Southern Boone Suicide Prevention & Awareness Implementation Plan

Board Approved January 18, 2022

INTRODUCTION

During the 2021-22 school year, the Southern Boone School District developed a task force to review suicide awareness, prevention, intervention, and postvention. The team consisted of counselors, mental health coordinators, building and district administration. The team met to review current suicide awareness and prevention policy and developed protocols and procedures which models the requirements outlined in policy JHDF: Suicide Awareness and Prevention. The team met several times during the year to create this document and provide the guidelines for implementing this critical work.

Team Members:

Superintendent - Chris Felmlee

Assistant Superintendent – Dr. Tim Roth

High School Administration – Dale Van Deven, Shane Ringen

Middle School Administration – Justin Griffith, Will Beaudoin

Elementary Administration – Amy James, Ashley Tanksley

Primary Administration - Brandy Clark, Lucas Karr

Primary Counselors - Karri Amelunke, Kathleen Downey

Elementary Counselors – Sharon Horton, Ashley Roth

Middle School Counselor –Sarah Williams, Brett Strauser

High School Counselors – Erin Morris, Krista Massman

Director Special Services - Dannette Liles

Assistant Director Special Services - Breena Eddy

School Psychologists - Tesla Woods, Madalyn Delcourt

Southern Boone Regional Mental Health Coordinator - Becky Hart

Southern Boone School District Suicide Awareness & Prevention Policy

Suicide is a leading cause of death among youths in Missouri and is a public health concern impacting all Missouri citizens. The Southern Boone School District is committed to maintaining a safe environment to protect the health, safety, and welfare of students.

Policy JHDF: Suicide Awarenss and Prevention outlines critical protocols and procedures the district will use to educate employees and students on the resources and actions necessary to promote suicide awareness and prevent suicide. The goals of the district are to help students who may be at risk of suicide without stigmatizing or excluding students from the school. No student will be excluded from school based solely on the district's belief that the student is at risk of suicide.

Staff trained in mental health usually lead suicide prevention efforts in schools. However, it is important to remember that no one can establish effective suicide prevention strategies alone. The participation, support, and active involvement of guardians and others in the school and community are essential for success.

In alignment with Missouri House Bill No. 1583 and Missouri Revised Statute 170.048, the Missouri Department of Elementary and Secondary Education (DESE) shall develop a model policy for districts to adopt by July 1, 2018.

Access to staff trained in mental health directly improves students' physical and psychological safety, academic performance, cognitive performance and learning, and social-emotional development. These mental health professionals (school counselors, school psychologists, and in some cases, school nurses) ensure that services are high quality, effective, and appropriate to the school context. These professionals provide support for infusing mental health services and healthy living skills into the learning environment. These professionals can support both instructional leaders and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning.

Having these professionals as integrated members of the school staff empowers principals to more efficiently and effectively arrange resources, ensure coordination of services, evaluate their effectiveness, and adjust supports to meet the diverse needs of their student populations. Improving students' access to mental health supports and healthy living skills also allows for enhanced collaboration with community providers to meet the more intense or clinical needs of students.

How Schools Can Help Prevent Suicide

Suicide prevention experts recommend using a multifaceted approach in which specific components are implemented in a particular sequence. These components include:

1. **Protocols for helping students at risk of suicide, including:**
   - A protocol for helping a student who may be at risk of suicide,
   - A protocol for responding to students who attempt suicide at the school,
   - Agreements with community providers to provide behavioral health services to students
2. **Protocols for responding to suicide death, including:**
   - Steps to take after the suicide of a student or other member of the school community,
   - Staff responsible for taking these steps,
   - Agreements with community partners to help in the event of a suicide.
3. **Staff education and training, including:**
   - Information about the importance of suicide prevention for all staff,
   - Training, for all staff, on recognizing and responding to students who may be at risk of suicide,
   - Training, for appropriate staff, on assessing, referring, and following up with students identified as at risk of suicide.
4. **Parent education, including:**
   - Information for parents about suicide and related behavioral health issues,
   - Strategies to engage parents in suicide prevention programs.
5. **Student education, including:**
   - One or more programs to engage students in suicide prevention,
   - Integration of suicide prevention into other student healthy behavioral health initiatives.
6. **Screening:**
   - A suicide risk assessment,
   - Parent, staff, and community mental health provider support for screening.

https://drive.google.com/open?id=100vaN1f3_LJ8Ej9TXqsmOfnBZ37oQPjV

https://docs.google.com/document/d/12vAEb7m5hguqlWtEDB6vbh_mUW67I1N_/edit?usp=sharing&ouid=100098251727568837241&rtpof=true&sd=true

Common Language and Definitions

The common language and definitions will guide us throughout our practices and procedures, providing best supports for our students, families, and staff. These definitions serve as a universal understanding for the implementation of district and building level crisis teams.

Behavioral health—A state of mental/emotional being and choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, severe psychological distress, suicide, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support.

Bereaved by suicide—Family members, friends and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).

Best practices—Activities or programs that are in keeping with the best available evidence regarding what is useful.

Community—A group of individuals residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans—Plans that use a multifaceted approach to addressing the problem: for example, including interventions targeting bio psychosocial, social, and environmental factors.

Connectedness—Closeness to an individual, group, or individuals within a specific organization; perceived caring by others; satisfaction with relationship to others; or feeling loved and wanted by others.

Contagion—A phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

Died by Suicide--The appropriate term to use when a person harms themselves with the goal of ending their life and die as a result. Avoid using terms such as "committing suicide" or "successful suicide" as these terms often carry negative meanings.

Evidence-based programs—Programs that have undergone scientific evaluation and have proven to be effective.

Gatekeepers—Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify persons at risk of suicide and refer them to treatment or support services as appropriate. Examples include clergy, first responders, pharmacists, caregivers and those employed in institutional settings, such as schools, prisons, and the military.

Intervention—A strategy or approach that is intended to prevent an outcome or to alter the course of a condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

Means—The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Means restriction—Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods—Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Mental health—The capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective, and relational).

Mental Health Crisis Response Team (MHCRT) – A team of district employees trained in suicide awareness and prevention.

Mental health services—Health services that are specifically designed for the care and treatment of persons with mental health problems, including mental illness. Mental health services include hospitals and other 24-hour facilities, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services and different intensive outreach approaches to the care of individuals with severe disorders.

Non-suicidal self-injury—Self-injury with no suicidal intent. Same as non-suicidal self-directed violence (see Centers for Disease Control and Prevention surveillance definitions box at the end of this appendix).

Postvention—Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death. Prevention—A strategy or approach that reduces the likelihood of risk of onset or delays the start of adverse health problems, or minimizes the harm resulting from conditions or behaviors.

Protective factors—Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Resilience—Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and protect from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors—Factors that make it more likely that individuals will develop a disorder. Risk factors may encompass biological, psychological or social factors in the individual, family, and environment.

Safety plan—Written list of warning signs, coping responses and support sources that an individual may use to avert or manage a suicide crisis.

Screening—Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools—Instruments and techniques (e.g., questionnaires, checklists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

Social support—Assistance that may include companionship, emotional backing, cognitive guidance, material aid, and specialized services and resources focused on specific aspects of psychological or behavioral well-being.

Stakeholders—Entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

Student at Risk of Suicide – A student who is demonstrating individual, relationship, community or societal factors that are associated with suicide and that in combination indicate that an individual might be contemplating suicide.

Suicide Crisis – A situation in which a person is attempting to kill him or herself or is seriously contemplating or planning suicide. Planning may include, but is not limited to, a timeframe and method for attempting suicide or obtaining or attempting to gain the means to attempt suicide. A suicide crisis is considered a medical emergency requiring immediate intervention.

Suicidal self-directed violence—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

Suicidal ideation—Thoughts of engaging in suicide-related behavior. Suicidal intent—There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

Suicidal plan—A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

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

Suicide attempt—A nonfatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicidal behaviors—Acts and/or preparation toward making a suicide attempt, suicide attempts, and deaths by suicide.

Suicide crisis—A suicide crisis, suicidal crisis, or potential suicide is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency requiring immediate suicide intervention and emergency medical treatment.

Suicide attempt survivors—Individuals who have survived a prior suicide attempt.

Suicide loss survivors—See bereaved by suicide.

RISK FACTORS

A risk factor is any personal trait or environmental quality that is associated with suicide.

- Risk factors are NOT causes.
- Examples:
    - **Behavioral Health** (depressive disorders, non-suicidal self-injury (NSSI), substance abuse)
    - **Personal Characteristics** (hopelessness, low self-esteem, social isolation, poor problem-solving)
    - **Adverse Life Circumstances** (interpersonal difficulties, bullying, history of abuse, exposure to peer suicide)
    - **Family Characteristics** (history of family suicide, parental divorce, history of family mental health disorders)
    - **Environment** (exposure to stigma, access to lethal means, limited access to mental health care, lack of acceptance)

PROTECTIVE FACTORS

A protective factor is a personal trait or environmental quality that can reduce the risk of suicidal behavior.

- Protective factors don't imply that anyone is immune to suicidality but they help reduce risk.
- Examples:
    - **Individual Characteristics** (adaptive temperament, coping skills, self-esteem, spiritual faith)
    - **Family/Other Support** (connectedness, social support)
    - **School** (positive experience, connectedness, sense of respect)
    - **Mental Health and Healthcare** (access to care, support through medical and mental health relationships)
    - **Access to Means** (restricted access to firearms/medications/alcohol, safety barriers for bridges)

PRECIPITATING EVENTS

A precipitating event is a recent life event that serves as a trigger, moving an individual from thinking about suicide to attempting to take his or her own life.

- Precipitating events are often confused with causing suicide.
- *No single event causes suicidality*; other risk factors are typically present.
- Examples of precipitating events are:
    - A breakup
    - A bullying incident
    - The sudden death of a loved one
    - Getting into trouble at school

WARNING SIGNS

A warning sign is an indication that an individual may be experiencing depression or thoughts of suicide.

