Broward County Public Schools

Suicide Prevention Manual

2020-2021

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The School Board of Broward County, Florida

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Online resources for Broward County Public Schools (BCPS) can be found at BCPS Mental Health and Wellness Portal http://www.bcps-mentalhealth.com/index.php.

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INTRODUCTION

Suicide is a serious public health problem that can have harmful effects on individuals, families and communities. This manual was written to provide school personnel with the information necessary to identify potential suicides and to intervene. In 2019, the Suicide Prevention Handbook was updated to reflect changes in the law that mandated that Threat Assessment Teams in schools respond to all threats by students, including potential harm to one's self. In the Fall of 2020, Broward County Public Schools (BCPS) transitioned to using an electronic system for assessing for risk of suicide and support planning. This manual reflects changes in policy and procedure, as well as updated information regarding best practices in the field of suicide prevention in school districts.

According to the Centers for Disease Control and Prevention[5], suicide is the second leading cause of death among young people aged 10-24. In 2017, 296 deaths by suicide for 10-24-year-olds occurred in Florida, ranking our state 21st in the nation for the number of deaths by suicide.

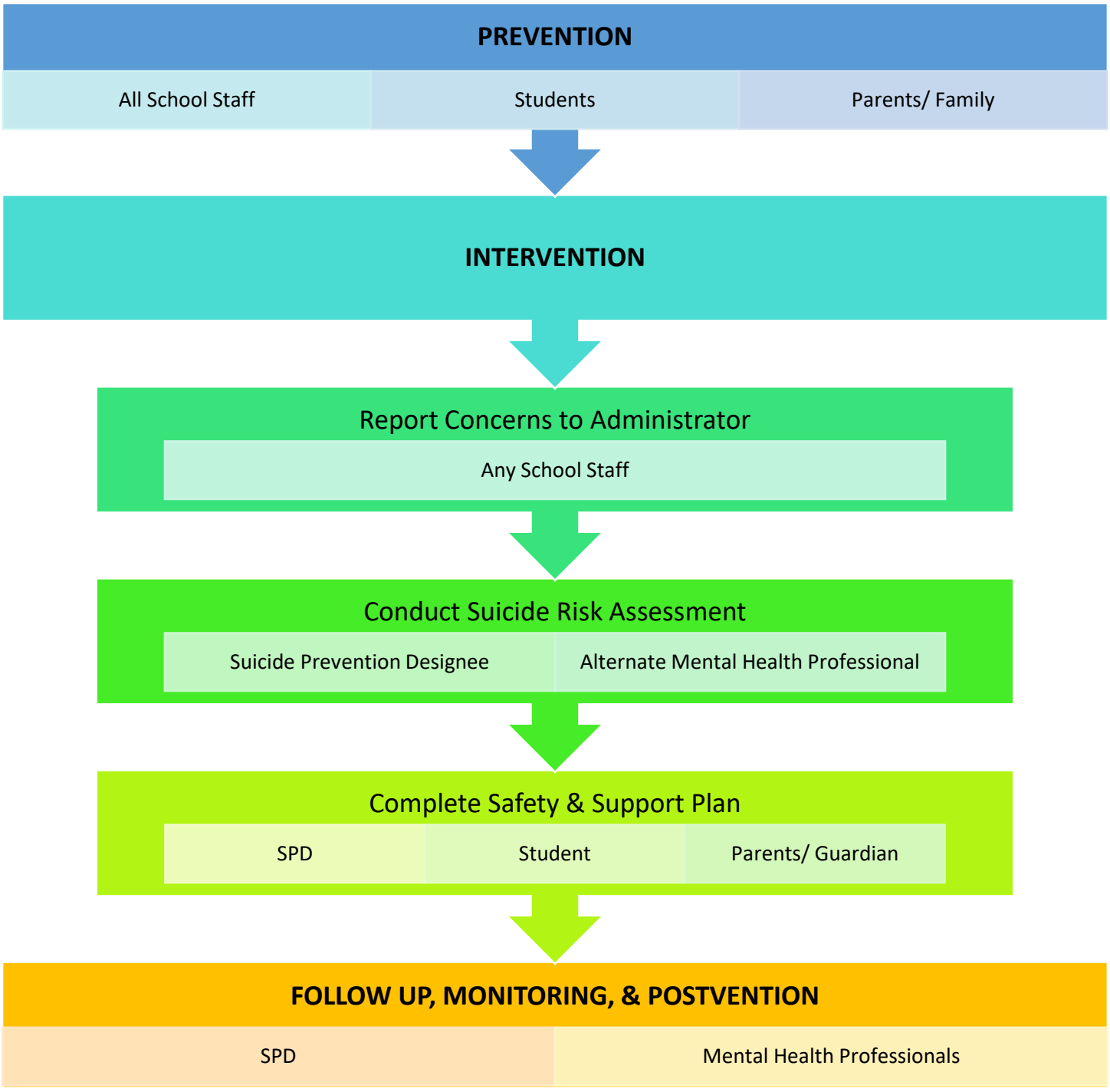
Deaths from youth suicide are only part of the problem. More young people survive suicide attempts than die. In addition, more youth are reporting that they have seriously thought about killing themselves and made a plan. Specifically, in the National High School Youth Risk Behavior Survey (YRBS)[11], administered by the Centers for Disease Control and Prevention in the Spring of 2019, the following data was revealed. The data was compiled and released in the Fall of 2020. The YRBS for Broward County revealed that 10.9% of students reported attempting suicide in the previous 12 months. In the survey, 3.7% of youth reported a suicide attempt that needed to be treated by a doctor or nurse. In 2019, 18.6% of students reported seriously considering suicide during the 12 months before the survey. Finally, 14.2% of students reported that they had made a plan on how they would kill themselves within the past 12 months.

What is also important to note from the YRBS is that just in Broward County, 36.9% of high school students reported feeling sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey. This number is significantly higher than it has ever been in the history of the survey. The work of suicide prevention is more important than ever.

The CDC also administers a similar survey to middle school students called the National Middle School Youth Risk Behavior Survey[4]. This data was collected in the Spring of 2019 and released in the Fall of 2020. 24% of middle school students reported seriously thinking about killing themselves. 15.5% of middle school students reported making a plan about how they would kill themselves and 9% of middle school students reported ever trying to kill themselves. It is important to note that this data cannot be compared to the high school data, as middle schoolers were asked to report on suicidal thoughts, ideations, and attempts in their lifetime, whereas high schoolers were asked to report on the previous 12 months.

