ESTABLISHING A CRISIS RESPONSE TEAM

School-wide supports play a crucial role in a school's preventative efforts related to suicide, as well as response. In conjunction with an overarching multi-tiered system of supports addressing school-wide prevention efforts including curriculum, universal screening, and a process for making referrals for risk assessments, it is imperative for a school's suicide prevention program to also include the capacity to respond when a student is at high-risk of suicide, or has died by suicide. Therefore, there are two essential components that every school must also have in place:

1. Protocols for helping students at possible risk of suicide (i.e., conducting the risk assessment).
2. Protocols for responding to a student death-by-suicide (thus preventing additional suicides).

An integral aspect of building a foundation capable of addressing these two components includes establishing a crisis response team, before a crisis happens. Not only should your school identify specific personnel to conduct suicide risk assessments, but a crisis response team shall also be identified in the event that a suicide occurs. As you identify members of your school's crisis response team, you may consider the following people:

- Superintendent/CEO/Executive Director
- Principal/Head Of School
- Assistant Principal(s), Directors(s), Dean
- Health Educator
- School Nurse
- Guidance Counselor/School Counselor
- Social Worker
- Special Education Personnel
- School Psychologist
- Contracted Mental Health Providers
- Teachers
- Athletic Personnel
- Clerical Support

Crisis/Suicide Response Team Roles and Responsibilities

The school site administrator is responsible for determining the appointment of all positions noted and determining who will be on site to assist. In most cases, the needs of the family, friends, and teachers for trauma services and counseling tends to be immediate and short term.

The school plays a crucial role in helping affected individuals cope with a suicide, and therefore must act quickly and effectively to deal with grief, speed the healing process, prevent further trauma, and reduce the likelihood of additional suicide attempts by others.

Volunteer community crisis counselors (county mental health counselors, local counseling agency personnel, and private psychologists) may be summoned from established organizations to assist the schools in responding to the suicide.

A clerical support person at the school site plays a key role in coordinating the technical and logistical aspects of the response.

Emergency services assist in responding to “high risk” individuals that may be in need of immediate psychiatric services.

Below is a list of potential crisis response team members and roles. Individual team members may be personnel from your school or from a local community agency. The following list is not an exhaustive list, and schools may include additional individuals or responsibilities to align to your school’s specific needs.

School Crisis/Suicide Coordinator: _____ Phone: _____

- Coordinates the crisis response upon notification.
- Main point of contact between administration and crisis response team members.
- Contacts or assigns additional crisis team members for assistance, if desired, to perform their assigned duties.
- Identifies key individuals affected by the suicide/death, including but not limited to, family members, friends, neighbors, teachers, students, etc.
- Develops the Crisis Response Plan that identifies needed trauma services (the first 24 hours; the next three days to a week; long-term follow up).
- Contacts and schedules Volunteer Crisis Counselors, as appropriate.
- Arranges for debriefing and develops a system to provide for coordination of referral and follow-up resources.
- Ensures referrals for more intensive treatment services have been made as needed to trauma victims (family, friends, teachers, etc.).
- Arranges for long-term treatment services, as needed, and links trauma victims to public and private service providers in the community.
- Maintains a disposition log of students referred to which agency(s).
- Schedules final debriefing within two weeks of the incident.

School Psychologist: _____ Phone: _____

- Assists in triage of students.
- Assists in announcing the death to victim's classmates.
- Provides crisis counseling (individually or in groups).
- Conducts additional risk assessments.

Community/Media Spokesperson: _____ Phone: _____

- Determines what/how information will be shared with the press/community; drafts all press releases.
- Receives all contacts from media and responds appropriately.
- Ensures that school personnel knows how to deal with media inquiries (e.g., what to say, who to direct inquiries to, etc.).
- Creates an environment that facilitates media cooperation with school requests and what is in the best interests of students and the community.
- Coordinates media interviews/access to school personnel.

Crisis Team Members:

1. _____, _____ Phone: _____
2. _____, _____ Phone: _____
3. _____, _____ Phone: _____
4. _____, _____ Phone: _____

- Immediately become available to assist the School Crisis/Suicide Crisis Coordinator when contacted. Free daily schedule for the day contacted and the following day if necessary.
- Assist the School Crisis/Suicide Crisis Coordinator in identifying affected individuals and in developing a Crisis Response Plan.
- Assist in contacting Community Crisis Counselors for assistance in providing needed trauma services.
- Provide immediate support, long-term support, and consultation to the Crisis/Suicide Crisis Coordinator.

Clerical Support Person: _____ Phone: _____

- Assists the School Crisis/Suicide Crisis Coordinator in determining room/space/availability for providing trauma services.
- Assists the School Crisis/Suicide Crisis Coordinator in assigning Community Crisis Counselors to rooms and maintains a log of where each counselor is located with the type of services/ intervention they are providing.
- Provides Community Crisis Counselors with: visitor passes; forms necessary to maintain student logs (see Section 4); any announcements; art materials; new information as it becomes available.
- Facilitates communication between the Community Crisis Counselors and the School Crisis/ Suicide Crisis Coordinator.
- Initial contact person for classroom teachers who need assistance with emotionally distraught students. Requests the assistance of site administrators or other personnel in retrieving such students.
- Provides clerical support to the School Crisis/Suicide Crisis Coordinator for information/ communication dissemination.
- Receives and directs all calls from community agencies and/or private professionals who offer to provide school support.
- Consider needs of crisis team members and crisis counselor volunteers (e.g., provide water, arrange lunch).
- Performs other needed support functions as identified by administrator.

