diego valley east
PUBLIC CHARTER SCHOOL

SCHOOL POLICY ON SUICIDE PREVENTION

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SCHOOL POLICY ON SUICIDE PREVENTION

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INTRODUCTION

Protecting the health and well-being of students is in line with school mandates and is an ethical imperative for all professionals working with children and youth. Because it is impossible to predict when a crisis will occur, preparedness is necessary for every schools. In a typical high school, it is estimated that three students will attempt suicide each year. On average, a young person dies by suicide every two hours in the US. For every young person who dies by suicide, an estimated 100-200 youth make suicide attempts. Youth suicide is preventable, and educators and schools are key to prevention.

The language and concepts covered by this policy are applicable for education levels K-12. While historically, many school-based suicide prevention policies have focused on middle and high school students current data has shown an increased (albeit still low) suicide rate for children at younger ages. Keeping in mind that a student talking about suicide must be taken seriously at any age, much of the information is relevant for elementary schools as well as older students.

As emphasized in the National Strategy on Suicide Prevention, preventing suicide depends not only on suicide prevention policies, but also on a holistic approach that promotes healthy lifestyles, families, and communities. Thus, this policy is intended to support the emotional and behavioral well-being of youth.

PURPOSE

The purpose of this policy is to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene and respond to suicide. The school:

a) recognizes that physical, behavioral, and emotional health is an integral component of a student's educational outcomes,
b) further recognizes that suicide is a leading cause of death among young people,
c) has an ethical responsibility to take a proactive approach in preventing deaths by suicide, and
d) acknowledges the school's role in providing an environment which is a sensitive to individual and societal factors that place children and youth at a greater risk for suicide and one which helps to foster positive youth development
e) Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components.

This policy is meant to be to be paired with other policies supporting the overall emotional and behavioral health of students

PARENTAL INVOLVEMENT

Parents and guardians play a key role in youth suicide prevention, and it is important for the school to involve them in age appropriate suicide prevention efforts. While parents and guardians need to be informed and actively involved in decisions regarding the student's welfare, the school mental health professional should ensure that the parents' actions are in the best interest of the student (e.g., when a student is LGBTQ and living in an un affirming household). Parents and guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with professional help when necessary. Parents and guardians should be advised to take every statement regarding suicide and a wish to die seriously and avoid assuming that the student is simply seeking attention. There are commercially available videos and programs to help train parents in recognizing suicide warning signs. Parents and guardians can also contribute to important protective factors — conditions that reduce vulnerability to suicidal behavior — for all students, especially vulnerable youth populations such as LGBTQ youth. Recent research shows that LGBTQ youth who are rejected by their parents are at a much higher risk of depression, suicide, illegal drug use, and unprotected sexual practices. Conversely, acceptance and support by family results in higher levels of self-esteem, lower levels of suicidal ideation and self-harm incidents, and better overall physical health.

DEFINITIONS

1. **At risk** Suicide risk is not a dichotomous concern, but rather, exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention by the school and the district. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset of potential mental health conditions or a deterioration of mental health. The student may have thoughts about suicide, including potential means of death, and may have a plan. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures. The type of referral, and its level of urgency, shall be determined by the student's level of risk — according to local district policy.

2. **Crisis team** A multidisciplinary team of administrative staff, mental health professionals, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention, response and recovery. Crisis Team members often include someone from the administrative leadership, school psychologists, school counselors, school social workers, school nurses, and others including support staff and/or teachers. These professionals have been specifically trained in areas of crisis preparedness and take a leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports. Crisis team members who are mental health professionals may provide crisis intervention and services.

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

4. **Postvention** Suicide postvention is a crisis intervention strategy designed to assist with the grief process following suicide loss. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school's healthy postvention effort can lead to readiness to engage further with suicide prevention efforts and save lives.

5. **Risk assessment** A evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated school staff (e.g., school psychologist, school social worker, school counselor, or in some cases, trained staff). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

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

7. **Self-harm** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm should receive mental health care. Treatment can improve coping strategies to lower the urge to self-harm and reduce the long-term risk of a future suicide attempt.

8. **Suicide** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. NOTE: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death. Additionally, parent or guardian preference shall be considered in determining how the death is communicated to the larger community.

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

10. **Suicidal behavior** Suicide attempts, injury to oneself Associated with at least one level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

11. **Suicide contagion** The process by which suicidal behavior or a suicide completion influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.

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

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SCOPE

This policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school sponsored out-of- school events where school staff are present. This policy applies to the entire school community, including educators, school and school staff, students, parents/guardians, and volunteers. This policy also covers age appropriate school responses to suicidal or high-risk behaviors that take place outside of the school environment.

IMPORTANCE OF SCHOOL-BASED MENTAL HEALTH SUPPORTS

Access to school-employed mental health resources and access to school-based mental health supports directly improves students' physical and psychological safety, academic performance, cognitive performance and learning, and social/emotional development. School-employed mental health professionals (school counselors, school psychologists, school social workers) ensure that resources are high quality, effective, and developmentally appropriate to the school context. School-employed mental health professionals are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health resources are properly and effectively infused into the learning environment. These professionals can support both instructional leaders' and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning.

Having these professionals as integrated members of the school staff empowers principals and administrators to more efficiently and effectively deploy resources, ensure coordination of resources, evaluate their effectiveness, and adjust supports to be be age appropriate and meet the dynamic needs of their student populations. Improving access also allows for enhanced collaboration with community providers to meet the more intense or clinical needs of students

RISK FACTORS AND PROTECTIVE FACTORS

Risk Factors for Suicide are characteristics or conditions that increase the chance that a person may try to attempt suicide. Suicide risk tends to be highest when someone has several risk factors at the same time or has long standing risk factors and experiences a sudden or devastating setback. These factors interact, and the more there are and the more they intensify, the greater the risk.