In 2019, a collaboration between the American Foundation for Suicide Prevention (AFSP), the American School Counselor Association (ASCA), the National Association of School Psychologists (NASP), and The Trevor Project published a document called *Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources*[1] that outlines model policies, best practices, and a common language for school districts to follow while implementing suicide prevention programs. This manual incorporates recommendations from this model policy and the latest in practice and research in suicide prevention and assessment. Additionally, this manual and provides guidance and current procedures for Suicide Risk Assessment (SRA) in Broward County Schools.

SUICIDE PREVENTION PROTOCOL FLOWCHART



CHAPTER 1: SUICIDE RISK ASSESSMENT BACKGROUND INFORMATION

POLICY AND LAW

The *Marjory Stoneman Douglas High School Public Safety Act* (SB 7026) took effect on March 9, 2018 and was amended on May 9, 2019 (SB 7030). The School Board of Broward County adopted SBBC 2130, Behavioral Threat Assessment Policy, in March 2019. Both the legislation and policy outlined mandates for threat assessment procedures responding to all threats, including those who pose a threat of harm to self. Both the law and the policy state that the threat assessment team shall include persons with expertise in counseling, instruction, school administration, principal, when available, and law enforcement. Persons with expertise in counseling include school counselors, school psychologists, school social workers, and family counselors. Additionally, SBBC 2130 instructs threat assessment teams to ensure safety and refer to school-based Suicide Prevention Designee for students deemed a threat to self. The SPD or alternate mental health professional will conduct a Suicide Risk Assessment (SRA) to determine the level of threat, intervene, and coordinate safety planning. SBBC 2130 states, "If an immediate mental health or substance abuse crisis is suspected, school personnel must follow policies to engage behavioral health crisis resources, including, but not limited to, mobile crisis teams and school resource officers, who have been trained in crisis intervention. These individuals shall provide emergency intervention and assessment, make recommendations, and refer the student for appropriate services."

The Florida Legislature passed SB 1418 on June 25, 2019. SB 1418 amends section (s.) 1012.583, Florida Statutes (F.S.), by requiring the Florida Department of Education (FLDOE) to develop a list of approved suicide screening instruments and establish additional criteria and posting requirements for "Suicide Prevention Certified Schools." The FLDOE, Office of Safe Schools has identified approved suicide risk assessment instruments and youth suicide awareness and training. The Broward County School's SRA module incorporates key components of the Columbia-Suicide Severity Rating Scale (C-SSRS) and Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) as part of a comprehensive assessment of suicide risk.

The FLDOE recommends that youth suspected of suicide risk be referred to a school-based mental health services provider (i.e., FLDOE-certified school psychologist, school social worker, school counselor or licensed mental health provider) for a suicide risk assessment using one of the approved instruments. The FLDOE also recommends that each district adopt a policy requiring a suicide risk assessment by a school-based mental health services provider prior to the initiation of an involuntary examination (Baker Act).

DEFINITIONS

Risk Factors: Characteristics associated with suicide- or conditions that increase the chance that a person may try to take their life. These can include environmental factors such as stressful life events, health factors such as mental health conditions, and historical factors such as family history of suicide. It is important to note that risk factors are not necessarily causes of suicide, but an individual may have a higher chance of suicidal ideations.

Protective Factors: The personal or environmental characteristics that protect individuals from suicide and assist in dealing more effectively with stressful events.

Warning Signs: Signs that indicate an immediate risk of suicide such as talking about suicide, researching ways to end one's life, and dramatic changes in mood and/or behavior.

Non-Suicidal Self-Injury (often referred to as self-harm): Any purposeful behavior that brings harm to one-self. The intention is not to end one's life. The purpose of non-suicidal self-injury could be an attempt to manage painful feelings, to gain a form of control in their life, to punish one-self, to exert influence over others, or to feel a sense of relief. Common forms of non-suicidal self-injury are cutting, burning, starving one-self, sabotaging relationships, pulling out hair, etc.

Suicidal Ideation: Refers to thinking about, considering or planning suicide.

Suicidal Threat: Direct or indirect verbal statements or behaviors that may indicate serious intent to kill oneself. Direct verbal statements could include, "I am going to kill myself" and "I want to die." Examples of indirect verbal statements could include, "I am such a burden to my friends and family" and "I wish I would never wake up."

Suicide Attempt: Is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury**.**

Completed Suicide: Purposeful self-injurious acts that resulted in loss of life.

Postvention: Intervention strategies that address the grief process for students and staff following a death by suicide.

FACTS AND MYTHS ABOUT SUICIDE

Suicide affects all people. Debunking common myths associated with suicide can help society understand the importance of promoting others to seek treatment and highlights the importance of addressing their mental health challenges.

Here are some of the most common myths and facts about suicide: [2,5,8,18].

MYTH: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

FACT: Talking about suicide provides the opportunity for communication. Fears shared are more likely to diminish. The first step in encouraging a person with thoughts of suicide to live comes from talking about those feelings. A simple inquiry about whether the person is intending to end their life can start the conversation. However, talking about suicide should be carefully managed, with a focus on listening, empathizing, and connecting the student to appropriate supports.

MYTH: Young people who talk about suicide never actually attempt or die by suicide.

FACT: Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Those who are most at risk will show other signs apart from talking about suicide.

MYTH: Suicide attempts or deaths happen without warning.

FACT: The survivors of a suicide (a survivor, in this context, is someone that has lost a loved one to suicide) often say that the intention was hidden from them. It is more likely that the intention was just not recognized. Many people who die by suicide do give warnings, such as making indirect statements, withdrawing from friends or discontinuing pleasurable activities, or not taking care of themselves. That is why it is so important to educate and be aware of the most common warning signs. They are described in detail later in this manual.

MYTH: If a person attempts suicide and survives, they will never make a further attempt.

FACT: A suicide attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each future suicide attempt.

MYTH: Once a person is intent on suicide, there is no way of stopping them.

