COQUILLE SCHOOL DISTRICT #8

Student Suicide Prevention Plan

ADI'S ACT- SB 52

Table of Contents

INTRODUCTION

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 entire school community. In 2019, the Oregon legislature passed Senate Bill 52, also known as "Adi's Act", which requires school districts to develop and implement a comprehensive student suicide prevention plan.

PURPOSE

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 a crisis 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. Accordingly, this guide is intended to help school staff understand their role and to provide accessible and effective tools.

COQUILLE SCHOOL DISTRICT:

- ❑ Recognizes that physical and mental health impacts student learning and the learning environment. Physical and mental health and wellness are integral components of student outcomes, both educationally and post graduation.
- ❑ Further recognizes that suicide is a leading cause of death among young people aged 10 - 24 in Oregon.
- ❑ Has an ethical responsibility to take a proactive approach in preventing suicide and educating our staff, students and parents on suicide prevention and intervention.
- ❑ Acknowledges the school's role in providing a culture and environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience.
- ❑ Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components.
- ❑ Will publish its policy and plan on the district website and will revisit and refine the plan as needed.

DEFINITIONS

AT-RISK

Risk for suicide exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention. A high-risk student may have thoughts about suicide, including access to means and a plan for their death. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has expressed 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. There are typically multiple warning signs and external factors contributing to a high risk students' wish to die.

SCHOOL TRAUMA ASSISTANCE TEAM (STAT)

The Coquille School District's School Trauma Assistance Team is a group of people (School counselors, Therapists, SRO's, Wellness Department, etc) who work in collaboration with school administrators to address crisis preparedness, intervention, response and postvention.

MENTAL HEALTH

A state of mental health, 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, school, social environment, early childhood adversity or trauma, physical health, and genes.

PARENT

As used in this plan, the term parent means a parent of a student and includes a natural parent, a legal guardian, or an individual authorized in writing to act as a parent in the absence of a parent or a guardian.

RISK ASSESSMENT

An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated staff (an onsite person who has been trained in the CSD protocols and the C-SSRS). The Columbia-Suicide Severity Rating Scale (C-SSRS) 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.

RISK FACTORS FOR SUICIDE

Characteristics or conditions that increase the chance that a person may attempt to die by suicide. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass bio-psycho-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.

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 increase the long-term risk of a future suicide attempt or accidental suicide.

Suicide
Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

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 unresolved mindset, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, unresolved mindset is not reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.

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

Suicide Contagion
The process by which suicidal behavior or a death by suicide 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, this often happens when a suicide is glamorized by public attention and excessive memorialization. Contagion is often preventable when safest practice postvention steps are closely followed.

Postvention
Suicide postvention is a crisis intervention strategy designed to assist with the grief process following a death by suicide. 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 act as prevention and save lives. All school postvention, no matter what the manner of death, should be treated the same.

QUICK FACTS - WHAT SCHOOLS NEED TO KNOW

Take suicidal behavior SERIOUSLY EVERY time. Take IMMEDIATE action!
Know who is trained to conduct a screener at your school. Contact the School Screener and a building administrator to inform her/him/they of the situation. NO student expressing suicidal thoughts should be sent home alone or left alone during the screening process. You must provide supervision!
If there is a reason to believe a student has thoughts of suicide, do not send the student home to an empty house.

- 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 (Coos County Mental Health Crisis Team consult, Local Police, Therapist, etc).

- All school personnel need to know that they are required to refer at-risk students to trained professionals; the burden of responsibility does not rest solely with the individual "on the scene."

- **Research has shown that talking about suicide (whether in a training, classroom or 1 on 1), 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/legal 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.

CONFIDENTIALITY

School employees are bound by laws of The Family Education Rights and Privacy Act of 1974; commonly known as FERPA. FERPA generally precludes schools from disclosing student information without first obtaining consent, but there are exceptions, including health and safety emergencies and communication with district staff who have a legitimate educational interest. Further, there are situations when confidentiality must NOT BE MAINTAINED, meaning that staff have a legal obligation to share information.

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 immediately. The details regarding the student can be discussed with those who need to intervene to keep the student safe. This is in compliance with FERPA.

GROUPS AT INCREASED RISK FOR SUICIDAL BEHAVIOR

ALSO TERMED OPPORTUNITY YOUTH

Coquille School District acknowledges the needs of these groups and plans to work actively to create and increase affinity groups and use restorative practices to better serve all students.

YOUTH LIVING WITH MENTAL AND/OR SUBSTANCE USE DISORDERS

Mental health conditions, in particular depression/dysthymia, attention-deficit hyperactivity disorder, eating disorders, intermittent explosive disorder, and conduct disorder are important risk factors for suicidal behavior among young people. An estimated one in five children have a diagnosable mental condition that will cause severe impairment, with the average onset of depression and dysthymia occurring between ages 11 and 14 years; therefore, school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk and enhance overall performance and improve long-term outcomes.

YOUTH WHO ENGAGE IN SELF-HARM OR HAVE ATTEMPTED SUICIDE

Risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Whether or not they report suicidal intent, one study found that 70 percent of adolescents admitted into inpatient psychiatric treatment who engage in self-harm report attempting suicide at least once in their life. Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. One study found that as many as 88 percent of people who attempt suicide for the first time and are seen in the Emergency Department go on to attempt suicide again within two years. Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources, transportation, insurance, copays, parental consent, etc.

YOUTH IN OUT-OF-HOME SETTINGS

Youth involved in the juvenile justice or child welfare systems have a high prevalence of risk factors for suicide. As much as 60 to 70 percent of young people involved in the juvenile justice system meet criteria for at least one psychiatric disorder, and youth in juvenile justice residential programs are three times more likely to die by suicide than the general youth population. According to a study released in 2018, nearly a quarter of youth in foster care had a diagnosis of major depression in the last year. Additionally, a quarter of foster care youth reported attempting suicide by the time they were 17.5 years old.

Youth Experiencing Homelessness

For unhoused youth, the rate of self-injury, suicidal ideation, and suicide attempts is over two times greater than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorder, and post-traumatic stress disorder. One study found that more than half of runaway and unhoused youth experience suicidal ideation.

Racial and Ethnic Minority Youth

American Indian/Alaska Native (AI/AN) Youth

In 2017, the rate of suicide among AI/AN youth ages 15-19 was over 1.6 times that of the general youth population. 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 ihs.gov/suicideprevention.

Black Youth

Among Black populations, suicide rates peak during adolescence and young adulthood, then decline. This is a different pattern than is seen in the overall U.S. population, where suicide rates peak in midlife. A particularly important risk factor associated with suicide behavior among Black youth is exposure to racism and trauma. Black youth who experience racism often feel alienated, rejected by society, ignored, marginalized, depressed, and anxious.