- Most individuals give warning signs or signals of their intentions.
- Changes that occur over a period of at least two weeks, including:
    - Changes in eating or sleeping patterns
    - Increased irritability/moodiness/rapid fluctuation in mood
    - Decreased interest in usual activities/hobbies
    - Increased isolation
    - Involvement with that law
- Talking, reading, or writing about suicide or death
- Talking about feeling hopeless, worthless or helpless
- History of depression
- Saying things like, “I’m going to kill myself”, “I wish I were dead”, or “I shouldn’t have been born”
- Visiting or calling people to say goodbye
- Giving things away
- Organizing or cleaning one’s bedroom “for the last time”
- Developing a sudden interest in drinking alcohol or using drugs
- Purposely putting oneself in danger
- Obsessing about death, violence, and guns or knives
- Previous suicidal thoughts or suicide attempts
- Serious behavior problems
- Having a past history or currently being emotionally, physically, or sexually abused

It is important to know that it takes a combination of stressors across different areas in one’s life to reach a point where someone feels hopeless enough to attempt suicide. This information is taken from *Preventing Suicide: A Toolkit for High Schools*, produced by the Substance Abuse and Mental Health Services Administration.

Risk and Responding to Students with Disabilities

Students with disabilities face problems similar to those experienced by other students, including relationship and family problems, academic and career concerns, anxiety, and depression. However, the problems of a student with disabilities may be compounded by unique factors such as prejudice or discrimination; the severity and visibility of a disability; loss of income and status; loss of caregivers or problems with developing or maintaining independence; difficulty with adjustment and other factors related to specific diagnoses, including mobility issues, impulsivity, or deficits in social skills.

Similar to other students, a number of personal and environmental factors can help protect students with disabilities from mental health problems and risk of suicidal behaviors (see protective factors above). Factors that are especially helpful for students with learning disabilities, emotional disabilities, and mobility disabilities include family connectedness and spirituality.

Risk and Responding to Bullying

It is important to remember that most students who are involved in bullying do not become suicidal. While studies have shown that young people who are bullied and those who bully others are at heightened risk for suicidal behavior, students who exhibit both pre-existing risk for suicide (namely the existence of depression, anxiety, substance use or other mental disorders) and who are concurrently involved in bullying or experiencing other negative life events are at highest risk. Individuals who are bullied in the absence of other risk factors have far fewer negative outcomes than those with pre-existing risk for suicide. Students who bully are also at risk and their behavior may reflect underlying mental health problems.

It is imperative to convey safe and accurate messages about bullying and suicide to students, especially to those young people who may be at risk for completing suicide. Suggesting that suicide is a natural response to bullying, or providing repeated opportunities for at-risk students to see their own experiences of bullying, isolation, or exclusion reflected in stories of those who have died by suicide, can increase contagion risk by contributing to thoughts that frame suicide as a viable solution. Idealizing young people who complete suicide after being bullied, or creating an aura of celebrity around them, may contribute to an at-risk student's illogical thoughts that suicide is the only way to have a voice or to make a difference for others.

Whenever possible, discussions on bullying and suicide should center on prevention (not statistics) and encourage help-seeking behavior.

Risk and Responding to Students Who Are Targets of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQIA+) Bias

LGBTQIA+ students are at heightened risk for suicidal behavior, which may be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization.

It is therefore especially important that school staff be trained to support at risk LGBTQIA+ students with sensitivity and cultural competency. School staff should not make assumptions about a student's sexual orientation or gender identity and affirm students who do decide to disclose this information. Information about a student's sexual orientation or gender identity should be treated as confidential. Additionally, when referring students to out-of-school resources, it is important to connect LGBTQIA+ students with LGBTQIA+-affirming local health and mental health service providers. Affirming service providers are those which adhere to best practices guidelines regarding working with LGBTQIA+ clients as specified by their professional association (e.g., http://www.apa.org/pi/lgbt/resources/guidelines.aspx).

For matters related to students who are targets of LGBTQIA+ bias and are exhibiting suicidal ideation and/or behaviors, the following should be considered:

- Assess the student for suicide risk
- Do not make assumptions about a student’s sexual orientation or gender identity. The risk for suicidal ideation is greatest among students who are struggling to hide or suppress their identity.
- Be affirming. Students who are struggling with their identity are on alert for negative or rejecting messages about sexual orientation and gender identity.
- Do not “out” students to anyone, including parents/guardians. Students have the right to privacy about their sexual orientation or gender identity.
- LGBTQIA+ students with rejecting families have an eight-fold increased risk for suicidal ideation than do LGBTQIA+ students with accepting families.
- Provide LGBTQIA+-affirming resources.
- Ensure students are provided safe environments and spaces where students can receive adult support, supervision and/or safety if needed.

Suicide Prevention Protocol

Mental Health Crisis Response Team (MHCRT)

Who are the team members and what are their roles and responsibilities?
The district will include suicide awareness and prevention in already established district or building crisis response teams. The Mental Health Crisis Response Team (MHCRT) is a team of district employees trained in suicide awareness and prevention. MHCRT's will be established at the district-level and a team at each building. MHCRT members will include administrators, counselors, and school nurses, and may include school psychologists, school resource officers, teachers and community members as appropriate. Teams are fluid and flexible based on the needs of the building and team member strengths. The MHCRT will be responsible for implementing the intervention protocol. MHCRT members are responsible for assessing the student's level of risk for suicide, contacting parent or guardian, creating a safety plan with and for students, following up and monitoring continued risk, and making hotline calls for student abuse and neglect if appropriate.

The district will use an evidence-supported/informed tool for determining whether a student is at risk of suicide or is having a suicide crisis. The MHCRT members will receive training and coaching in using the tool to assist in making these determinations and appropriately responding.

Suicide Prevention and Response Protocol Education for Staff

All district employees will receive information regarding this policy and the district's protocol for suicide awareness, prevention, intervention, and response. This information will be provided to current employees and each new employee hired. The information will focus on the importance of suicide prevention, recognition of suicide risk factors, strategies to strengthen school connectedness, and response procedures.

The district will also provide opportunities for district staff to participate in professional development regarding suicide awareness and prevention. Opportunities may include district-led training, access to web-based training, or training provided in other school districts or by local organizations or health professionals.

What is required for staff in the policy? – Importance of suicide prevention, suicide risk factors, strategies to strengthen school connectedness, and response protocol/procedures.

Suicide Prevention and Response Protocol Education for Students

Starting no later than 5th grade, students will receive age-appropriate information and instruction on suicide awareness and prevention. Information and instruction may be offered in health education, by the counseling staff or in other curricula as may be appropriate.

What is required for students in the policy? No later than 5th grade, age-appropriate information on suicide awareness and prevention, and peer responses to help other peers.

Suicide Prevention Education for Parents and Guardians

What is required for parents in the policy? – Importance of publication of the policy on the district website and resources made available, parent or guardian will be contacted by school officials when students are at risk of suicide, or who may be having a suicide crisis, and schools will provide or make available resources within the community to assist during these times. Parents are asked to partner with building and district staff members to provide information and participate in creating safety plans at school.

Prevention Tips for Parents:

- Do not be afraid to talk to your child.
- Know the risk factors and warning signs.
- Act immediately to get help.
- Turn to school and community mental health resources.
- Tighten the circle of care that surrounds your child.
- Remove all lethal means: Get the gun and other weapons out of the home.

School and Community Resources

The district will, in collaboration with local organizations and the Missouri Department of Mental Health, identify local, state and national resources and organizations that can provide information or support to students and families. Copies of or links to resources will be available to all students and families on the district's website and in all district schools. A section of resources are available for parents, students, and staff at the end of this manual.

Publication & Distribution

The Southern Boone Suicide Prevention & Awareness Implementation Plan will be made available on the Southern Boone district website

.Southern Boone Suicide Prevention & Awareness Implementation Plan:

	MHCRT (Crisis Response Team)	**Staff**	**Students**
Primary	**Who Delivers the Training?** BCSMHC Regional Coordinator **What Training & When?** ● Suicide Risk Assessment Training ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, School Psychologists, Admin, SRO, and/or, Teachers **What Training & When?** ● Safe Schools Suicide Prevention and Awareness Video & District Policy & Procedure ● Annual and on-going	**Who Delivers the Training?** Counselors **What Training & When?** ● Age appropriate social/emotional classroom counseling lessons. ● Follow-up as needed & appropriate throughout the school year for all grades using internalizing protocol. ● Annual and on-going

Elementary	**Who Delivers the Training?** BCSMHC Regional Coordinator **What Training & When?** ● Suicide Risk Assessment Training ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, School Psychologists, Admin, SRO, and/or, Teachers **What Training & When?** ● Safe Schools Suicide Prevention and Awareness Video & District Policy & Procedure ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, Admi, SRO, and/or, Teachers **What Training & When?** ● Age appropriate social emotional counseling lessons. ● Follow-up as needed & appropriate throughout the school year for all grades. ● Annual and on-going
Middle School	**Who Delivers the Training?** BCSMHC Regional Coordinator **What Training & When?** ● Suicide Risk Assessment Training ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, School Psychologists, Admin, SRO, and/or, Teachers **What Training & When?** ● Safe Schools Suicide Prevention and Awareness Video & District Policy & Procedure ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, Admin, and/or, Teachers **What Training & When?** ● 6th-8th grade age appropriate counseling lessons & health curriculum. ● Follow-up as needed & appropriate throughout the school year for all grades. ● Annual and on-going
High School	**Who Delivers the Training?** BCSMHC Regional Coordinator **What Training & When?** ● Suicide Risk Assessment Training ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, School Psychologists, Admin, SRO, and/or, Teachers **What Training & When?** ● Safe Schools Suicide Prevention and Awareness Video & District Policy & Procedure ● Annual and on-going	**Who Delivers the Training?** Counselors, Nurses, School Psychologists, Admin, SRO, and/or, Teachers **What Training & When?** ● 9th grade Health curriculum ● High school age appropriate counseling lessons. ● Follow-up as needed & appropriate throughout the school year for all grades. ● Annual and on-going

Suicide Intervention Protocol

A concern about a student may come to the attention of school teams in many ways: a friend may express concern, a teacher notices changes, a parent may call. When this occurs, crisis response team (MHCRT)

members will assume risk is present and begin the intervention protocol. Minimally, the assessment is completed and the parents are contacted. Immediate attention to these concerns is critical.

Mental Health Crisis Response Team

Who are the team members and what are their roles and responsibilities?