FACT: Suicides can be prevented. People can be helped. Suicidal crises can be relatively short-lived. Immediate practical help such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or die by suicide. Such immediate help is valuable at a time of crisis, but appropriate counseling will then be required.

MYTH: People who threaten suicide are just seeking attention.

FACT: All suicide attempts must be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-seeking device. It is likely the young person has tried to seek help and may have been dismissed therefore, this attention is needed. The attention they get may well save their lives.

MYTH: Suicide is hereditary.

FACT: Although suicide can be over-represented in families, attempts are not genetically inherited. Members of families share the same emotional environment, and the death by suicide of one family member may well raise the awareness of suicide as an option for other family members.

MYTH: True depression is rare in young people.

FACT: Depression is common in adolescents. Remember, 36% of high school students in Broward County alone, self-reported symptoms of depression in the 2019 YRBS. It may manifest itself in ways which are different from its manifestation in adults, but it is prevalent in children and adolescents.

MYTH: Marked and sudden improvement in the mental state of an individual who attempted suicide following a suicidal crisis or depressive period signifies the suicide risk is over.

FACT: The opposite may be true. In the three months following an attempt, a young person is at most risk of dying by suicide. The apparent lifting of the problems could mean the person has made a firm decision to die by suicide and feels better because of this decision.

MYTH: Young people thinking about suicide cannot help themselves.

FACT: While contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain full self-direction and self-management in their lives.

MYTH: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.

FACT: All people who interact with adolescents in crisis can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

MYTH: Most young people thinking about suicide never seek or ask for help with their problems.

FACT: Evidence shows that they often tell their school peers of their thoughts and plans. Most adults with thoughts of suicide visit a medical doctor during the three months prior to killing themselves. Adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others.

MYTH: Young people thinking about suicide are always angry when someone intervenes, and they will resent that person afterwards.

FACT: While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned sometime later, the vast majority express gratitude for the intervention.

Myth: People who die by suicide are selfish and take the easy way out.

FACT: Typically, people do not die by suicide because they do not want to live—people die by suicide because they want to end their suffering. These individuals are suffering so deeply that they feel helpless and hopeless. Individuals who experience suicidal ideations do not do so by choice. They are not simply, "thinking of themselves," but rather they are going through a very serious mental health symptom due to either mental illness or a difficult life situation.

Myth: The most common method of death by suicide in adolescents in drug overdose.

FACT: The most common method of death by suicide in adolescents is gun violence, followed by hanging.

AT RISK STUDENT POPULATIONS

It is important for schools and mental health professionals to be aware of the student populations that are at a higher risk for suicidal ideations and behavior. *The Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources*[1] publication defines these specific populations:

Youth Living with Mental and/or Substance Use Disorders
Mental health conditions, in particular depression/dysthymia, attention-deficit hyperactivity disorder, eating disorders, intermittent explosive disorder, and conduct disorder are important risk factors for suicidal behavior among young people. Although mental health conditions are a risk factor for suicide, the majority of people with mental health concerns do not engage in suicidal behavior.

Youth Who Engage in Self-Harm or Have Attempted Suicide
Suicide risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources (e.g., transportation, insurance, copays, parental consent, etc.).

Youth in Out-of-Home Settings
Youth involved in the juvenile justice or child welfare systems have a high prevalence of risk factors for suicide. As much as 60 to 70 percent of young people involved in the juvenile justice system meet criteria for at least one

psychiatric disorder, and youth in juvenile justice residential programs are three times more likely to die by suicide than the general youth population.

Youth Experiencing Homelessness

For youth experiencing homelessness, the rate of self-injury, suicidal ideation, and suicide attempts is over two times greater than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorder, and post-traumatic stress disorder.

American Indian/Alaska Native (AI/AN) Youth

In 2017, the rate of suicide among AI/AN youth ages 15-19 was over 1.6 times that of the general youth population. Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma.

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

The CDC finds that LGBTQ youth are 4.5 times more likely, and questioning youth are over twice as likely to consider attempting suicide as their heterosexual peers. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. It is not their sexual orientation or gender identity that place LGBTQ youth at greater risk of suicidal behavior, but rather these societal and external factors: the way they are treated, shunned, abused, or neglected, in concert with other individual factors such as mental health history.

Youth Bereaved by Suicide

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

Youth Living with Medical Conditions or Disabilities

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive delays that make problem-solving a challenge, and other chronic limitations.

CHAPTER 2: SUICIDE PREVENTION

Preventing suicide is a priority and all stakeholders (i.e. parents, students, and staff) have a role in suicide prevention, including reporting suicidal concerns for students. Everyone at school can help save lives, identify students at risk, and get them help. Mental health professionals play a distinct role in suicide prevention within schools due to their specialized training. All mental health professionals must follow the district best practices and procedures for suicide prevention and consult with the Suicide Prevention Designee to implement the Suicide Prevention Protocol described in this manual. When a concern is identified, the administrator at the site will involve the appropriate mental health staff in the implementation of the Suicide Risk Assessment procedures including School Counselors, School Psychologists, School Social Workers, and Family Counselors.

ROLES AND RESPONSIBILITIES OF ADMINISTRATOR

- ❑ Respond to all reports where there is potential for harm to self
- ❑ Identify a Suicide Prevention Designee (SPD) and a secondary designee, who is equipped to take appropriate steps to address suicide risks that arise to ensure student safety.
- ❑ Ensure that the SPD and secondary designee attend Suicide Assessment for Mental Health Professionals training. Sessions will be scheduled throughout the academic year. The training is 3.5 hours.
- ❑ Notify the ESLS SEDNET department at 754-321-3421 of the SPD
- ❑ Notify all school staff of the SPD and secondary designee and how to contact them during a suicide related crisis.
- ❑ Training is also available for all school staff and takes approximately 1 hour. Administrators can request training at a school based on availability.

