

Adel School District #21 Suicide Prevention Policy Guide

**A GUIDE TO YOUTH SUICIDE PREVENTION,
INTERVENTION, AND POSTVENTION
PROCEDURES FOR SCHOOLS**

Table of Contents

Purpose of Protocols and Procedures.....	3
Quick Notes: What Schools Need to Know.....	3
Suicide Prevention Protocol.....	4
Suicide Intervention Protocol.....	5
Suicide Assessment and Intervention Flow Chart.....	6
Suicide Risk Assessment – Level 1.....	7-8
Suicide Behavior Risk and Protective Factors.....	9
Columbia-Suicide Severity Rating Scale (C-SSRS).....	10-15
Student Coping Plan.....	16
Student Re-Entry Plan.....	17-20
Suicide Postvention Protocol.....	21
Resources.....	22
Confidentiality.....	23
Lake Health District SB561 Communication and Response Protocol.....	24-26
Local Resources for Training and Support.....	27-28
Acknowledgments.....	29
Appendix.....	30-31
Appendix B.....	32

Purpose of Protocols and Procedures

The U.S. Surgeon General promotes the adoption of suicide prevention protocols by local school districts to protect school personnel and to increase the safety of at-risk youth and the entire school community. This document is intended to help school staff understand their role and to provide accessible tools.

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

School Boards and school personnel may choose to implement additional supportive measures to fit the specific needs of an individual school community. The purpose of these guidelines is to assist school administrators and school counselors in their planning.

Quick Notes: What Schools Need to Know

- School staff are frequently considered the first line of contact with potentially suicidal students.
- Most school personnel are neither qualified, nor expected, to provide the in-depth assessment or counseling necessary for treating a suicidal student. They are responsible for taking reasonable and prudent actions to help at-risk students, such as notifying parents, making appropriate referrals, and securing outside assistance when needed.
- All school personnel need to know that protocols exist to refer at-risk students to trained professionals so that responsibility does not rest solely with the individual “on the scene”.
- Research has shown talking about suicide, or asking someone if they are feeling suicidal, will *not* put the idea in their head or cause them to kill themselves.
- School personnel, parents/guardians, and students need to be confident that help is available when they raise concerns regarding suicidal behavior. Students often know, but do not tell adults, about suicidal peers. Having supports in place may lessen this reluctance to speak up when students are concerned about a peer.
- Advanced planning is critical to providing an effective crisis response. Internal and external resources must be in place to address student issues and to normalize the learning environment for everyone.

Suicide Prevention Protocol

Suicide can be prevented. Following these simple steps will help ensure a comprehensive school based approach to suicide prevention for staff and students.

Staff:

All staff should receive training (or a refresher) once a year on the policies, procedures, and best practices for intervening with students and/or staff at risk for suicide. The QPR Suicide Prevention model provides training on best practices.

- Annual QPR Training for ALL staff
- Annual review of prevention, intervention, and postvention protocols.

Specific staff members receive specialized training to intervene, assess, and refer students at risk for suicide. Training should be best practice suicide program such as ASIST: Applied Suicide Intervention Skills Training.

- 2 ASIST Trained staff per school to be renewed every three years
- Through annual QPR training references to who is the suicide prevention/intervention coordinators within the district.

Students:

Students should receive developmentally-appropriate, student-centered education about suicide and suicide prevention throughout their elementary and high school years. The purpose of this curriculum is to teach students how to access help at their school for themselves, their peers, or others in the community.

Examples include but are not limited to:

- Character Strong
- Messaging of resources including printed material and social media posted annually

Parents:

Provide parents with informational materials to help them identify whether their child or another person is at risk for suicide. Information should include how to access school and community resources to support students or to others in their community that may be at risk for suicide.

- School District Website-Counseling Program

Suicide Intervention Protocol

Warning Signs for Suicide

Warning signs are the changes in a person's behavior, feelings, and beliefs about oneself that indicate risk. Many signs are similar to the signs of depression. Usually these signs last for a period of two weeks or longer, but some youths behave impulsively and may choose suicide as a solution to their problems very quickly, especially if they have access to firearms.