The most frequently cited risk factors for suicide are:

- Mental Health Conditions
    - Major depression (feeling down in a way that impacts your daily life)
    - Bipolar disorder (extreme mood swings)
    - Substance use disorders (Alcohol, prescribed or illicit drugs)
    - Anxiety disorders (excessive worry, obsessions or panic attacks)
    - Eating disorders
- Hopelessness
- Problems with alcohol or drugs
- Past suicide attempt(s)
- Family history of suicide or mental health problems
- Problems with impulse control or aggression
- Serious medical condition and/or pain
- Personality traits that create a pattern of intense, unstable relationships, or trouble with the law
- Psychosis, i.e marked change in behavior, unusual thoughts, and behavior or confusion about reality
- History of early childhood trauma, abuse, neglect or loss
- Current family stressor transitions
- History of head trauma

Protective Factors for Suicide are characteristics or conditions that may help to decrease a person's suicide risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them. These factors do not eliminate the possibility of suicide, especially in someone with risk factors. Protective factors help to create resiliency, or an ability to "bounce back" from setbacks encountered throughout life.

Protective factors for suicide include:

- receiving effective mental health care
- positive connections to family, peers, and community
- access to welcoming and affirming faith-based institutions, supportive social groups and clubs
- the skills and ability to solve problems
- presence of healthy role models
- development of coping mechanisms, safety plans, and self-care strategies
- Cultural, Spiritual or faith based beliefs that promote connections and help-seekin

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It is important for the school to be aware of student populations that are at elevated risk for the following suicidal behavior based on various factors:

1. Youth living with mental and/or substance use disorders. While the large majority of people with mental disorders do not engage in suicidal behavior, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bi-polar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are important risk factor suicidal behavior among young people. The majority of people suffering from these mental disorders are not engaged in treatment, therefore school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk.

2. **Youth who engage in self-harm or have attempted suicide.** Suicide risk among those who engage in self- harm is significantly higher than the general population. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow up care.

3. Youth in out-of-home settings. Youth involved in the juvenile justice or child welfare systems have a high prevalence of many risk factors for suicide. Young people involved in the juvenile justice system die by suicide at a rate about four times greater than the rate among youth in the general population. Though comprehensive suicide data on youth in foster care does not exist, one researcher found that youth in foster care were more than twice as likely to have considered suicide and almost four times more likely to have attempted suicide than their peers not in foster care.

4. Youth experiencing homelessness. For youth experiencing homelessness, rates of suicide attempts are higher than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorders, and post-traumatic stress disorder. One study found that more than half of runaway and homeless youth have had some kind of suicidal ideation.

5. American Indian/Alaska Native (AI/AN) youth. In 2009, the rate of suicide among AI/AN youth ages 15-19 was more than twice that of the general youth population.8 Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see http://www.nctsnet.org/nctsn_assets/pdfs/AI_Youth-CurrentandHistoricalTrauma.pdf.

6. **LGBTQ (lesbian, gay, bisexual, transgender, or questioning) youth.** The Center for Disease Control (CDC) finds that LGBTQ youth are four times more likely, and questioning youth are three times more likely, to attempt suicide as their straight peers. The American Association of Suicidology reports that nearly half of young transgender people have seriously considered taking their lives and one quarter report having made a suicide attempt. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ which elevate the risk of suicidal behavior for LGBTQ youth.

7. **Youth bereaved by suicide.** Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.

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

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PREVENTION

School Policy Implementation The school suicide prevention team will be responsible for planning and coordinating implementation of this policy for the school.

Staff Professional Development All staff shall receive, at minimum, annual professional development on risk factors, warning signs, protective factors, age appropriate response procedures, referrals, postvention, and resources regarding youth suicide prevention. The professional development shall include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings (e.g., youth in foster care, group homes, incarcerated youth), those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer and Questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities. Additional professional development in risk assessment and crisis intervention shall be provided to school-employed mental health professionals and school nurses.

Youth Suicide Prevention Programming Developmentally appropriate, student-centered education materials shall be integrated into the curriculum of all K-12 health classes and other classes as appropriate. The content of these age-appropriate materials shall include the importance of safe and healthy choices and coping strategies focused on resiliency building, and how to recognize risk factors and warning signs of mental health conditions and suicide in oneself and others. The content shall also include help-seeking strategies for oneself or others and how to engage school resources and refer friends for help. In addition, schools shall provide supplemental small-group suicide prevention programming for students. It is not recommended to deliver any programming related to suicide prevention to a large group in an auditorium setting.

Publication and Distribution This policy will be distributed annually and included in all parent and student handbooks and on the school website. All school personnel are expected to know and be accountable for following al policies and procedures regarding suicide prevention.

ASSESSMENT AND REFERRAL

When a student is identified by a peer, educator or other source as potentially suicidal — i.e., verbalizes thoughts about suicide, presents overt risk factors such as agitation or intoxication, an act of self-harm occurs, or expresses or otherwise shows signs of suicidal ideation — the student shall be seen by a school-employed mental health professional, such as a school psychologist, school counselor, school social worker, within the same school day to assess risk and facilitate referral if necessary. Educators shall also be aware of written threats and expressions about suicide and death in school assignments. Such incidences require immediate referral to the appropriate school-employed mental health professional. If there is no mental health professional available, a designated staff member (e.g., school nurse or administrator) shall address the situation according to protocol and in a sensitive age appropriate manner until a mental health professional is brought in.

