Rensselaer Central Schools Policy on Suicide Prevention

Purpose

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

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

Toward this end, the policy is meant to be paired with other policies supporting the emotional and behavioral health of students more broadly.

Scope

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

Definitions

1. **At risk** A student who is defined as high risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures.

2. **Crisis team** A multidisciplinary team of primarily administrative, mental health, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention/response and recovery. These professionals have been specifically trained in crisis preparedness through recovery and take the leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.

3. **Mental health** A state of mental and emotional being that can impact choices and actions that affect wellness. Mental health problems include mental and substance use disorders.

4. **Postvention** Suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.

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

6. **Risk factors for suicide** Characteristics or conditions that increase the chance that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and or social factors in the individual, family, and environment.

7. **Self-harm** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Can be categorized as either non-suicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

8. **Suicide Death** caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death.

9. **Suicide attempt** A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

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

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

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

Prevention

1. **District Policy Implementation** A district level suicide prevention coordinator shall be designated by the Superintendent. This may be an existing staff person. The district suicide prevention coordinator will be responsible for planning and

coordinating implementation of this policy for the school district. Each school principal shall designate a school suicide prevention coordinator to act as a point of contact in each school for issues relating to suicide prevention and policy implementation. This may be an existing staff person. All staff members shall report students they believe to be at elevated risk for suicide to the school suicide prevention coordinator.

2. **Staff Professional Development** All staff will receive annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention. The professional development will include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities. Additional professional development in risk assessment and crisis intervention will be provided to school employed mental health professionals and school nurses.

3. **Youth Suicide Prevention Programming** Developmentally-appropriate, student-centered education materials will be integrated into the curriculum of all K-12 health classes and/or classroom lessons with School Counselor. The content of these age-appropriate materials will include: 1) the importance of safe and healthy choices and coping strategies, 2) how to recognize risk factors and warning signs of mental disorders and suicide
in oneself and others, 3) help-seeking strategies for oneself or others, including how to engage school

resources and refer friends for help. In addition, schools may provide supplemental small group suicide prevention programming for students.

4. **Publication and Distribution** This policy will be distributed annually and included in all student and teacher handbooks and on the school website.

Assessment & Referral

When 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 employed mental health professional within the same school day to assess risk and facilitate referral. If there is no mental health professional available, a school nurse or administrator will fill this role until a mental health professional can be brought in.

For youth at risk:

1. School staff will continuously supervise the student to ensure their safety.

2. The principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.

3. The school employed mental health professional or principal will contact the student's parent or guardian and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local Emergency Department, but in most cases will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider.

4. Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

In-School Suicide Attempts

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

1. First aid will be rendered until professional medical treatment and/or transportation can be received, following district emergency medical procedures.
2. School staff will supervise the student to ensure their safety.
3. Staff will move all other students out of the immediate area as soon as possible.
4. If appropriate, staff will immediately request a mental health assessment for the youth.
5. The school employed mental health professional or principal will contact the student's parent or guardian, as described in the Parental Notification and Involvement section.
6. Staff will immediately notify the principal or school suicide prevention coordinator regarding in-school suicide attempts.
7. The school will engage as necessary the crisis team to assess whether additional steps should be taken to ensure student safety and well-being.

Re-Entry Procedure

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.

1. 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.
2. The parent or guardian will provide documentation from a mental health care provider that the student has undergone examination and that they are no longer a danger to themselves or others.
3. The designated staff person will periodically check in with student to help the student readjust to the school community and address any ongoing concerns.

Out-of-School Suicide Attempts

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

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

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

Parental Notification and Involvement

In situations where a student is assessed at risk for suicide or has made a suicide attempt, the student's parent or guardian will be informed as soon as practicable by the principal, designee, or mental health professional. If the student has exhibited any kind of suicidal behavior, the parent or guardian should be counseled on "means restriction," limiting the child's access to mechanisms for carrying out a suicide attempt. Staff will also seek parental permission to communicate with outside mental health care providers regarding their child.

Through discussion with the student, the principal or school employed mental health professional will assess whether there is further risk of harm due to parent or guardian notification. If the principal, designee, or mental health professional believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate. If contact is delayed, the reasons for the delay should be documented.

Postvention

1. **Development and Implementation of an Action Plan** The crisis team will develop an action plan to guide school response following a death by suicide. A meeting of the crisis team to implement the action plan should take place immediately following news of the suicide death. The action plan may include the following steps:

a) **Verify the death**. Staff will confirm the death and determine the 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 but will use the opportunity to discuss suicide prevention with students.

b) **Assess the situation**. The crisis team will meet to prepare the postvention response, to consider how severely the death is likely to affect other students, and to determine which students are most likely to be affected. The crisis team 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.

c) **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 faculty that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement 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 crisis team 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.

d) **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 crisis team will work with teachers to identify students who are most likely to be significantly affected by the death. In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting students who generate concern.

e) **Initiate support services**. Students identified as being more likely to be affected by the death will be assessed by a school employed mental health professional to determine the level of support needed. The crisis team will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, crisis team members will refer to community mental healthcare providers to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs.

f) D**evelop memorial plans**. The school should not create on-campus physical memorials (e.g. photos, flowers), funeral services, or fly the flag at half-mast because it may sensationalize the death and encourage suicide contagion. School should not be canceled for the funeral. Any school-based memorials (e.g., small gatherings) will include a focus on how to prevent future suicides and prevention resources available.