Latinx Youth

Suicide and suicide attempts are especially concerning among Latinx adolescent girls, who have the highest suicide rates among all adolescent groups nationwide. Statistics reveal that in the United States, 15.6% of Latinx adolescent girls have attempted suicide one or more times and 25% have thought about it. Risk factors include alienation - including disconnection from family or family origin, acculturative stress and family conflict, hopelessness and fatalism, discrimination, and racism.

Asian Youth

For Asian Americans and Pacific Islanders between the ages of 15 and 19, suicide was the leading cause of death in 2016, according to CDC data, accounting for 31.8 percent of all deaths. Asian youth may be susceptible to different risks than other racial/ethnic groups, such as ethnic and cultural socialization or orientation, poverty, education related stress, familialism, discrimination, and acculturation that can take root at a young age, affecting mental health outcomes.

LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) Youth

The CDC finds that LGBTQ+ youth are 4.5 times more likely, and questioning youth are over twice as likely to consider attempting suicide as their heterosexual peers. One study found that 40 percent of transgender people attempted suicide sometime in their lifetime — of those who attempted, 73 percent made their first attempt before the age of 18. 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 health condition), these experiences can place them at increased risk. It is not their sexual orientation or gender

identity that place LGBTQ+ youth at greater risk of suicidal behavior, but rather these societal and external factors: the way they can be treated, shunned, abused, or neglected, in connection with other individual factors such as mental health history.

YOUTH BEREAVED BY SUICIDE

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are nearly four times as likely to attempt suicide themselves.

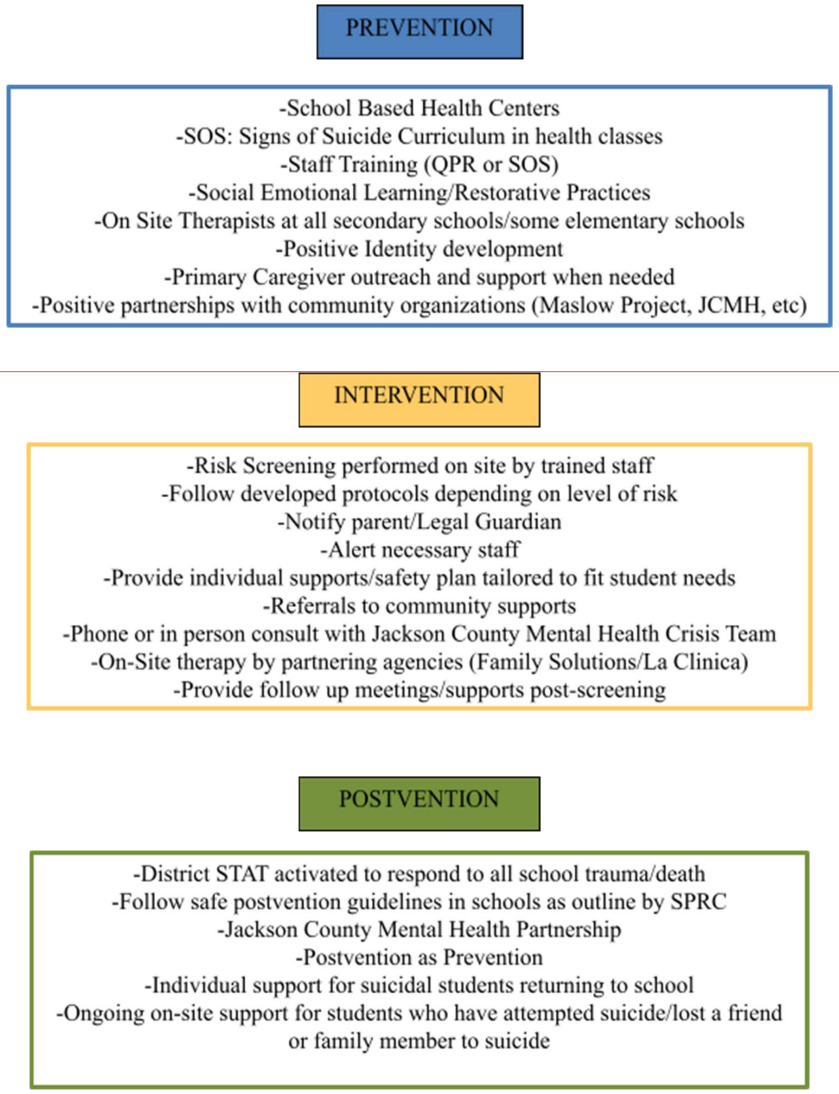
YOUTH LIVING WITH MEDICAL CONDITIONS OR DISABILITIES

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 delays 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.

COMPREHENSIVE SUICIDE PREVENTION PLAN COMPONENTS

Coquille School District takes a strategic approach to preventing suicide. It includes specific components implemented in a particular sequence: prevention, intervention, and postvention (PIP). Prevention efforts work best when they are connected to effective intervention and safe postvention efforts. This plan outlines CSD's approach to these three areas and is dedicated to developing a suicide prevention program using an approach that considers cultural factors, such as the role of the family, level of acculturation, language acculturation, language preferences, and religious beliefs. This process includes staff and student awareness surrounding identity, human dignity, and connection.

The following PIP diagram shows CSD's approach to these three crucial areas:



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PREVENTION PROCEDURES

Coquille School District takes intentional steps to create a school culture that encourages positive coping skills by building protective factors while communicating about suicide in a safe and healthy way. Suicide prevention includes mental and physical wellness education, accessible resources, staff training, mental health awareness campaigns, restorative practices, and building a culture of belonging. The district has adopted the staff and student training programs set forth below:

PROGRAM	WHO	TIME
QPR Question, Persuade, Refer Gatekeeper Training for all student-facing staff members. Contacts: Taileigh Prickett, SCESD- CMH Partner or visit https://jcsuicideprevention.org/training-info/	All student-facing staff.	2 hours First responders
Columbia Suicide Severity Rating Scale (C-SSRS) Evidence-based first responder to gauge risk and response level needed during a potential suicidal engagement. Includes protocols for both initial and follow-up screening and documentation. Contacts: Sonia Amlin, Michele Bullington, Alexandra Campbell, SE Counselors	School staff designated to run point on students who may be suicidal. This is a training for anyone deemed appropriate by on-site admin.	90 Minute in person training (30 minutes video, 60 minute slides, discussion, scenarios)
ASIST Training Applied Suicide Intervention Skills Training is for anyone who may come in to contact with a person with thoughts of suicide. This training teaches participants an effective process for asking about suicide and making plans to stay safe. This training also explore societal views of suicide, taboos around suicide, and each person's personal views on the topic. Refer to Taileigh Prickett for upcoming trainings or visit https://jcsuicideprevention.org/training-info/	Anyone who may administer the CSSRS should also be trained in ASIST every 3 years.	2 full days, in person.
CALM- Counseling Access to Lethal Means This training is designed from anyone who may come in to contact with a suicidal person and need to discuss with them their access to harmful or deadly weapons or means.	Anyone who is trained to do a risk to self screening.	Free 2 hour online training https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