For At-Risk Youth:

1. School staff will continuously supervise the student to ensure their safety.
2. The principal and a crisis team member will be made aware of the situation as soon as reasonably possible.
3. The school employed mental health professional or designee will contact the student's parent or guardian, as described here in after in the Parental Notification and Involvement section and will assist the family with urgent referral.
4. Urgent referral may include, but is not limited to, working with the parent or guardian to set up an outpatient mental health or primary care appointment and conveying the reason for referral to the healthcare provider; in some instances, particularly life-threatening situations, the school may be required to contact emergency services, or arrange for the student to be transported to the local Emergency Department, preferably by a parent or guardian
5. If parental abuse or neglect is suspected or reported, the appropriate state protection officials (e.g., local Child Protection Services) shall be contacted in lieu of parents as per law
6. Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

BEST PRACTICE: SUICIDE PREVENTION TASK FORCE

It is recommended that schools establish a suicide prevention task force in conjunction with adopting a suicide prevention policy. Such a task force should consist of administrators, parents, teachers, school-employed mental health professionals, representatives from community suicide prevention services, and other individuals with expertise in youth mental health, under the administration of a suicide prevention coordinator.

The purpose of such a task force is to provide advice to the administration and school board regarding suicide prevention activities and policy implementation, and to keep aware of current research, data, trends, and evolving best age appropriate practices. In addition, the task force can help to compile a list of community resources to assist with suicide prevention activities and referrals to community mental health providers.

REFERRALS AND LGBTQ YOUTH

LGBTQ youth are at heightened risk for suicidal behavior, which may be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. It is therefore especially important that school staff be trained to support at-risk LGBTQ youth with sensitivity, cultural competency, and affirming practices.

School staff should not make assumptions about a student's sexual orientation or gender identity and should validate students who do decide to disclose this information. Information about a student's sexual orientation or gender identity should be treated as confidential and not disclosed to parents, guardians, or third parties without the student's permission. In the case of parents who have exhibited rejecting behaviors, great sensitivity needs to be taken in what information is communicated with parents.

Additionally, when referring students to out-of-school resources, it is important to connect LGBTQ students with LGBTQ-affirming local health and mental health service providers. Affirming service providers are those that adhere to best practices guidelines regarding working with LGBTQ clients as specified by their professional association (e.g., apa.org/pi/lgbt/resources/guidelines.aspx).

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IN-SCHOOL SUICIDE ATTEMPTS

In the case of an in-school suicide attempt, the health and safety of the student is paramount. In these situations:

1. First aid will be rendered until professional medical treatment and/or transportation can be received, following school emergency medical procedures.
2. School staff will supervise the student to ensure their safety.
3. Staff will move all other students out of the immediate area as soon as possible.
4. The school-employed mental health professional or principal shall contact the student's parent or guardian. (pursuant to school/state codes, unless notifying the parent will put the student at increased risk of harm)
5. Staff shall immediately notify the principal or school suicide prevention coordinator regarding the incident of in-school suicide attempt
6. The school shall engage the crisis team as necessary to assess whether additional steps should be taken to ensure student safety and well-being, including those students who may have had emotional or physical proximity to the victim
7. Staff shall request a mental health assessment for the youth using an age appropriate response as soon as possible.

RE-ENTRY PROCEDURE

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), whenever possible, a school-employed mental health professional, the principal, or designee shall meet with the student's parent or guardian, and if appropriate, include the student to discuss re-entry. This meeting shall address next steps needed to ensure the student's readiness for return to school and plan for the first day back. Following a student hospitalization, parents may be encouraged to inform the school counselor of the student's hospitalization to ensure continuity of service provision and increase the likelihood of a successful re-entry.

1. A school-employed mental health professional or other designee shall be identified to coordinate with the student, their parent or guardian, and any outside health care providers. The school-employed mental health professional shall meet with the student and their parents or guardians to discuss and document a re-entry procedure and what would help to ease the transition back into the school environment (e.g., whether or not the student will be required to make up missed work, the nature of check-in/check-out visits, etc.). Any necessary accommodations shall also be discussed and documented.
2. While not a requirement for re-entry, the school may coordinate with the hospital and any external mental health providers to assess the student for readiness to return to school health providers to assess the student for readiness to return to school.
3. The designated staff person shall periodically check-in with the student to help with readjustment to the school community and address any ongoing concerns, including social or academic concerns using age appropriate responses in a sensitive way.
4. The school-employed mental health professional shall check-in with the student and the student's parents or guardians at an agreed upon interval depending on the student's needs either on the phone or in person for a mutually agreed upon time period (e.g. for a period of three months). These efforts are encouraged to ensure the student and their parents or guardians are supported in the transition, with more frequent check-ins initially, and then fading support.
5. The administration shall disclose to the student's teachers and other relevant staff (without sharing specific details of mental health diagnoses) that the student is returning after a medically related absence and may need adjusted deadlines for assignments. The school-employed mental health professional shall be available to teachers to discuss any concerns they may have regarding the student after re-entry.

OUT-OF-SCHOOL SUICIDE ATTEMPTS

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member will:

1. Call 911 (police and/or emergency medical services).
2. Inform the student's parent or guardian.
3. Inform the school's suicide prevention coordinator and principal.

If the student contacts the staff member and expresses suicidal ideation, the staff member should maintain contact with the student (either in person, online, or on the phone). The staff member should then enlist the assistance of another person to contact the police while maintaining verbal engagement with the student.

WHEN SCHOOL PERSONNEL NEED TO ENGAGE LAW ENFORCEMENT

A school's crisis response plan shall address situations when school personnel need to engage law enforcement. When a student is actively suicidal and the immediate safety of the student or others is at-risk (such as when a weapon is in the possession of the student), school staff shall call 911 immediately. The staff calling shall provide as much information about the situation as possible, including the name of the student, any weapons the student may have, and where the student is located. School staff may tell the dispatcher that the student is a suicidal emotionally disturbed person, or "suicidal EDP", to allow the dispatcher to send officers with specific training in crisis de-escalation and mental illness.