Student Flow/Campus Security: _____ Phone: _____

- Written protocol to teachers for directing student flow to counseling rooms.
- Set up escort system for students needing to access counseling rooms.
- Patrol campus to ensure that students remain on campus and are in designated areas.
- Request additional administrative support, if needed, to direct student flow and maintain campus security.
- Drafts/approves written or verbal information disclosed to public, students, and families.

PREVENTION CHECKLIST

ADAPTED FROM SAMHSA SUICIDE PREVENTION TOOLKIT TO ALIGN WITH AB 2246

*An asterisk identifies an AB 2246 requirement to be included in each LEA's Pupil Suicide Prevention Policy, AB 2246 requires any LEA that serves pupils in grades 7 to 12 to adopt a suicide prevention policy, to be board approved prior to the 2017-2018 school year.

Suicide Prevention Activities	Yes	No	Not Sure	If no, or not sure. Next steps:
Protocols for helping students at risk of suicide				
We have a written protocol for helping students who may be at risk of suicide that was developed in consultation with school and community stakeholders.*				
At a minimum, the written policy addresses prevention, intervention, and postvention.*				
The written protocol includes the steps for personnel to refer students for risk-assessments. Including but not limited to teacher referrals, peer referrals, self-referrals and concerns via social media.				
The written policy addresses youth bereaved by suicide.*				
The written policy addresses youth with disabilities, mental illness, and/or substance use disorders.*				
The written policy addresses youth experiencing homelessness or in out-of-home settings, such as foster care.*				
The written policy addresses LGBTQ youth.*				
We have a written protocol for responding to students who attempt suicide at school.				
We have established agreements with outside providers to provide effective and timely mental health services to our students.				
Protocols for after a suicide				
The written protocol includes responding to the suicide of a student.				
Personnel who will implement the suicide response protocol (i.e., crisis response team) are familiar with this protocol and the tools that will help them fulfill their responsibilities.				
Community partners who can assist in the event of a suicide have been identified.				

Personnel education and training				
The written policy addresses trainings to be provided to teachers on suicide awareness and prevention.*				

Suicide Prevention Activities	Yes	No	Not Sure	If no, or not sure. Next steps:
Personnel education and training				
Training material approved by the LEA includes how to identify appropriate mental health services, both at the school site and within the larger community, and when and how to refer youth and their families to those services.*				
All professional and support personnel have received information about the importance of school-based suicide prevention efforts.				
All professional and support personnel have been trained to recognize and respond appropriately to students who may be at risk of suicide.				
School personnel includes those who have been trained to assess, refer, and follow up with students identified as being at risk of suicide.				
The written policy includes that a school employee acts only within the authorization and scope of the employee's credential or license. Nothing is construed as authorizing or encouraging a school employee to diagnose or treat mental illness unless the employee is specifically licensed to do so.*				
Parent/Guardian education and outreach				
We educate the parents of our students about suicide and related mental health issues.				
We have a sufficient level of participation in our programs to educate parents about suicide.				
Student education				
We have implemented at least one type of program to engage students in suicide prevention.				
Suicide prevention is integrated into other student health/mental health courses and initiatives.				
Screening				
We have implemented a suicide screening program.				
We have the support of parents, school personnel, and other community mental health professionals.				

In order to ensure your school personnel is prepared to prevent and/or intervene in a suicide crisis, please respond to the additional questions for consideration listed below which were adapted from the *Idaho Guidelines for School-Based Suicide Intervention*:

1. Does the school community know who the Crisis Response Team members are?
2. Does the entire school community understand that students at risk should not be left unattended, even to get help?
3. Do school personnel understand that it is not their responsibility to assess the seriousness of a situation, but that all suicidal behavior must be taken seriously and reported, using the school protocols?
4. Do the protocols inform personnel about what to do if there is any reason to suspect a weapon is present/readily available?
5. Have the confidentiality guidelines been provided and discussed with ALL personnel?
6. Will personnel receive any feedback on students whom they refer for an evaluation of suicidal risk?
7. Are procedures in place that meet personnel needs in the event of a crisis?
8. Does the school have a procedure to alert personnel of an emergency while school is in session and do substitutes and volunteers know this procedure?
9. Has a list of local, appropriate, and accessible mental health contacts in the community been created, have contacts been interviewed, and assessed for willingness to work with the school crisis response team on issues related to the student's well-being and return to school?
10. If needed, will someone request emergency personnel, including law enforcement and/or ambulance? Who will make the determination? (*Please refer to the section titled "When to Contact Law Enforcement"*. At a minimum, if the student has a dangerous weapon the law enforcement should be called.)
11. Do school procedures designate someone to contact the parent/guardian when suicide risk is suspected, regardless of assessed risk level?
12. Does the school have procedures for when the parent/guardian is unreachable?
13. Does the school have procedures for when a parent refuses to get help for their child?
14. Has someone been designated to call the agency for the parents/guardians ahead of their arrival and to follow up to see that they do arrive?
15. Does the school provide information to parents about the importance of removing lethal means?
16. Did a personnel designee request a signed release of confidentiality between the mental health agency and/or hospital and/or doctor and parent/guardian?
17. Are there protocols concerning how to help a student re-enter school after an absence or hospitalization for mental illness including suicidal behavior? (*Please refer to the section on re-entry procedures within this handbook*)