Mental health crisis response team (MHCRT) is a team of district employees trained in suicide awareness and prevention. MHCRT's will be established at the district-level and a team at each building. MHCRT members will include administrators, counselors, and school nurses, and may include school psychologists, school resource officers, teachers and community members as appropriate. Teams are fluid and flexible based on the needs of the building and team member strengths. The MHCRT will be responsible for implementing the intervention protocol. MHCRT members are responsible for assessing the student's level of risk for suicide, contacting parent or guardian, creating a safety plan with and for students, following up and monitoring continued risk, and making hotline calls for student abuse and neglect if appropriate.

Protocol for Responding to Students at Risk for Suicide and/or Self-Injury:

The following are general procedures for all employees when responding to any reports of students at risk for suicide or exhibiting self-injurious behaviors while in Southern Boone schools, while on school property, at school-sponsored functions or activities, on school buses or in vehicles used to transport students, and at school events where school staff are present. District employees will respond immediately in situations where they have a reasonable belief that a student may be at risk of suicide or may be having a suicide crisis.

Students Who May Be at Risk of Suicide

Any district employee who has a reasonable belief that a student may be at risk of suicide, even though the student is not having a suicide crisis as defined in this policy, will take the following steps:

1. Make every effort to locate the student immediately, and do not leave the student alone.
2. Notify a MHCRT member or the building administrator or designee. If the employee cannot reach the building administrator, designee or any of the MHCRT members, the employee will contact the student's parent/guardian. If the parent/guardian is also unavailable, or at the parent's/guardian's request, the employee will contact emergency services.

When a MHCRT member or the building administrator or designee receives notification that a student may be at risk of suicide, he or she will take the following steps:

1. If the student cannot be located or leaves after being located, a MHCRT member or the building administrator or designee will contact the parent/guardian to explain the district's concern.
2. If the student has been located, a MHCRT member or the building administrator or designee will use an evidence-supported/informed tool to determine whether the student is at risk of suicide and the appropriate response. Regardless of the determination, the building administrator or designee will contact the student's parent/guardian to discuss the concern.
3. If it is determined that the student may be at risk of suicide, a school counselor and a MHCRT member will meet with the student and his or her parents/guardians to discuss support and safety systems, available resources, coping skills and collaborative ways to support the student.

Students Who May Be Having a Suicide Crisis

If an employee reasonably believes that a student is having a suicide crisis, the employee will take the following steps:

1. Make every effort to locate the student immediately, and do not leave the student alone.
2. Immediately report the situation to a MHCRT member or the building administrator or designee. If the employee cannot reach the building administrator, designee or any of the MHCRT members, the employee will notify the student's parent/guardian and contact emergency services. The employee may also contact the National Suicide Prevention Lifeline (800-273-8255) for assistance. As soon as practical, the employee will notify the building administrator or designee.

When a MHCRT member or the building administrator or designee receives notification that a student is believed to be having a suicide crisis, he or she will take the following steps:

1. If the student cannot be located or leaves after being located, a MHCRT member or the building administrator or designee will contact the parent/guardian to explain the district's concern.
2. If the student has been located, the MHCRT member or the building administrator or designee will, based on his or her training and an assessment of the student, determine the appropriate action, including whether to call emergency services, and implement the appropriate response.
3. At an appropriate time after the crisis has passed, a school counselor and a MHCRT member will meet with the student and his or her parents/guardians to discuss support and safety systems, available resources, coping skills and/or collaborative ways to support the student.

Defining Screening & Assessment

When Are Students Screened for Suicide Risk?

Screening can be applied either universally or selectively. A universal screening program is applied to everyone in a population regardless of whether they are thought to be at a higher risk than the average person. For example, a universal screening program might include every student in the district.

When Are Students Assessed for Suicide Risk?

Suicide assessment is characteristically used when there is some indication that an individual is at risk for suicide; for example, when a student has been identified as such by a suicide screening or a mental health professional notices signs the student may be at risk. Suicide assessment may also be used to help develop support plans and track the progress of individuals who are receiving mental health support because they have been assessed as being at risk for suicide.

In the event a student is identified by a staff person as potentially suicidal, i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, the student will be seen by a school mental health professional (school counselor, administrator, or school psychologist) within the same school day to assess risk and facilitate referral.

Assessing Student for Risk of Suicide

The following is a summary checklist of general procedures for the mental health crisis response team members to respond to any reports or evidence, observations, suspicions of students exhibiting suicidal behavior/ideation and/or self-injury. The urgency of the situation will dictate the order in which the subsequent steps are followed.

A. Respond Immediately

- Report concerns or incidents to the administrator or MHCRT member immediately. Make direct contact with the administrator or designee. For example, do not leave a note in their mailbox, send an e-mail, leave a voicemail or wait until the end of the day to report concerns about a student at risk for suicide.
- Ensure that any student sent to the office for assessment is accompanied by a staff member, not a student. Do not leave the student unsupervised.

B. Secure the Safety of the Student

- Supervise the student at all times.
- For immediate, emergency life threatening situations call 911.
- If a student is agitated or cannot be contained, call for immediate assistance, contact the school resource officer (SRO) or local law enforcement agency.
- District employees should not transport students exhibiting the behaviors noted above.
- May contact law enforcement to conduct a well-being check, as appropriate. Even after hours when you may not be with the student.

C. Assess for Suicide Risk

- The designated school member should meet with the student to complete the risk assessment.
- School MHCRT members may collaborate with additional team members to determine the level of risk using an evidence-supported/informed tool.
- The student should be supervised at all times by the mental health crisis response team member or designee.
- The designated crisis team member should gather essential background information that will help with assessing the student's risk for suicide (e.g., what the student said or did, information that prompted concern or suspicion, copies of any concerning writings or drawings).
- Phone calls for consultation should be made in a confidential setting and not in the presence of the student of concern.

Assessing students should take place in a private comfortable area. The forms and questionnaires for the assessment provide a framework for collecting information. The interviewer may wish to introduce the evidence-supported/informed tool with a statement such as:

"I am concerned about you and your well-being. I am going to ask some questions in order to provide you some additional support."

Some students may be uncomfortable if the interviewer is actively taking notes during the conversation. In order to avoid raising suspicions and opposition, the forms are designed for completion after the interview. If a student maintains an attitude of non-compliance or hostility about answering the interview questions, the interviewer should assume moderate/high risk.

D. Suspected Abuse and Neglect

If any employee of the district has reasonable cause to believe a student has been or may be subjected to abuse or neglect or observes the student being subjected to conditions or circumstances that would reasonably result in abuse or neglect, suspicion that contacting the parent may escalate the student's current level of risk, and/or the parents/guardians are contacted and unwilling to respond, the employee will contact the Child Abuse and Neglect Hotline in accordance with law and Board policy.

Missouri Hot-Line # 1-800-392-3738

E. Determine Appropriate Follow-up Plan

The follow-up plan will be based upon severity and potential risk. There are circumstances that might increase a student's suicide risk. Examples may include bullying, suspension, expulsion, relationship problems, significant loss, interpersonal conflict, or sexual orientation/gender bias. The follow-up plan determined by the team should be documented and managed by the school mental health professional.

Actions may include:

- Develop a safety plan.
    - Identify caring adults in the school, home and community environment.
    - Discuss and identify helpful coping skills.
    - Provide afterhours resource numbers,
    - Suicide Prevention Lifeline 1-800-273-8255;
    - Trevor Project Lifeline for LGBTIA+ Youth (866) 488-7386

  For additional resources, go to the resource section of this manual.
- Mobilize a support system and provide resources.
    - Connect the student and family with social, school and community supports.
    - For mental/physical health support, refer the student to a designated support staff member within the school building, a community resource provider, or their health care provider.
- Monitor and manage
    - The administrator and/or school mental health professional should monitor and manage the case as it develops and until it has been determined that the individual no longer poses an immediate threat to self.
    - Maintain consistent communication with appropriate parties on a need to know basis.
    - Plan for re-entry, as needed.

F. Student Re-Entry Guidelines

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), a school employed mental health professional, the principal, or designee will meet with the student's parent or guardian, and if appropriate, meet with the student to discuss re-entry and appropriate next steps to ensure the student's readiness for return to school.

- A school employed mental health professional or other designee will be identified to coordinate with the student, their parent or guardian, and any outside mental health care providers.
- The parent or guardian may provide documentation from a mental health care provider that the student has undergone examination and they are no longer a danger to themselves or others.
- The designated staff person will provide periodical check-ins, based on reentry guidelines, to help the student readjust to the school community and address any ongoing concerns.
- Assess for 504/IEP eligibility and implement 504/IEP plan when appropriate

G. Document All Actions

<u>Documentation Procedures</u>

The administrator/school mental health professional shall maintain records and documentation of actions taken at the school for each case.

- Notes, documents and records related to the incident are considered confidential information and remain privileged to authorized personnel. These notes should be kept confidential and placed in a secure location.
- If a student for whom a risk assessment has been completed, transfers to a school within or outside the District, the sending school may contact the receiving school to share information and concerns, as appropriate, to facilitate a successful supportive transition.

Sharing Interview Results with Parents

Contacting a parent or legal guardian is a **requirement** of suicide intervention. Often a parent's greatest fear is that something may happen to harm their child. As such, receiving a call about the possibility of self-harm and suicide can elicit an emotional reaction. While most parents will be very thankful and supportive of the school team for sharing concerns about their child, the caller should be prepared to stay calm, focused, and professional when sharing difficult information.

At the completion of the interview, if the interviewer deems the risk of suicide to be low, a phone call alerting the parents may be sufficient. If the parent is unavailable, you may leave a message requesting the parent return your call, however, information regarding the risk assessment should not be left in the message. In all cases, every attempt to contact the parent must be made prior to the student leaving school. Designee may work with the student to create a safety plan and set a follow up time to meet with a school counselor or trusted adult.

Moderate and high-risk categories require "in person" contact. The parent or guardian is provided with information including the location and phone numbers for mental health/hospital assessments and community resources.

After an Assessment

The school counselor will also make an appointment with the student for a follow-up visit when the student returns to school. If the risk assessment results in an acute or long-term hospitalization, the school team will use the school re-entry plan to support the student upon their return to school. If the risk is "High" and the interviewer has intense concerns about the student's immediate safety, the interviewer along with the administrator will ask the parent to commit to transporting the student immediately for an emergency assessment. A school counselor or a MHCRT member will periodically follow up with students and parents/guardians of students who have been identified as being at risk of suicide or who have had a suicide crisis to offer additional assistance.