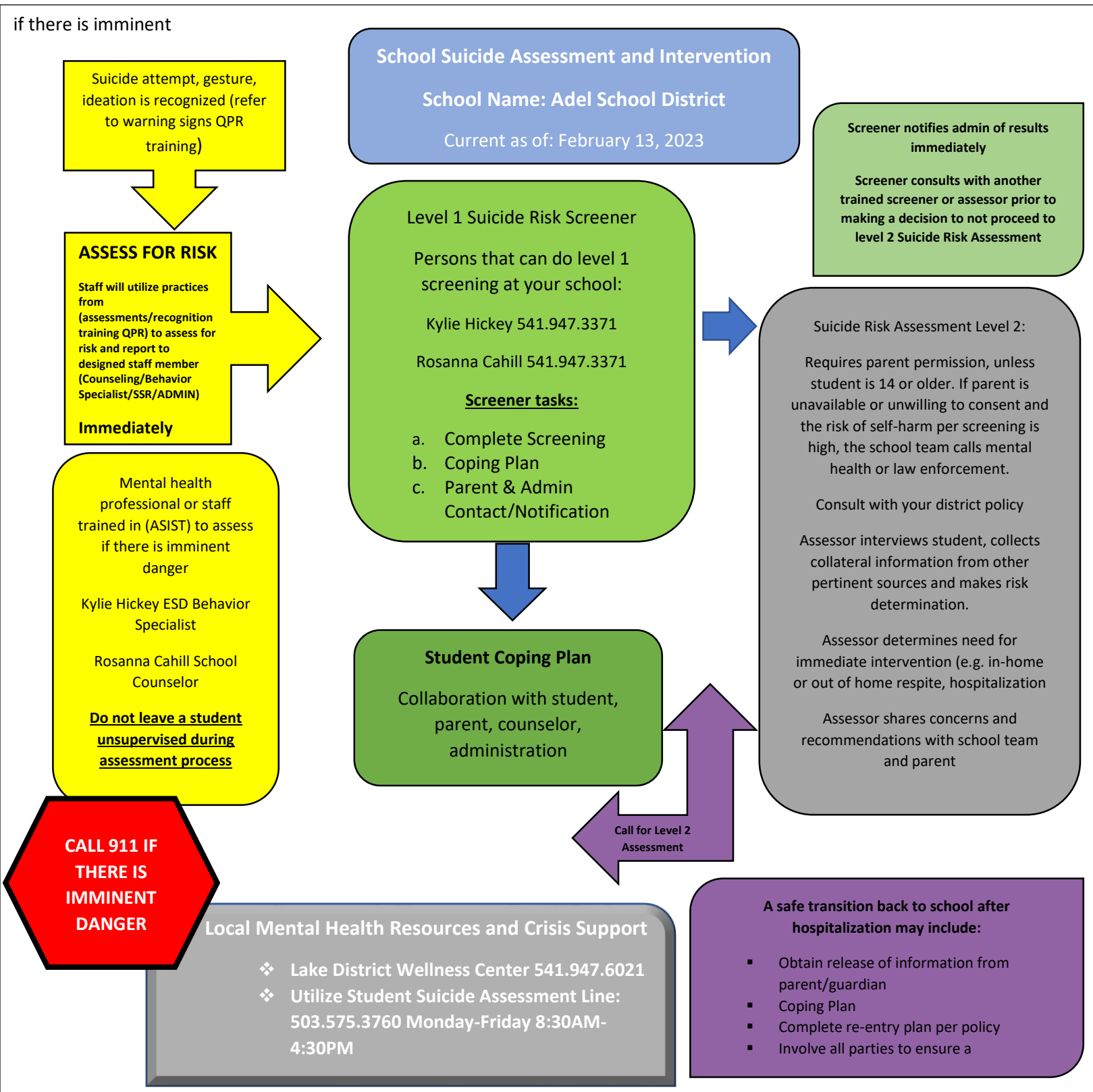
Warning signs that may indicate an immediate danger or threat:

- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves – seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide

If a suicidal attempt, gesture, or ideation occurs or is recognized:

- Staff will take all suicidal behavior and comments seriously **EVERY TIME**
- Call 911 if there is immediate danger
- It is critical that **any** school employee, who has knowledge of someone with suicidal thoughts or behaviors, communicate this information immediately and directly to a school based mental health person school counselor, behavior specialist, administrator, or an ASIST trained “gatekeeper”
- Staff will stay with the student until relieved by a school counselor, behavior specialist, resource officer, administrator or designated ASIST trained “gatekeeper”
- **A Suicide Risk Assessment: Level 1 will be performed by a trained school staff member. The screener will do the following:**
 - Interview student using Suicide Risk Assessment: Level 1 screening form (C- SSRS)
 - Complete a Student Coping Plan if needed
 - Contact parent to inform and to obtain further information
 - Determine need for a *Suicide Risk Assessment: Level 2* based on level of concern
 - Consult with another trained screener prior to making a decision to *not* proceed to a Level 2
 - Inform administrator of screening results

**See following School Based Suicide Intervention Process flowchart for additional information*



Suicide Risk Assessment – Level 1

1. IDENTIFYING INFORMATION

Name: _____ School: _____ DOB: _____ Age: _____
IEP/504? _____ Address: _____
Parent/Guardian #1 name/phone # (s): _____
Parent/Guardian #2 name/phone # (s): _____
Screener's Name: _____ Position: _____
Contact Info: _____
Screener consulted with: _____

2. REFERRAL INFORMATION

Who reported concern: Self Peer Staff Parent/Guardian Other
Contact Information: _____
What information did this person share that raised concern about suicide risk?

3. PARENT/GUARDIAN CONTACT

1. Name of the parent/guardian contacted: _____ Date Contacted: _____
2. Was the parent/guardian aware of the student's suicidal thoughts/plans? Yes No
3. Parent/guardian's perception of threat? _____

4. INTERVIEW WITH THE STUDENT

a. Does the student exhibit any of the following warning signs?

- Withdrawal from others Yes No
- Written statements, poetry, stories, electronic media about suicide Yes No
- Preoccupation with death Yes No
- Feelings of hopelessness Yes No
- Substance Abuse/Mental Health Issue Yes No
- Current psychological/emotional pain Yes No
- Discipline issues Yes No
- Conflict with others (friends/family) Yes No
- Experiencing bullying or being a bully Yes No
- Recent personal or family loss or change (i.e., death, divorce) Yes No
- Recent changes in appetite Yes No
- Family problems Yes No
- Giving away possessions Yes No
- Current trauma (domestic/relational/sexual abuse) Yes No
- Crisis within the last 2 weeks Yes No
- Stresses from: gender ID, sexual orientation, ethnicity Yes No
- See Risk Factors Page for additional signs: _ Yes No

- Does the student admit to thinking about suicide? Yes No
- Does the student admit to thinking about harming others? Yes No
- Does the student admit to having a plan? Yes No
- If so, what is the plan (how, when, where)? _____
- Is the method to carry out the plan available? Yes No
- Explain: _____
- Is there a history of previous gesture(s) or attempts? Yes No
- If yes, describe: _____
- Is there a family history of suicide? Yes No
- Explain: _____
- Has the student been exposed to suicide by others? Yes No
- Explain: _____
- Has the student been recently discharged from psychiatric care? Yes No
- Date/Explain: _____
- Does the student have a support system? Yes No
- List an adult the student can talk to **at home**: _____
- List an adult the student can talk to **at school**: _____
- Additional supports: _____

b. Protective Factors (see supplemental Risk & Protective Factor sheet and attach)