18. Does the school have a system to collect all documentation related to the crisis?

19. Have all involved school personnel been debriefed and offered support if needed, and has the school reached out to offer support to the parents/guardians?

20. Do school personnel, parents/guardians of the student, and mental health agency(ies) that are involved have a process to put together a plan to re-integrate the student, alert relevant personnel, and decide how to help the student at school?

21. Are there systems/teams in place to address the needs of other students who are exhibiting high risk behaviors, especially friends and classmates of this student?

22. How will the student's teacher(s), coaches, and other contacts be reminded of the student's confidentiality rights?

UNDERSTANDING SELF-HARM BEHAVIOR

The Diagnostic Statistical Manual, 5th Edition (DSM-V) defines Nonsuicidal Self-Injury (NSSI) as the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned, includes behaviors such as cutting, burning, biting and scratching skin. There have been ongoing discussions whether self-harm should be the used to describe NSSI. Therefore, the terms continue to be used interchangeably. For the purposes of this handbook, behaviors consistent with the definition of NSSI will be referred to as self-harm. The Association for Supervision and Curriculum Development (ASCD) states that student self-harming behaviors can be one of the most perplexing and challenging behaviors that administrators, teachers, nurses, and counseling personnel encounter in their schools (see http://www.ascd.org/publications/educational_leadership/dec09/vol67/num04/Helping_Self-Harming_Students.aspx).

Self-Harming Behaviors May Include:

- Cutting oneself (i.e., with a razor blade, knife, or other sharp object to cut the skin).
- Punching oneself or punching things (like a wall).
- Burning oneself with cigarettes, matches, or candles.
- Pulling out ones hair.
- Breaking bones or bruising oneself.

Self-harming behavior is widespread among adolescents and is often misunderstood by others. Research indicates that students who self-harm may have never experienced suicidal thoughts or attempted to end their lives (Selekman, 2009). According to The U.S. Department of Health and Human Services, individuals who self-harm do not usually mean to end their own lives, but are at higher risk for attempting suicide if they do not get help. The most widely accepted theory in understanding why self-harming occurs is that it provides the individual with a sense of emotional relief when dealing with personal problems. When a student lacks healthy outlets for stress or positive coping strategies many stressors may contribute to developing a habit of self-harming. These stressors may include:

Social Challenges

- Peer rejection.
- Lacking social skills.
- Social isolation.
- Lacking possession of prized popular possessions (i.e., iPhone, name brand clothing).
- Cyberbullying.

Factors Related to Stress

- Balance between social, academic, multiple extracurricular commitments.
- Academic pressure from parents.
- Massive homework loads.

"Quick-Fix" Solutions

- Culture of immediate gratification.
- Modeled behavior (i.e., prescription medication as "quick fixes").

Emotional Disconnection and Invalidation

- Disconnected family unit.
- Higher connection to "screen time" than real-life interactions.

Fears About the Future

- Preparation for college.
- Uncertainty about college acceptance.

According to the Mayo Clinic on Self-harm/Cutting (see http://www.mayoclinic.org/diseases-conditions/self-harm/symptoms-causes/dxc-20165427), there are several identified risk factors that may predict self-harming behaviors.

Risk Factors

AGE	Most people who self-injure are teenagers and young adults, although those in other age groups also self-injure. Self-harm often starts in the early teen years, when emotions are more volatile and teens face increasing peer pressure, loneliness, and conflicts with parents or other authority figures
HAVING FRIENDS WHO SELF INJURE	People who have friends who intentionally harm themselves are more likely to begin self-injuring.
LIFE ISSUES	Some people who injure themselves were neglected or abused (sexually, physically or emotionally) or experienced other traumatic events. They may have grown up and still remain in an unstable family environment, or they may be young people questioning their personal identity or sexuality. Some people who self-injure are socially isolated
MENTAL HEALTH ISSUES	People who self-injure are more likely to be highly self-critical and be poor problem-solvers. In addition, self-harm is commonly associated with certain mental disorders, such as borderline personality disorder, depression, anxiety disorders, post-traumatic stress disorder and eating disorders.
EXCESSIVE ALCOHOL OR DRUG USE	People who harm themselves often do so while under the influence of alcohol or recreational drugs.