Sharing Interview Results with Students 18 years or older

If the student is 18 years-old, or legally emancipated, and refuses to seek an assessment, ask an SRO to become involved or call the Ashland Police Department. If the officer believes the student should seek an assessment, and the student still refuses to go, the officer may decide to take the young adult into protective custody and transport the student to an appropriate open facility for assessment.

When Students/Parents Contact Staff Members after Hours

Students sometimes contact staff members about self-harm outside the school day, often in the evenings or on weekends. When this occurs, staff members should take the following steps:

1. Contact the student's parents/guardians to make them aware of the student's concerning call, email, social media post, or other forms of communication.
2. If unable to reach the parent or guardian, call 911 and request a welfare check on the student based on the student's communication.
3. Contact the building MHCRT member, so they are aware of the student's communication and your subsequent request for a welfare check.

We cannot wait until the next school day to determine the student's safety; we take these steps to help keep the student safe.

Building administration will ensure all staff members are aware of this policy and these steps since students regularly contact teachers and coaches in addition to counselors, and administrators.

Sharing Interview Results with School Teams

While the specifics of what is shared during the suicide prevention intervention may be considered confidential, it is important that professionals that have responsibilities for the health and wellbeing of the student be informed of the suicidal risk so they are vigilant about warning signs and risk factors. This team may include the building administrator, school resource officer, school counselor, and teacher(s). All professionals that need this information will maintain confidentiality at all times.

Confidentiality

Employees are required to share with the MHCRT and administrators or their designees any information that may be relevant in determining whether a student is at risk of suicide, is having a suicide crisis or is otherwise at risk of harm. Employees are prohibited from promising students that information shared by the student will be kept secret when the information is relevant to the student's safety or the safety of another person.

Release of a student's individually identifiable education records will be made in accordance with the Family Educational Rights and Privacy Act (FERPA). In accordance with FERPA, information contained in a student's education records may be revealed at any time to the student's parents/guardians and school personnel who have a legitimate interest in the information. Education records may be shared with other appropriate persons when necessary to protect the health or safety of the student or others.

Suicide Postvention Protocol

Development and Implementation of an Action Plan - The mental health crisis response team (MHCRT) will develop an action plan to guide school response following a death by suicide. A meeting of the MHCRT should take place immediately following news of the death by suicide and begin implementing the phases of the plan. The action plan may include the following steps:

- **Verify the death**. The district law enforcement liaison or designee will verify the death and cause of death through communication with a coroner's office, local hospital, the student's parent or guardian, or police department. Even when a case is perceived as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian will not permit the cause of death to be disclosed, the school will not share the cause of death. However, the MHCRT members will convene and discuss appropriate opportunities to discuss suicide prevention with students.

- **Assess the situation**. The crisis team will meet to prepare the postvention response and to consider who may be significantly affected by the death. The MHCRT will also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. If the death occurred during a school vacation, the need for or scale of postvention activities may be reduced.

- **Share information**. Before the death is officially classified as a suicide by the coroner's office, the death can and should be reported to staff, students, and parents/guardians with an acknowledgement that its cause is unknown. Inform the staff that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. These statements will be provided by the Superintendent or designee. These statements should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Public address system announcements and school-wide assemblies should be avoided. The Superintendent or designee may prepare a letter (with the input and permission from the student's parent or guardian) to send home with students that includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available.
- **Initiate support services.** Students identified as being more likely to be affected by the death will be assessed by a school mental health professional to determine the level of support needed. MHCRT members will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, MHCRT members will refer to community mental health care providers to ensure a smooth transition from the crisis intervention phase to meeting underlying and ongoing mental health needs.
- **Avoid suicide contagion.** It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high risk students is to prevent another death. The building MHCRT members will work with teachers to identify students who may be significantly affected by the death. In the staff meeting, MHCRT members will review suicide warning signs and procedures for reporting students who generate concern.

Shared Protocols and Resources

SUICIDE INTERVENTION CHECKLIST

PROTOCOL FOR RESPONDING TO STUDENTS AT RISK FOR SUICIDE/SELF-INJURY

The following is a summary checklist of general procedures for the school counselor, nurse, or administrator to respond to any reports of students exhibiting suicidal behavior/ideation and/or self-injury. The urgency of the situation will dictate the order of these steps:

A. RESPOND IMMEDIATELY AND SECURE THE SAFETY OF THE STUDENT

- ✓ Do not leave the student unsupervised.
- ✓ Report concerns to administrator/MHCRT member immediately. (If student currently in harm)
- ✓ This may include calling law enforcement and/or SRO.

B. ASSESS FOR SUICIDE RISK (see Suicide Risk Assessement Tool)

- ✓ MHCRT Member (School Counselor, School Psychologist, Nurse, or Administrator/designee) assesses student at risk for suicide using the evidence-supported suicide risk assessment tool.
- ✓ The MHCRT member and at least one other school site MHCRT member to determine level of risk.

C. DETERMINE APPROPRIATE ACTION PLAN

- ✓ Determine action plan based on level of risk.
- ✓ Communicate with parent/guardian. If High Risk, parent pick-up required and use the Parent Notification Letter.
- ✓ Mobilize a support system; provide resources to parents and staff as needed (FACE referral, Local mental health clinics, warning signs, risk factors, and protective factors).
- ✓ If student is transported to hospital by ambulance without a parent or guardian, designated staff should accompany student.

D. DETERMINE APPROPRIATE FOLLOW-UP PLAN

- ✓ Develop a safety plan and communicate with necessary staff.
- ✓ Refer to Behavior RTI team and consider tiered supports.
- ✓ Monitor and manage. (Schedule follow-up meetings and school monitoring).

E. SUSPECTED CHILD ABUSE/NEGLECT (Follow hotline procedures and include information about the student's suicide risk) ***Missouri Hot-Line # 1-800-392-3738***

F. STUDENT RE-ENTRY GUIDELINES

- ✓ Re-entry plan when student is out of school, such as for hospitalization.
- ✓ If student transfers to a new school, coordinate re-entry with that school.

G. COMPLETE SUICIDE RISK ASSESSMENT LOG

H. DOCUMENT ALL ACTION

- ✓ Consider necessary information to share for student grade-level and building transitions.

IS STUDENT AT RISK?

Conduct assessment and complete checklist

HIGH RISK

Student has a specific plan

DO

Consult with building MHCRT

Inform SRO or law enforcement of status if self harming or immediate threat to others

Contact parents/guardian **IMMEDIATELY** and meet in person

Provide resources

Follow-up

DO NOT

Leave student alone

Allow student to go to bathroom or locker alone

Allow student to leave school by himself/herself

COMPLETE INTERVENTION REPORT/PLAN OF ACTION

Parents/guardian take student for an assessment.

Safety Plan, Re-Entry Meeting

Consider if police or Children's Division should be contacted if you are concerned about parents/guardian seeking support for student.

MODERATE/LOW RISK

Student has passing thoughts of death with no immediate plan.

They have "reasons to live" and support from friends/family.

Parents/Guardian notified of student's concerns **BEFORE** end of school day

Maintain close home/school communication

Provide support/follow-up with resources

Encourage parents/guardian to consult with doctor/therapist

DEBRIEF SCHOOL CRISIS TEAM

Suicide Risk Assessment Tool

Student Name/DOB: _____ Location: _____
Date: _____

The purpose of this interview is to determine a student's level of suicide risk. The assessing party should be trained to use this tool.

DIRECTIONS: For the items with the ASK specification, please directly pose these questions to the student. Take note of the student's responses in the space provided and circle the appropriate response (yes, no, or unable to assess). You may need to gather collateral information to determine the accuracy of the student's responses and/or get additional data. Gathering additional data may include talking to caregivers, teachers, peers, and/or school mental health professionals (e.g., school counselors, school psychologists), as well as reviewing student history and records.

WARNING SIGN	QUESTION	NOTES	RESPONSE
Current Problem *ASSESS* the extent of the current problem or situation that indicated a need for a suicide risk assessment	**ASK:** Tell me what happened After the student responds, proceed to *Current Ideation and Communication of Intent*		
Current Ideation and Communication of Intent *ASSESS* for current suicidal ideation, as well as the frequency, duration, and intensity of these thoughts. *ASSESS* for direct or indirect communication of ideas or intent to harm/kill themselves. Communication may be verbal, non-verbal, electronic, written, in text, or on social media.	**ASK:** Sometimes, people in a situations like this think about suicide/killing themselves. Are you having these thoughts? If **NO**, proceed to *Past Ideation* If **YES…** **ASK:** About how much in a typical day, do you think about suicide? How long have you been feeling this way? **ASK:** How often do you have these thoughts? Can you give me examples? **ASK:** How intense are the thoughts?		Yes No Unable to assess [redacted] Yes No Unable to assess

	ASK: Have you ever shared your thoughts of suicide with anyone else? To whom? What did they say when you told them?		
Past Ideation *ASSESS* for previous thoughts of suicide	**ASK:** Have you ever had thoughts of suicide in the past? If **NO**, proceed to *Previous Attempts* If **YES…** **ASK:** How long ago? Tell me what happened?		Yes No Unable to assess [redacted]
Previous Attempts *ASSESS* for previous suicide attempts	**ASK:** Have you ever tried to kill yourself? If **NO**, proceed to *Plan* If **YES…** **ASK:** How long age? What did you do? What happened?		Yes No Unable to assess [redacted]
Plan and Means and Access ASSESS for whether the student has thought through a plan. Make sure to ask about the specifics of the plan ASSESS whether the student has the means and access to materials needed to carry out plan	**ASK:** Have you ever thought about how you would harm/kill yourself? If **NO,** proceed to *Stressors* If **YES**… **ASK:** What is your plan? **ASK:** Do you have a plan to harm/kill yourself now? **ASK:** How would you carry out the plan? When would you do it? Where would you do it? **ASK:** What is the likelihood that you would take action to end your life? How likely is it that you would die from this plan?		Yes No Unable to assess [redacted] Yes No Unable to assess [redacted] Yes No Unable to assess [redacted]