Youth Mental Health First Aid YMHFA is designed for adults who regularly interact with young people. This course introduces common mental health challenges for youth, reviews typical adolescent development and teaches a 5 step action plan for how to help you people in crisis and non-crisis situations. Contacts: Sonia Amlin, Michele Bullington, and Alexandra Campbell, CSD SE Counselors	Any school personnel interested or deemed appropriate by on site admin.	7 hours in person
Connect Postvention Training (NAMI) Training around the planned response after a suicide to identify protective factors and reduce risk of those impacted by suicide. Contact Rama Eshelbrenner, Connect Coordinator, CHW; Melissa Pallin, NBMC	School counselors, school psychologists, admin, anyone likely to use the STAT manual after a suicide.	4 hours

Staff Training and Education

Suicide prevention activities are best conducted in the context of other prevention efforts such as health and wellness curriculum, sexual violence prevention, drug awareness, unhoused youth, wraparound services, social-emotional learning, trauma-informed education, disability identification and services, and supports for underrepresented populations such as positive identity development and affinity groups. Prevention efforts are best characterized as being part of a multi-tiered system of support (MTSS) where universal practices across domains are employed, increasingly intensive training and supports are engaged as screening, and intervention outcomes are evaluated.

Only trained school staff members may act as School Screeners who perform Risk to Self assessments and follow suicide response protocols and safety planning. Trained screeners in your school can be:
❑ School Counselors
❑ School Psychologists
❑ School Nurses
❑ School Therapist
❑ School Administrator(s) or anyone designated by an SA and is trained
* If you are uncertain who the specific trained screeners are in your building, ask your building administrator.

Student Training and Education

All students K - 12 will receive direct instruction on social emotional learning/mental health and wellness promotion using restorative practices.

School Program	
Social/Emotional Learning curriculum (SEL) including regulating emotions	K - 5
Mental health as a part of physical health	K - 5
Social, Academic, Emotional Behavior Risk Screeners are provided for a social-emotional health baseline and progress monitoring of all students.	K - 5
Wellness, community and strength-building (protective factors) embedded in guidance lessons taught during advisory.	6 - 8
Social, Academic, Emotional Behavior Risk Screener to provide a mental health baseline and progress monitoring of all students.	6 - 8
Suicide prevention direct instruction in health classes in collaboration with	7 - 8
Wellness, community and strength-building (protective factors) embedded in counseling guidance lessons.	9 - 12
Social- Emotional Counselors provide easily accessible crisis resources	7-12
A student safety screening software program, BARK, is on the district server to detect high risk searches.	K - 12

Intervention Procedures

The risk of suicide is raised when any peer, teacher, caregiver, or school employee identifies someone as potentially suicidal because s/he/they has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated other warning signs. It is critical that any school employee who has knowledge of a suicide threat **reports** this information immediately and directly to a trained School Screener (school counselor or administrator) and school administrator so that the student of concern receives appropriate attention. A suicide risk screening will need to be completed for every student expressing comments and/or thoughts of suicide. Every effort should be made to conduct a screening the same day staff members are made aware of the risk for suicide.

If imminent danger exists, call **911** immediately. This is especially important if the student of concern is not in class or left the campus and a plan to suicide is discovered. All threats of self-harm must be taken seriously.

SCREENING PROCESS

If imminent danger to the student is present (such as where a suicide attempt is in progress or the student is having an acute mental health crisis), the trained school screener or other staff member is to call 911.

If the student is not in immediate but a concern about suicide risk exists, the trained school screener initiates the screening process.

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1. Suicide screening is conducted by school staff trained in screening (school counselor, school psychologist, or anyone designated and trained to do screenings) or a school administrator.
2. The trained school screener conducts a Risk to Self of the student using the Columbia - Suicide Severity Rating Scale (C-SSRS) screening tool and follows the color coded protocol to determine if the student is low, medium or high risk.
3. After the assessment, the trained school screener will consult with another trained school screener or Lines for Life (Student Suicide Assessment Line - 503-575-3760, line is open Monday-Friday, 8:30AM-4:30PM for Remote Suicide Risk Assessment and Safety Planning (RSRASP) support) to determine if a full Suicide Assessment is appropriate. Sharing decision-making with another professional is best practice. The outcome of the consultation will be one of the following:

    a. When a full assessment is not warranted (Student is low or medium risk and agrees to safety)

        1. Inform the parent or legal guardian the same day that a screening was conducted and why. Parents are a critical part of the student's care team and possess information that the school may not have access to.

        2. If low risk, schedule follow up meetings with the student 14 and 30 days after the comments or ideation are scheduled and the person doing the follow up is determined. If necessary, create a Support Plan with the student (and parent or legal guardian, if possible) before the end of the day. Provide student and parents with printed list of resources.

        3. If medium risk, schedule follow up meetings and create a Safety Plan with the student (and parent or legal guardian, if possible) before the end of the day. Schedule follow up appointment with student 7 and 14 days in advance. Provide student and parents with printed list of resources including CMH crisis line to be used should student feel suicidal off campus or parents needs consult/support on next steps.

b. When a full assessment **IS** warranted.

1. After consultation, if concern about suicidal ideation is sufficiently high, the trained school screener will contact and assist the student's parent or legal guardian in referring the student to an in-depth suicide assessment by an external licensed and qualified Mental Health Professional (Coos County Mental Health Crisis Team 541-751-2500). A full Risk Assessment of students aged 13 or under will require parental consent. Further assessment and consult may be done over the phone with school screening team, parents, student, and MH professional at CMH.
2. A School Safety Plan (included below) should be developed and updated upon the student's return to school prior to or the morning of re-entry. Schedule a minimum of two follow ups 14 days and 30 days after the screening. Consider assigning a check in person for the student to have regular meetings when needed or consider referring to school therapist for ongoing support.

***Follow up dates of 14 and 30 days after assessed risk are minimum scheduled contacts. It should be understood that Student Support and Student Safety Plans may include daily, bi-weekly, or weekly follow ups with the student.**

DOCUMENTATION

- ❑ Document when the parents or legal guardians were notified. (If applicable, document contacts with DHS). This can be done on the guardian notification form which is found in the CSD appendices.
- ❑ The trained school screener will keep the original screener in the Student's CUM file with the building administrator in a sealed "CONFIDENTIAL" envelope.