Signs and Symptoms

There are many signs that a student may be self-harming. Personnel should not act shocked if they discover that a student is self-harming. Students who engage in self-harming behaviors should be taken seriously by personnel and treated with compassion. Signs that a student is self-harming may include regularly wearing of long sleeves and long pants, especially when the weather does not call for this type or clothing, social media posts related to self-harming, and social isolation. Symptoms can vary from superficial scratches to the skin's surface to cuts or burns that result in permanent scarring. The most common body parts that students inflict harm to includes the hands, arms, stomach, and thighs.

Interventions for Self-Harming Behaviors

School-based professionals play an important role intervening when a student is suspected to be engaging in self-harm. It is important that personnel do not reprimand, punish, or bombard the student with questions upon the discovery that a student may be harming themselves. The personnel member who makes this discovery is required to refer the student to the appropriate mental health professional on site to conduct a self-harm assessment. The referring personnel member may consider introducing the student to the mental health provider and remaining with the student until they appear able to interact with the person completing the self-harm assessment.

According to the National Association of School Psychologists (NASP) there is no single and definitive approach to treating self-harming behavior. The most promising treatments involve a combination of cognitive behavioral therapy with possible medication for underlying disorders which can only be recommended and provided by a clinical mental health professional. Treatment may involve hospitalization or outpatient care, but ideally the student can maintain as normal a routine as possible. The goal is to help him or her identify the underlying cause of their pain and help them develop alternative coping and communication skills (Lieberman, 2004). Due to the complexity of self-harming behaviors and the level of support required, school-based intervention should be provided in conjunction with other treatment options. Also, consider "Next Steps for Support" on (page 2.8).

Selekman, M. D. (2009). The adolescent and young adult self-harming treatment manual: A collaborative strengths-based brief therapy approach. New York: Norton. Lieberman, Richard (2004). Understanding and Responding to Students Who Self-Mutilate. National Association of Secondary School Principals in cooperation with NASP.

CONDUCTING A SELF-HARM ASSESSMENT

The following guidelines are based on Cornell's Research Program on Self-harm and Recovery, "Non-Suicidal Self-harm in Schools: Developing & Implementing School Protocol," The entire document is available to be used as a resource in developing a protocol for your LEA and can be found in *Appendix J.* Cornell's research program suggests that having an established protocol limits ineffective responses and maximizes a school's ability to intervene appropriately when students are engaging in self-harming behaviors.

School personnel should be prepared to identify self-harm in order to make a referral to the appropriate personnel member for a risk assessment. If it is reported that a student is engaging in self-harm, it is recommended that school personnel immediately refer the student to a school mental health professional (i.e., school psychologist, school counselor, social worker, or nurse) who is trained to assess the student for both self-harm and risk of suicide.

The components of a risk assessment shall include gaining information regarding:

- **History**: *how long has the student been self-injuring.*
- **Frequency**: *how often the student is engaging in self-harming behavior(s).*
- **Method(s):** *what behavior the student is engaging in (i.e., cutting, scratching, etc.) and where, on their bodies, they may injuring (i.e., arms, legs, abdomen, etc.).*
- **Triggers**: *identify patterns in what causes the student to self-harm.*
- **Psychological Purpose**: *determine the function of the self-harming behavior.*
- **Disclosure**: *identify whether the parents are aware. Remind the student of confidentiality and the exception pertaining to their safety.*
- **Help Seeking & Support**: *discover whether the student has been treated for self-harming behaviors in the past, or if they are currently in counseling. Inquire about the student's perceived support system.*
- **History and/or current presence of suicidal ideation**: *ask the student if they have experienced thoughts of ending their life. If the student answers yes, or if, the assessor's clinical judgment indicates that the student has experienced suicidal ideation then a suicide risk assessment should follow (page 3.1).*

The American School Counselor Association requires confidentiality between students and counselors except in the event that the student is at risk for harm of self or others.

For the recommended assessment tool from The Cornell Research Program on Self-harm and Recovery see Appendix K, Non-Suicidal and Self-harm Assessment Tool (NSSIAT).

The person conducting the self-harm assessment must notify the student's parent(s)/guardians. For guidance on notifying parents, please refer to the parental notification guidelines included in this chapter (page 2.5). In addition to maintaining student safety, the goal of self-harm assessments is to inform the school team and family of how to plan appropriate treatment for the student's current behaviors and determine the next steps for on-going support. This will likely include referring the student to a community mental health provider as appropriate and holding a Student Study Team (SST) meeting. Additionally, this may result in a request for a comprehensive assessment for special education to be conducted by the LEA, see "Considerations for At-Risk Students" (section 4).

Risk Assessment Components adapted from: Bubrick, K., Goodman, J. & Whitlock, J. (2010). Non-suicidal self-harm in schools: Developing and implementing school protocol. [Fact sheet] Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults. Retrieved from http://crpsib.com/userfiles/NSSI-schools.pdf

GUIDELINES FOR NOTIFYING PARENTS WHEN STUDENTS SELF-HARM

If a student has been identified as engaging in self-harm, parents/guardians must be notified. The American School Counselor Association requires confidentiality between students and counselors except for when a student is considered at risk for harm. Parent notification should occur even if the student is not deemed as being in imminent danger.