	ASK: Do you have access to weapons, guns, medication, etc? **ASK:** Have you made any preparations to carry out the plan? Have you rehearsed your plan?		[redacted]
TRANSITION: Now, I'm going to ask you some more questions. These questions are more about your mood, habits, and any recent stress you may have experienced.			
Stressors *ASSESS* whether the student has experienced recent stressors or triggers that may influence their decision to die by suicide.	**ASK:** Has anything stressful/traumatic happened to you (e.g., domestic violence, community violence, natural disaster)? **ASK:** Have you experienced victimization or been the target of bullying/harassment/discrimination? Describe. **ASK:** Has someone close to you died recently or have you been separated from someone who is important to you (e.g., death, parent separation/divorce, relationship breakup)? **ASK:** Has anyone close to you ever died by suicide? Who? How long ago? How? After student responds, proceed to *changes in mood/behavior*		Yes No Unable to assess Yes No Unable to assess Yes No Unable to assess Yes No Unable to assess [redacted]
Changes in Mood/ Behavior *ASSESS* whether the student had demonstrated abrupt changes in behaviors and/or dramatic changes in	**ASK:** In the past year, have you ever felt so sad that you stopped doing things you usually do or things that you enjoy? What are the activities you no longer do?		Yes No Unable to assess [redacted]

mood and appearance.	**ASK:** Tell me about your concentration/focus recently? **ASK:** Do you ever act before you think? **ASK:** Some people in your situation have lost hope; I'm wondering if you have lost hope that your life will get better, too? After student responds, proceed to *Mental Illness*		Yes No Unable to assess Yes No Unable to assess [redacted]
Mental Illness *ASSESS* for whether the student has a history of mental illness (e.g., depression, conduct disorder, anxiety disorder)	**ASK:** Have you ever experienced mental health difficulties (e.g., depression, anxiety)? What kind? **ASK:** Have you ever seen a counselor/therapist or someone to help with sadness, worry, stress, etc? ***Note**: Students may not know this information, so you should try to collect collateral information from other adults (e.g., caregivers, teacher, school counselor)		Yes No Unable to assess Yes No Unable to assess [redacted]
Substance Use *ASSESS* for whether the student has been using and/or abusing drugs and/or alcohol	**ASK**: Do you use alcohol or drugs? If **NO**, proceed to *Protective Factors* If **YES**… **ASK:** Which ones? **ASK:** How often do you use drugs or alcohol? **ASK:** Where do you typically use drugs or alcohol?		Yes No Unable to assess [redacted]

	ASK: How much do you use?		
Protective Factors ASSESS for whether the student can identify plans for the future and indicate reasons to live	**ASK:** Do you have an adult at school that you can go to for help? **ASK:** Do you have an adult outside of school that you can go to for help? **ASK:** What are your plans for the future?		Yes No Unable to assess Yes No Unable to assess

Risk Determination

DIRECTIONS: Use response from interview and self-report questionnaire (if high school or above) to determine the student's current level of risk. Use the following chart to indicate with a check mark the warning signs the student demonstrates (interview and self-report items that you may consider are included). Determine their level or risk based on the warning signs demonstrated, as well as your clinical judgment.

RISK LEVEL DEFINITION	POTENTIAL WARNING SIGNS	INTERVIEW AND SELF-REPORT QUESTIONS
□ **No Known Current Risk** own current evidence of suicidal ideation.	□ No known history of suicidal ideation/behavior or self-injurious behavior □ No current evidence of depressed mood/affect. For example, statement made was a figure of speech, intended as a joke or was a repetition or song lyrics or movie script.	Interview: Current ideation, Past ideation, Past attempts, Plan, Changes in mood/behavior, Stressors, Mental illness Self-Report: 1-4, 7, 8, 10-14, 16-20
□ **Low Risk** ot pose imminent danger to self; insufficient evidence for suicide risk.	□ Passing thoughts of suicide; evidence of thoughts may be found in notebooks, internet postings, drawings, etc. □ No plan □ No history of previous attempts □ No means or access to weapons □ Recent loses □ No alcohol or substance abuse □ Support system in place □ May have some depressed mood/affect □ Sudden changes in personality/behavior	Interview: Current ideation, Communication of intent, Plan and Means and access, Past ideation, Previous attempts, Substance use, Protective factors, Stressors, Mental illness, Changes in mood/behavior Self-Report: 1-4, 6-21
□ **Moderate Risk** ose imminent danger to self, but there is insufficient evidence to demonstrate a viable plan of action to do harm.	□ Thoughts of suicide □ Some details indicating a plan for suicide □ Unsure of intent □ History of self-injurious behavior and previous attempts and/or hospitalization □ Difficulty name future plans or feeling hopeless	Interview: Current ideation, Communication of intent, Plan and Means and access, Past ideation, Previous attempts, Substance use, Protective factors, Stressors, Mental illness, Changes in mood/behavior Self-Report: 1-4, 6-21

	□ History of substance use or current intoxication □ Recent trauma (e.g., loss, victimization)	
□ **High Risk** imminent danger to self with a viable plan to do harm; exhibits extreme or persistent inappropriate behaviors, may qualify for hospitalization ** if one of the first two bolded items are checked, determination of high risk is appropriate	□ **Current thoughts of suicide** □ **Plans with specifics (indicating when, where, and how)** □ Access to weapons or means in hand □ Making final arrangements □ History of previous attempts and/or hospitalization □ Isolated and withdrawn and current sense of hopelessness □ No support system □ Mental health history □ Recent trauma	Interview: Current ideation, Communication of intent, Plan and Means and access, Past ideation, Previous attempts, Substance use, Protective factors, Stressors, Mental illness, Changes in mood/behavior Self-Report: 1-4, 6-21

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
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 and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: Was this within the past three months?**	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

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

SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors

C-SSRS Suicidal Ideation Severity	Month
1. Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	
1. Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	

YES to question 2, ask questions 3, 4, 5, and 6. If NO to question 2, go directly to question 6.

1. Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
1. Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	
1. Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	
6) C-SSRS Suicidal Behavior: *"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" Was it within the past 3 months?	**Lifetime** **Past 3 Months**

Current and Past Psychiatric Dx: □ Mood Disorder □ Psychotic disorder □ Alcohol/substance abuse disorders □ PTSD □ ADHD □ TBI □ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic) □ Conduct problems (antisocial behavior, aggression, impulsivity) □ Recent onset **Presenting Symptoms:** □ Anhedonia □ Impulsivity □ Hopelessness or despair □ Anxiety and/or panic □ Insomnia	**Family History:** □ Suicide □ Suicidal behavior □ Axis I psychiatric diagnoses requiring hospitalization **Precipitants/Stressors:** □ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated) □ Chronic physical pain or other acute medical problem (e.g. CNS disorders) □ Sexual/physical abuse □ Substance intoxication or withdrawal □ Pending incarceration or homelessness □ Legal problems □ Inadequate social supports

□ Command hallucinations □ Psychosis	□ Social isolation □ Perceived burden on others **Change in treatment:** □ Recent inpatient discharge □ Change in provider or treatment (i.e., medications, psychotherapy, milieu) □ Hopeless or dissatisfied with provider or treatment □ Non-compliant or not receiving treatment
□ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing	
Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: □ Ability to cope with stress □ Frustration tolerance □ Religious beliefs □ Fear of death or the actual act of killing self □ Identifies reasons for living	**External:** □ Cultural, spiritual and/or moral attitudes against suicide □ Responsibility to children □ Beloved pets □ Supportive social network of family or friends □ Positive therapeutic relationships □ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior) If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS Lifetime/Recent for comprehensive behavior/lethality assessment.	
C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	**Month**
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	
Reasons for Ideation	

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both? (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	
Total Score	

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☐ Consult with building mental health crisis response team including administration. ☐ Contact parents immediately and arrange to meet in person. ☐ Provide resources for student (Lifeline card, apps for smartphone: My 3) ☐ Provide parent resources for additional support (parent notification letter, outside resources, contact numbers for evaluation and treatment) ☐ Stay with student until student is transported for out of district assessment ☐ Follow-up and document outcome of external assessment ☐ Create Safety Plan ☐ Schedule follow-up with student and monitor ☐ Utilize Re-Entry Plan ☐ Share risk factors and warning signs with appropriate staff
Moderate Suicide Risk Suicidal ideation with method, **WITHOUT plan, intent or behavior in past month** (C-SSRS Suicidal Ideation #3) **Or** Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) **Or** Multiple risk factors and few protective factors	
Low Suicide Risk Wish to die or Suicidal Ideation **WITHOUT method, intent, plan or behavior** (C-SSRS Suicidal Ideation #1 or #2) **Or** Modifiable risk factors and strong protective factors **Or** □ No reported history of Suicidal Ideation or Behavior	☐ Consult with building mental health crisis response team including administration. ☐ Contact parents/guardian immediately and inform of concerns. ☐ Provide resources and encourage parents to consult with doctor/therapist. ☐ Provide resources for student (Lifeline card, apps for smartphone: My 3) ☐ Create Safety Plan ☐ Schedule follow-up with student and monitor ☐ Maintain close home/school communication

Step 5: Documentation

Risk Level :

[ ] High Suicide Risk
[ ] Moderate Suicide Risk
[ ] Low Suicide Risk

Clinical Note:

- Your Clinical Observation
- Relevant Mental Status Information
- Methods of Suicide Risk Evaluation
- Brief Evaluation Summary
    - Warning Signs
    - Risk Indicators
    - Protective Factors
    - Access to Lethal Means
    - Collateral Sources Used and Relevant Information Obtained
    - Specific Assessment Data to Support Risk Determination
    - Rationale for Actions Taken and Not Taken
- Provision of Crisis Line 1-800-273-TALK(8255)
- Implementation of Safety Plan (If Applicable)

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

Southern Boone County School District - PARENT INTERVENTION REPORT

Student Name _____ Date_____

I understand that my child has been assessed as being high risk for suicide due to suicidal ideation with intent or intent with a plan <u>in past month.</u>

SUGGESTED EMERGENCY RESOURCES

Missouri Psychiatric Center (MUPC)	https://www.muhealth.org/locations/missouri-psychiatric-center	573-884-1300 3 Hospital Dr, Columbia, MO
Burrell	https://www.burrellcenter.com/	573-777-8300 3401 Berrywood Dr., Columbia, MO
FACE of Boone County	https://faceofboonecounty.org	573-771-3223 105 E Ash St #100, Columbia, MO
Centerpointe	https://centerpointehospitalcolumbia.com	573-615-2001 1201 International Drive Columbia, Missouri
Or contact your current mental health care provider for a same day evaluation		

I understand that I have been advised to take my child immediately to the appropriate medical and/or mental health providers for evaluation and any treatment recommended by the provider.