PARENTAL NOTIFICATION AND INVOLVEMENT

The principal, designee, or school mental health professional shall inform the student's parent or guardian on the same school day, or as soon as possible, any time a student is identified as having any level of risk for suicide or if the student has made a suicide attempt (pursuant to school/state codes, unless notifying the parent will put the student at increased risk of harm). Following parental notification and based on initial risk assessment, the principal, designee, or school mental health professional may offer age appropriate recommendations for next steps based on perceived student need. These can include but are not limited to, an additional, external mental health evaluation conducted by a qualified health professional or emergency service provider.

When a student indicates suicidal intent, schools shall attempt to discuss safety at home or "means safety" with parent or guardian, limiting the students access to mechanisms for carrying out a suicide attempt e.g., guns, knives, pills, etc. In addition, during means counseling, which can also include safety planning, it is imperative to ask parents whether or not the individual has access to fire arms, medication or other lethal means.

Lethal means counseling shall include discussing the following:

Firearms

- Inquire of the parent or guardian if firearms are kept in the home or are otherwise accessible to the student
- Recommend that parents store all guns away from home while the student is struggling — e.g., following state laws, store their guns with a relative, gun shop, or police
- Discuss parents' concerns and help problem-solve around offsite storage, and avoid a negative attitude about guns — accept parents where they are, but let them know offsite storage is an effective, immediate way to protect the student
- Explain that in-home locking is not as safe as offsite storage, as children and adolescents sometimes find the keys or get past the locks
    - If there are no guns at home:
        - Ask about guns in other residences (e.g., joint custody situation, access to guns in the homes of friends or other family members)
    - If parent won't or can't store offsite:
        - The next safest option is to unload guns, lock them in a gun safe, and lock ammunition separately (or don't keep ammunition at home for now)
        - If guns are already locked, ask parents to consider changing the combination or key location —parents can be unaware that the student may know their "hiding" places

Medications

- Recommend the parent or guardian lock up all medications (except rescue meds like inhalers), either with a traditional lock box or a daily pill dispenser
- Recommend disposing of expired and unneeded medications, especially prescription pain pills
- Recommend parent maintain possession of the student's medication, only dispensing one dose at a time under supervision
    - If parent won't or can't lock medication, advise they prioritize and seek specific guidance from a doctor or pharmacist regarding the following:
        - Prescriptions, especially for pain, anxiety or insomnia
        - Over-the-counter pain pills
        - Over-the-counter sleeping pills

Staff will also seek parental permission, in the form of a Release of Information form, to communicate with outside mental health care providers regarding the student's safety plan and access to lethal means.

After a Suicide Death

Development and Implementation of an Action Plan The crisis response team, led by a designated crisis, shall develop a crisis response plan to guide school response following a death by suicide. This plan may be applicable to all school community related suicides whether it be student (past or present), staff, or other prominent school community member. Ideally, this plan shall be developed long before it is needed. A meeting of the crisis team to implement the plan shall take place immediately following word of the suicide death, even if the death has not yet been confirmed to be a suicide. **Action Plan Steps:**

1) **Get the Facts.** The designated school official (e.g. the school's principal or superintendent) shall confirm the death and determine the cause of death through communication with the student's parent or guardian, the coroner's office, local hospital, or police department. Before the death is officially classified as a suicide by the coroner's office, the death shall be reported to staff, students, and parents or guardians, with an acknowledgement that its cause is unknown. When a case is perceived as being an obvious instance of suicide, it shall not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian prefers the cause of death not be disclosed, the school may release a general statement without disclosing the student's name (e.g., "We had a ninth-grade student die over the weekend"). If the parents do not want to disclose cause of death, an administrator or mental health professional from the school who has a good relationship with the family shall be designated to speak with the parents to explain the benefits of sharing mental health resources and suicide prevention with students. If the family refuses to permit disclosure, schools may state "The family has requested that information about the cause of death not be shared at this time." Staff may also use the opportunity to talk with students about suicide.

2) **Assess the situation.** The crisis response team shall meet to prepare an age appropriate postvention response according to the crisis response plan. The team shall consider how the death is likely to affect other students, and determine which students are most likely to be affected. The crisis response team shall also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide.

The team and principal shall triage staff first, and all teachers directly involved with the victim shall be notified in-person and offered the opportunity for support

3) **Share information.** Inform the faculty and staff that a sudden death has occurred, preferably in an all-staff meeting. The crisis response team shall provide a written statement for staff members to share with students and also assess staff's readiness to provide this message in the event a designee is needed. The statement shall include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Staff shall respond to questions only with factual information that has been confirmed. Staff shall dispel rumors with facts, be flexible with academic demands, encourage conversations about suicide and mental health, normalize a wide range of emotional reactions, and know the referral process and how to get help for a student. Avoid public address system announcements and school-wide assemblies in favor of face-to-face notifications, including small-group and classroom discussions. The crisis response team may prepare a letter — with the input and permission from the student's parent or guardian — to communicate with parents which includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available. If necessary, a parent meeting may also be planned. Staff shall direct all media inquiries to the designated school or district spokesperson. Another consideration related to communication after a suicide death involves educating parents and other adults on suicide grief, since adult behavior following a suicide death can have a great impact on students, particularly elementary school-aged students.