The person who contacts the family should be the personnel member who was responsible for completing the risk assessment for self-harm with the student. For example, if a teacher refers a student to the school counselor and the school counselor meets with the student to determine their level of risk, the school counselor would then call the parent/guardian. It is recommend that personnel remain aware of and sensitive towards the family's culture, including attitudes towards suicide, mental health, privacy, and help-seeking. The person contacting the family may notify parents via telephone or request for the parent/guardian to come to the school to meet in person. The following guidelines outline steps to take when contacting parents to inform of self-harm:

1. Notify the parents about how the student was referred to you (i.e., was it a peer referral, personnel referral, social media post).
2. Explain the importance of removing dangerous items from the home (i.e., tools with which the student has demonstrated history of self-harm).
3. Share any plans to support student well-being and safety while at school.
4. Discuss available options for individual and/or family therapy. Provide the parents with the contact information of mental health service providers in the community. If possible, call and make an appointment while the parents are with you.
5. Ask the parents to sign the Parent Contact Acknowledgment Form confirming that they were notified of their child's risk and received referrals to treatment. Attach the Parent Fact Sheet (located on page 1.41 of this handbook) for parent's reference.
6. Tell the parents that you will follow up with them in a specified number of days. If this follow-up conversation reveals that the parent has not contacted a mental health provider, revisit the importance of accessing support, discuss why they have not contacted a provider, and offer to assist with this process.
7. If the parents refuse to seek services for a child under the age of 18 who continues to demonstrate self-harming behavior, consider the appropriateness of contacting child protective services as a mandated reporter.
8. Document all contacts with the parents.
9. See "Next Steps for Support," to determine whether a Student Study Team (SST) meeting, assessment for special education eligibility and/or Educationally Related Mental Health Services (ERMHS) should be considered.

Adapted from DiCara, C., O'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.gov/suicide/docs/GuidelineS'/o2010-2009--w%20discl.pdf

PARENT CONTACT ACKNOWLEDGMENT OF SELF-HARM

School_____

Personnel Member Completing the Form_____

Student_____

This is to verify that I have spoken with personnel member _____ on _____ (date), concerning my child's self-harming behavior. I have been advised to seek the services of a mental health agency or therapist immediately.

I understand that _____(name of personnel member) will follow up with me, my child, and the agency to whom my child has been referred for services within two weeks.

Parent Signature: _____ Date: _____

Personnel Member Signature: _____ Date: _____

____(Initial) I have received the Parent Fact Sheet on Self-harm

Adapted from: Substance Abuse and Mental Health Services Administration. *Preventing Suicide: A Toolkit for High Schools.* HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services: Substance Abuse and Mental Health Services Administration, 2012.

PARENT FACT SHEET

Self-Harm

What is Self-Harm?

Self-harm occurs when an individual chooses to inflict wounds upon themselves because of psychological distress. Although it is difficult to understand, this behavior becomes a coping mechanism for some people. Feelings of anxiety and distress, being “outside” one’s body, and a need for self-punishment are among the reasons self-injurers cite for their behavior.

Why Do They Do It?

Research has not been able to clearly define the life factors that lead to self-harm. Some self-injurers come from loving homes. There is evidence that sexual and physical abuse, feeling invalidated, and sexual identity issues may play a role in the self-harm of some. The theme that is repeated throughout the research is that self-injurers are using the self-harm to relieve extremely uncomfortable feelings.

What Do I Do Now?

- Take a deep breath--this is tough, but it is better that you know about it.
- Realize that you cannot solve the problem, but you can access help.
- Access help!! Find a mental health professional and make an appointment as soon as possible.
- Do NOT tell your child that they must stop self-injuring. It won’t work and will just create frustration.
- DO remove readily available items for cutting, but realize your child will probably find something else.
- DO immediately attend to physical damage and take your child to professional medical care when needed.
- DO provide a listening ear when your child needs someone to talk to - create an accepting atmosphere for him or her.
- DO help coordinate safety plans for your child between your mental health professional and the school mental health personnel.
- DO keep the school updated about any changes in your child’s intervention plan and his or her overall status.

SELF-HARM: NEXT STEPS FOR SUPPORT

In addition to following guidelines for parent notification, it is recommended that school teams consider the need for additional support while at school to maintain student safety and continued access to education.

When a general education student has displayed behavior that indicates heightened social-emotional distress or increasing mental health need, such as self-harming, the following is recommended:

Schedule a Student Study Team (SST) prior to the student's return to school in order to provide supports needed to ensure safety and well-being at school. This may include implementation of general education intervention supports and/or development of a safety plan and/or Care Card (page 3.12-3.13) contingent upon parent consent. An SST may not delay a student's return to school. If the school is not able to schedule an SST prior to the student's return, it is recommended to schedule a meeting to discuss re-entry with the appropriate school personnel. This meeting, which may include the parent, the student, the school administrator, and/or mental health personnel in order to immediately provide supports as needed until the SST is held. The SST meeting should:

- Discuss observations and concerns with parents and team members.
- Identify patterns of behavior in the home, or possible environmental factors which may impact social-emotional wellbeing and/or behavior.
- Document areas of concern including areas of suspected disability, if applicable.
- Brainstorm interventions to support immediate needs as well as a plan for monitoring progress and when/how the team will revisit effectiveness.
    - *Interventions must be individualized to meet the student's need. Commonly used interventions may include check-ins with supportive personnel, opportunity to learn and practice new coping skills, short-term access to general education counseling support, etc.*
- Lowest risk option: SST should recommend assessment for Special Education services to include Educationally Related Mental Health Services (ERMHS) assessment.
    - *Provide continued access to necessary supports during the assessment period to maintain safety.*

If a student with an Individualized Education Program (IEP) is displaying emotional needs, including but not limited to self-harm, it is recommended that the IEP team convene to discuss if ERMHS are required. As with any other IEP related service, an assessment is required to identify areas of need to inform subsequent goals and services. The team may also consider the need for a Functional Behavior Assessment (FBA) and/or Behavior Intervention Plan (BIP). Please see the *ERMHS Assessment* section for more information. If ERMHS services are already in place, the team will determine if goals should be updated and services increased and/or changed to address the student's escalating needs.

SUICIDE RISK ASSESSMENT

The following section references a number of forms/assessment instruments to be used by mental health professionals who possess the appropriate licensure and/or credential to conduct suicide assessments. They are provided as resource documents to be used when determined appropriate by the professionals involved in the assessment. They are not intended to be used by untrained professionals.

STEPS TO CONDUCTING A RISK ASSESSMENT

Once a student has been referred for being at risk for suicide, a suicide risk assessment must be conducted immediately. According to the National Suicide Prevention Resource Center, the key components of a suicide risk assessment are:

- Assessing risk factors
- Suicide Inquiry: thoughts/plan/intent/access to means

  For an additional resource, refer to the section titled, Sample Interview Risk Assessment Questions (page 3.5).
- Assess protective factors
- Clinical judgment
- Document

1. Risk Factors

   There are several factors that may place a student at higher risk for suicide which should be considered when determining a student's level of risk. (See page 1.31 for a list of possible risk factors).

2. Suicide Inquiry

   When suicide warnings and risk factors emerge, a suicidal inquiry is warranted. The purpose of the inquiry is to obtain specific details that will help determine the student's overall risk for suicide. Students should be asked directly about suicide in an empathetic but nonleading way. The assessor must demonstrate caution against asking leading questions. For example, a student could be asked "Are you thinking about ending your life?" An assessor should not ask a question such as, "You're not thinking about ending your life, are you?"

Sample Questions for Suicidal Thinking

- "Sometimes, people in your situation (describe the situation) lose hope, I'm wondering if you may have lost hope too?"
- "Have you ever thought things would be better if you were dead?"
- "With this much stress (or hopelessness) in your life, have you thought of hurting yourself?"
- "Have you ever thought about killing yourself?"

Sample Question for Prior Attempt

- "Have you ever tried to kill yourself or attempted suicide in the past?" If yes, "How long ago?"

Suicidal Ideation

If these questions reveal no evidence of suicidal ideation, the assessor may end the suicide inquiry, but, should make sure to document the finding. If the student initially denies suicidal thoughts but the assessor continues to be suspicious, the inquiry should continue until the assessor, utilizing their clinical judgment, is reasonably convinced that there is no potential suicidal ideation. An assessor may choose to seek support from an additional mental health professional either for consultation purposes or to assist with the suicide inquiry.

If the student is having suicidal thoughts, the assessor shall ask specifically about frequency, duration, and intensity.

Sample Questions for Suicidal Ideation

- "When did you begin having suicidal thoughts?"
- "Did any event (stressor) precipitate the suicidal thoughts? Tell me about it."
- "How often do you have thoughts of suicide? How long do they last?"
- "What do you do when you have suicidal thoughts?"
- "How strong are they? Do you think about acting on them?"
- "What did you do when they were strongest?"

Plan

After discussing the context of suicidal thoughts, assessors should inquire about planning. The student should be asked directly if they have a plan. If the student reports a plan, the assessor should try to elicit as many details as possible.

Sample Questions About Planning

- "Do you have a plan or have you been planning to end your life?" If so, "How would you do it?" Then you may want to follow up with, "Where/when would you do it?"
- "Do you have the (drugs, guns, rope, medication) that you would use?"

Intent

Determine the extent to which the student intends to carry out the plan and believes the plan or act to be lethal vs. self-injurious. Also, explore the student's reasons to die vs. reasons to live. Ask the student about abandoned attempts, rehearsals, preparation (such as tying a noose or loading a gun), and non-suicidal self-injurious actions, as these are indicators of the student's intent to follow through with their plan. Consider the student's judgment and level of impulse control.

Sample Questions About Intent

- "How confident are you that this plan would actually end your life?"
- "What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held the pills or gun, tied the rope)?"
- "Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?"
- "What makes you feel better (e.g., contact with family, use of substances)?"
- "What makes you feel worse (e.g., being alone, thinking about a situation)?"
- "How likely do you think you are to carry out your plan?"
- "What stops you from killing yourself?"