2. **External Communication** The school principal or designee will be the sole media spokesperson. Staff will refer all inquiries from the media directly to the spokesperson. *The spokesperson will*:

a) Keep the district suicide prevention coordinator and superintendent informed of school actions relating to the death.

b) Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation, means of suicide, or personal family information.

c) Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide, and not to use the phrase “suicide epidemic” – as this may elevate the risk of suicide contagion. They should also be encouraged not to link bullying to suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available.

Sample Language for Student Handbook

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

1. Students will learn about recognizing and responding to warning signs of suicide in friends, using coping skills, using support systems, and seeking help for themselves and friends. This will occur in all health classes and/or classroom lessons with a school counselor.

2. Each school will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources.

3. When a student is identified as being at risk, they will be assessed by a school employed mental health professional who will work with the student and help connect them to appropriate local resources.

4. Students will have access to national resources which they can contact for additional support, such as:

• The National Suicide Prevention Lifeline – 1.800.273.8255 (TALK), www.suicidepreventionlifeline.org

• The Trevor Lifeline – 1.866.488.7386, www.thetrevorproject.org

5. All students will be expected to help create a school culture of respect and support in which students feel comfortable seeking help for themselves or friends. Students are encouraged to tell any staff member if they, or a friend, are feeling suicidal or in need of help.

6. Students should also know that because of the life or death nature of these matters, confidentiality or privacy concerns are secondary to seeking help for students in crisis.

7. For a more detailed review of policy changes, please see the district’s full suicide prevention policy.

Suicide Prevention & Response:

A Comprehensive Resource Guide for Indiana Schools

2018

The Indiana Department of Education would like to thank the following individuals and organizations for their contributions to the development of this document:

Laurie Gerdt, Community Health Network, Indiana Suicide Prevention Network Advisory Council
Dr. Brandie Oliver, Butler University
Indiana Suicide Prevention Network Advisory Council Members

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime/Recent Version

Version 1/14/09

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

Disclaimer:

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

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

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

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)

Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)

	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing 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	____	

Version 1/14/09

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

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

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?*	
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	
5) 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?*	
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 □ Command hallucinations □ Psychosis	**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 □ 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 <u>specifically</u> 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)	☐ **Initiate local psychiatric admission process** ☐ **Stay with patient until transfer to higher level of care is complete** ☐ **Follow-up and document outcome of emergency psychiatric evaluation**
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	☐ **Directly address suicide risk, implementing suicide prevention strategies** ☐ **Develop Safety Plan**
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	☐ **Discretionary Outpatient Referral**

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)

Risk Levels

Risk Level	Observed Behavior/Information Disclosure	Recommendations and Follow Up
LOW	Has thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. General thoughts of suicide WITHOUT a specific method or plan.	Refer to school counselor or other provider (if risk is detected outside of school). Create a collaborative safety plan, notify involved staff and share plan. Parents should be contacted and a plan should be made for follow up contact to determine how often check-ins and meetings will take place. Counselor/suicide prevention coordinator checks in with student daily for first week, once a week for the next three weeks or as student/family deems appropriate.
MODERATE	Endorses thoughts of suicide and has thought of at least one method to kill self but not a specific plan. "I thought about taking an overdose but I never made a specific plan …and I would never go through with it."	Do not leave the student unsupervised. Create a collaborative safety plan, notify involved staff and share plan. Parents should be contacted and plans made for them to come to the school. Recommend parent/guardian make appointment with a mental health counselor. Determine if additional crisis response is necessary.
HIGH	Active suicidal thoughts of killing oneself and reports having some intent to act on such thoughts. Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.	Do not leave the student unsupervised. Make plans to transport student to the emergency room or crisis department. Parents should be contacted and plans made for them to come to the school and assist with getting the student to a safe environment. If parents are unavailable, contact school resource officer or police for transport.

If parent/guardian cannot be reached by the end of the day or parent/guardian refuses to pick up:

- Contact Director of Safety/School Safety Specialist of [INSERT NAME of SCHOOLSAFETY HERE] at _____ *or*
- Contact School Safety Officer, _____ at _____ *or*
- [INSERT LOCAL POLICE DEPARTMENT HERE] for pick up and transport at xxx-xxx-xxxx *or*
- *As a last option: Call CPS at 1-800-800-5556. File a DCS report.