I agree to provide appropriate information to my child's school regarding any evaluations and/or treatment received from the mental health provider that will prepare the school to support my child's reentry into the academic setting.

I understand that any referral information provided to me that identifies medical, mental health, or related health providers is meant for my consideration only and not a requirement that I use these providers. I am free to select other providers of my choice.

The school/district is not responsible for evaluation expenses for any service providers.

Parent Signature:_____ Date: _____
Print Name:

Parent/guardian current address and phone contact information

Staff member signature: _____ Date: _____ __

Copies provided for parent, Suicide Response Designee, Administrative Designee

STUDENT RE-ENTRY Checklist

Student Name/DOB: _____School:

School Mental Health Professional: _____

_____

In planning for the re-entry of a student who has been out of school for any length of time, including mental health hospitalization, or if the student will be transferring to a new school, the school site administrator/designee may consider any of the following action items:

Returning Day	☐ Have parent escort student on first day back. Use Suicide Risk Monitoring Tool, and develop a re-entry communication and safety plan, in the event of future emergencies.
Hospital Discharge Documents	☐ Request discharge documents from hospital or Medical Clearance for Return to School from parent on/before first day back.
Meeting with Parents	☐ Engage parents, school support staff, teachers, and student as appropriate in a Re-Entry Planning Meeting. ☐ Identify on-going mental health resources in school and/or in the community ☐ Modify academic programming, as appropriate ☐ Offer suggestions to parents regarding monitoring personal communication devices, including social networking sites, as needed. ☐ Notify student's teacher(s), as appropriate.
Identify Supports	☐ Assist the student in identifying adults they trust and can go to for assistance at school and at home.
Address Bullying, Harassment, Discrimination	☐ As needed, ensure that any bullying, harassment, discrimination is being addressed.
Designate Staff	☐ Designate staff (school mental health professionals) to check in with the student during the first couple weeks periodically.
Release/Exchange of Information	☐ Obtain consent by the parent to discuss student information with outside providers using the Southern Boone School District Consent for Release of Student Information.

Student Safety Plan

(Adapted from Barbara Stanley & Gregory Brown)

Common warning signs that a crisis may occur or develop:

1. _____

2. _____

3. _____

Coping strategies that may help take my mind off of problem concerns without contacting another person:

1. _____

2. _____

3. _____

People or social settings that will take my mind off of problems:

1.Name: _____ Phone #: _____

2.Name: _____ Phone #: _____

3.Place: _____ Place: _____

Professional agencies, providers or hotlines I or my parent or guardian can contact during a future crisis situation:

1.Name: _____ Phone #: _____

2.Name: _____ Phone #: _____

3.Name: _____ Phone #: _____

4. National Suicide Prevention Lifeline: 1-800-273-8255

Ways I can make my environment safe:

1. _____

2. _____

One thing that is really important for me and that is worth living for:

_____

How To Handle A Potentially Suicidal Student from a Virtual Platform

(As Directed from MSCA)

If you are **currently working with a student** who appears to be experiencing a suicidal crisis, begin **at Step 1**.

If you are **informed of a student** who may be having a suicidal crisis by another member of the school community, **proceed to Step 2.**

Step 1: If a student you are working with appears to be having a suicidal crisis use active listening to:

- Establish a trusting relationship with the student
- Decrease the intensity of the student's emotions
- Ask about the student's current state of mind, if he/she has a plan, if he/she has a way to carry the plan out, and when (date, time) the student intends to carry out the plan

Step 2: Inform parents/families

If you are in direct contact with the student in crisis maintain video/voice contact with the student while this contact is made, if possible. For example, you might ask the student to bring the phone/laptop to the parent/guardian/another adult, if the parent/guardian/another adult is in the same place as the student.

If the parent/guardian is NOT in the same place as the student:

- **For the safety of the student, talk with another adult who is currently with the student:**
    - Share the information you have with the adult
    - Tell the adult you are calling 911 for a wellness check at the address they are currently at
    - Ask the adult to stay with the student until emergency responders are with the student
    - Contact the parent/guardian to let them know where the student is at and that you have called 911 and asked for a wellness check

If the parent/guardian is WITH the student:

- Share the information you have with parent/guardian

- Tell the parent/guardian to stay with the child until the 911 Emergency Responders/Crisis Team arrives for an assessment
- Verify the address and phone number the student is currently at
- **Call 911 (if you believe the student is in imminent danger or you are unsure. Call the crisis line if you do not believe the student is in imminent danger, but does require an evaluation: 866-495-6735**
- Notify 911 or Crisis Line of your concerns regarding the student. Have as much of the following information as possible available from your Student Management System or parent/guardian:
    - Student's name
    - Student's birthdate
    - Name(s) of parent/guardian who has custody
    - Phone numbers and addresses of parent/guardian(s) who have custody
    - Address and phone number(s) of people student is currently with

If the parent/guardian is not available, the risk to the student is high, and/or the student is alone:

- Verify the address the student is at and the phone number
- **Call 911 and ask for a wellness check at the address the student is currently at**
- Stay on the line with the student as long as possible, or until emergency responders arrive. (If you have a second phone available, contact 911 with one phone while keeping the student on the first phone)
- Give parent/guardian contact information and addresses to emergency responders
- Continue to try and contact family members regarding concerns

Step 3: Document information received, decisions made and actions taken

- **Document the statements you received from the student, family, other adult, Crisis Line and/or 911 dispatcher and first responders. Also document the time you talked with the student, called parents/guardians, called 911 or Crisis Line, contacted administrator and/or school counselor.**
- Contact your administrator to alert him/her regarding concerns and actions taken
- Notify the school counselor your building so they can follow up with the student and family:

If you have concerns about any student, the student is not in imminent danger, and you aren't sure how to proceed, please call your administrator or one of the counselors. If the counselor for your building isn't available, please contact another counselor on the list.

Adapted from: ASCA FAQ's Virtual School Counseling Ethics, March 25, 2020
https://www.schoolcounselor.org/school-counselors/legal-ethical/faqs-virtual-school-counseling-ethics

Handling a Death of Student or Staff Member

- Follow the protocol you have for a death under normal conditions
    - Family contact
    - Sharing of information with students/staff
    - Family wishes for remembrance
- Confer with your Crisis Team members via Zoom or in whatever format you feel is best
- Notify relevant individuals, such as specific teachers, parents, students
    - Consider extending whatever system you've established for checking-in with vulnerable students to individuals affected by the death, including students, families, and school personnel
- Provide students, parents and staff members with any restrictions that may be in place due to the event.
- Share your office hours and the hours of others on your team who would be appropriate to provide counseling and support; think about extending those hours for a set period of time
- Discuss having virtual opportunities for grief sharing; perhaps include grief specialists from the community
- Discuss if/how to honor the individual, the means, the timing, and how to notify people
- Provide information from various community resources
- Debrief with fellow Crisis Team members and do frequent check-ins with one another

Returning to "Normal" Schooling

- Before transitioning back to business-as-usual, talk with your crisis team (and others as needed) about any potential implications of school resuming for vulnerable/impacted individuals in the school community (including students and all adults), keeping in mind how circumstances may have affected "typical" grief processes and how much experiences may vary from person to person.
    - Consider opportunities for informal events to help re-orient the entire school community to business-as usual
        - School counselors and members of the crisis team can make plans to be highly visible in the hallways and entrances to school and classrooms; stop in to greet teachers and staff members
        - Consider/plan ideas for classroom meetings for teachers to use in the first few days back to school
    - Participate in planning meetings to fully prepare school staff for student re-entry based on current circumstances (i.e. teachers could easily become overwhelmed when trying to meet students where they are after long periods of absence with inconsistent access to learning during the absence - be mindful of how other factors, such as SES, may exacerbate those differences)
    - Work with your school administrator and other school counselors to develop a plan to acknowledge and address the trauma individuals (students and staff) may have experienced or been exposed to (i.e., prolonged periods of isolation, depression, social anxiety, grief). Be prepared to address a possible spike in reports of child abuse and neglect.

        - Make a list of students for whom you have high concern; make checking in with them a priority once school resumes
- Call a meeting of your crisis team to discuss what worked in the plan and what needs to be adjusted
- Talk with your administrator about having debriefing meetings with teachers/teams of teachers to discuss the successes and challenges they felt during the time the virtual platform had to be used
- If school is closed for the remainder of the school year, it's possible that some staff members may not be returning in the fall; this makes saying goodbye an issue. Consider putting together a video of brief messages from those staff members and/or a booklet of written messages from staff members who may be leaving. This could be highly valuable to students and staff alike.

Southern Boone Suicide Postvention
Crisis Measures, Guidelines & Suggestions

Responsibilities will be divided between the members of the Building Mental Health Crisis Response Team. Use this checklist as a guideline. Items may be adjusted to fit the needs of individual buildings and situations.

PHASE I: IMMEDIATE ACTION

___ Administration verify facts of the situation/incident with parent(s) and law enforcement.
- Confirm the cause of death
- If the cause of death is unconfirmed, report that the cause is still being determined.
- If the family does not want the cause of death disclosed, state "The family has requested that information about the cause of death not be shared at this time."

___ Administration gathers Building Mental Health Crisis Response Team (MHCRT) in conjunction with District Administration to assign procedures below; meet as needed. Establish a central room for MHCRT control needs (large conference room).

___ Determine ONE person to maintain contact with family throughout the entire process. Offer condolences. Stays in communication between family and staff re: needs/communication flow/funeral services/etc., as to not overwhelm family.

___ Determine any security needs; ask local law enforcement or the School Resource Officer for extra patrol to help with keeping media off campus, etc.

___ Depending on timing of the event, consider building supervision needs such as: Greeting students as they enter or exit the building, or monitor exits and areas where crisis may have occurred, supervising passing periods, lunches, etc.

___ Notify Superintendent or designee to arrange extra district staff support from various schools/community. Needs to consider:
- two district lead counselors K-5 and 6-12

- Educational Therapist
- Boone County Mental Health Program
- Substitute teachers for teachers and office staff, etc.
- Make food and drink available in the staff gathering areas.