4) **Avoid suicide contagion.** Actively triage particular risk factors for contagion, including emotional proximity (e.g., siblings, friends, or teammates), physical proximity (witness, neighbor) and pre-existing mental health issues or trauma. Explain in an all-staff meeting that one purpose of trying to identify and provide services to other high-risk students is to prevent another death. The crisis response team shall work with teachers to identify students who are most likely to be significantly affected by the death, or who exhibit behavioral changes indicating increased risk. In the staff meeting, the crisis response team shall review suicide warning signs and procedures for referring students who present with increased risk. For those school personnel who are concerned that talking about suicide may contribute to contagion, it has been clearly demonstrated through research that talking about mental health and suicide in a nonjudgmental, open way that encourages dialogue and help-seeking does not elevate risk.

5) **Initiate Support Services.** Students identified as being more likely to be affected by the death will be assessed by a school mental health professional to determine the level of support needed. The crisis response team shall coordinate support services for students and staff in need of individual and small group counseling as needed. School-employed mental health professionals will provide on-going and long-term support to students impacted by the death of the student, as needed. If long term intensive services by a community provider are warranted, the school- employed mental health professional will collaborate with that provider and the family to ensure continuity of care between the school, home, and community. Together with parents or guardians, crisis response team members shall provide information for partner community mental health providers, or providers with appropriate expertise, to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs. These discussions may include debriefing (orientation to the facts), reflection on memories, reminders for and re-teaching of coping skills, and encouraging spending time with friends and caregivers as soon as possible. Students and staff affected by the suicide death shall be encouraged to return to a normal routine as much as possible, understanding that some deviation from routine is to be expected.

6) **Develop memorial plans.** The school shall develop policy regarding memorialization due to any cause and strive to treat all deaths the same way. Avoid planned on-campus physical memorials (e.g. photos, flowers, locker displays), funeral services, tributes, or flying the flag at half-staff, because it may inadvertently sensationalize the death and encourage suicide contagion among vulnerable students. Spontaneous memorials may occur from students expressing their grief. Cards, letters, and pictures may be given to the student's family after being reviewed by school administration. If items indicate that additional students may be at increased risk for suicide and/or in need of additional mental health support (e.g. writing about a wish to die or other risk behavior), outreach shall be made to those students to help determine level of risk and appropriate response. The school shall also leave a notice for when the memorial will be removed and given to the student's family. Online memorial pages shall use safe messaging, include resources to obtain information and support, be monitored by an adult, and be time limited. School shall not be canceled for the funeral or for reasons related to the death. Any school-based memorials (e.g., small gatherings) shall include a focus on how to prevent future suicides and prevention resources available.

7) **Postvention as Prevention.** Following a student suicide, schools may take the initiative to review and/or revise existing policies

8) **External Communication** No external communication should take place. Refer all inquiries to the Principal.

MESSAGING AND SUICIDE CONTAGION

Research has shown a link between certain kinds of suicide-related media (including social media) coverage and increases in suicide deaths. Suicide contagion has been observed when the number of stories about individual suicides increases, or when a particular death is reported in great detail. The coverage of a suicide death being prominently featured in a media outlet or on social media, or headlines about specific deaths being framed dramatically have also been observed to contribute to suicide contagion. Research also shows that suicide contagion can be avoided when the media reports on suicide responsibly, such as by following the steps outlined in "Recommendations for Reporting on Suicide" at ReportingOnSuicide.org, as well as through the National Association for School Psychologists media guideline: Responsible Media Coverage of Crisis Events Impacting Children and Youth.

Contagion can play a role in cases of self-harm behavior. These behaviors may originate with one student and can spread to other students through imitation. Because adolescents are especially vulnerable to the risk of contagion, in the case of a suicide death it is important to acknowledge the student's death in a way that does not inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the importance of seeking help for self or others when there is concern about underlying mental health issues, such as depression or anxiety, and provide resources on where to seek help. Although many people who die by suicide do have a diagnosable or known underlying mental health issue, schools can also help students understand the importance of recognizing the signs of suicide, building resiliency and coping skills, and helping to decrease the stigma associated with seeking help for mental health concerns.
However, schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student's family and friends. Refer to the American Foundation for Suicide Prevention's After a Suicide: A Toolkit for Schools resource, listed in the Resources section, for sample notification statements for students and parents or guardians, sample media statements, and other model language.

Finally, it is important for schools to encourage parents and guardians to monitor student social media pages after a death by suicide. Students often turn to social networking websites or apps as outlets for communicating information and expressing their thoughts and feelings about the death. Parents and guardians should be advised to monitor social media accounts for warning signs of suicidal behavior. Students should be encouraged to report concerning social media posts, such as tweets, statuses, and Instagram posts.

BULLYING AND SUICIDE

The relationship between bullying and suicide is highly complex, as is the relationship between suicide and other negative life events. Research indicates that persistent bullying can lead to or worsen feelings of isolation, rejection, exclusion and despair, as well as depression and anxiety, which can contribute to suicidal behavior in those at-risk.

While studies have shown that young people who are bullied and those who bully others are at heightened risk for suicidal behavior, youth who exhibit both pre-existing risk for suicide (e.g., a history of depression, anxiety, substance use or other health conditions) and who are concurrently involved in bullying or experiencing other negative life events are at highest risk.22 Individuals who are bullied in the absence of other risk factors have far fewer negative outcomes than those with pre-existing risk for suicide. Youth who bully are also at-risk, and their behavior may reflect underlying mental health problems or previous childhood trauma. One study found that those who are bullied (cyber or in person) are 19 times more likely to experience suicidal ideation than youth with no history of bullying

It is imperative to convey safe and accurate messages about bullying and suicide to youth, especially to young people who may be at-risk for suicide. Suggesting that suicide is a natural response to bullying, or providing repeated opportunities for at-risk students to see their own experiences of bullying, isolation, or exclusion reflected in stories of those who have died by suicide, can increase contagion risk by contributing to thoughts that frame suicide as a viable solution. Idealizing young people who complete suicide after being bullied or creating an aura of celebrity around them may contribute to an at-risk student's illogical thoughts that suicide is the only way to have a voice or to make a difference for others. However, when school personnel know that a student is involved in bullying, they should not hesitate to ask students direct questions about thoughts of suicide