**A report should be filed on a case-by-case basis and only when deemed necessary based on Indiana Code, Chapter 5: Duty to Report Child Abuse or Neglect. All steps should be taken when possible to maintain a collaborative relationship with the student's guardian in order to promote the well-being of the child.*

RE-ENTRY PROTOCOL

Re-entry meetings will take place after suicidal ideation or a suicide attempt and before the student returns to school. Re-entry meetings will be documented using Re-entry meeting notes form. Meeting scheduled in partnership with counselor and admin.

Family and School personnel who must participate are:

Student
Parent/Guardian
School Counselor
Administrator

Optional Attendees:

Nurse
Family Advocate
School Psychologist

Purpose of the re-entry meeting:

-Review steps taken by family and student to follow up on suicidal ideation or attempt.

-Discuss resources in place or connect to additional resources.

Family is encouraged to bring ROIs
Family is encouraged to bring assessment/appointment notes

-Share recommendations by student's medical practitioner and/or therapist.

-Address questions/concerns about missed work, credits, absences etc.

-Create or discuss school safety plan. Include in discussion:

Open or closed lunch/passing periods
Access to bathrooms and nurse
Notification of teachers/coaches/after school activity supervisors
Supervision during after school activities/sports
Duration of safety plan

-Next steps in case of continued safety concern (when a student is sent home and with whom)

Re-entry Meeting Notes

Student Name: Date:
Incident Date: Absence Date(s) From/To:

Re-entry meeting participants:

□ Steps taken by family and student to follow up on suicidal ideation or attempt. Discuss resources in place or connect to additional resources. (ROI, Assessment/Appointment notes)

□ Recommendations by student's medical practitioner and/or therapist.

□ Questions/concerns about missed work, credits, absences etc.

□ School safety plan. (Restrictions during lunch/passing periods. Supervision during after school activities/sports. When to notify teachers/coaches/after school activity supervisors and by whom. Duration of safety plan and check in/review process.)

□ Next steps in case of continued safety concern. (When student needs to go home and with whom.)

Student: _____ Date: _____
Parent: _____ Date: _____
Counselor: _____ Date: _____
Administrator: _____ Date: _____

School Safety Plan

Name _____

Completed By (Staff)_____ **Today's Date** _____

Causes: Things that tend to set me off (make me feel mad, sad, upset):

Warning signs that I am mad, sad or upset (how can I/others tell?):

I am responsible for my behavior and if life becomes overwhelming, I'm upset, and I want to harm myself in any way, I will do the following:

Coping Strategies: Things or activities I can do to help me calm myself at school.

1. _____
2. _____
3. _____
4. _____

While at school, the adults I can contact for support are:

Name: _____ **Location:** _____

Name: _____ **Location:** _____

While at home or away from home, the adults I can contact for support are:

Name:_____ **Phone:** _____

Name:_____ **Phone:** _____

If I feel suicidal, I will call 1-800-273-TALK or my mental health professional contact. I also can use the Safe School Helpline by calling 800-418-6423 or going to safeschoolhelpline.com

Parent contact made by: _____

Parent Name/Number: _____

Copy to student, counselor, administrator, and a confidential, central location (tbd by building)

Instructions for Teachers/Support Staff

Date: _____

Our student _____ is on a Safety Plan at school. While the student is in your classroom please follow the procedures checked below. **Keep this confidential at all times and follow this plan until further notice.**

 If the student has left class to use the bathroom, please monitor the time the student is gone. Call the office at x_____if you are concerned that the student has been gone too long.

 If he/she is visibly upset or expressing thoughts of unsafe behavior, call the office at x_____ and send him/her to talk with the psychologist, counselor or administrator. **Always request an office escort and call the office so we know the student is on their way**.

☐ Make sure this document is included with your sub notes when you are absent.

☐

☐

Contact the student's counselor if you have any questions or concerns.

Counselor: _____ x_____

Copy to teachers, counselor, admin, security, nurse, dean

Suicide Prevention Steps for Parent/Guardians

1.) Show you care – Listen carefully and talk openly with your student about their thoughts and feelings (specifically about suicide and/or self-harm). And take care of yourself too-crisis lines/websites are also great resources for parents.

2.) Contact your medical care provider for an appointment and/or referral for treatment. Complete release of information document (ROI) for communication with school and provide school's risk assessment information to your medical provider.

3.) Contact your preferred mental health professional for immediate risk assessment and assistance. A crisis line is available at 1-800-273-TALK or locally Valley Oaks Health Crisis Line: 800-859-5553,

4.) Remove potential threats to safety, for example: weapons, medications, sharps, toxic household substances (e.g. bleach), belts, etc.

5.) Supervise and monitor – Avoid leaving your student alone or letting them isolate themselves behind closed doors.

6.) Schedule a re-entry meeting with your student's school counselor and administrator before your student returns to school. This meeting is required before your student returns to classes.

Counselor: _____

Phone #: _____