Suicide Risk Level Check List
(Based on CSD Risk to Self Protocol)

1) I believe this student is **Low Risk** based on the following information gathered using the CSSRS screening tool and risk to self protocol (check all that apply):
    - The student answered no to questions regarding suicide on the Columbia Suicide Severity Rating Scale. If the student answered yes to any questions, they were "yellow" questions.
    - The student verbally agrees to safety and family was informed of the screening and safety agreement
    - Administration and the screening team are in agreement that the student is no or low risk to self for suicide.

2) I believe this student is **Medium Risk** based on the following information gathered using the CSSRS screening tool and risk to self protocol (check all that apply):
    - The student answered yes to the question in the "yellow and orange" section of the CSSRS. These questions are about suicidal ideation and intent to act.
    - Student may agree to safety and be willing to make a safety plan with the help of a counselor or admin, and parent input.
    - The student and guardian were given information and resources regarding getting a further assessment through Coos County Mental Health Crisis Team and may go there at any time if guardian or student feels at risk for suicide attempt or feels unsafe in any way.
    - Student will have regular follow ups with a trusted adult or Mental Health Professional upon their return to school.

3) I believe this student is **High Risk** based on the following information gathered using the CSSRS screening tool and risk to self protocol (check all that apply):
    - The student answered yes to questions in all categories. Questions are about ideation, intent to act, planning/preparation, access to lethal means, and past suicide attempts.
    - Student may have refused to answer any questions but there is evidence (written, spoken, reported) that the student has suicidal ideation with intent to act and access to lethal means. Students with prior suicide attempts who are refusing to cooperate with screening process should also be considered high risk.
    - CMH Crisis Team was contacted for consultation, next steps and safety planning.
    - Guardian was immediately notified of level of risk and is a part of the next steps planning with counselor/CMH/admin.
    - Student will have regular follow ups with a trusted adult or Mental Health Professional upon their return to school.

Individual Student Safety Plan

Student Name and ID #: School Attending:
Student DOB: IEP or 504: Y N
Parent/Guardian Name/Phone Number:
Emergency Contact Name/Phone Number:

Safety Concerns (Check all that apply)

- Suicidal thoughts
- Self harm
- Leaving supervised areas
- Aggression towards others

Briefly describe concerning behavior and others it may have impacted:

Triggers for concerning student behavior (people, places, noises, home situations, etc):

Student Supports

(This portion should be completed by the student, their guardian, and teacher/staff input if necessary. The bulk of the support ideas should come from student).

Self: What can you do to help yourself feel better or calm down when you are experiencing triggers or feelings that are hard to cope with?

1)
2)
3)

Family/Friends: What can family and friends say, do or suggest to help you feel better/supported? What has worked for you in the past?

1)
2)
3)

Staff/School: Who would you like to involve and what can we do at school to help you when you are struggling, feeling triggered or needing extra support?
1)
2)
3)

The following strategies are not helpful for me (i.e. "you need to calm down."):

Student Safety Plan Crisis Response

What will staff or family do when this student is behaving in a way that puts themselves or others at risk for harm?
Staff Crisis Response:

Family/home Crisis Response:

Name two specific people on campus and two people/resources at home who are designated for respond in the even of a crisis:

1) 2)
3) 4)

How will this plan be monitored? Daily? Weekly? Monthly?

Who is designated to monitor and update this plan as needed?

If a student is displaying suicidal or homicidal behavior and you need immediate assistance, or you need support or consultation creating a safety plan with student and family, please call Coos County Mental Health Crisis Team at 541-751-2500.

Process Following Suicide Attempt or Acute Mental Health

1. Collaborate with parents and legal guardians, if possible, to select interventions, and develop a school support or safety plan, as needed.
2. Provide parents and legal guardians with school and community crisis intervention resources.
3. Schedule minimum follow up meetings 14 days after and 30 days after comments, ideation and/or attempt. Designate a trained school screener or administrator to serve as the school point person for follow up communication and ongoing support/safety plan organization.

Developing a School Support/Safety Plan

After every suicide screening, the trained school screener consults with another mental health professional or administrator to determine if a School Support/Safety Plan is necessary and schedules follow up meetings.

The School **Support Plan** provides a structure for intentional support, designates the responsibilities of each person, and includes a review date to ensure follow-through and coordinated decision making. A designated staff member will serve as the school point person for follow-up communication with parents and, legal guardians and community providers for students who have been screened for suicide.

The School **Safety Plan** provides a more extensive structure for support, designates responsibilities of each person, supervision, and includes a review date to ensure follow-through and coordinated decision making. A designated staff member will serve as the school point person for follow-up communication with parents and legal guardians, and community providers, for students who are moderate to high risk or who have attempted suicide. If the child is transitioning after a hospital stay a re-entry meeting to develop a plan should take place prior to re-entry. CSD's school safety plan is found with the CSD appendices.

Developing a Re-Entry Plan

The re-entry process occurs after a student has been hospitalized for an attempt or has been out of school for a mental health crisis. Students who have made a suicide attempt are at a higher risk of re-attempting during the first 90 days after the attempt unless the parents, community therapists/agencies (if applicable to student) and school staff work together utilizing evidence - based prevention protocols. It is important for the student to be monitored by parents or guardians, mental health professionals, and designated school professionals in order to establish a support system. It is critical to connect the student, his/her/their parents or legal guardians, the mental health team working with the student,

as well as the school counselor so that pertinent information flows, and a safety net is created.

The Re-Entry Meeting and/or School Safety Plan is scheduled by the designated school counselor or mental health specialist with the student, parent or legal guardian, and administrator. The district suicide prevention specialist, student case manager (if SPED), or CMH, may be available to help, as needed, to complete the Safety Plan.

1. A re-entry meeting should occur when students are returning to school following a suicide attempt, even if the school did not complete a suicide screening. This is a best practice approach contributing to student safety.
2. The Safety Plan should be completed upon the student's return to school (prior to attending classes).

NOTIFYING PARENTS AND OTHERS

PARENTS MUST ALWAYS BE NOTIFIED WHEN THERE APPEARS TO BE ANY RISK OF SELF-HARM.

a. Whenever a student has directly or indirectly expressed suicidal thoughts or demonstrated other warning signs, the student's parent is to be informed the same day. Such notice shall be made by the trained School Screener.

b. If the student discloses thoughts of suicide or if the trained School Screener has reason to believe there is a current risk for suicide, the trained School Screener will request that a parent/ legal guardian come to school to discuss the screening results and will help develop the safety plan, usually in collaboration with the parent or legal guardian and student. This can be completed over the phone, or via zoom, though it is not preferred.

c. If the student denies experiencing thoughts of suicide and the trained School Screener does not have reason to believe there is a current risk of suicide, it is still CSD policy that the trained School Screener notify the parent to share that a screening was conducted and why.

d. If a student is in crisis and the trained School Screener has exhausted all methods to reach the parent or legal guardian (emergency contacts, siblings school contacts, work, etc) and student is considered high risk for suicide, the student may be referred to CMH/MRT or the Emergency Department as high risk for suicide is considered a potentially life threatening emergency.