Whenever possible, discussions on bullying and suicide should be age appropriate and center on prevention and resiliency, not statistics, and should encourage help-seeking behavior

RESOURCES

GUIDEBOOKS AND TOOLKITS

"Preventing Suicide: A Toolkit for High Schools" – U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services http://store.samhsa.gov/product/Preventing-Suicide-A- Toolkit-for-High-Schools/SMA12-4669

"After a Suicide: A Toolkit for Schools" – American Foundation for Suicide Prevention and Suicide Prevention Resource Center www.afsp.org/schools

"Guidelines for School-Based Suicide Prevention Programs" – American Association of Suicidology http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf

"Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel" – Maine Youth Suicide Prevention Program http://www.maine.gov/suicide/docs/Guideline.pdf

"Trevor Resource Kit" – The Trevor Project thetrevorproject.org/resource kit

"Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender (LGBT) Children" – Family Acceptance Project http://familyproject.sfsu.edu/publications

National Center for School Crisis and Bereavement http://www.stchristophershospital.com/pediatric-specialties-programs/specialties/690

Supporting the Grieving Child and Family American Academy of Pediatrics schoolcrisiscenter.org/wp-content/uploads/2017/04/Final-Clinical-Report-Supporting-the-GrievingChild-and-Family.pdf

Guidelines For Schools Responding to a Death by Suicide National Center for School Crisis and Bereavement https://www.schoolcrisiscenter.org/wp-content/uploads/2019/07/guidelines-death-by-suicide.pdf

"Signs of Suicide Prevention Program (SOS)" – Screening for Mental Health, Inc. http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/

CRISIS and SUPPORT SERVICES FOR STUDENTS

Crisis Text Line Text TALK to 741-741 to text with a trained crisis counselor for free, 24/7

National Suicide Prevention Lifeline: The Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis or their friends and loved ones. Call 1.800.273.8255 (TALK). Callers are routed to the closest possible crisis center in their area. http://www.suicidepreventionlifeline.org

The Trevor Lifeline: The only nationwide, around-the- clock crisis intervention and suicide prevention lifeline for lesbian, gay, bisexual, transgender, and questioning young people, 13-24, available at 1.866.488.7386.

Trevor Chat: A free, confidential and secure instant messaging service that provides live help for LGBTQ youth by trained volunteers 24/7. TheTrevorProject.org/Help

Trevor Text: Text "TREVOR" to 678-678. Standard text messaging rates apply. Available 24/7.

TrevorSpace: An online international peer-to-peer community for LGBTQ young people and their friends thetrevorproject.org

RELEVANT RESEARCH

"Youth Risk Behavior Surveillance System" – Centers for Disease Control and Prevention. Monitors health-risk behaviors among youth, including a national school- based survey conducted by CDC and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments. http://www.cdc.gov/healthyyouth/yrbs/index.htm

2012 National Strategy for Suicide Prevention: A report by the U.S. Surgeon General and the National Alliance for Suicide Prevention outlining a national strategy to guide suicide prevention actions. Includes up-to-date research on suicide prevention. http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

Appendix I

Student Risk Identification Protocol

1. INITIAL CONTACT
   - As soon as information is disclosed, stay with the student or designate one or more other adult(s) to stay with the student. *Never leave the student alone.* *Should the student inform you that they are in possession of lethal means (knife/blade, medication, gun, etc.), immediately contact 911, and then notify your Administrative Team.
   - The initial person of contact must notify, an Administrator immediately (no emails) and contact the School Counselor, School Psychologist or School Social Worker. Neither parents nor other staff members need to be notified at this point.
   - Release the student to the School Counselor, School Psychologist, School Social Worker or member of the Administrative Staff or Designee.
2. RISK IDENTIFICATION
   - The School Counselor, School Psychologist, School Social Worker
     i. Check Beyond SST and Contact Manager for historical safety/crisis information.
     ii. Conduct a risk severity review (step 1-screener, step 2-checklist and step 3-severity rating scale). Refer to the regional phone tree/crisis line for additional consultation as needed.
     iii. If a student has an IEP consult with school psychologist for additional support.
     iv. Document with a "C200" in contact manager or Counseling tab
   - Administrative Team member, or other designated staff
     i. Check Beyond SST and Contact Manager for historical safety/crisis information
     ii. Conduct a risk severity review (screener and checklist). Make a follow- up consultation call, refer to your regional phone tree/crisis line.
     iii. If a student has an IEP consult with school psychologist for additional support.
     iv. Document with a "C200" in contact manager or Counseling tab
   - If there is suspected or confirmed abuse/neglect, contact local protective services. DO NOT contact the parent. Proceed as advised by protective services, not according to protocol.
3. ACTION
   - If student is low-risk: Contact parents/guardian to inform them of situation. Release student to Parent/Guardian. Provide parent/guardian with a copy of the Verification of Emergency Release of Student Form with attached resources. (If there is suspected or confirmed abuse/neglect, contact local protective services. DO NOT contact the parent. Proceed as advised by protective services, not according to protocol).

     i. Complete the Verification of Emergency Release of Student Form and provide a copy at the time of release
     ii. If parent/guardian is not able to pick-up student, request emergency contact or other permitted (approved by parent/guardian) adult to accompany the student home.
     iii. Seek consultation with School Administration if parent/guardian is not available or if student is an adult/unaccompanied minor
     iv. Complete section 1 of the Student Follow Up Support Plan
     v. Send email to SST chairperson requesting student to be added to Beyond SST

        i.e. Subject Line: PRIORITY

        cc: Site Administrator, School Psychologist, School Counselor, School Social Worker