ROLES AND RESPONSIBILITIES OF SUICIDE PREVENTION DESIGNEE (SPD)

- ❑ Acts as the primary person trained to assess and intervene in suicide related incidents.
- ❑ Assess students identified as exhibiting behaviors suggesting they may be at risk for suicide.
- ❑ Due to the significance of the role of SPD, potential candidates:
    - o Must be trained in a mental health related field
    - o Must be comfortable asking probing questions to determine risk of suicide
    - o Must be full time staff to ensure availability if an incident arises
    - o Must become familiar with the Suicide Prevention Manual
    - o Must attend SRA training

ROLES AND RESPONSIBILITIES OF OTHER MENTAL HEALTH PROFESSIONALS

- ❑ Identify students at-risk for mental health concerns
- ❑ Provide direct support to students
- ❑ Refer children and families to resources, often through the Behavioral Health Partnership
- ❑ Train school staff on risk factors, protective factors, warning signs and SRA procedures
    - o The District's Suicide Prevention Specialists may also assist with training staff and suicide risk presentations
- ❑ Conduct suicide risk assessments
    - o When considering the most appropriate staff to conduct the SRA, the SPD should be considered first. However, there may be times that it is most appropriate for an alternate mental health professional to conduct the assessment. The SRA in the EdPlan module may ONLY be completed by a Mental Health Professional.

SUICIDE PREVENTION CURRICULUM

Crisis Connections[6] is a full-service resource center that operates several different hotlines and provides suicide and crisis intervention, school resources, professional training and continuing education, support groups, and referral services. The agency has created and published three suicide prevention training curricula that may be for use in suicide prevention and coping skills education for students. Schools interested in these curricula may reach out to the SEDNET office (754-321-3421) for more information.

- ❑ **Riding the Waves** is a developmentally appropriate student curriculum for 5th grade students. Lessons address healthy emotional development, depression, and anxiety. This curriculum's overarching goal is to build the emotional skills and coping skills within children to prevent suicide at its earliest stages. The curriculum contains 12 short (20-40 minutes) lessons that include interactive discussions and skill-building activities.

- ❑ **Look Listen Link** is a classroom-based prevention program for middle school students that consists of four 45-minute lessons that cover stress, anxiety, depression, and suicide prevention and skills practice. The students also learn suicide intervention skills. These trainings are designed so that classroom teachers or counselors can incorporate them into their health, social skills, or family life curricula. Students participate in discussions, interactive exercises, and role-play practice and observation. Look Listen Link has been designated as a "Best Practice program" by the *Suicide Prevention Resource Center*.

- ❑ **Helping Every Living Person (H.E.L.P.)** is a classroom- based prevention program for high school students that was developed in partnership with Look Listen Link. It consists of four 45-minute lessons that cover stress, anxiety, depression, and suicide prevention and skills practice. The students also learn suicide intervention skills. These trainings are designed so that classroom teachers or counselors can incorporate them into their health, social skills, or family life curricula. Students participate in discussions, interactive exercises, and role-play practice and observation. H.E.L.P. has been designated as a "Best Practice program" by the *Suicide Prevention Resource Center*.

RISK FACTORS

Life stressors, family factors, past suicidal behavior, psychiatric diagnosis (e.g., anxiety, depression, bipolar, personality disorders, and conduct disorders, have the highest rates of suicidal ideations and behaviors), academic difficulties and relationship troubles have all been found to be significant risk factors for completed and attempted suicide in children and adolescents[13].

Factors that may increase risk of suicide:

- ❑ Trauma (Post-Traumatic Stress Disorder)
- ❑ Individuals who are or have experienced physical, sexual, and/or emotional abuse
- ❑ Unexpected crisis, triggering events, or anniversaries of triggering events
- ❑ Chronic medical conditions
- ❑ History of suicide attempts or family history of suicide
- ❑ Substance abuse or misuse
- ❑ Mental health disorders (current or past)
- ❑ Impulsivity and recklessness

- ❑ Aggressiveness
- ❑ Low self-esteem
- ❑ Withdrawal/ isolation
- ❑ Lack of connection to school or community (bullying)
- ❑ Social pressure (athletics/ good grades/ good behavior)
- ❑ Access to lethal means
- ❑ Trouble with the law
- ❑ Lack of familial connection or family dysfunction
- ❑ Relationship troubles (more so with older students)

WARNING SIGNS

Between 50-75% of students give some type of warning of their suicidal intentions. Sometimes these are subtle hints, while other times it is direct statements or actions. The behaviors listed below may be some of the signs that someone is thinking about suicide[5,13].

Talking about:

- ❑ Wanting to die
- ❑ Threats/Suicidal Statements (i.e. "I want to die", "I wish I was never born", "I wish I could fall asleep and not wake up", "Everyone would be better off without me")
- ❑ Suicide in their school assignment (drawing or writing)

Feeling:

- ❑ Empty, hopeless, helpless, trapped, or having no reason to live
- ❑ Loss of interest in pleasurable activities
- ❑ Extremely sad, anxious, agitated, full of rage, or humiliated
- ❑ Being a burden to others
- ❑ Unbearable emotional or physical pain

Changing behavior, such as:

- ❑ End of life planning, such as writing a note or giving away prized possessions
- ❑ Changes in physical appearance, no longer taking care of themselves
- ❑ Changes in habits such eating, sleeping, behavior, or studying/ grades
- ❑ Withdrawing from friends, saying goodbye, or making a will
- ❑ Taking dangerous risks such as reckless driving
- ❑ Sudden personality changes
    - o May include aggression, hostility, agitation, impulsivity or rage
    - o On the other hand, may be euphoric or much more calm than usual (as they have made their decision and have a plan to end their pain)
- ❑ Loss of energy or being tired all the time
- ❑ Displaying extreme mood swings
- ❑ Using drugs or alcohol more often
- ❑ Researching or seeking lethal means

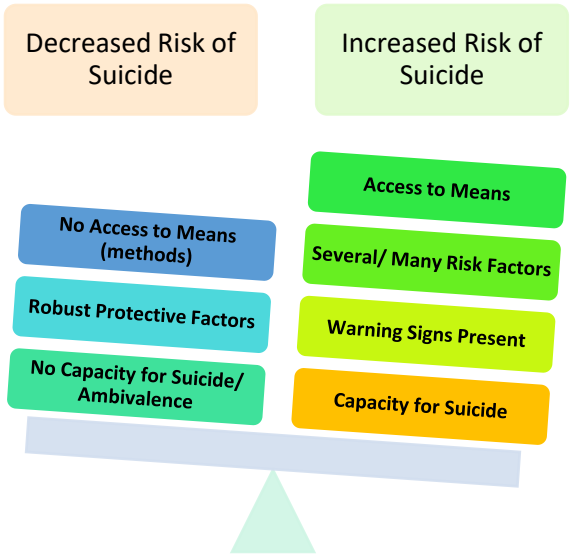
***For additional information on risk factors and warning signs, please refer to Appendix F**

