be taken to prevent further suicides that may be caused in part by the atmosphere, or "contagion," of the crisis.

In several clusters of suicides or suicide attempts, the crisis situation was preceded by one or more traumatic deaths--intentional or unintentional--among the youth of the community. For example, in the 9 months preceding one cluster of four suicides and two suicide attempts among persons 15-24 years of age, there were four traumatic deaths among persons in the same age group and community--two from unintentional injuries, one from suicide, and one of undetermined intentionality. One of the unintentional-injury deaths was caused by a fall from a cliff. Two of the persons who later committed suicide in the cluster had been close friends of this fall victim; one of the two had witnessed the fall.

The hypothesis that a traumatic death can kindle a suicide cluster regardless of whether it is caused by intentional or unintentional injuries has not yet been tested. Nevertheless, the available anecdotal evidence suggests that some degree of implementation of the response plan be considered when a potentially influential traumatic death occurs in the community--especially if the person who dies is an adolescent or young adult.

We should emphasize that the fear of a contagious effect of suicide is not the only reason to implement this plan. For example, suppose that in the wake of some local economic downturn a community noted an excess of suicide deaths among persons who had been laid off from work. This would be a suicide cluster, and it would be entirely appropriate for the coordinating committee to implement the response plan. It is irrelevant that the suicides are not apparently related to contagion from previous suicides but to a "common-source" problem, since there is an identified population (laid-off workers) potentially at a suddenly increased risk of suicide.

Whether and when to implement the response plan should be determined by the coordinating committee. At this stage of our understanding of suicide clusters, we cannot specify that the response plan should be implemented only under a particular list of circumstances. Until further scientific investigation and experience with suicide clusters provides us with a more empirical basis for deciding when to implement the response plan, we must rely on prudent judgments by community leaders regarding the potential for further suicides in their communities.

V. If the response plan is to be implemented, the first step should be to contact and prepare the various groups identified above.

A. Immediately notify those who will play key roles in the crisis response of the deaths that prompted the implementation of the response plan (if they are not already aware of them).
B. Review the respective responsibilities and tasks with each of these key players.
C. Consider and prepare for the problems and stresses that these persons may encounter--burnout, feelings of guilt if new suicides occur, and the like--as they carry out their assigned tasks.

Comment: Timely preparation of the groups involved is critical. In a past cluster that began with a scenario similar to that described in Section III above, the teachers and the students both heard about the suicide deaths at the same time over the school loudspeaker. The teachers were entirely unprepared to deal with the emotional response of the students and did not know what to say to them or where to refer those who were most upset. It would have been far preferable to have called a pre-school meeting with the teachers to outline the problem, discuss the appropriate roles of the teachers, and announce the various resources that were available (9). Support staff at the school--secretaries, bus drivers, janitors, nurses, and others--might also have been included at the meeting. Such preparation could have been of enormous help in several past suicide clusters.

VI. The crisis response should be conducted in a manner that avoids glorifying the suicide victims and minimizes sensationalism.

A. Community spokespersons should present as accurate a picture as possible of the decedent(s) to students, parents, family, media, and others (see Section VIII, below).
B. If there are suicides among persons of school age, the deaths should be announced (if necessary) in a manner that will provide maximal support for the students while minimizing the likelihood of hysteria.

Comment: Community spokespersons should avoid glorifying decedents or sensationalizing their deaths in any way (9). To do so might increase the likelihood that someone who identifies with the decedents or who is having suicidal thoughts will also attempt suicide, so as to be similarly glorified or to receive similar positive attention. One community that had had several suicides among high school students installed a "memorial bench" on the school grounds, with the names of the suicide victims engraved on the bench. Although this gesture was undoubtedly intended to demonstrate sincere compassion, such a practice is potentially very dangerous.

Spokespersons should also avoid vilifying the decedents in an effort to decrease the degree to which others might identify with them. In addition to being needlessly cruel to the families of the decedents, such an approach may only serve to make those who do identify with the decedents feel isolated and friendless.

If the suicide victims are of school age, the deaths should be announced privately to those students who are most likely to be deeply affected by the tragedy--close friends, girl friends, boy friends, and the like. After the teachers are briefed (see Section V), the suicide deaths might be announced to the rest of the students either by individual teachers or over the school loudspeaker when all the students are in homeroom or some other similarly small, supervised groups. Funeral services should not be allowed to unnecessarily disrupt the regular school schedule.

VII. Persons who may be at high risk should be identified and have at least one screening interview with a trained counselor; these persons should be referred for further counseling or other services as needed.

A. Active measures:
    1. Identify relatives (siblings, parents, children) of the decedents and provide an opportunity for them to express their feelings and to discuss their own thoughts about suicide with a trained counselor.

2. Similarly, identify and provide counseling for boy friends/girl friends, close friends, and fellow employees who may be particularly affected by the deaths.