        Please add this student to Beyond SST database and upload attached documents. (i.e. Student Follow-Up Support Plan)
     vi. For follow up, upload documents to existing record to Beyond SST by SST chairperson
     vii. SST optional- depends on team decision

- If student is medium-risk: Contact parents/guardian to inform them of situation. Complete the Student Follow Up Support Plan. Release student to Parent/Guardian. Provide parent/guardian with a copy of the Verification of Emergency Release of Student Form with additional local mental health resources.

    i. If parent/guardian is not able to pick-up student, request emergency contact to accompany the student home.
    ii. Seek consultation with School Administration if parent guardian or emergency contact is not available or if student is an adult/unaccompanied minor
    iii. Complete section 1 of the Student Follow Up Support Plan
    iv. Send email to Beyond SST chairperson requesting an SST to be held within 1 week of student risk identification

        i.e. Subject Line: PRIORITY: Urgent SST Request

        cc: Site Administrator, School Psychologist, School Counselor, School Social Worker

        There is an immediate need to schedule an SST for (Student name, DOB). Please add this student to Beyond SST as soon as possible and upload attached documents. (i.e. Student Follow-Up Support Plan)

    v. For follow up, upload documents to existing record to Beyond SST by SST chairperson

- If student is high-risk: Immediately contact MOBILE CRISIS TEAM (PMRT/Law Enforcement) and parent/guardian. (Only use an alternative action plan if one has been previously established. See Beyond SST or IEP). Proceed as directed by MOBILE CRISIS TEAM (PMRT/Law Enforcement).

    I. If Student released to MOBILE CRISIS TEAM (PMRT/Law Enforcement)
        i. Complete emergency personnel information on Verification of Emergency Release of Student Form
        ii. Complete section 1 of the Student Follow Up Plan
        iii. Send email to Beyond SST chairperson requesting student to be added to Beyond SST database

        i.e. Subject Line: PRIORITY
        cc: Site Administrator, School Psychologist, School Counselor, School Social Worker

        Please add this student to Beyond SST database and upload attached documents.
        A re-entry meeting will be scheduled within a week of students return to school

    II. If Student NOT released to MOBILE CRISIS TEAM (PMRT/Law Enforcement)
        i. If parent/guardian is not able to pick-up student, request emergency contact to accompany the student home
        ii. Seek consultation with School Administration if no parent guardian or emergency contact is available or if student is an adult/unaccompanied minor
        iii. Complete Verification of Emergency Release of Student form with additional local mental health resources.
        iv. Complete section 1 of the Student Follow Up Support Plan
        v. If first crisis, request student be added to Beyond SST by SST chairperson
        vi. If this is a follow up, upload documents to existing record to Beyond SST by SST chairperson
    vii. Send email to Beyond SST chairperson requesting student to be added to Beyond SST database

        i.e. Subject Line: PRIORITY: Urgent SST Request
        cc: Site Administrator, School Psychologist, School Counselor, School Social Worker

        Please add this student to Beyond SST database and upload attached documents. (i.e. Student Follow-Up Support Plan) A re-entry meeting to be scheduled within a week of students return to school.

4. FOLLOW-UP

- Confirm SST meeting will be held within 1st week of incident (Non-Hospitalized Student- medium or high risk)
- Confirm Re-entry meeting will be held within 1st week of student return to school (Hospitalized students)
    i. Collaborative process with Supervising Teacher taking into consideration relationship with parent
- Re-entry meeting for students with Special Education can be held as an IEP Meeting if parent agrees and all required members are present (Or a formal IEP can be scheduled for later date)
    i. Collaborative process with Supervising Teacher/Case Manager and School Psychologist taking into consideration relationship with parent
- Complete Section 2 on the Student Follow Up Plan during SST or Re-entry meeting
- Upload all required documents to Beyond SST by SST chairperson
- Document dates of contacts with student via Contact Manager/Counseling Tab using "C-200 Follow-Up" (Refer to Section 1 of the Student Follow Up Support Plan)

Appendix II

INITIAL CONTACT
STUDENT RISK IDENTIFICATION PROTOCOL

If you see or hear a student…

- ❑ Threatening to hurt or kill themselves.
- ❑ Looking for ways to kill themselves (seeking pills, weapons, or other means).
- ❑ Talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

***If you feel that you or others are in immediate danger OR should a student inform you that they are in possession of lethal means (knife/blade, medication, gun, etc.), immediately contact 911, and then notify your Administrative Team. Do not put yourself or others in harm's way.**

****Proceed to Step 1 only if there is no immediate danger present****

Step 1: Keep the Student Safe

- ❑ Stay with the student at all times or designate one or more other adults to stay with the student. ***Never leave the student alone.***

Step 2: Notify, Administrator immediately and contact the School Counselor, School Psychologist or School Social Worker

- ❑ The initial person of contact must notify, an Administrator **immediately** (no emails) and contact the School Counselor, School Psychologist or School Social Worker. Neither parents nor other staff members need to be notified at this point.
- ❑ Release the student to a designated site member.

Designated Sites Members:

Name and phone number	Name and phone number	Name and phone number
Name and phone number	Name and phone number	Name and phone number
Name and phone number	Name and phone number	Name and phone number

***SST CHAIR PERSON** _____

When talking to a suicidal person…

- *Be yourself*. Let the person know you care, that he/she is not alone. The right words are often unimportant. If you are concerned, your voice and manner will show it.
- *Listen*. Let the suicidal person unload despair, ventilate anger. No matter how negative the conversation seems, the fact that a conversation is happening is a positive sign.
- *Be sympathetic, non-judgmental, patient, calm, accepting*. The student is doing the right thing by talking about his/her feelings.
- *Offer hope*. Reassure the student that help is available and that the suicidal feelings are temporary. Let the person know that his or her life is important to you.