5. ACTIONS TAKEN

- Yes No Called 911 (contact date/time/name)
- Yes No Crisis Response Plan created with student
- Yes No Copy of Crisis Response Plan given to student, original placed in confidential file within CUM file
- Yes No Parent/guardian contacted
- Yes No Released back to class after parent (and/or agency) confirmed Crisis Response Plan and follow up plan established. Notes: (please use separate page)
- Yes No Called DHS
- Yes No Released to parent/guardian
- Yes No Parent/guardian took student to hospital
- Yes No Parent/guardian scheduled mental health evaluation appointment
- Notes:
- Yes No Provided student and family with resource materials and phone numbers
- Yes No School Based Mental Health Provider follow up (date/time) scheduled:
- Yes No School Administrator notified (date/time): _____

- Limited or NO risk factors noted. **NO FURTHER FOLLOW-UP NEEDED.**
- Several risk factors noted but no imminent danger. Completed Crisis Response Plan. Will follow up with student on Date/Time: _____
- Several risk factors noted: referred for Level 2 Suicide Risk Assessment from County Mental Health or student's private counselor (contact date/time/name): _____
- Consulted with and approved by: 1. _____ 2. _____

Suicide Behavior Risk and Protective Factors

RISK FACTORS (Mark all that apply)

- Current plan to kill self
- Current suicidal ideation
- Access to means to kill self
- Previous suicide attempts
- Family history of suicide
- Exposure to suicide by others
- Recent discharge from psychiatric hospitalization
- History of mental health issues (major depression, panic attacks, conduct problems)
- Current drug/alcohol use
- Sense of hopelessness
- Self-hate
- Current psychological/emotional pain
- Loss (relationship, work, financial)
- Discipline problems
- Conflict with others (friends/family)
- Current agitation
- Feeling isolated/alone
- Current/past trauma (sexual abuse, domestic violence)
- Bullying (as aggressor or as victim)
- Discrimination
- Severe illness/health problems
- Impulsive or aggressive behavior
- Unwilling to seek help
- LGBT, Native-American, Alaskan Native, TAG, male

Protective Factors (mark all that apply)

- Engaged in effective health and/or mental healthcare
- Feels well connected to others (family, school, friends)
- Positive problem solving skills
- Positive coping skills and resiliency
- Restricted access to means to kill self
- Stable living environment
- Willing to access support/help
- Positive self esteem
- High frustration tolerance
- Emotional regulation
- Cultural and/or religious beliefs that discourage suicide
- Does well in school
- Has responsibility for others



COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

NATIONAL SUICIDE PREVENTION LIFELINE



Columbia-Suicide Severity Rating Scale (C-SSRS)

The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is a questionnaire used for suicide assessment developed by multiple institutions, including Columbia University, with NIMH support. The scale is evidence-supported and is part of a national and international public health initiative involving the assessment of suicidality. Available in 103 different languages, the scale has been successfully implemented across many settings, including schools, college campuses, military, fire departments, the justice system, primary care and for scientific research.

Several versions of the C-SSRS have been developed for clinical practice. The **Risk Assessment** version is three pages long, with the initial page focusing on a checklist of all risk and protective factors that may apply. This page is designed to be completed following the client (caller) interview. The next two pages make up the formal assessment. The C-SSRS Risk Assessment is intended to help establish a person's immediate risk of suicide and is used in acute care settings.

In order to make the C-SSRS Risk Assessment available to all Lifeline centers, the Lifeline collaborated with Kelly Posner, Ph.D., Director at the Center for Suicide Risk Assessment at Columbia University/New York State Psychiatric Institute to slightly adjust the first checklist page to meet the Lifeline's Risk Assessment Standards. The following components were added: helplessness, feeling trapped, and engaged with phone worker.

The approved version of the C-SSRS Risk Assessment follows. This is one recommended option to consider as a risk assessment tool for your center. If applied, it is intended to be followed exactly according to the instructions and cannot be altered.

Training is available and recommended (though not required for clinical or center practice) before administering the C-SSRS. Training can be administered through a 30-minute interactive slide presentation followed by a question-answer session or using a DVD of the presentation. Those completing the training are then certified to administer the C-SSRS and can receive a certificate, which is valid for two years.

To complete the C-SSRS Training for Clinical Practice, visit <http://c-srs.trainingcampus.net/>

For more general information, go to <http://cssrs.columbia.edu/>

Any other related questions, contact Gillian Murphy at gmurphy@mhaofnyc.org

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

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

(* elements added with permission for Lifeline centers)

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.			
Suicidal and Self-Injury Behavior (Past week)		Clinical Status (Recent)	
<input type="checkbox"/>	Actual suicide attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Interrupted attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Aborted attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Other preparatory acts to kill self	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Self-injury behavior w/o suicide intent	<input type="checkbox"/>	Lifetime
Suicide Ideation (Most Severe in Past Week)		<input type="checkbox"/>	Hopelessness
<input type="checkbox"/>	Wish to be dead	<input type="checkbox"/>	Helplessness*
<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	Feeling Trapped*
<input type="checkbox"/>	Suicidal thoughts with method (but without specific plan or intent to act)	<input type="checkbox"/>	Major depressive episode
<input type="checkbox"/>	Suicidal intent (without specific plan)	<input type="checkbox"/>	Mixed affective episode
<input type="checkbox"/>	Suicidal intent with specific plan	<input type="checkbox"/>	Command hallucinations to hurt self
Activating Events (Recent)		<input type="checkbox"/>	Highly impulsive behavior
<input type="checkbox"/>	Recent loss or other significant negative event	<input type="checkbox"/>	Substance abuse or dependence
	Describe:	<input type="checkbox"/>	Agitation or severe anxiety
		<input type="checkbox"/>	Perceived burden on family or others
<input type="checkbox"/>	Pending incarceration or homelessness	<input type="checkbox"/>	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
<input type="checkbox"/>	Current or pending isolation or feeling alone	<input type="checkbox"/>	Homicidal ideation
Treatment History		<input type="checkbox"/>	Aggressive behavior towards others
<input type="checkbox"/>	Previous psychiatric diagnoses and treatments	<input type="checkbox"/>	Method for suicide available (gun, pills, etc.)
<input type="checkbox"/>	Hopeless or dissatisfied with treatment	<input type="checkbox"/>	Refuses or feels unable to agree to safety plan
<input type="checkbox"/>	Noncompliant with treatment	<input type="checkbox"/>	Sexual abuse (lifetime)
<input type="checkbox"/>	Not receiving treatment	<input type="checkbox"/>	Family history of suicide (lifetime)
Other Risk Factors		Protective Factors (Recent)	
<input type="checkbox"/>		<input type="checkbox"/>	Identifies reasons for living
		<input type="checkbox"/>	Responsibility to family or others; living with family
		<input type="checkbox"/>	Supportive social network or family
		<input type="checkbox"/>	Fear of death or dying due to pain and suffering
		<input type="checkbox"/>	Belief that suicide is immoral, high spirituality
		<input type="checkbox"/>	Engaged in work or school
		<input type="checkbox"/>	Engaged with Phone Worker *
		Other Protective Factors	
		<input type="checkbox"/>	