___ Update student information in School Information System (after printing student's schedule for class visits)

- Mark student as "Deceased" in SIS to stop all auto communication to family
- Make a new family profile in SIS for surviving members in the family
- Mark siblings as excused to prevent additional calls to family
- Assist family with updating school communication with the district (Remind, SeeSaw, etc.)
- Remove student work from classrooms (consider fine/practical arts and other electives)
- Empty student locker in coordination with family (give them choice to come do it)

___ Notify faculty

- Arrange for staff meeting, if possible
- Deploy information teams to travel class by class if necessary (written, verbal, email). A written note helps maintain consistent messaging.
- Determine if faculty members are able to return to class and deliver messaging to students
- Notify faculty to check email for messaging if appropriate
- Arrange for substitute teachers from other school to serve as "floaters" for teachers who are not able to return to class

___ Refer all media requests to the Superintendent or Designee.

___ Determine siblings (school-age children) that reside in the home who attend Southern Boone County Schools, inform the building principal. Communication should be made by the Superintendent or designee.

___ Superintendent and Building Principal coordinate to develop and distribute written statements.

___ Principal to provide staff announcement, if needed, or use a written form for teachers to individually read to class. (**DO NOT USE PUBLIC ADDRESS SYSTEM**).

___ Determine need to alter school schedule/dismissal time/extracurricular activities, if necessary. Maintain as much consistency as possible in daily schedule. (ex: greet at doors)

___ Communicate with Transportation Department regarding deceased student and determine needs of students affected. (Ex: ask staff member to ride home with sibling, counselor visit on bus, etc.)

PHASE II

___ Establish a central control room and meet as group with all visiting district support members to determine roles of support

- Assign counselors, school psychologists, staff, and BCSMHC regional coordinators to Crisis Rooms; provide them with a building map w/room numbers, time schedule of school day, talking points re: any info that can be shared, and also how to address specific crisis-related questions. (ex: gun in building/gun control/etc. as approved by principal.)
- School counselors will coordinate as needed with the Mid-Mo School Counselor Crisis Team.
- Assign counselors to meet with individual rooms of students affected.
- Monitor halls, restrooms, exits, and area where crisis may have occurred.

___ Designate Crisis rooms with supplies (Ex: water bottles, candy/gum, paper, markers/colors/pencils, tissues, and sign-in sheets for student attendance.)

___ Designate Counseling staff to be present in each class hour of deceased student's (and siblings) schedule on the following school day. Notify teachers that this will be occurring for additional support.
*May also be needed in any classrooms in areas of crisis, if occurred on campus.

___ Identify students and staff who may have immediate needs
- Those with a connection to the student in question or recent loss (current and past teachers, coaches, activity sponsors, etc.)
- Those who witnessed or were in area of event, sound, smell, visual cues
- Those who have suffered from suicide ideation or crisis
- Document all student/parent meetings for future follow up checks

___ Determine the necessity of assigning counselors to call selected parents (of potentially at-risk students) to inform them of the crisis and what is being done.

___ Contact Technology Coordinator about shutting down chromebook/securing data for student privacy.

PHASE III: AFTER ACTION AND FOLLOW-UP

___ Update information regularly to staff, including an email that contains:
- Remind students that counselors and crisis rooms are available. Share locations and process to call if student needs an escort
- Talking points and class activities for teachers to utilize, if needed
- Consider how to handle student's desk
- Parameters for what staff can/cannot share with students/public
- How to request a sub if needed at any point during day for breaks
- Be aware of comments by students that need to be addressed by the counselor/admin.
- Provide as much consistency as possible to "normal routine" and daily schedule. Structure helps and is calming for most students.

___ Moment of silence, simple, factual, gentle, short (only if given permission from family, or once obituary is public). Do not over-sensationalize due to unknown affect it may have on those listening. Always pair this with "how can we keep it from happening again"; bending the conversation around awareness and prevention.

___ If created, keep memorials/shrine in a neutral place. If memorial has to be moved, talk with student groups/student council/close friends to gain input regarding choices/include them in decisions (before touching anything.) Remind students that all belongings are property of the family; explain to students this is done out of respect. Allow close friends/groups to help move memorial respectfully.

___ If event occurred on campus, additional hall monitors/counselor in specific area of crisis throughout following week to offer support to both students and staff working in area.

___ Develop follow-up plan for checking on staff, visiting with students previously seen/close to situation (ex: Google doc shared w/administration/counselors/social worker/school psychologists to show students who have been seen, dates, times, frequency.)

___ Designate a family coordinator. Staff food/money collection/support to family goes through this person. Send food/card to family in first week from the school community. Online media/money donations "GoFundMe" type service is coordinated outside of school environment/non-school personnel.

___ Debrief with faculty, daily or weekly as needed. Remind of EAP services available with district's insurance plan. Keep EAP brochures available in teacher mailroom, via email, etc.

___ Debriefing with MHCRT members, daily or weekly as needed until concerns have calmed. Meet two weeks/one month after to revisit any changes for the future.

___ Send Thank you notes to all outside staff/resources that helped during and after the crisis.

___ For a Suicide: Reference "Preventing Suicide: A Toolkit for High Schools" and "After A Suicide: A Toolkit for Schools" (SPRC)

___ Anticipate that a group of teachers may want to organize additional optional "after school meeting" on or off campus to debrief re: situation, for fellowship, as needed (separate from "faculty debriefing"). This provides discussion of ways to help each other, the family, triage, food, services, etc.

___ Anticipate needs as the anniversaries pass re: the death for staff and students (Ex: one week, one year, prom, graduation, etc.)

I Never Thought this Would Happen!
How to Help Your Teen Deal with Suicide Grief: A handout for parents
Terri Erbacher, PhD

Has your child lost a friend or loved one to suicide?
Not only is your child grieving the loss of someone close to him/her, but this grief is intensified because the death was a suicide. The healing process may be painful and may seem unnaturally slow as suicide grief is extremely complex. Helping your child understand his or her emotions, as well as learning something about suicide in general, may help to ease some of his/her pain.

The first question is often *WHY* do some teens complete suicide?
We don't know for sure because when youth die by suicide, they take the answers with them. But, we do know that many are experiencing a number of stressors and many have a mental disorder, like depression, which is often undiagnosed, untreated, or both. We also know that most teens do not want to die, they just want their emotional pain to end. Help your teen see this and see that there are other ways to deal with this emotional pain, such as by getting help when needed.

Grief Symptoms/Behaviors your child may experience:

Emotional Effects
Shock & Disbelief
Anger & Irritability
Depression/Sadness
Despair or Helplessness
Terror/Fear
Guilt or Self-Blame
Anxiousness or Worry
Loss of pleasure in activities
Confusion

Physical Effects
Fatigue
Insomnia or Disturbed Sleep
Stomach/Headaches
Decreased Appetite
Hyperarousal or Easily Startled

Cognitive Effects
Difficulty Concentrating
Trouble Making Decisions
Trouble Remembering
Impaired Self-Esteem
Intrusive Thoughts or Memories
Crying Easily
Change in Daily Patterns
Nightmares
Regression in Behavior

Social/Behavioral Effects
Social Withdrawal or Isolation
Increased Relationship Conflict
Refusal to go to School or Activities
Risk Taking Behaviors (substance use)
Aggression or Oppositional Behavior

While the above are common symptoms, help your child understand that there is no RIGHT way to grieve. It is an individualized process and your child must grieve at his or her own pace. This is especially true for complex suicide grief, which leaves many questions unanswered.

Some things you can do:
Be available and ask if your child wants to talk, but realize a teen may not come to you
Listen to your child without judgment and let your teen tell his/her own story freely
Share your own feelings and concerns honestly
It is okay to tell your teen that you don't know answers to some difficult questions
Try to re-establish routine, with appropriate expectations, as soon as possible
Encourage your child to continue engaging in their typical activities, sports, etc.
Try not to take anger or irritability personally as it may be directed toward parents
Let your teen have his/her personal space
Be careful not to glamorize, thereby positively reinforcing, suicide as an option
Emphasize the importance of seeking help when needed
Be aware of depression and/or suicidal ideation in your child (see warning signs)
Accompany your child to funeral or viewings if they would like to go

Suicidal Warning Signs:
A previous suicide attempt
Current talk of suicide or making a plan
Strong wish to die or a preoccupation with death
Signs of depression, such as moodiness, hopelessness, withdrawal
Increased alcohol and/or drug use
Hinting at not being around in the future or saying good-bye
Readily accessible firearms
Impulsiveness and taking extreme or unnecessary risks
Lack of connection to family and friends (no one to talk to)

What is a Suicidal Emergency?
It may be an emergency if your child expresses any of these:
Intense feeling of being a burden
Intense feeling of not belonging
Intense feelings of hopelessness; that things will not get better
Intense thoughts of lethal self-harm
Describing a specific plan
Seeking means of self-harm

These warning signs are especially noteworthy in light of a recent suicide death or other loss of someone close to your child. If your child mentions suicide, take it seriously. *If there seems to be a suicidal emergency, do not leave your child alone. Get help immediately:*

- *Take them to a local crisis center*
- *Call 911*

Remember that the NUMBER ONE protective factor in the life of a child is a caring adult who listens to a child without judgment. This is most often a parent!

Source: Erbacher, T.A. (2013). Lending a Helping Hand: Suicide in Schools: Empowering School Districts. Booklet published by the Delaware County Intermediate Unit, Morton, PA.