EXCEPTION - ABUSE OR NEGLECT

Parents and legal guardians need to know about a student's suicidal ideation unless the trained School Screener, after conferring with the school administrator, reasonably believes that child abuse or neglect would result from disclosure and would place the student at an imminent increased risk of harm. In such a case, the trained School Screener or other staff person must make a report to the Child Welfare Hotline through the Department of Human Services at (855) 503-7233 or Medford Police Department The trained School Screener will also review with the student that they will be communicating with essential staff members in order to keep them safe.

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

PRIVACY IS OF UTMOST IMPORTANCE, AND EVERY EFFORT WILL BE MADE TO RESPECT THE CONFIDENTIALITY OF THE STUDENT WHILE ATTENDING TO THE SAFETY NEEDS OF THE STUDENT AND SCHOOL BUILDING. THE STUDENT AND PARENT SHOULD BE INFORMED OF THE LIMITED INFORMATION SHARING THAT THE DISTRICT REQUIRES:
For safety reasons, the school building administrator will be notified of every suicide ideation or attempt and district documentation protocols will be followed.
Depending on the School Support/Safety Plan, specific school staff may receive certain information about concerns as part of a plan to maintain safety and provide support to the student. The student and parent are invited to help develop this plan.
The full safety plan, next steps and guardian notification form will be kept in the student's cumulative file as well as a copy locked in SE counselor's office.

Commented [TS3]: Do we want to reeval this?

Guidelines for When A Student Returns To School Following Absence for Suicidal Behavior

Meeting with parents about their child prior to his/her return to school is integral to making decisions concerning needed supports and the student's schedule. Students who have made a suicide attempt are at increased risk to attempt to harm themselves again and effective handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school; this involvement helps the student to regain some sense of control.

Confidentiality is extremely important in protecting the student and enabling school personnel to render assistance. Families are more likely to disclose information if they know the school has a helpful, nonthreatening manner of dealing with students who have attempted suicide.

Assuming the student will be absent after a suicide attempt or serious threat and possibly hospitalized in a treatment facility, schools should follow these steps:

1. Update everyone on the crisis team about the situation.
2. Ask the parents/guardian to sign a written release of information so information can be shared between school personnel and treatment providers. This helps provide continuity of care to best assist the student.
3. Inform the student's teachers regarding the number of probable days of absence.
4. Instruct teachers to provide the student with assignments, if appropriate.
5. Determine if there are any other students that may have been directly affected by the suicidal behavior and need immediate attention.

Some suggestions to ease a student's return to school are as follows:

1. Prior to the student's return, a meeting between the School Crisis Team designee who is trusted by the student and parents/guardian should be scheduled to discuss possible arrangements for support services and to create an individualized re-entry plan.
2. Seek recommendations for aftercare from the student's therapist. If the student has been hospitalized, a Crisis Team member should attend the discharge meeting at the hospital.
3. The designated crisis team member should:

a. Review and file written documents as part of the student's confidential health record.

b. Serve as case manager for the student. Understand what precipitated the suicide attempt and be alert to what might precipitate another attempt. Be familiar with practical aspects affecting the student, i.e. medications, full vs. partial study load recommendations.

c. Help the student through re-admission procedures, monitor the re-entry, and serve as a contact for other staff members who need to be alert to re-occurring warning signs. Ask the student if he/she has special requests about what is said or done by school.

d. Serve as a link with the parent/guardian, and with the written permission of the parent/guardian, serve as the school liaison with any external medical or mental health service providers supporting the student.

4. Classroom teachers need to know whether the student is on a full or partial study load and be updated on the student's progress in general. They do not need clinical information or a detailed history.
5. Discussion of the case among personnel directly involved in supporting the student should be specifically related to the student's treatment and support needs. Discussion of the student among other staff should be strictly on a "need to know" basis. That is, information directly related to what staff has to know in order to work with the student.
6. Discussion of any specific case in classroom settings should be avoided entirely since such discussion would constitute a violation of the student's right to confidentiality, and would serve no useful purpose to the student or his/her peers.
7. The school should maintain contact with the parents to provide progress reports and other appropriate information, and be kept informed of any changes in the aftercare plan.
8. It is appropriate for school personnel to recommend to other students that they discuss their concerns or reactions with an appropriate administrator or other designated school personnel. The focus of these discussions should not be on the suicidal individual, but on building help-seeking skills and resources for others who might be depressed or suicidal.

Following are some of the issues that might arise upon re-entry to school, as well as options for resolving the specific issue.

1. **Issue**: Transition from the hospital setting

   Options:
   - Visit the student in the hospital or home to begin the re-entry process with permission from the parent/guardian.
   - Consult with the student to discuss what support he/she feels that he/she needs to make a more successful transition. Seek information about what the student would like communicated to friends and peers about what happened.
   - Request permission to attend the treatment planning meetings and the hospital discharge conference.
   - Arrange for the student to work on some school assignments while in the hospital.
   - Include the therapist/counselor in the school re-entry planning meeting.

2. **Issue:** Family concerns (denial, guilt, lack of support, social embarrassment, anxiety, etc.)

   Options:
   - Schedule a family conference with designated school personnel or home-school coordinator to address their concerns.
   - Include parents in the re-entry planning meeting.
   - Refer the family to an outside community agency for family counseling services.

3. **Issue**: Social and Peer Relations

Options:

- Schedule a meeting with friends prior to re-entry to discuss their feelings regarding their friend, how to relate and when to be concerned.
- Place the student in a school-based support group, peer helpers program but not as the helper, or buddy system.
- Arrange for a transfer to another school if indicated.
- Be sensitive to the need for confidentiality and how to restrict gossip.

4. **Issue**: Academic concerns upon return to school

Options:

- Ask the student about his/her academic concerns and discuss potential options.
- Arrange tutoring from peers or teachers.
- Modify the schedule and adjust the course load to relieve stress.
- Allow make-up work to be adjusted and extended without penalty.
- Monitor the student's progress.

5. **Issue**: Medication

Options:

- Alert the school nurse to obtain information regarding prescribed medication and possible side effects.
- Notify teachers if significant side effects are anticipated.
- Follow the policy of having the school nurse monitor and dispense all medication taken by the student at school.