Don't…

- Argue with the suicidal person. Avoid saying things like: "You have so much to live for," "Your suicide will hurt your family," or "Look on the bright side."
- Act shocked, lecture on the value of life, or say that suicide is wrong.
- Promise confidentiality. Refuse to be sworn to secrecy. A life is at stake and you may need to speak to a mental health professional in order to keep the suicidal person safe. If you promise to keep your discussions secret, you may have to break your word.
- Offer ways to fix their problems, or give advice, or make them feel like they have to justify their suicidal feelings. It is not about how bad the problem is, but how badly it's hurting the student.

Additional Warning Signs

VERBAL	BEHAVIORAL
❖ Talking about wanting to die or kill oneself ❖ Talking about feeling hopeless or having no reason to live ❖ Talking about feeling trapped or in unbearable pain ❖ Talking about being a burden to others ❖ Talking about harming self or harming others ❖ Showing rage or talking about seeking revenge	❖ Displaying extreme mood swings ❖ Giving away their possessions to friends or staff ❖ Withdrawing or feeling isolated ❖ Acting anxious or agitated, or behaving recklessly ❖ Making final arrangements ❖ Putting themselves in harm's way ❖ Looking for ways to kill oneself ❖ Increasing the use of alcohol or drugs

Resources

Psychiatric Mobile Response Team Law Enforcement Insert Local Number	National Suicide Prevention Lifeline (800) 273-8255 https://suicidepreventionlifeline.org/
California Youth Crisis Hotline (800) 843-5200 Text 741-741 https://suicidepreventionlifeline.org/	The Trevor Project Hotline (866) 488-7386 Text START to 678678 https://www.thetrevorproject.org/

Appendix III

SCREENER
Step 1

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

	Past Month		Lifetime (Worst Point)	
Ask questions that are bolded and underlined.	**YES**	**NO**	**YES**	**NO**
Ask Questions 1 and 2				
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*				
2) *Have you actually had any thoughts of killing yourself?*				
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.				
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"				
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"				
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*				

How long ago did the Worst Point Ideation occur? _____

	YES	NO
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Appendix IV

Checklist
Step 2

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt ☐ Lifetime	☐
☐	Interrupted attempt ☐ Lifetime	☐
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐
☐	Other preparatory acts to kill self ☐ Lifetime	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

Suicidal Ideation Check Most Severe in Past Month	
☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan

Activating Events (Recent)	
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
Describe:	
☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone

Treatment History	
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Not receiving treatment

Other Risk Factors	
☐	
☐	

Clinical Status (Recent)	
☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)
Protective Factors (Recent)	
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school

Other Protective Factors	
☐	
☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

Appendix V

Severity Rating Scale
Step 3

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent

Version 1/14/09 m9/12/17

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice, *pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

Severity Rating Scale Step 3

SUICIDAL IDEATION *Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.*	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
INTENSITY OF IDEATION *The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.* Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm,*** just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts _____	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____	Yes ☐ No ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Appendix VI

STUDENT FOLLOW UP SUPPORT PLAN

SECTION 1

(Completed During Initial Screening)

Student: _____ Documenting Personnel: _____

Student contact #: _____ Initial Screening Date: _____

Parent/Guardian Information _____

Special Education: Yes ☐ No ☐ _____

504 Plan: Yes ☐ No ☐ _____

Foster/Probation: Yes ☐ No ☐ _____

Follow-Up Contact Plan

Risk Level (based on screening): Low ☐ (1x per week) Medium ☐ (2x+ per week) High ☐ (3x+ per week)

Staff Name	Frequency	Planned Date(s) of Contact

SECTION 2

(Completed during SST or Re-Entry Meeting)

Crisis Response Plan

Warning Signs/Triggers	Strategies that Work	Strategies that Don't Work

Behavior Supports

What will staff, student, and family do to lessen the likelihood of unsafe behavior (i.e., supervision, transition planning, transportation to and from school, plan for unstructured time, closed campus, searches, etc.)?	Who / Back-up person?
How will plan be monitored?	Who / Back-up person?
How will decision be made to terminate the plan? (i.e. has student met ultimate outcome, have goals been met, is student safe)	Who / Back-up person?

Current Agencies or Outside Professionals Involved

Name	Agency	Phone

Student Safety Team Members

Name	Signature	Title	Date

Next Review Date: _____

(Within 30 calendar days from initiation of plan or last review date)

SST/Re- Entry Meeting Scheduled ☐ SST scheduled Date and Time: _____

SST/Re- Entry Meeting Held ☐ Date and Time: _____

Documentation Upload ☐ _____

Follow Up Mtg Scheduled ☐ _____

Support Plan Attached ☐ _____

Appendix VII

VERIFICATION OF EMERGENCY RELEASE OF STUDENT

I, _____, the parent, legal guardian or permitted adult (approved by parent/guardian) of _____, met with school personnel on _____ to discuss the emergency release of student. I was notified that this student is at risk based on the student risk identification screening and have been further advised to seek outside psychological /psychiatric consultation as soon as possible. I was provided with local community resource information. The school will implement school based follow-up assistance as needed.

_____ _____

Adult Student, Parent, Guardian or permitted adult (approved by parent/guardian) Date

_____ _____

School Personnel Date

FOR SCHOOL USE ONLY

Emergency Response Information
(i.e. law enforcement/ child protective/welfare services, crisis team, medical response)

Name	Badge #	Department	Phone Number