National State & Community Mental Health Resources

University Behavioral Health - Child/Adolescent Psychiatry Clinic	1000 W. Nifong Blvd. Building 2, Suite 140 Columbia, MO 65203 https://www.muhealth.org/conditions-treatments/behavioral-health	573-884-1130
Robert Kline, PhD	1905 Cherry Hill Dr., Suite 200 Columbia, MO http://www.drklineonline.com/	573-445-3903
Mike Mayer, Mary Flanagan, Scott & Associates	3407 Berrywood Dr. Suite 200 Columbia, MO http://www.comocounseling.com/our-counselors/	573-443-1177
Chris Hawf, M.Ed., LPE, BCPC	2000 E. Broadway, Suite 275 Columbia, MO	573-447-3300
University of Missouri-Columbia Jeremy Skinner, PhD Nan R. Presser, PhD	211 S. 8th Columbia, MO	573-882-4677
Marianne Branham, LCSW	2716 Forum Blvd Columbia, MO	(573) 673-6799
Burton, Dueker, Midkiff, and Branham	601 Business Loop 70 W. Suite 221 Columbia, MO	573-442-2502
Michael Kaplan, LCSW, LLC	1805 E. Walnut St. Columbia, MO	573-884-1400
Family Counseling Center	117 N. Garth Columbia, MO http://compasshealthnetwork.org/location/columbia/	573-449-2581
Center for Family and Individual Counseling	2804 Forum Blvd., Suite 4 Columbia, MO http://www.capstherapy.net/LocateUs.en.html	573-446-5034
Deborah Wright MU Assessment & Consultation Clinic	701 S Providence Rd, Columbia, MO 65203	573-884-0377
Marilyn Cashon, PhD	2011 Chapel Plaza Court, Suite 1 Columbia, MO	573-442-9270

Christine Lawrence, Ph.D.	601 W. Nifong Blvd. Columbia MO https://www.loacounselingandcoaching.com/our-services	573- 214-0436
Grace Counseling LLC	718 West McCarty Street Jefferson City, MO 65101 http://www.gracecounselingllc.com/GraceCounselors.en.html	573-644-6128
Stephanie Parsons, LCSW	2306 Bluff Creek Drive Columbia, MO https://www.comocounselingassociates.com/meet-our-clinicians1	573-874-8818
Jennifer Patrick, LCSW	1303 Edgewood Drive Jefferson City, MO 65109 https://www.jcmg.org/providers/patrick-jennifer/	(573) 635-5264
Anxiety & Depression Clinic	2600 Forum Blvd Ste G, Columbia, MO 65203 www.comoclinic.com	(573) 239-9915
Kindred Collective	2800 Forum Blvd., Suite 4A Columbia, MO 65203 https://www.kindredcollectivecomo.com/	573-340-5145
Patti Alewel, M.S., LCSW	1001 Southwest Blvd., Suite F Jefferson City, MO 65109 https://www.allcarecounseling.net/	573-636-0025
Eileen Long, MSW, LCSW	1001 Southwest Blvd. Suite F Jefferson City, MO 65109 https://provider.kareo.com/eileen-long	573-424-1108
Ashland Family Counseling	409A Redbud Ln. Ashland, MO 65010 https://www.ashlandfamilycounseling.com/	573-250-2210

Community Resources

Hotlines and Helplines

Child Abuse and Neglect Hotline	Missouri: 1-800-392-3738 National: 1-800-4A CHILD (22-4453)
Child Support General Information	1-800-859-7999
Family Support Division	1-800-392-1261 https://mydss.mo.gov/
Domestic Violence Hotline	1-800-799-7233 https://www.thehotline.org/
Food Stamp Case Information https://apps.dss.mo.gov/fmwBenefitCenter/Account/Login.aspx	1-800-392-1261
National Suicide Prevention Line	1-800-273-TALK (8255)
Mid-Missouri Crisis Line	1-573-445-5035
KUTO Line Kids under 21 peer counseling https://cap4kids.org/stlouis/586211635/	1-888-644-5886
Love, Columbia Coordinates community resources	573-256-7662
Missouri Crisis Access Response System (MOCARS) 24/7 https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/behavioral-health-crisis-hotline	1-800-356-5395
Missouri School Violence Hotline https://www.mshp.dps.missouri.gov/MSHPWeb/Courage2ReportMO/index.html	1-866-748-7047
MO HealthNet https://dss.mo.gov/mhd/	1-800-392-2161
National Alliance for Mentally Ill (NAMI) https://nami.org/Home	1-800-950-NAMI (6264)
Parental Stress Helpline (Crisis)	1-800-632-8188

https://www.parentshelpingparents.org/stressline

Office of Child Advocate	573-522-8024
ParentLink WarmLine	1-800-552-8522 573-882-7323

Self Help, Support, and Advocacy Groups

Al Anon-information line www.al-anon.org www.midmissouri.al-anon.org	573-443-3059
Alateen- Support group for teens dealing with alcohol issues https://al-anon.org/newcomers/teen-corner-alateen/	1-800-344-2666
Narcotics Anonymous	1-800-662-HELP (4357)

Agencies

Assistance League of Mid-Missouri Assault Survival Kits, Literacy Book Bags, Hygiene kits, School Enrichment Program, Operation School Bell,Parent Packs, Upscale Resale Shop https://www.assistanceleague.org/mid-missouri/	573-445-3848
Big Brothers/Big Sisters of Central Missouri Children from single-parent households are matched in a one-on-one relationship with an adult role model.	573-874-3677
Boone County Family Resources Offers supported living programs, life skills training, early intervention and family support services, and case management/service coordination; Trustline provides free background checks of potential caregivers of	573-874-1995

persons served by the agency

Burrell 573-777-8300
Burrell is a private, not for profit organization that provides a wide range of mental health services for individuals and families, business and industry, and educational programs for community and professional groups.

CenterPointe Hospital
Provides behavioral health services for patients of all all ages and their families 855-623-7016

Central Missouri Autism Project 573-441-6278
Assessment in home family support; parent training; occupational and music therapy; family connections support group crisis intervention; school consultation; IEP support; public education
https://dmh.mo.gov/dev-disabilities/autism/central

Columbia/Boone County Health Department 573-874-7355
Healthcare and a number of other services offered at free or reduced rates based on income.

Comprehensive Human Services
Provides shelter, safety, education, and empowerment to physically or emotionally abused or neglected youth, to physically or emotionally abused women and their children and to survivor of sexual abuse or violence; operate the Front Door Shelter

True North 573-875-0503
Hotline 1-800-548-2480
573-875-1367
1-787-774-3344

Family Counseling Center of Missouri 573-449-2581
Individual and group therapy for batterers, Support groups for battered men, Professional therapy for women, children and men

Jefferson City Rape and Abuse Crisis Service
Hotline: 800-303-0013
Shelter and motel placement
Hotline: 573-634-4911
Domestic violence and sexual assault crisis
Office: 573-634-8346
Intervention, Case management, Court advocacy,
Support groups for women and children,
Professional therapy for women, children
and men, Structured program for children,
Non-residential services
https://www.racsjc.org/

Love Basket, Inc.
636-797-4100
confidential counseling to men and women
in Missouri and Kentucky who are
considering making an adoption plan
https://lovebasket.org/

Missouri Psychiatric Center
573-884-1255
Psychiatric inpatient for children,
Adolescents, and adults; outpatient
Services for adolescents and children
including screening and evaluation,
case management, family preservation,
and individual and group therapies.

Planned Parenthood Health Center - Columbia
573-443-0427
Family planning services, birth control
Services; patient education; STD screening

Rainbow House Regional Child Advocacy Center/Shelter
Shelter/Crisis Line: 573-474-6600
Shelter, Safe House, Information/Referral
Crisis hotline, Professional Counseling
Crisis intervention

The Shelter – True North
Hotline: 800-548-2480
Shelter and motel placement,
Phone: 573-875-1370
Domestic violence and sexual assault
crisis intervention, Case management,
Court advocacy, Support groups for women,
and children, Professional therapy for women,
Structured program for children, Hospital
advocacy program, Community education,
Non-residential services

University of Missouri-Assessment and Consultation Clinic Provides a number of assessments and psycho-educational information	573-884-6052
University of Missouri – Student Counseling Center Personal counseling, academic effectiveness program; testing services; employee assistance program; consultations; group counseling; stress management lab; educational programs	573-882-6601
University of Missouri-Psychological Services Clinic Individual psychotherapy for adults, children, adolescents, marital and couples therapy; family therapy; child and adult assessment	573-882-4677

Southern Boone County R-1 Schools
Authorization for Release of Information

Section I

Date: _____

Student's Name: _____

Date of Birth: _____ **Student ID**: _____

School: _____ **Grade**: _____

Section II

Parent/Legal Guardian Name: _____ give my informed consent for Southern Boone County R-1 School District:

- ☐ to release the specific information identified below ***to***:
- ☐ to obtain specific information identified below ***from***:

Name of individual or entity: _____

Address: _____

_____

☐ Health Records	Created between	_____	and	_____
☐ Medical Reports	Created between	_____	and	_____
☐ Psychological Reports	Created between	_____	and	_____
☐ Psychiatric Reports	Created between	_____	and	_____
☐ Special Education Records	Created between	_____	and	_____
☐ Other (*specify*)	Created between	_____	and	_____
		(date)		**(date)**

For the purpose of: _____

Section III

I understand this authorization:

- Can be stopped at any time by sending a written request to Southern Boone County R-1 Schools
- takes effect the day I sign it
- and expires on _____

I further understand:

- I may refuse to sign this authorization and it will not affect my child's ability to receive educational services.
- I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).
- A copy of this release form is as valid as an original.
- I will receive a copy of this authorization.

Signature: _____ Date: _____

Parent, Guardian, or Student — mm/dd/yyyy

Signature: _____

School Official / Title

Address: _____

FERPA and HIPPA Information

Family Educational Rights and Privacy Act (FERPA)
34 CFR Part 99
State Statute 99.30 Under what conditions is prior consent required to disclose information? (a) The parent or eligible student shall provide a signed and dated written consent before an educational agency or institution discloses personally identifiable information from the student's education records, except as provided in $ 99.31. (b) The written consent must:
(1) Specify the records that may be disclosed; (2) State the purpose of the disclosure; and (3) Identify the party or class of parties to whom the disclosure may be made. (c) When a disclosure is made under paragraph (a) of this section:
(1) If a parent or eligible student so requests, the educational agency or institution shall provide him or her with a copy of the records disclosed; and
(2) If the parent of a student who is not an eligible student so requests, the agency or institution shall provide the student with a copy of the records disclosed. and requirements contain at least
(c) core descript formation.

Health Insurance Portability and Accountability Act (HIPAA)
45 CFR Part 164
State Statute 164.508 Uses and disclosures for which an authorization is required. (c) Implementation specifications: Core elements and requirements--
(1) Core elements. A valid authorization under this section must contain at least the following elements:
(i) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
(ii) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use OT disclosure.
(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.
(iv) A description of each purpose of the requested use or disclosure. The statement at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
(v) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
(vi) Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for

the individual must also be provided.
(2) Required statements. In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:
(i) The individual's right to revoke the authorization in writing, and either:
(A) The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
(B) To the extent that the information in paragraph (c)(2)(i)(A) of this section is included in the notice required by Sec. 164.520, a reference to the covered entity's notice.
(ii) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
(A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or
(B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.
(iii) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this subpart.
(3) Plain language requirement. The authorization must be written in plain language.
(4) Copy to the individual. If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.