6. **Issue**: Behavior and attendance problems

Options:

- Meet with teachers to help them anticipate appropriate limits and consequences of behavior.
- Discuss concerns and options with the student.
- Consult with discipline administrator.
- Request daily attendance report from attendance office.
- Make home visits or regularly schedule parent conferences to review attendance and discipline record.
- Arrange for counseling for student.
- Place the student on a sign in/out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day.

7. **Issue**: On-going support*

Options:

- Assign a school liaison to meet regularly with the student at established times.
  Talk to the student about his/her natural contact at school – try to assign the person who already has a relationship with the student.
- Maintain contact with the therapist and parents.
- Ask the student to check in with the school counselor daily/weekly.
- Utilize established support systems, support groups, friends, clubs and organizations.
- Schedule follow-up sessions with the school counselor.
- Provide information to families on available community resources when school is not in session.

*In the event that a student loses a family member to suicide, school personnel should understand that suicide evokes a special, complicated grief and most of the on-going support considerations mentioned in #7 would also apply.

Supporting Parents through Their Child's Suicidal Crisis

Family Support is Critical

When an adolescent experiences a suicidal crisis, the whole family is in crisis. If at all possible, it is important to reach out to the family for two very important reasons:

First, the family may very well be left without professional support or guidance in what is often a state of acute personal shock or distress. Many people do not seek help – they don't know where to turn.

Second, informed parents are probably the most valuable prevention resource available to the suicidal adolescent.

Remember, a prior attempt is the strongest predictor of suicide. The goal of extending support to the parents is to help them to a place where they can intervene appropriately to prevent this young person from attempting suicide again. Education and information are vitally important to family members and close friends who find themselves in a position to observe the at-risk individual.

Common Parental Reactions to Hearing that Their Child is Suicidal

- Acute personal shock and distress
- Totally paralyzed by anxiety
- Very confused, puzzled, or in denial
- Embarrassed
- Blamed, stigmatized
- Angry, belligerent, threatening

Concerns of the Helper/Professional

- Safety of the youth
- Professional responsibilities
- Gaining cooperation from parent(s)

Concerns of the Parent

- Maintain some equilibrium
- What to do; where to turn for help
- The safety of the youth

Parents May Need Support to:

- Overcome their emotional reactions
- Accept the seriousness of the situation
- Recognize their key role in helping their child
- Recognize the importance of finding (professional) help
- Understand the importance of removing firearms from their environment
- Identify personal coping mechanism and support systems
- Understand their limits
- Establish some hope

How crisis team member can be Helpful:

- "Just be there" (through the immediate crisis)
- Reflective listening – acknowledge the impact, the fear, the anger…
- Avoid judging, blaming
- Provide information and referrals
- Emphasize safety; strongly recommend removing lethal means from the home and provide information on how to do that
- Support any and all acceptance of responsibility and efforts to help
- Model limit setting and self-care

Things You Can Ask – or Say – Once the Immediate Crisis has Passed:

- "How can I help?"
- "How are you coping?"
- "Who can you talk to? How are you in touch with these people? Would it help if I called them for you?" (sometimes just picking up the phone is more than they can do for themselves.)
- "I can appreciate how this has turned your world upside down. It is great that you have been willing to get help. None of us can do this alone."
- "How have we (professionals) been helpful? What has not been helpful? What could we do better?"

How to Support Grieving Youth

What To Do:

- Learn about the grief process
- Be absolutely genuine and truthful
- Demonstrate love and respect by being attentive
- Encourage talking about feelings and about the deceased friend
- Listen, no matter what!
- Offer to attend the visitation or funeral with a youth
- Allow crying – perhaps lots of crying
- Expect laughter – a sign of happy memories
- Follow the lead of the "survivor" with patience and kindness
- Offer opportunities for remembering; i.e., special events, birthdays
- Expect that your presence may be important, while talking may be limited ("Silence is Golden")
- Share some of your experience with loss, but keep the focus on the person you are supporting
- Help to identify others to talk to (i.e., minister, priest, rabbi or counselor)
- Understand that memorials can be very comforting (i.e., writing a poem, a song, a letter, recording a tape, making a scrapbook, or buying a bouquet)
- Believe in healing and growth

What To Avoid:

- Giving a lot of advice
- Arguing over trivial matters
- Making moralistic statements about the person who died
- Minimizing the loss
- Discouraging or time-limiting the grieving process
- Assigning new responsibilities right away
- Giving platitudes as a way to comfort (e.g., she's in a better place, etc.)

Common Youth Reactions to Suicide and Recommended Responses

Everyone grieves differently. Personal and family experiences with death, religious beliefs, community exposures and cultural traditions all play a role. Below are some of the more or less predictable adolescent reactions to a suicide and suggested responses.

♦ **Shock and Denial**. At first there may be remarkably little response. The reality of the death has yet to be absorbed. "You are kidding, right?" "This is just a joke – it can't be true."
Suggested Response: Acknowledge the shock, anticipate the reaction to come, and demonstrate a willingness to talk when students are ready.

♦ **Anger and Protection**. Generally speaking, "black and white" thinking sets in. Students want someone to blame for this and may openly express/direct anger at the deceased's parents, teachers, or boy or girlfriend. "Why did you let this happen?" "It is all your fault that this happened!"
Suggested Response: Listen and then listen some more. Gently explain that it is natural to want to find a reason for things we don't understand. Suggest that suicide is a very complicated human behavior and that there are always multiple reasons…and that blaming another individual may put that person at risk of suicide also.

♦ **Guilt**. Students close to the deceased may blame themselves. "If only I had called him back last night;" "I should have known…I should not have teased him…"
Suggested Response: Remind students that only the person who kills him/herself is responsible for having made that decision.

♦ **Anger at the Deceased**. This is surprisingly common, among close friends as well as those who were not close to the deceased. "How could she do something so stupid?"
Suggested Response: Allowing and acknowledging some expression of anger is helpful. Explain that this is a normal stage of grieving. Acknowledgement of anger often lessens its intensity.

♦ **Anxiety**. Students sometimes start to worry about themselves and/or other friends. "If she could get upset enough to kill herself, maybe the same thing will happen to me (or one of my friends)."
Suggested Response: Help students differentiate between themselves and the dead person. Remind them that help is always available. Discuss other options and resources. Practice problem solving.

♦ **Loneliness**. Those closest to the deceased may find it almost impossible to return to a normal routine, and may even resent those who appear to be having fun. They may feel empty, lost, totally disconnected. They may become obsessed with keeping the memory of their friend alive.
Suggested Response: Encourage students to help each other move forward in positive ways. Notice anyone who seems to be isolating from others and reach out to them, offering resources to help with grieving process.