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

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. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i> If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit 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. <i>Have you actually had any thoughts of killing yourself?</i> If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
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." <i>Have you been thinking about how you might do this?</i> If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i> If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
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. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i> If yes, describe:		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
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.			
<u>Lifetime - Most Severe Ideation:</u> _____ Type # (1-5) Description of Ideation		Most Severe	Most Severe
<u>Recent - Most Severe Ideation:</u> _____ Type # (1-5) Description of Ideation			
Frequency <i>How many times have you had these thoughts?</i> (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 <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time		_____	_____
Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (0) Does not attempt to control thoughts		_____	_____
Deterrents <i>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 committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (0) Does not apply		_____	_____
Reasons for Ideation <i>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?</i> (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others couldn't go on and to end/stop the pain (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
<p>Actual Attempt: A potentially self-injurious act committed with at least some wish to die, <i>as a result of act</i>. 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.</p> <p>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:</p> <p>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of Attempts</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of Attempts</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (<i>if not for that, actual attempt would have occurred</i>). 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. Oncethey 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.</p> <p>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:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of interrupted</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of interrupted</p>
<p>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.</p> <p>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:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of aborted or self-interrupted</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of aborted or self-interrupted</p>
<p>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).</p> <p>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:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of preparatory acts</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of preparatory acts</p>

	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; <i>medical</i> 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; <i>medical</i> 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	<i>Enter Code</i> _____	<i>Enter Code</i> _____	<i>Enter Code</i> _____
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	<i>Enter Code</i> _____	<i>Enter Code</i> _____	<i>Enter Code</i> _____

Student Coping Plan

Student Name: _____ DOB: _____

Date of Plan: _____

Warning signs that I am not safe:

- 1.
- 2.
- 3.

Things I can do to keep myself safe (in the case that I was thinking about suicide):

- 1.
- 2.
- 3.

An adult I can talk to at home when I feel it would be better if I were not alive:

An adult I can talk to at school when I feel it would be better if I were not alive:

Identify reasons for living:

- 1.
- 2.
- 3.

(optional) My plan to reduce or stop use of alcohol/drugs:

- 1.
- 2.
- 3.

I can call any of the numbers below for 24 Hour Crisis Support:

- **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)
- **Oregon Youthline** 1-877-968-8491 or text “teen2teen” to 839-863
- **Lake Health District 24 Hour Crisis Line** 541-889-9167

My follow-up appointment is: _____ with: _____

Copies, as agreed upon with student, will be sent to:

Student Re-Entry Plan

After a Suicide Attempt or Hospitalization

Transition back to school after a suicide attempt or hospitalization can be a difficult one, especially if the attempt was public. The student's privacy going forward is critical and the student and their parent(s) need to be an integral part of the decisions made in the re-entry plan.

The return to school requires individualized attention and planning. It is important that staff who have direct contact with the student be aware of the student's plan in order to monitor potential continued risk.

Counselor/Administrator Guidelines:

Prior to return:

1. Meet with the student and their parent(s) before the return to school and fill out the Student Re-Entry Plan.
2. Respect the student's wishes as to how their absence is discussed. If the attempt is common knowledge, help the student prepare for questions from peers and staff. If no one is aware, help the student create a short response to explain the absence. Role play so that the student can try out different responses to different situations (peer to peer & staff-student), if needed. Being prepared helps reduce anxiety and helps the student feel more in control.
3. Reassure the student and family that sharing information with school personnel will be done on a need to know basis. Staff that have direct contact should be informed so they can actively assist the student academically.
4. Identify the staff that will need to know by name and role.
5. Reassure the student that staff will be available to help the student with any academic issues and that it will be important for the student to reach out if they are feeling worried about school work.
6. Obtain a Release of Information from the parent so the mental health provider can talk to the school counselor.
7. If needed, schedule a student interview team meeting if a student has a diagnosis or condition that will last more than 6 months that may hinder access to education. Determine if a 504 plan would be sufficient.

After return to school:

1. Continue to monitor and support the student, as needed.
2. Have regular contact with the student's parent(s) and therapist to provide feedback and gain information on how best to support the student.

Staff Guidelines:

After return to school:

1. Welcome the student's return to school as you would any other students' return from an extended absence. Let them know you are glad they are back – "Good to see you".
2. Be aware that the student may still be dealing with symptoms of depression which can affect concentration and motivation.

3. Be aware that the student may be adjusting to medication and may be dealing with side effects including fatigue or jitteriness.
4. Keep the reason for the student's absence **CONFIDENTIAL**.
5. Discuss missed classwork and homework and arrangements for completion. Adjust expectations, if needed. If possible, provide alternative assignments instead of having the student try to make up all the work; provide temporary interventions during re- entry.
6. Keep an eye on the student's academic performance as well as their social/emotional interactions. If you see that they are isolating or being shunned by peers or is falling further behind academically, follow-up with the student's counselor.
7. Pay close attention to further absences, tardies, and requests to be excused during class and share any concerns with the student's counselor.
8. Encourage the student to use the school counselor for additional support.