3. Protective Factors

Protective factors are personal or environmental characteristics that reduce the probability of suicide. Protective factors can buffer the effects of risk factors for low to moderate risk students. Protective factors may provide a poor counterbalance to individuals who are at high-risk for attempting suicide (i.e., someone with strong ideation, intent, a plan, preparatory behaviors, and impaired judgment). It is important for the assessor to determine whether protective factors may be relevant to a student and their ability to cope with life's stressors.

The assessor should inquire about the student's perceived support system (i.e., family and social support), their own individual characteristics and behaviors (i.e., self-esteem, mood, resilience), their experience with school (i.e., sense of safety and belonging) and their access to mental health and/or physical healthcare providers and caregivers. Strengthening protective factors can be a part of safety planning. For a list of potential protective factors please refer to page 1.37 of this handbook.

4. Clinical Judgment of Suicide Risk and Immediate Response

When a student has been referred for a suicide risk assessment, it is important that the school site administrator is notified. Assessing suicide risk is a complex process, especially when students experience medical illnesses, mental health/substance abuse problems, as well as a myriad of family, contextual and environmental risk and protective factors.

The graph below illustrates measuring the level of suicide risk in relation to risk/protective factors and suicidality in order to determine immediate action. The Low Risk category describes students with thoughts of death or wanting to die, but without suicidal thoughts, intent or a plan. Alternatively, students with highly specific plans for suicide, preparatory acts such as suicide rehearsals, and/or clearly articulated intent are categorized as High Risk. Impaired judgment (intoxication, psychosis, TBI, impulsiveness) further exacerbates that risk.

There is no screening tool or questionnaire that can accurately predict which students with suicide risk will go on to make a suicide attempt, either fatal or non-fatal. **The person conducting the suicide risk assessment shall utilize their clinical judgment to determine whether the student presents a low, moderate or high risk of suicide.** Low, moderate, and high risk levels may include the following characteristics and immediate responses:

Risk Level	Risk/ Protective Factors	Suicidality	Immediate Response
High	Mental health disorders paired with precipitating event and/or risk factors, perceived protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal.	Contact law enforcement or identified community agency equipped for immediate crisis response & evaluation.
Moderate	Multiple risk factors, few protective factors.	Suicidal ideation with plan, but no intent or behavior.	Evaluation by identified community agency equipped for crisis response/ evaluation or law enforcement may be warranted. Develop safety plan/care card.
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior.	Referral to community mental health professional, symptom reduction, create safety plan/care card.

Additional considerations in determining an immediate response include but are not limited to:

- Family Involvement: It is recommended that the student's family is contacted unless the student's family is an identified risk factor. In instances when the family is considered a risk factor include law enforcement in the decision of when to contact the appropriate family members.
- Consultation: Clinical judgment should not lie at the sole discretion of one individual. Consultation with mental health professionals and/or appropriate administration is always warranted.
- 24/7 Ongoing Support: School-based support is only accessible during regular school hours. Regardless of level of risk for suicide, the student must be given access to support that is available 24-hours-a-day, 7-days-a-week. Therefore, it is essential to consult with appropriate family and community members to ensure the student will receive ongoing observation, intervention and care.

Please refer to the chapter titled, "When to Contact Law Enforcement" on page 3.11 for more information relating to the involvement of law enforcement.

5. Document

It is the responsibility of the person completing the risk assessment to ensure proper documentation of the school's response. The Suicide Risk Documentation Form on page 3.16 may be used. It is not recommended, nor is it common practice to maintain documentation in a student's cumulative school file. Schools should determine methods for maintaining suicide risk assessment documentation which may include keeping forms in a secured location (i.e., locked file cabinet).

Please refer to Appendix L, the "Suicide Assessment Five-Step Evaluation and Triage (SEAT) for Mental Health Professionals" to access a tool that includes the process outlined in this chapter.

Adapted from: Western Interstate Commission for Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009) Suicide Prevention Toolkit for Rural Primary Care. A Primer for Primary Care Providers. Boulder, Colorado: Western Interstate Commission for Higher Education. (Online resource: http://www.sprc.org/sites/default/files/pctoolkit_full.pdf)

SUICIDE RISK ASSESSMENT:

SAMPLE INTERVIEW QUESTIONS

This section is intended for use by mental health service providers for interviewing students at risk for suicide. The questions listed below do not constitute a formal risk assessment tool. Please refer to the following section, "List of Suicide Risk Assessment Tools" (page 3.8) for research-based assessment tools to be used by mental health providers. In the event that a mental health provider is not available, a designated personnel member to support students in crises may refer to these questions in determining the next steps to refer a student for a formal risk assessment, see "When to Contact Law Enforcement" (page 3.18).

Inquiring about a student's level of risk or intent to harm themselves requires having some level of rapport with the student. If no rapport has been previously established between the personnel member and the student, time must be taken to establish a certain level of rapport. Prior to inquiring about the student's intent to harm, questions may be asked about the student's current life circumstances and feelings. It is important to take the time for the student to respond. Risk assessments may require ample time in order for the student to feel comfortable with the personnel member's questioning.

The questions shown below are not necessarily intended to be asked verbatim, the assessor shall utilize professional discretion to align questions that are appropriate to the student. Questions may be selected or rephrased dependent on the context gained during rapport building.