♦ **Hope and Relief**. Once the reality of death has been accepted, and the acute pain of the loss subsides, students find that life resumes a large degree of normalcy and they come to understand that over time, they feel better. They can remember their friend without extreme pain.
Suggested Response: Simply remain open to listening to student's feelings, especially on the anniversaries (two weeks, months, years, etc.). Recognize the importance of both mourning and remembering.

POSTVENTION PROCEDURES: AFTER A DEATH OCCURS

Postvention means any compassionate, healing, and effective "post-intervention" activities conducted after a suicide. Postvention seeks to reduce the risk of imitations or "contagion", supports the needs of those bereaved by a suicide, provides safe messaging to students, families, and the community, and supports the mental health of the entire school community. Appropriate

postvention activities serve to enhance future prevention efforts and save lives. Postvention includes procedures and practices addressing immediate, intermediate, and long-term response planning. Postvention also involves active crisis response strategies that strive to treat the loss in similar ways to that of other sudden deaths within the school community and to return the school environment to its normal routine as soon as possible while providing grief support. It includes addressing communication with staff, students, outside providers and families, identifying other potentially at-risk students, and other difficult issues such as memorialization. This includes having a system in place to work with the multitude of groups that may eventually be involved, such as students, staff, parents and legal guardians, community, media, law enforcement, etc. In Oregon, postvention is specifically defined under OAR 309-027-0200(8). Coquille School District works in collaboration with Lines for Life, Suicide Prevention Resource Center, the Oregon Health Authority and Coos County Mental Health per Senate Bills 561, 485 and 981.

POSTVENTION GOALS	POSTVENTION CAUTIONS
❑ Support the grieving process ❑ Prevent suicide contagion ❑ Reestablish healthy school climate ❑ Provide long-term support ❑ Integrate and strengthen protective factors ❑ Treat all deaths the same ❑ Provide resources for students, parents and staff	❑ Avoid romanticizing or glorifying event or vilifying victim ❑ Do not provide excessive details ❑ Do not eulogize victim or conduct school-based memorial services ❑ Do not release information in a large assembly or over the intercom ❑ Hold school based memorials or gatherings outside of school hours

CSD Postvention Response Procedures

1. Principal or administrator notified of suspected or known student death by suicide. Principal/Administrator notifies the School Resource Officer (SRO) or SE Counselor.
2. SRO or designated personnel confirms the cause of death.
3. SRO or designee notifies Superintendent and the District School Trauma Assistance Team (STAT) Lead of confirmed death.
4. SE Counselor notifies Coos County Mental Health as a courtesy.
5. STAT Lead contacts building Principal/Administrator to estimate level of need or response resources required and determines what information is to be shared. Lead directs Principal and other administration to the STAT Manual, which contains sample announcements and tips for delivering news to staff and students. STAT Manual contains checklists for the day and resources for talking to the bereaved family and drafting letters home to parents.
6. Principal or administrator communicates with the family to offer condolences and determines their wishes for communication about the death.
7. Superintendent's office prepares any media statements.
8. The Principal/Administrator meets prior to announcing news to staff and prepares for possible substitutes.
9. Administrator and STAT Lead meet to assign responsibilities:
    1. Identifies potentially at-risk students and staff, e.g., those knowledgeable about or connected to the deceased.
    2. Creates scripts for teachers to use from provided templates. Provides script and response to line staff (building secretaries, etc.)
    3. Gathers Safe Room supplies (water, snacks, paper, markers, cards, etc)
    4. Gathers input on concerns from teachers and staff.
    5. Maintains contact with the SRO and/or other administrator throughout the process.
10. The Principal/Administrator holds all-staff or stand-up meeting as soon as possible and distributes scripts and other resources for teachers to use.
11. Building staff, as directed by the administrator, notify students, and distributes any needed notifications or resource handouts.
12. The Principal/Administrator crafts and sends a message (using provided templates in STAT Manual) to parents and others in the school community.
13. CSD monitors media information, including social media.
14. The Principal/Administrator holds end-of-day meeting with the on site first responders, therapists, supports, and STAT Lead and provides communication with staff, and determines any follow-up resources or coordination needed.
15. The Principal/Administrator communicates needs for follow up to the District STAT Lead.

Commented [AC4]: Is this the same notification process that we will be adopting as well?

Commented [AC5]: Because of the link of the Crisis Response Team and Coos County Mental Health, do we feel this step is necessary to have here?

Commented [AC6]: Are we going to be putting together some type of manual for each building to have?

Commented [TS7]: We need to add immediate/mid/and long range action steps-- PPL impacted by traumatic loss (PHSD?)

Each building has a copy of the STAT Manual which contains step by step guidance on how to safely and effectively manage postvention. The STAT Manual contains sample announcement letters, sample letters home, checklists to manage the day and week ahead, as well as resources to assist with staff and student grief. If you would like a copy of the STAT Manual emailed to you, contact Tanya Sinko SE Counselor supervisor at 541-396-2181 ext. 1210 or tsinko@coquille.k12.or.us.

Commented [AC8]: Can we maybe try and reach out for a copy of this manual to see if this is something we would like to adopt? Or thinking of going a different direction?

RISK IDENTIFICATION STRATEGIES BY SCHOOL ADMIN/COUNSELORS/THERAPISTS
❑ 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 LBGTQ, who are participants in fringe groups, and those who have weak levels of social/familial support.
❑ NOTIFY parents and legal guardians of highly affected students, provide recommendations for community-based mental health services, hold evening meetings for parents and guardians, provide information on community-based funeral services/memorials, and collaborate with media, law enforcement and community agencies.

REVIEW AND FEEDBACK PROCESS

Coquille School District believes in lifelong learning. Rooted in this belief, a procedure has been created for a student, parents, and/or legal guardians to request the school district review the actions that a school takes when responding to a suicidal risk. Any parent, or legal guardian, with concerns about the district's actions with regard to suicide prevention and response may contact the Student Health and Wellness Coordinator to discuss such concerns. A person wishing to make a formal complaint may do so following the district's process.

SE Coordinator Tanya Sinko
tsinko@coquille.k12.or.us
Phone: 541-396-2181 ext. 1210

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The Trevor Project
Oregon Health Authority (OHA)
Oregon Department of Education (ODE)
Coos County Mental Health
National Institute of Mental Health (NAMI)
Center for Disease Control (CDC)
Suicide Prevention Resource Center (SPRC)
Lines for Life
National Association of School Psychologists (NASP)

Youth Mental Health Resources 2022-2023

- **Coos County Mental Health Crisis Services:** This resource can provide free assessments for people who are experiencing thoughts of suicide or are in the midst of a mental health crisis and need support.
  Location: 281 LaClaire St, Coos Bay, OR 97420
  Phone: 541-751-2500

- **To find a local therapist** online who accepts your insurance visit: https://www.psychologytoday.com/us/therapists and click "find a therapist." Here you can input your insurance type and be matched with local therapists who are currently accepting your insurance and new patients.