PROTECTIVE FACTORS

It has been shown that having a presence of protective factors can create a buffer to the risk factors and reduce the potential risk of suicidal ideations and behaviors. A student that has many protective factors and a healthy support system can bounce back from difficult situations and often shows more resiliency than a student that has limited or no protective factors. Once a student is considered at risk, schools, families, and friends should work to build these factors in and around the student. While this list is not all-inclusive, some of the more common examples of protective factors are[1,5,8,13,18]:

- ❑ Family cohesion and parental/family support
- ❑ Effective coping skills and problem-solving skills
- ❑ Support from teachers and other relevant adults
- ❑ Positive relationships with peers
- ❑ Reduced access to means for suicidal behavior
- ❑ Impulse control
- ❑ Avoidance of alcohol and drugs
- ❑ Religious, spiritual and cultural beliefs that discourage suicide
- ❑ Participation in constructive recreation
- ❑ Stable and consistent living environment
- ❑ Access to effective mental and physical health care
- ❑ Strong sense of self-worth or self-esteem
- ❑ Sense of personal control or determination
- ❑ Sense of connectedness at school and in the community
- ❑ Responsibilities to others or pets
- ❑ Ambivalence

The Relationship Between Risk Factors and Protective Factors



CHAPTER 3: SUICIDE RISK ASSESSMENT (SRA)

OVERVIEW OF SRA PROCESS AND PROCEDURES

Broward School's SRA process involves: 1) gathering information about the incident, 2) screening, records review, clinical interview 3) analysis, determination of risk level, and interventions, and 4) creating a support plan.

Student Risk Intake Form

☐ Complete Student Risk Intake Form to assess the student's risk to self and/or others.
- ☐ If a threat to self is identified, follow the Suicide Risk Assessment (SRA) process below.
- ☐ Take immediate actions for imminent threats.

SRA Part 1: Information about the Event

☐ Prior to completing SRA Part 1on EdPlan, all team members must be added to the student of concern's team on the EdPlan Team and Family/Others tab

☐ **Information about the Event**

SRA Part 2: Mental Health Records Review and Clinical Interview

☐ **Initial Screener**
☐ **Mental Health Records Review**
☐ **Interviews and Artifacts**

SRA Part 3: Analysis, Risk Level, and Interventions

☐ **Risk Factors and Warning Signs**
☐ **Protective Factors**
☐ **Additional Contributing Risk Factors**
☐ **Capacity to Carry Out Self Harm**
☐ **SEDNET Reporting**
☐ **Determination of Risk Level**
- ☐ Unfounded risk
- ☐ Low risk
- ☐ Moderate risk
- ☐ High Risk

☐ **Parent Notification**
☐ **Mandatory Actions**
☐ **Additional Responses**
☐ **Meeting Participants**

Safety and Support Plan

☐ **Mandatory Actions with Student**
☐ **Safety and Support Plan Steps**
☐ **Meeting Participants**

SUICIDE RISK ASSESSMENT PROCEDURES

Broward County Public School's SRA process involves: 1) gathering information about the incident, 2) records review and information gathering (clinical interview), 3) analysis, determination of risk level, and interventions, and 4) creating a safety and support plan. Overall, the corresponding school's SRA Team will utilize these procedures to evaluate the presence of factors that indicate whether suicide might be a possibility and develop risk management strategies to reduce risk of suicide. EdPlan serves as the BCPS electronic platform for SRA records. When report of threat to self is received, SRA teams must follow procedures and complete all components below on the Risk Assessment tab in EdPlan.

ASSESSING FOR SUICIDE RISK

One of the most important steps in effective suicide prevention in schools is to identify who needs help. The SRA Module was developed using best practice standards and models from Columbia University, Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Suicide Prevention Lifeline (NSPL). The *Columbia Lighthouse Project*[6] developed the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS). The C-SSRS supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the tool ask people about suicidal ideation, preparatory steps, and suicide attempt.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA)[18], housed within the US Department of Health & Human Services "leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families." Their publication, Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)[15], provides brief overview on conducting a suicide assessment using a five-step evaluation and triage plan. The five-step plan involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan.

The National Suicide Prevention Lifeline (NSPL) developed a set of evidence-based Suicide Risk Assessment Standards to assess for suicide risk in their centers nationwide. Those core principals and subcomponents were used to create the Desire Capability Intent Buffers (DCIB) Suicide Risk Assessment[14]. When there is desire paired with capability and/or intent, this significantly increases the suicide risk and the impact of the buffers, or protective factors, must be considered.

THE SRA TEAM

The SRA team requires the participation of a mental health professional to conduct the assessment. For the purposes of support and safety planning, the team should also include the student and parent. The team may also include additional mental health professionals, administrators, and instructional staff. It may be important to consult additional personnel with knowledge of the student, such as teachers, ESE Counselors, Family Therapists, Behavior Specialists, or other professionals, in the case where the student has a specialized service assigned.