B. Strategies to identify associates of the decedents or others who may be at increased risk of suicide might include: identifying the pall bearers at the funeral services of the decedent(s); checking with the funeral director regarding visitors who seemed particularly troubled at the services; keeping a list of hospital visitors of suicide attempters; and verifying the status of school absentees in the days following the suicide of a student.
    1. In the case of suicides among school-age persons, enlist the aid of teachers and students in identifying any students whom they think may be at increased risk of suicide.
    2. Identify and refer past and present suicide attempters for counseling if these persons were substantially exposed to suicide (see below), regardless of whether they were close friends of the decedents.
    3. "Substantially exposed" persons would include, for example, students in the same high school or workers at the same job location as the suicide victims. In past suicide clusters, such persons have committed or attempted suicide even though they did not personally know the victims who had committed suicide earlier in the cluster.
    4. Identify and refer persons with a history of depression or other mental illness or with concurrent mental illness who were substantially exposed to suicide (see Section VII.A.4.a, above).
    5. Identify and refer persons whose social support may be weakest and who have been substantially exposed to suicide. Examples of such persons include:

        a. students who have recently moved into the school district
        b. students who come from a troubled family persons who have been recently widowed or divorced, or who have recently lost their jobs.

C. Passive Measures:

    1. Consider establishing hotlines or walk-in suicide crisis centers--even temporarily--if they do not already exist in the community; announce the availability of such hotlines/centers.
    2. Provide counselors at a particular site (such as school, church, community center) and announce their availability for anyone troubled by the recent deaths.
    3. If suicides have occurred among school-age persons, provide counselors in the schools if possible; announce their availability to the students.

4. Enlist the local media to publish sources of help--hotlines, walk-in centers, community meetings, and other similar sources.
5. Make counseling services available to persons involved in responding to the crisis

Comment: The recommendations for active measures to identify persons at high risk of suicide are based largely on scientific evidence that certain factors increase the risk of suicide. For example, mental illness (especially depressive illness) (10) and a history of past suicide attempts (11) are both strong risk factors for suicide. Certain sociologic factors such as unemployment (12), being widowed or divorced (13,14), other bereavement (15,16), and mobility (17), also appear to be important risk factors for suicide.

The role of imitation or "contagion" is, as we noted above, less well-established than the risk factors listed above. Nevertheless, the anecdotal evidence from suicide clusters is quite compelling, and several of the specific suggestions made above regarding who should be considered for screening are based on such evidence. For example, in one high school-based cluster, two persons who committed suicide late in the cluster had been pall bearers at the funerals of suicide victims who had died earlier in the cluster. It is likely that persons who are exposed to one or more of the aforementioned risk factors--depression or recent loss, for example--may be more susceptible to a contagious effect of suicide.

VIII. A timely flow of accurate, appropriate information should be provided to the media.

A. Make certain that a single account of the situation is presented by appointing one person as information coordinator. This person's duties would include:
    1. meeting frequently with designated media spokespersons (see Section VIII-B, below) to share news and information, and to make certain that the spokespersons share a common understanding of the current situation
    2. "directing traffic"--referring requests for particular types of information to selected media spokespersons or to others (e.g., academic resources)
    3. maintaining a list of local and national resources for appropriate referral of media inquiries
    4. scheduling and holding press conferences.
B. Appoint a single media spokesperson from each of the relevant community sectors--public health, education, mental health, local government, and the like.
    1. Each sector represented on the coordinating committee should have a spokesperson. This person is not necessarily the same representative who serves on the coordinating committee.

2. Spokespersons from additional agencies or public groups may be designated as appropriate.

C. These spokespersons should provide frequent, timely access to the media and present a complete and honest picture of the pertinent events. When appropriate, regularly scheduled press conferences should be held.
    1. Avoid "whitewashing"--that is, saying that everything is under control or giving other assurances that may later prove unwarranted. This practice would undermine the credibility of the community spokespersons.
    2. Discuss the positive steps being taken, and try to get the media to help in the response by reporting where troubled persons can go for help.
D. The precise nature of the methods used by decedent(s) in committing suicide should not be disclosed. For example, it is accurate to state that an individual committed suicide by carbon monoxide poisoning. But it is not necessary--and is potentially very dangerous--to explain that the decedent acquired a hose from a hardware store, that s/he hooked it up to the tail pipe of a car, and then sat in a car with its engine running in a closed garage at a particular address. Such revelations can only make imitative suicides more likely and are unnecessary to a presentation of the manner of death.
E. Enlist the support of the community in referring all requests for information to these spokespersons.

Comment: If some suicide clusters spread through "contagion," the vehicle for such contagion is information, perhaps sensationalized information, about the suicides that have occurred. The role of the media in causing or exacerbating a suicide cluster is controversial, but some investigators will no longer even discuss an evolving suicide cluster with media representatives for fear that newspaper or television accounts will lead to further suicides. Although a definitive understanding of this issue must be left to future research, it is prudent in the meantime to try to prevent needlessly sensationalized or distorted accounts of evolving suicide clusters.

The media spokespersons should meet as a group and with the information coordinator regularly; under certain circumstances, they may need to check with each other several times a day. Gaining the cooperation of the community in referring requests to these spokespersons is a formidable task and will require early and ongoing efforts if it is to be accomplished. It may be helpful to assure community members that it is all right to say “no” to media phone calls or requests for interviews.