NOTE: Be sure to warn the student about the limits of confidentiality.

Under the Family Educational Rights and Privacy Act (FERPA), parents are generally required to provide consent before school officials disclose personally identifiable information from students' education records. There are exceptions to FERPA's general consent rule, such as disclosures in connection with health or safety emergencies. This provision in FERPA permits school officials to disclose information on students, without consent, to appropriate parties if knowledge of the information is necessary to protect the health or safety of the student or other individuals. When a student is believed to be suicidal or has expressed suicidal thoughts, school officials may determine that an articulable and significant threat to the health or safety of the student exists and that such a disclosure to appropriate parties is warranted under this exception *(United States Department of Education, Dear Colleague Letter dated August 18th 2015: http://ptac.ed.gov/sites/default/files/DCL%20Final%20Signed-508.pdf*). ***The assessor should notify the student that exceptions to confidentiality includes instances when a student may present a danger to self or others.***

Establishing Rapport

1. "I/Others have noticed lately that you seem__ (different, down, tired, to be dressing differently, etc.). OR You look (sad, mad, angry, upset) today. Tell me about how you are feeling."
2. "How are you feeling right now? How have you been feeling lately? Do your feelings come and go? How long have you been feeling this way?"
3. "Your (parents, teacher, friends) are concerned about you. Why do you think they would be concerned?"

Ideation

1. “Have you thought of hurting yourself or someone else?”
2. “Have you thought about suicide?”
3. “Do you have any of these thoughts/ideas right now?”
4. “Have you ever attempted suicide? How long ago? What did you do? Did your parents find out? What happened? How do you feel about that situation now?“

Other Risk Factors

1. “Sometimes people in your position start to feel…”
    - Hopeless?
    - Helpless?
    - Like you are a burden on others?
    - Trapped?
    - … Are you feeling this way too?
2. “What are your sleep patterns? Do you sleep too much? Not enough? What keeps you up at night?”
3. “Tell me about your eating habits? Loss of appetite? Eating too much? Have you been eating nutritious food?”
4. “Tell me about your friendships?”
5. “Are you feeling really angry now or in the past?”
6. “Have you been involved in any violent acts now or in the past? Has anything violent happened to you either recently or in the past?”
7. “What risky behaviors have you been involved in now or in the past (Drinking, using drugs, speeding, fighting, unprotected sex or sex with multiple partners, etc.)?”
8. “Have you been diagnosed with depression, bipolar disorder, or anxiety? Do you feel depressed? Does your mood change frequently?”
9. “Are you hanging out with friends? Getting along with family? Participating in school/church/community activities?”
10. “Who do you talk to about how you are feeling? Who have you confided in about this latest sadness?”
11. “Have you ever witnessed/seen/been exposed to someone else’s suicide attempt or death by suicide?”
12. “Have you given away or are you planning to give away any of your belongings?”
13. “Are you experiencing agitation or anxiety?”
14. “Have you attempted suicide? When? How?”

Lethality

1. “Do you have a plan of suicide? If yes, what is your plan?”
2. “When do you plan to do this?”
3. “How do you plan to do this? Where is the means (guns, pills, rope, etc.)?”

Protective Factors

1. “Who is available and willing to talk to you and help you? Which family members? Which friends? Other adults like teachers?”
2. “Who can help you in a crisis? Who do you admire?”
3. “What do you want to be/what do you want to do in the future?”
4. “What are your strengths? What are you good at? If negative response, ask what would your mom/dad/friend say you are good at?”
5. “What do you believe in? What would you stand up for?”
6. “What do you do after school?”
7. “What are your hobbies? Are you part of any teams, clubs, etc.?”
8. “Are you seeing a counselor outside of school? Are you taking any medications?”

Sources: Children and Adolescents Screening Tools: www.nimh.nih.gov/suicideresearch/measures.pdf Boise School District Suicide Risk Incident Report Dr. Peter Wollheim, Professor of Communication, Boise State University SPAN Idaho

SUICIDE RISK ASSESSMENT TOOLS

There are a variety of assessment tools that qualified mental health professionals can use to assess student suicide risk. They include:

Beck Scale for Suicide Ideation (Pearson)

http://www.pearsonassessment.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=05-8018-443&Mode=summary

Suicide Ideation Questionnaire (PAR)

http://www4.parinc.com/Products/Product.aspx?ProductID=SIQ

Suicide Ideation Questionnaire-JR (SIQ-Jr); (PAR)

http://www4.parinc.com/Products/Product.aspx?ProductID=SIQ

Suicide Probability Scale (Western Psychological Services)

http://portal.wpspublish.com/portal/page?_pageid=53,69317&dad=portal&_schema=PORTAL

Inventory of Suicide Orientation-30 (Pearson)

http://psychcorp.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=PAg126&community=CA_Psych_AI_Behavior)

All of the above tools are published, validated by research, have been used with adolescents, and take about 10 minutes to complete. The Beck Scale is also available in Spanish.

Adapted from: Substance Abuse and Mental Health Services Administration. *Preventing Suicide: A Toolkit for High Schools.* HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services: Substance Abuse and Mental Health Services Administration, 2012.