Student Re-Entry Plan

Student: _____ Date: _____

School: _____ Grade: _____ Date to be reviewed: _____

Primary School Contact (a qualified school professional who will create and monitor the Support plan):

Secondary School Contact (a qualified school professional available to the student when the primary contact is not):

Re-Entry meeting participants:

Accommodations/Support Options – check those that apply

- Re-entry meeting with counselor before returning to class
- Reduced schedule for gradual re-entry
- Return to previous full-day schedule
- Return to full-day schedule but with class changes made to the schedule
- Change of placement
- Other: _____
- Shortened assignments
- Extended time for work
- Provide alternative work
- Working lunch
- Arrange with teachers to not call on student unless hand is raised
- Assigned classmate as volunteer assistant
- Preferential seating, near door to allow leaving class for breaks
- Alternate work environment
- Alternate transition plan between classes (buddy walk, early dismissal, staff escort)
- Alternate seating plan (away from bully)
- Other: _____
- Student allowed to take breaks inside the classroom
- Student allowed to take breaks outside the classroom
- Student allowed to check in with the counselor as needed
- Audio or listening options (i.e. sound canceling headphones) as deemed appropriate in class
- Other: _____

- School Safety Plan completed

Next steps in case of continued safety concern:

Parental/Guardian/Student needs and/or additional information:

Date of next meeting: _____

Suicide Postvention Protocol

Schools must be prepared to act and provide postvention support and activity in the event of a serious attempt or a suicide death. Suicide Postvention has been defined as “the provision of crisis intervention, support, and assistance for those affected by a suicide” (American Association of Suicidology).

The school’s primary responsibility in these cases is to respond to the tragedy in a manner which appropriately supports students and the school community impacted by the tragedy. This includes having a system in place to work with the multitude of groups that may eventually be involved, such as students, staff, parents, community, media, law enforcement, etc.

KEY POINTS (derived from *After a Suicide: A Toolkit for Schools, 2011*)

- Prevention (postvention) after a suicide attempt or completion is very important. Schools should be aware that adolescents and others associated with the event are vulnerable to suicide contagion or, in other words, increased risk for suicide.
- It is important to not “glorify” the suicide and to treat it sensitively when speaking about the event, particularly with the media.
- It is important to address all deaths in a similar manner. Having one approach for a student who dies of cancer, for example, and a different approach for a student who dies by suicide reinforces the stigma that still surrounds suicide.
- Families and communities can be especially sensitive to the suicide event.
- Know your resources.

POSTVENTION GOALS

- Support the grieving process
- Prevent imitative suicides – identify and refer at-risk survivors
- Reestablish healthy school climate
- Provide long-term surveillance

POSTVENTION RESPONSE PROTOCOL

- Reference “Responding to Schools in Crisis” A School Response Team Resource Manual
 - Checklist for the day of crisis
 - Reference flow chart of crisis response protocol
 - Resources and Guidance
- Using SRT Manual
 - Verify suicide and facts
 - Estimate level of response resources required
 - Determine what and how information is to be shared – do NOT release information in a large assembly or over the intercom. Do not “glorify” the death.
 - Mobilize the school’s Postvention Team School Response Team (ESD Superintendent)
 - Inform faculty and staff
 - Identify and refer at-risk students and staff
 - Be aware that persons may still be traumatized months after the event. Refresh staff on prevention protocols and be responsive to signs of risk.

RISK IDENTIFICATION STRATEGIES

- **IDENTIFY** students/staff that may have witnessed the suicide or its aftermath, have had a personal connection/relationship with the deceased, who have previously demonstrated suicidal

behavior, have a mental illness, have a history of familial suicide, or who have experienced a recent loss.

- **MONITOR** student absentees in the days following a student suicide, those who have a history of being bullied, who are LGBTQ, who are participants in fringe groups, and those who have weak levels of social/familial support
- **NOTIFY** parents of highly affected students, provide recommendations for community-based mental health services, hold evening meetings for parents, provide information on community-based funeral services/memorials, and collaborate with media, law enforcement and community agencies.

KEY POINTS TO EMPHASIZE TO STUDENTS, PARENTS, MEDIA

- Prevention (warning signs, risk factors)
- Survivors are not responsible for the death
- Mental illness etiology
- Normalize anger / help students identify and express emotions
- Stress alternatives and teach positive coping skills
- Help is available

CAUTIONS

- Avoid romanticizing or glorifying event or vilifying victim
- Do not provide excessive details or describe the event as courageous or rational
- Do not eulogize victim or conduct school-based memorial services
- Address loss but avoid school disruption as best as possible

(School Postvention – www.sprc.org)

RECOMMENDED RESOURCES

After A Suicide: A Toolkit for Schools
www.afsp.org

Suicide Prevention Resource Center
www.sprc.org

American Foundation for Suicide Prevention
www.afsp.org

To speak with a counselor or schedule an appointment:

Lake District Wellness 541-947-6021

For Emergencies: 911, local emergency room

YOUTHLINE

Call 877-968-8491

Text “teen2teen” to 839863

Chat at www.oregonyouthline.org

A teen-to-teen crisis and help line. Contact us with anything that may be bothering you; no problem is too big or small! Teens available to help daily from 4-10pm Pacific Time (off-hour calls answered by Lines for Life).

Confidentiality

HIPAA and FERPA

School employees, with the exception of nurses and psychologists who are bound by HIPAA, are bound by laws of The Family Education Rights and Privacy Act of 1974; commonly known as FERPA.

There are situations when confidentiality must NOT BE MAINTAINED; if at any time, a student has shared information that indicates the student is in imminent risk of harm/danger to self or others, that information MUST BE shared. The details regarding the student can be discussed with those who need to intervene to keep the student safe. This is in compliance with the spirit of FERPA and HIPAA known as “minimum necessary disclosure”.