The cooperation of parents is especially essential in the context of a school-based suicide cluster. Interviews with students about the suicide of one or more of their peers can be very stressful. Parents who do not wish to have their children interviewed may be able to prevent such interviews by refusing to sign a release statement. A

handout addressing how media requests should be handled might be prepared and distributed to parents, students, and other appropriate persons.

Gaining the cooperation of media representatives in this regard is also a formidable task. In the midst of a crisis, the frequent presentation of accurate and credible information is the best means of establishing such cooperation. It is preferable, however, to develop a working relationship with local media representatives before a crisis occurs.

IX. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.

Comment: If a particular method or site was used in previous suicides or suicide attempts, modification efforts should be addressed to these methods or sites first. For example, if the decedent(s) jumped off a particular building, bridge, or cliff, barriers might be erected to prevent other such attempts. If the decedent(s) committed suicide by carbon monoxide poisoning in a particular garage, access to that garage should be limited or monitored or both. If the decedent(s) committed suicide with a firearm or by taking an overdose of drugs, then restricting immediate access to firearms or to potentially lethal quantities of prescription drugs should be considered. In the case of suicides committed in jail, belts and other articles that may be used to commit suicide by hanging should be removed, and vigilance over the jail cells should be increased. Some of these modifications can be accomplished directly through the efforts of the coordinating committee, while others (limiting access to drugs or firearms) can only be suggested by the committee for others to consider.

Although immediate environmental modifications may be suggested by methods used in previous suicides, the modifications need not be limited only to those methods. If there is concern, for example, that the risk of suicide for particular adolescents may have been increased because of the influence of previous traumatic deaths, then common methods of suicide--firearm injury, carbon monoxide poisoning, overdose--should be made temporarily unavailable if possible. The coordinating committee should consider a variety of potentially relevant environmental factors in developing this element of the response strategy.

X. Long-term issues suggested by the nature of the suicide cluster should be addressed.

Comment: Common characteristics among the victims in a given suicide cluster may suggest that certain issues need to be addressed by the community. For example, if the decedent(s) in a particular suicide cluster tended to be adolescents or young adults who were outside the main stream of community life, efforts might be made to bring

such persons back into the community. Or, if a large proportion of the suicide attempters or completers had not been suspected of having any problems, then a system should be developed (or the present system altered) so that troubled persons could receive help before they reached the stage of overt suicidal behavior.

Communities should consider establishing a surveillance system for suicide attempts as well as completed suicides. Suicide-attempt surveillance systems are almost nonexistent; yet the benefits of such systems are potentially great. In the context of a suicide cluster, such a system would allow persons who have attempted suicide in the past to be identified. Such persons are known to be at high risk of further suicide attempts. It would also allow for ongoing identification of high-risk persons during and after the current crisis. Communities should consider establishing suicide-attempt surveillance systems in their local emergency departments or wherever appropriate.

This plan should be modified according to the community's experience with its operation. Parts of the plan that have worked well in a given setting should be stressed in the updated plan, and parts that were inapplicable or that did not work should be excluded. Finally, the Centers for Disease Control requests that communities that use the plan notify us of their experiences with the plan to allow appropriate updating of this document.

> **Please write to:** Chief, Intentional Injuries Section Mailstop F-36 Centers for Disease Control 1600 Clifton Road NE Atlanta, GA 30333

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*Participants in the workshop included: Eugene Aronowitz, Ph.D., Department of Community Mental Health, Westchester County, N.Y.; Ines Assafi, M.S.W., Jefferson County Mental Health Center, Lakewood, CO; Dennis Blomquist, Guidance and Counseling for Mankato Public Schools, Mankato, MN; Ronald G. Burmood, Ph.D., Omaha Public Schools, Omaha, NE; Betsey S. Comstock, M.D., Baylor College of Medicine, Houston, TX; Karen Dunne-Maxim, R.N., M.S., New Jersey Youth Suicide Prevention Project, Princeton Junction, NJ; John W. Farrell, M.S.W., New Jersey State Department of Health, Trenton, NJ; Louis C. Goetting, IV, South Brunswick Township, Monmouth Junction, NJ; Madelyn S. Gould, Ph.D., New York State Psychiatric Institute/Columbia University, New York, NY; Myra Herbert, M.S.W., Fairfax Public Schools, Fairfax, VA; Karen Hymbaugh, Indian Health Service, Albuquerque, NM; Elizabeth N. Jones, Ed.S., American Association of Suicidology, Gainesville, FL; Alan J. Krumholz, M.D., Leominster Hospital Medical Center, Leominster, MA; James A. Mercy, Ph.D., CDC; Patrick W. O'Carroll, M.D., CDC; William Parkin, D.V.M., New Jersey State Department of Health, Trenton, NJ; Michael Petrone, M.D., New Jersey State Department of Health, Trenton, NJ; Julie Rayburn- Miller, M.S.W., Association of State and Territorial Health Officers,

Jefferson City, MO; Jon Shaw, M.D., National Institute of Mental Health, Rockville, MD; Carole E. Steele, R.N., M.S., Crisis Center of Collin County, Plano, TX; and John A. Steward, M.P.H., CDC.