- For local youth programs, therapy and **supports for kids with OHP or Tricare** please visit:https://www.kairosnw.org/programs or http://www.optionsonline.org/

- **Waterfall Clinic-**
  Location: 189 Waite St. #1 North Bend, OR. 97459
  Phone: 541- 756-6232

The following resources are 24/7, free to you, and quick to access when you or a loved one are needing immediate mental health support or are having thoughts of suicide:

- **988 Suicide and Crisis Lifeline:** Just pick up your phone and dial or text 988 to be directly connected to a trained counselor who can guide you through your crisis and give suggestions and support around safety and suicidal thoughts.

- **741-741 Crisis Text Line:** Just text the word home to 741-741 to be connected to a trained crisis counselor.

- **The Trevor Lifeline for LGBTQ Youth**: call 1-866-488-7386 or visit thetrevorproject.org for tons of resources for LGBTQ youth and families.

- **The Trans Lifeline**: call 1-877-565-8860 or visit https://translifeline.org/ for tons of resources for trans people who are all ages and stages.

- https://www.linesforlife.org/: This is a great website to check out for mental health promotion, suicide prevention, and substance abuse resources and support.

- Please see your School Counselor for more resources and support services.

FORMS AND CHECKLISTS

WARNING SIGNS FOR SUICIDE

There is no definitive list of warning signs of suicide.

Ideation - *Thoughts of Suicide*	Expressing suicidal feelings through talking, gesturing, writing, or drawing. Desire to die
Suicide Plan	Having a plan for suicide and/or obtaining the means to follow-through on a suicidal attempt.
Unbearable Pain	Often as a result of a loss/crisis. Expressing they are suffering a great deal and feel there is no hope.
Displaying Signs of Depression	Such as a loss of pleasure in activities they used to enjoy, prolonged sad mood, changes in eating or sleeping patterns.
Making Final Arrangements	Saying good-bye as if they won't be seeing someone again. Giving away favorite possessions.
Self-Destructive Behavior	Such as the start of or increase in alcohol or drug use, risky sexual behavior, reckless driving.
Changes in Behavior	Such as pulling away from family, friends, or social groups; anger or hostility.
Previous Suicide Attempt	This significantly increases the likelihood that someone will complete suicide.
Exposure to Suicide	Friend or family member who attempted or completed suicide.
Abuse	Physical or sexual abuse, being mistreated.
Social Isolation	May lead to feelings of helplessness and depression. Lack of support. Unwilling to seek help.
Depression, Anxiety, Agitation	Primarily Major Depressive Disorder. Feeling trapped.
Access to Lethal Means	Such as guns, weapons, knives, medications in the house.
Perceived Major Trouble	Such as trouble at school, at home, or with the law.
Peer Victimization	Bullying, extreme embarrassment or humiliation.

5 Steps to Help a Suicidal Student

Take all suicidal behavior seriously.

1.	Establish Rapport	Express your concern about what you are observing in their behavior.
2.	Ask the question *It is important that this question is asked directly and it is not asked in a roundabout way.*	"Are you thinking about suicide?"
3.	If "Yes", then do not leave this student alone.	Stay with the student.
4.	Offer comforting things to say	Such as, "Thanks for telling me, I am here to help."
5.	Escort student to a Primary Intervener	Primary Interveners: School Counselors, School Psychologists, School Nurses, and Principals

Suicidal Behavior Risk and Protective Factors

Risk Factors	Protective Factors
○ 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 challenges ○ Current drug/alcohol use Sense of hopelessness ○ Self-hate or self-injurious behavior ○ Current psychological/emotional pain ○ Loss (relationship, work, financial) ○ Relationship issues (friends/family/school) ○ Feeling isolated/alone ○ Current/past trauma ○ Bullying ○ Discrimination and lived experience with oppression ○ Chronic pain/physical health problems ○ Impulsive or aggressive behavior	● Engaged in effective physical and/or mental healthcare ● Feeling connected to others (family, friends, school, at least one trusted adult) ● Positive problem-solving skills • Healthy coping skills ● Restricted access to means to kill self ● Stable living environment ● Willing to access support/help ● Positive self esteem ● Resiliency ● High frustration tolerance ● Emotional regulation ● Cultural and/or religious beliefs that discourage suicide Successful at school ● Has responsibility for others ● Financial stability ● Future planning ● Acceptance of identity (family, peers, school) **KEEP IN MIND**: A person with an array of

○ Unwilling to seek help ○ Members of disproportionately at-risk groups (LGBTQ+, Black, Indigenous, People of Color, etc.)	protective factors in place can still struggle with thoughts of suicide. It is important to consider this when conducting a risk assessment.

SUICIDE RISK FACTORS AND WARNING SIGNS CHECKLIST

Risk Factors

	Mental illness		Local suicide cluster
	Substance use disorder		Lack of social support and sense of isolation
	Hopelessness		Asking for help is associated with stigma
	Impulsive/aggressive tendencies		Lack of healthcare
	Trauma or abuse history		Exposure to a suicide death
	Major physical or chronic illness		Non-suicidal self-injury
	Previous suicide attempt		Cultural/religious beliefs that suicide is an acceptable solution to coping challenges
	Family history of suicide		Other:
	Recent loss of relationship		
	Access to lethal means		

Warning Signs

	Talks about wanting to die/kill self		Acts anxious, agitated, or reckless
	Looks for ways to kill self		Sleeps too little or too much
	Reports feeling hopeless		Withdraws or reports feeling isolated
	Reports feeling having no purpose		Shows rage or talks about seeking revenge
	Reports feeling trapped		Displays extreme mood swings
	Reports feeling in unbearable pain		Other:
	Talks about being a burden		
	Increasing use of alcohol or drugs		

From NASP (2020a)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

SUICIDE IDEATION DEFINITIONS AND PROMPTS		
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Have you wished you were dead or wished you could go to sleep an not wake up?		
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.		
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?		

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?**	**YES**	**NO**

Low Risk
(i.e., current comments, thoughts of suicide, but no suicide plan, acknowledges helping resources and protective factors)

Moderate Risk
(i.e., prior attempt, thoughts of and plan for behavior or no resources, but no time frame for behavior)

High Risk
(i.e., thoughts of suicide, plan for behavior, time frame for behavior specified, and no helping resources)