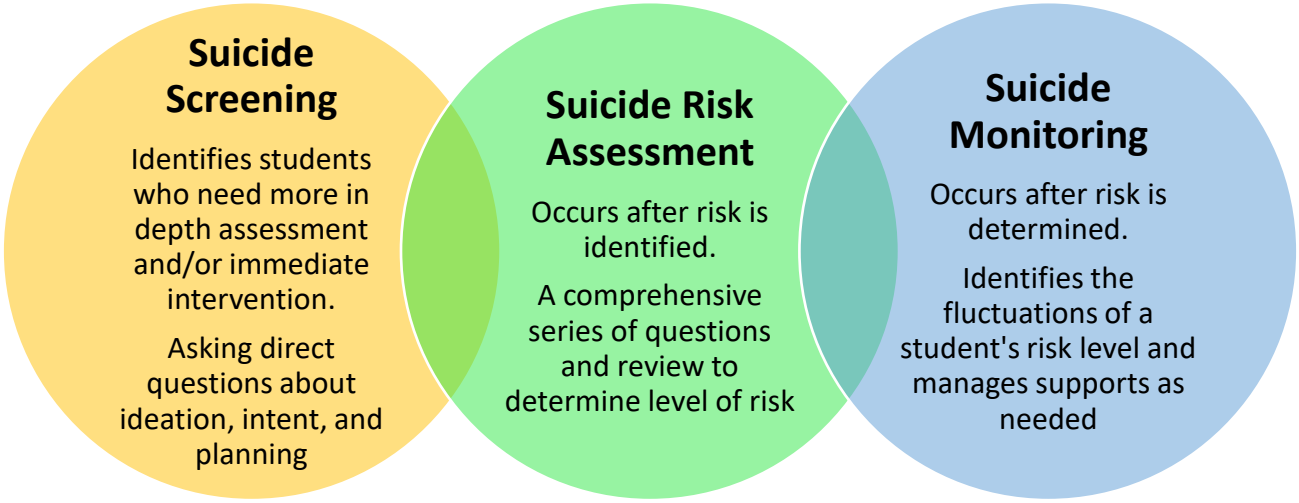
However, the following staff may conduct a suicide risk assessment:

- ❑ School Counselors
- ❑ School Psychologists
- ❑ School Social Workers
- ❑ Family Counselors

When determining who should conduct the suicide risk assessment or who should be consulted during the assessment, it is important to consider the following factors:

- ❑ Which mental health professional has built rapport with the student?
- ❑ Who the student feels most comfortable discussing sensitive topics?
- ❑ Who has completed training in suicide risk assessment?

SUICIDE RISK COMPONENTS



All components are embedded into the BCPS Suicide Risk Assessment Module for convenience and ease of reporting, documenting, and monitoring.

INTERVIEWING

There is no definitive way to approach inquiring about suicide, but it is essential that this is assessed in anyone who is demonstrating a pattern of warning signs. When assessing a student who may be at risk, the mental health professional may want to ask about several topics, starting with more general questions and gradually focusing on more direct ones, depending on the individual's answers. This must be done with respect, sympathy and sensitivity. It may be possible to raise the topic when the patient talks about negative feelings or depressive symptoms. It is important not to overreact even if there is reason for concern. Areas that you may want to explore include:

- ❑ Are they feeling hopeless, or that life is not worth living?
- ❑ Have they made plans to end their life?
- ❑ Have they told anyone about it?

- ❑ Have they carried out any acts in anticipation of death (e.g. putting their affairs in order)?
- ❑ Do they have the means for a suicidal act (e.g., do they have access to pills, insecticide, firearms…)?
- ❑ Is there any available support (e.g., family, friends, caregivers)?

Tips on asking the "suicide" question:

- ❑ Talk to the student in a private setting.
- ❑ Acknowledge that the student is in distress.
- ❑ Allow the student to talk freely.
- ❑ Stay with the student at all times.
- ❑ Take suicide statements seriously.
- ❑ Keep calm.
- ❑ Do not agree to keep the student's suicidal intentions a secret.
- ❑ Do not offer simple solutions to serious problems.
- ❑ Be direct: "Are you thinking of killing yourself?" instead of "You're not thinking of hurting yourself?"

When a student is at risk of suicide, this information should be recorded clearly in EdPlan. It important that the mental health professional share awareness of risk with other team members. Additionally, it is advisable to be open and honest with the student about your concerns regarding the risk of suicide and the procedure once they are deemed to be at risk.

AVOIDING COMMON PITFALLS

Always remain calm and patient. Do not act shocked or surprised. Take your time and avoid rushing through the questions. Addressing the student in a calm, caring, non-reactive manner may help put him/her at ease. At the very least you want to minimize the chances of increasing the feelings of hopelessness.

Never leave the student alone or send the student away. This may reinforce feelings of isolation and hopelessness.

Maintain privacy when talking to the student while also ensuring assistance is readily available if needed. When meeting with a student in an office, leave the door partially open or have a second staff person in the room if feasible.

Set expectations for confidentiality. Issues such as danger to self or others and physical and sexual abuse cannot be kept secret. If any adult in the state of Florida knows, or reasonably suspects, abuse or neglect of a child, he or she must report it to the Child Abuse Hotline: (1-800-962-2873). Follow District protocols for abuse reporting.

Be supportive. Let the student know that you care and are concerned for their safety. Assure the student that SRA is in no way disciplinary and is to help keep the student physically and emotionally safe at school.

Normalize the student's feelings. Not to be confused with normalizing suicide or suicide risk, as that would be counterproductive. However, normalizing the feelings that the student is having and that they are not alone in these feelings.

Always treat threats of suicide as real. Never dare a student to attempt suicide. Communicate that you respect the student's feelings. Assuming that a student is only seeking attention leads to under-reacting and reinforces the

student's feeling that no one understands or cares. Even if a student is seeking attention, you must act. The benefits could certainly outweigh the costs of not doing so. If a student has threatened suicide before, take each incident seriously. The student needs help.

Avoid debating with the student about whether suicide is right or wrong. The goal is to listen and show concern. Avoid discussing morality, the value of life and how such a tragic act would affect family and friends. Some people in the student's life may be contributing to the suicidal crisis, and the student may wish to hurt these people through suicide.

Never try to physically take a weapon from a student. Doing so could endanger your life, the life of the student, and the lives of other people. Immediately call for assistance from security/SRO, or if needed, 911.

ENGAGING PARENTS

Parents and guardians play a crucial role in the suicide risk assessment. Parent notification must occur when a student is determined to be at-risk for suicide, unless there is suspicion of abuse or neglect (in which case staff will follow District procedures for suspected abuse and neglect) or if the student is at the age of majority. If the student is at the age of majority and gives written consent the family can be contacted. Information regarding a child's suicidal risk may be difficult for a parent to hear. They may be in shock or disbelief. They may feel anxious or embarrassed. They may even feel guilty for not realizing what their child was going through. During parent notification, it is important to be supportive and understanding throughout the process and to maintain supervision for the child until the parent arrives at school. Be mindful of cultural differences and potential language barriers[8].