REQUEST FROM STUDENT TO WITHHOLD FROM PARENTS

The school suicide prevention contact person can say “I know that this is scary to you, and I care, but this is too big for me to handle alone.” If the student still doesn’t want to tell his/her parents, the staff suicide contact can address the fear by asking, “What is your biggest fear?” This helps reduce anxiety and the student gains confidence to tell parents. It also increases the likelihood that the student will come to that school staff again if he/she needs additional help.

EXCEPTIONS FOR PARENTAL NOTIFICATION: ABUSE OR NEGLECT

Parents need to know about a student’s suicidal ideation unless a result of parental abuse or neglect is possible. The counselor or staff suicide contact person is in the best position to make the determination. The school staff will need to let the student know that other people would need to get involved on a need to know basis.

If a student makes a statement such as “My dad/mom would kill me” as a reason to refuse, the school staff can ask questions to determine if parental abuse or neglect is involved. If there is no indication that abuse or neglect is involved, compassionately disclose that the parent needs to be involved.

Lake Health District
Lake County
SB561 COMMUNICATION AND RESPONSE PROTOCOL

Date: August 14, 2017

Subject: Suicide Postvention Policy

Purpose: This policy provides a procedure for identifying community partners and local communication pathways for information sharing inclusive of mobilization of a postvention responses surrounding suicides in Lake County of persons 24 years of age and younger.

Policy: Suicide is the second leading cause of death among 24 years of age and younger in Oregon. Lake Health District is committed to working collaboratively with the community to establish suicide prevention activities along with postvention and contagion-reduction protocols. Lake Health District, the Community Mental Health Program (CMHP), serving on behalf of the Local Mental Health Authority (LMHA), will provide oversight to ensure the coordination of community processes and submitting data to the state for suicides that meet Oregon Senate Bill 561 criteria.

Communication Protocol:

1. Lake Health District, as the CMHP, will assume the lead communication role to the state when an individual 24 years of age and younger dies by suicide or suspected suicide.
2. The Critical Incident Stress Debriefing Lead will be the Lead Response; backup is the Suicide Response Coordinator (See contacts at end of document)
3. The District Attorney's office, or other identified agency/individuals, will notify Lake Health District within 72 hours providing the following information as available:
 - a. Name of deceased;
 - b. Family and extended family of deceased;
 - c. School attended or facility where person worked and resided;
 - d. Race/Ethnicity of the deceased;
 - e. Gender of the deceased;
 - f. Age of the deceased;
 - g. Gender identity of the deceased;
 - h. Sexual orientation of the deceased;
 - i. Means of death; and,
 - j. Was the youth in the custody of a government agency (e.g., Department of Human Services [DHS], Oregon Youth Authority [OYA], etc.).
4. Upon request, institutions of higher education, school districts, private schools and other Lake County based education options will provide directory information, per policy and FERPA, to Lifeways.
5. As appropriate, Lake Health District will communicate the death to the applicable community partners to initiate response protocols.
6. Lake Health District will collect information and submit the required Oregon Health Authority (OHA) form to the OHA Suicide Intervention Coordinator via secure email within 7 days of the death.
7. The District Attorney's office, or other identified agency/individuals, will notify Lake Health District of final disposition of the fatality review if not ultimately determined to be a suicide.
8. The District Attorney's office will be the designated media spokesperson.

Response Protocol:

Lake Health District, as the CMHP, will assume the Lead Response role for overall County and OHA communication and response processes when a person through the age of 24 dies by suicide when there is no other Lead identified/available; and/or for the purposes of larger community coordination as needed.

The Critical Incident Debriefing Lead will serve as the Lead Response. In the event an individual's residence is in a county other than Lake, Lake Health District Lead Response will reach out to the LMHA in the county of residence for notification of the individual's death.

Immediate postvention response (implemented in the immediate days and weeks after suspected suicide):

Lake Health District Lead Response:

1. Verify the death and cause as available from the Medical Examiner, Law Enforcement or school personnel.
2. Coordinate with effected organizations (law enforcement, schools, etc.) to determine who will take the lead in a given suicide- if not already identified.
3. As appropriate, activate other community Critical Incident Debriefing (CISD) trained clinicians. Such clinicians will operate under the direction of the CISD Lead who will be determined by the Lake Health District Crisis Supervisor or designee.
4. During response process, identify "at risk" individuals in order to prevent contagion;
5. Provide psychoeducation resources on grieving, depression, PTSD, and suicide to those "at risk" and others in the community.
6. Collect information on "at risk" individuals and provide or coordinate outreach as needed;
7. As appropriate, link impacted parties to resources.
8. As appropriate, Lake Health District will disseminate information regarding safe reporting best practices for the media.
9. As appropriate, Lake Health District will disseminate information regarding best practice postvention procedures (for example, how to communicate with school staff, parents appropriately, how to help siblings re-introduce themselves into the school setting).

Non-Lake Health District Lead Response:

1. Lead will be determined by the impacted organization.
2. Organization/Lead will outreach and coordinate with community partners as needed for immediate response and documentation purposes (law enforcement, schools, Lifeways, etc.).
3. Organization will follow internal protocols.
4. Organization will determine which, if any, of the following are appropriate and may request additional support as needed. Additional options may be considered as well.
 - Request activation of other community Critical Incident Stress Debriefing (CISD) trained clinicians and coordinate services.
 - During response process, identify those "at risk" in order to prevent contagion;
 - Providing psychoeducation resources on grieving, depression, PTSD, and suicide to those "at risk" and others in the community
 - Collect information on "at risk" individual and provide or coordinate outreach as needed;
 - Link impacted parties to resources.
 - Monitor social media as appropriate

- Request assistance from the Lake Health District Lead Response for dissemination of information regarding safe reporting best practices for the media.
- Request assistance from the Lake Health District Lead Response for dissemination of information regarding best practice postvention procedures (for example, how to communicate with school staff, parents appropriately, how to help siblings re-introduce themselves into the school setting).