When the parent arrives at school, calmly and objectively explain the suicide risk determination, the partnership and role they play in the process, and what steps will be taken next. Parents and guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with resources and professional help when necessary. They can also contribute to vital protective factors and help build some social buffers and supports around their child. Parents and guardians should be advised to take every statement regarding suicide and a wish to die seriously. Ultimately, a parent's cooperation with assessment and safety and support planning will positively impact the student's success in intervention supports. SAMHSA[18] recommends the following tips for engaging parents that include, but are not limited to:

- ❑ Invite the parent's perspective. Ask them to state what behaviors they have been seeing at home and discuss what behaviors you have seen at school to find commonalities.
- ❑ Acknowledge and validate the parent's feelings, even if that is anger. State that this is very difficult and scary for everyone involved and you appreciate their presence or participation in this process.
- ❑ Align yourself with the parent, whenever possible. You are partners in keeping the student safe.
- ❑ Listen for myths of suicide and suicidal ideation that may be clouding their perspective and hindering them from taking the action steps.
- ❑ When a parent assumes the child is attention seeking, try to find something to agree on and move the conversation towards a direction that reiterates the goal of the assessment.
- ❑ Stress the importance of getting help and following through on referrals. Let the parents know what to expect from the referral process and that you will follow up with them in a few days.

A Note About Confidentiality

The SPD should be aware of confidentiality and its limits when sharing information with the parents/ legal guardians. As a Mental Health Professional, it is natural to feel as though sharing this sensitive information with the parents might damage the relationship with the student. However, in the case of suicide risk, it is necessary to break confidentiality in order to keep the student safe[17]. The SPD should always inform the student of the limitations of confidentiality prior to beginning a suicide risk assessment. While there may be a risk of damage to the counseling relationship when divulging this private information to their parents, this is manageable and reparable though clinical skills and interventions whereas a completed suicide is irreparable. A suicide risk assessment is an education record, which parents have the right to request at any time.

ASSESSMENT PROCEDURES

Accurate assessment of a suicidal student is a critical and necessary component of a comprehensive evaluation of children and adolescents. The goal of the suicide risk assessment process is to be preventative, not disciplinary. Having knowledge of the risk factors for suicide is a key prerequisite for assessing risk. School Counselors, School Psychologists, School Social Workers, and Family Counselors have training in suicide prevention and should follow the protocol outlined in this manual to assist a student who has been thinking about suicide. Additionally, the procedures outlined in this manual are based on best practice guidelines regarding suicide risk assessment.

Student Risk Intake Form

The Student Risk Intake Form is to be utilized to document the initial report of concern. The Student Risk Intake Form is the beginning of the process and will always lead to either a Behavioral Threat Assessment (BTA) and/or Suicide Risk Assessment (SRA). It is completed by a school-based administrator or mental health professional (SRA only) using information from the individual(s) making the report. This form must be listed as a finalized document on the EdPlan Documents tab.

- ❑ **Information About the Incident**
  - Today's Date
  - Who reported this initial concern?
    - Reporter Name
    - Affiliation to School
    - Contact Number
  - Who was this concern reported to?
    - Name of Individual
    - Affiliation to School
    - Contact Number
  - Date Reported
  - Time Reported (if known)
  - Date Administrator Learned of Incident
  - DMS Incident Number (only applicable for BTA process)
  - Date/Time of Incident
  - Location of Incident

- ❑ **Narrative Details:** Write a narrative below detailing the incident, threat to self, threat to others, and/or concerning behavior reported. Please include the location and time of the incident, threat, or concerning behavior. Determine if there are other individuals who witnessed the student engaging in threatening, aberrant, or concerning behavior. Where threats were communicated, quote where possible, and use quotation marks to indicate direct quote. Attach original documentation, if available, later in the BTA and/or SRA processes.

- ❑ **Primary Target(s):** If a threat to others has been made, has the intended target been identified?

- ❑ **Witness(es):** If additional witnesses were identified by the reporter, please list them.
  - Name of Witness
  - Affiliation
  - Contact Number

- ❑ If **both** a threat to self and others is selected, **both the BTA and SRA processes** must be completed. Each situation is unique and needs to be assessed to determine which process to follow first. If you require assistance, please contact the Psychological Services Department (754) 321-3440 and/or SEDNET Department (754) 321-3421.

- ❑ **Intake Outcome(s) Considerations**
  - **If** the individual is suspected of posing a **threat of harm to others**, then mobilize the threat assessment team and conduct BTA within 24 hours. Refer to the BTA manual for more specific procedures.

  - **If** the individual is suspected of posing a **threat of harm to self**, then ensure the student is medically safe, maintain adult supervision, and contact a Suicide Prevention Designee (SPD) or other mental health professional to conduct Suicide Risk Assessment (SRA) immediately.
    - **If imminent threat to self is suspected and if the student is on campus, follow Baker Act procedures immediately. If the student is not on campus, then contact law enforcement immediately.** If a Baker Act Assessment was initiated, document the name of the Baker Act Assessment Initiator, the date/time initiated, and the outcome of the Baker Act Assessment if known (e.g., Was the student transported to the hospital? Was the student hospitalized?).
    - **The following actions are also mandatory:**
      - Ensure the student is medically safe first.
      - Keep the student with an adult to provide supervision.
      - Contact the SPD or another mental health professional.
      - Contact the SRO, Local Law Enforcement or the Mobile Crisis Response Team at (954) 463-0911.
      - Notify parent of the at-risk student and attempt to enlist their support in creating a safety and support plan.
      - Schools should not contact the legal guardian to take the student off campus whether it is to their home or to a hospital.

  - If **both** a threat to self and others is selected above, **both the BTA and SRA processes** must be completed. Each situation is unique and needs to be assessed to determine which process to follow

first. If you require assistance, please contact the Psychological Services Department (754) 321-3440 and/or SEDNET Department (754) 321-3421.

SRA Part 1: Information about the Event

- ❑ Prior to completing SRA Part 1 in EdPlan, all team members must be added to the student of concern's team on the EdPlan Team and Family/Others tab (See APPENDIX A).
- ❑ In addition to initial information obtained through the Student Risk Intake Form, Part 1 documents more specific details regarding the incident and/or threat report and any immediate actions taken when an imminent threat has been identified. The SRA Part 1 is to be completed by the SPD or an alternate mental health professional using information from the individual(s) making the report. SRA Parts 1-3 must be completed within 24 hours of receiving the report.