Intermediate postvention response (implemented in the several months after a suicide has been confirmed):

1. As requested, Lake Health District, schools or other community providers will provide services to impacted individuals including family members and peers of the deceased.
2. On-going risk assessment of impacted individuals will occur through natural organizational contacts, i.e. higher education counseling, school counseling, etc., as available.
3. Additional psychoeducation on suicide prevention and dissemination of information and other suicide prevention resources will be provided as requested.
4. Action review for individuals 24 years of age and younger will occur via the Lake County Child Fatality Review Multidisciplinary Team. The evaluation process shall include an assessment of the effectiveness of meeting the needs of grieving families and families of choice; friends or others with relationships with the deceased; and the wider network of community members impacted by the suspected youth suicide.
5. Schools and community partners will provide Lake Health District with a plan for Intermediate and Long-Term activities.
6. Action review for individuals 24 years of age and younger will occur via Community Youth Action Alliance.

Long Term postvention response (implemented up to a year after the suicide):

1. As requested, Lake Health District will provide psychoeducation outreach activities to educate the general public on the risk and impact of suicide.
2. As requested, Lake Health District will continue to keep in touch with individuals at higher risk and continue to conduct risk assessments.
3. Lake Health District Lead Response will coordinate with community partners for provision of Question, Persuade, Respond (QPR), and/or ASIST training to community at-large and community partners.
4. Impacted organizations will continue to monitor for the risk of contagion especially during critical periods including graduation, anniversary of death and any other identified critical dates.

Contact(s)

Suicide Response Coordinator

Heidi Martinez

Local Resources for Training and Support

QPR – Suicide Prevention and Risk Reduction

Ages 16-adult 2 hours

Recommended for all staff

QPR Gatekeeper Training is designed to teach lay and professional “gatekeepers” the warning signs of a suicide crisis and how to respond. QPR is often used in schools as a universal training for all staff members that can be completed within 2-3 hours.

Local trainers: Kylie Hickey khickey@lakeesd.k12.or.us, JD Herman hermann.joseph@lakeview.k12.or.us, and Kevin Purnell kevin.purnell@malesd.org (Regional)

ASIST Workshop – Applied Suicide Intervention Skills Training

Ages 16-adult 2 Days

Recommended for all school based mental health providers and select staff members

LivingWorks ASIST is a two-day face-to-face workshop featuring powerful audiovisuals, discussions, and simulations. At a LivingWorks ASIST workshop, you'll learn how to prevent suicide by recognizing signs, providing a skilled intervention, and developing a safety plan to keep someone alive. Because ASIST is a more intensive gatekeeper training, schools often benefit from having at least one staff member trained in the curriculum.

Local trainers: JD Herman hermann.joseph@lakeview.k12.or.us, Breann Vandenberg breann.vandenberg@oregonstate.edu, and Kevin Purnell kevin.purnell@malesd.org (Regional)

Youth Mental Health First Aid (Adult program available too)

ALL staff within the school community

4 hour course specifically for educators – can be taught in 1, 2, or 4 days

Local Trainer: Breann Vandenberg breann.vandenberg@oregonstate.edu,

Identify, understand and respond to signs of mental illness and substance use disorders in youth. How to apply Mental Health First Aid in a variety of situations, including when a youth is experiencing a mental health crisis-including suicide risk. Next to family, schools represent the most important sources of support in the lives of young people. All staff within the school community provide opportunities to help a youth experiencing a mental health issue and to recognize suicidal behavior and prevent youth suicide. www.mentalhealthfirstaid.org

Trauma Informed Care

Adults working within systems – i.e. education system; 4 hours

Becoming “trauma-informed” means recognizing that people often have many different types of trauma in their lives. People who have been traumatized need support and understanding from those around them. Often, trauma survivors can be re-traumatized by well-meaning caregivers and community service providers. TIC seeks to educate our communities about the impact of trauma on clients, co-workers, friends, family, and even ourselves. Understanding the impact of trauma is an important first step in becoming a compassionate and supportive community.

www.traumainformedoregon.org

Local coordinators/trainers: Stephanie Castro castros@lakeview.k12.or.us David Castro castrod@lakeview.k12.or.us

Local Resources Continued (miscellaneous)

Lake County Resource Guide: <https://www.lcrg.org/>

Connect Suicide Postvention Training

For School Based Mental Health Professionals and Administrators

3 to 6-hour course tailored specifically for educators

Please contact:

Lake County Suicide Response Coordinator

Heid Martinez. HMartinez@LakeHealthDistrict.org

Lake Health District (541) 947-2114

After training, participants in Connect Suicide Postvention will have increased:

- Understanding of how to coordinate a safe and supportive response to a suicide
- Knowledge of appropriate memorial activities, safe communication, and responses to media inquiries
- Understanding how to reduce the risk of suicide-related phenomena (contagion, copy-cat, and pacts)
- Understanding of the complexity of suicide-related grief for different age groups and over time
- Knowledge of strategies to encourage help-seeking, reducing stigma, and promoting healing for survivors
- Knowledge of resources for survivors of suicide loss
- Competency in how to recognize and respond to suicide warning signs in survivors and community members after a suicide
- Opportunities for networking, relationship building, problem solving, and information sharing among participants

Local Phone Numbers

Local Mental Health Authority: Lake Health District (541) 947-2114

Lake District Wellness Center-541-947-6021

State and National Phone Numbers

YOUTHLINE

Call 877-968-8491

Text “teen2teen” to 839863

Chat at www.oregonyouthline.org

A teen-to-teen crisis and help line. Contact us with anything that may be bothering you; no problem is too big or too small! Teens available to help daily from 4-10pm Pacific Time (off-hour calls answered by Lines for Life).

Trevor Project Crisis Line – LGBTQIA+ Youth

1-866-4-U-Trevor (1-866-488-7386) www.theTrevorProject.org

Text “TREVOR” to 678-678

Lines of Life (adults) 800-273-8255 or text “273TALK” to 839863

Acknowledgments

Original content and design of this guide is a result of a partnership between The Oregon Health Authority and the Deschutes County Children and Families Commission and Health Services. Changes have been made by the Lake Education Service District with the permission of the Deschutes County Prevention Coordinator. This guide can be applied to any school district seeking to proactively address suicide. For the original document, please call 541-330-4632. Special thanks to the Marion & Polk County Suicide Intervention Task Force (2008) for its creation of the Screener’s Handbook, in which some content has been applied in this guide.

Research Sources

Information for this guide was derived from the following sources:

1. After a Suicide: A Toolkit for Schools. American Foundation for Suicide Prevention/Suicide Prevention Resource Center Workgroup, 2011.
2. King, Keith A., 15 “Prevalent Myths about Adolescent Suicide”, Journal of School Health April 1999; Vol. 69, No. 4:159
3. Rudd, MD, Berman AL, Joiner, TE, JR., Nock MK, Silverman, MM, Mandrusiak, M, et al. (2006). Warning Signs for Suicide: Theory, Research, and Clinical Applications. *Suicide and Life-Threatening Behavior*, 36 (3), 255-262.
4. Suicide Prevention, Intervention and Postvention Policies and Procedures. Developed by Washington County Suicide Prevention Effort, August 2010.
5. www.oregon.gov/DHS/ph/ipe
6. www.surgeongeneral.gov
7. www.sprc.org
8. <https://afsp.org/model-school-policy-on-suicide-prevention>
9. <http://www.sprc.org/sites/default/files.resource-program/AfteraSuicideToolkitforSchools.pdf>

APPENDIX A

Sample Language for Middle and High School Student Handbooks

Protecting the health and well-being of all students is of utmost importance to the school district. The school board has adopted a suicide prevention policy which will help to protect all students through the following steps:

- Students will learn about recognizing and responding to warning signs of suicide in friends, using coping skills, support systems, and seeking help for themselves and friends. This curricular content will occur in all health classes throughout the school year, not just in response to a suicide, and the encouragement of help-seeking behavior will be promoted at all levels of the school leadership and stakeholders
- Each school or district will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources
- When a student is identified as being at-risk, a risk assessment will be completed by a trained school staff member who will work with the student and help connect the student to appropriate local resources
- Students will have access to national resources that they can contact for additional support, such as:

Local Phone Numbers

Local Mental Health Authority: Lake Health District (541) 947-2114

State and National Phone Numbers

YOUTHLINE

Call 877-968-8491 Text “teen2teen” to 839863

Chat at www.oregonyouthline.org

A teen-to-teen crisis and help line. Contact us with anything that may be bothering you; no problem is too big or too small! Teens available to help daily from 4-10pm Pacific Time (off-hour calls answered by Lines for Life).

Trevor Project Crisis Line – LGBTQIA+ Youth

1-866-4-U-Trevor (1-866-488-7386) www.theTrevorProject.org Text “TREVOR” to 678-678

Lines of Life (adults) 800-273-8255 or text “273TALK” to 839863

All school personnel and students will be expected to help create a school culture of respect and support, in which students feel comfortable seeking help for themselves or friends. Students are encouraged to tell any staff member if they or a friend are feeling suicidal, or are in need of help. While confidentiality and privacy are important, students should know that when there is risk of suicide, safety comes first. For a more detailed review of policy changes, please see the district’s full suicide prevention policy.

Adapted from: afsp.org/ModelSchoolPolicy

Sample Language for Elementary School Student Handbooks

Protecting the health and well-being of all students is of utmost importance to the school district. While suicide in elementary school-aged children is rare, the number of 6- to 12-year-olds who visited children's hospitals for suicidal thoughts or self-harm has **more than doubled** from 2016 to 2019. Current research suggests that this number has likely doubled again since the beginning of the

pandemic. Experts agree conversations about mental health should begin early on if we want a better chance at prevention suicidal behavior.

The school board has adopted a suicide prevention policy which will help to protect all students through the following steps:

- Students will learn about recognizing emotions and develop coping skills to help them self-regulate when emotions are strong and/or inhibited. This curricular content will occur through Character Strong lessons in the classroom at an age appropriate level.
- Help-seeking behavior will be promoted at all levels of the school leadership, staff, and stakeholders
 - Each school or district will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources
 - When a student is identified as being at-risk, a risk assessment will be completed by a trained school staff member who will work with the student and parent to help connect the student to appropriate local resources.
- Students will have access to national resources that they can contact for additional support, such as:

Local Phone Numbers

Local Mental Health Authority: Lake Health District (541) 947-2114

State and National Phone Numbers

YOUTHLINE

Call 877-968-8491 Text “teen2teen” to 839863

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Trevor Project Crisis Line – LGBTQIA+ Youth

1-866-4-U-Trevor (1-866-488-7386) www.theTrevorProject.org _ Text “TREVOR” to 678-678

Adapted from: afsp.org/ModelSchoolPolicy

APPENDIX B

School Suicide Prevention Checklists Two guides to help school teams

Step by Step

Lines for Life & Willamette Education Service District

Step by Step was developed in Oregon to assist schools with suicide prevention efforts by supplying easy-to-use tools and strategies for decreasing youth suicide and increase awareness surrounding mental health and wellness. The guide includes a comprehensive prevention, intervention and postvention checklist. Link: <https://oregonyouthline.org/step-by-step/>

Developing Comprehensive Suicide Prevention, Intervention, and Postvention Protocols: A Toolkit for Oregon Schools

Cairn Guidance

This toolkit was designed to provide Oregon schools with guidance on how to implement suicide prevention, intervention, and postvention efforts by supplying relevant protocols and example tools to support each component. The guide also includes a comprehensive prevention, intervention and postvention checklist.

Link: <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Documents/Oregon-School-Suicide-Protocol-Toolkit.pdf>