- ❑ **Information About the Incident**
- ❑ Today's Date
- ❑ Who reported this initial concern?
    - Reporter Name
    - Affiliation to School
    - Contact Number
- ❑ Who was this concern reported to?
    - Name of Individual
    - Affiliation to School
    - Contact Number
- ❑ Date Reported
- ❑ Time Reported (if known)
- ❑ Date Administrator Learned of Incident
- ❑ DMS Incident Number (only applicable for BTA process)
- ❑ Date/Time of Incident
- ❑ Location of Incident
- ❑ What was the context for the suicidal actions, behaviors, statements, or thoughts?
- ❑ What was happening at the time and/ or just before?

SRA Part 2: Mental Health Records Review and Clinical Interview

- ❑ Please begin the assessment by establishing rapport and communicating the concern for the student's safety. For younger children or those with disabilities, utilize developmentally appropriate language.

- ❑ **Initial Screener**
    - The evidence-based Columbia Screener consists of yes/no questions to triage suicide risk.
    - At the conclusion of the screener, if imminent threat to self is suspected follow Baker Act procedures immediately. If it is determined that the student is not in imminent risk, continue the assessment by completing analysis and determination. If more information is needed to determine risk, additional tools are available on the Main Menu in the SRA tab.

- ❑ **Mental Health Records Review**
    - Write your name and the date and time that you entered the information below.

- Includes 4 questions to document any knowledge you have of the student's mental health history related to suicide and Baker Acts.
- If answered "Yes" to any of screener the questions, provide more information.
- Describe the student's mental history, if known in both school and community, including or history of suicidality.

❑ **Interviews and Artifacts**

- Additional interviews/assessment tools may be utilized to assist the team in answering analysis questions, determining risk level, and planning for support for the student (e.g., SAFE-T, Desire Capability Intent Buffers-DCIB). These can be found in the Suicide Risk Assessment tab of the EdPlan library on the Main Menu. Please upload all additional notes and/or assessments into EdPlan by clicking the + sign.
- Additional interviews/ assessment tools are optional. All interviews and documentation must be entered into EdPlan using the embedded interview. Any tools uploaded as a PDF will be considered in addition to the assessment in EdPlan.
- Artifacts related to suicide risk and assessment may also be uploaded in this section.

SRA Part 3: Analysis, Risk Level, and Interventions

❑ **Risk Factors and Warning Signs**

- Consider whether the setting around the student (e.g., friends, family members, coworkers, etc.) has exposed them to suicide as a way to cope or resolve problems.
- Consider whether the student appears to be expressing sentiments of finality or desperation to address their hopelessness or despair.
- Consider the level of violence to which the student has been exposed.
- Interview the student using the following 7 questions to determine risk factors and warning signs.

❑ **Protective Factors**

- The presence of resiliency factors can lessen the potential of risk factors to lead to suicidal ideation and behaviors. Once a child or adolescent is considered at risk, schools, families, and friends should work to build these factors in and around the youth (please utilize age appropriate language).
- Interview the student using the following 9 questions to determine resiliency factors. These may include family support, friendships, connections in school, cultural beliefs, coping skills, and access to resources.

❑ **Key Observations**

- Include important observations of the student from the interview (e.g., affect, demeanor, body language).

❑ **Additional Contributing Risk Factors:**

- Consider if the student has experienced recent stressors (e.g., failure, loss, and/or loss of status) and is having difficulty coping. Use all information gathered during this assessment and any prior knowledge to answer the following questions. These questions are not asked directly to the student, rather they are gathered using clinical observation form the interview, teacher reports, parent input, and/ or administrator input to identify and additional risk factors or potential triggers.

- **Capacity to Carry Out Self Harm:**
  - Please state the method that student is talking about that relates to suicide AND what accessibility does the student have to the means? Methods include:
    - Fire
    - Pill
    - Asphyxiation
    - Hanging
    - Poison
    - Self-Injury/ Cutting
    - Jump
    - Razor of Glass
    - Drug/ Alcohol
    - Knife
    - Drowning
    - Gun
    - Other (please specify)

- **Type of Suicide Risk**
  - Please identify the type of suicide risk the student is presenting with. Choose the highest level of risk based on the information gathered.
    - Ideation- thinking about, considering or planning suicide
    - Threat- expressive intent to hurt oneself or die by suicide
    - Self-Harm- hurting oneself without the intent to die
    - Attempt- a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior

- **Reasons for Suicide Risk** (select all that apply)
  - Identify all reasons for suicide risk based on information gathered.
    - Family Complications
    - Child Abuse
    - Loss of Relationship
    - School Problems
    - Bullying
    - Peer Issues
    - Loner
    - Low Self Esteem
    - Depression
    - Sexual Identity
    - Hearing Voices
    - Returning to School after Hospitalization
    - Returning to School after School Break
    - Other (please specify)

- **Determination of Risk Level**
  - Unfounded risk- No evidence of suicidal actions, behaviors, statements or thoughts could be identified
  - Low risk- Modifiable risk factors, strong protective factors; thoughts of death, no plan, intent or behavior
  - Moderate risk- The student presents with multiple risk factors with few protective factors. There may be suicidal ideation with a plan, but no intent or behavior.
  - High Risk- Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant, few protective factors; potentially lethal suicide attempt or persistent ideation with strong intent or suicidal rehearsal, plan

- **Parent Notification:**
  - Schools must notify the legal guardian when there is a concern regarding suicide. Schools should not contact the legal guardian to take the student off campus whether that is home or to a hospital prior to assessing for risk. The school is responsible to assess and take action once a concern has been reported or identified. Although the school must assess, a legal guardian can, once they arrive at the school, decide to take the student. The school should advise the guardian of the risk and concern for the student. Please be advised that while parental consent is not required when conducting a suicide risk assessment, parent notification is required.
  - Record the outcome of the notification, as well as the parent's response and involvement in the suicide risk assessment.

- **Mandatory Actions**
  - If the student is deemed by the SPD to be high risk for suicide or has engaged in a suicide attempt, administration will be informed immediately (following contact with any needed immediate medical emergency services) and Baker Act procedures.
  - Select mandatory interventions from the list provided and note who is the person responsible for each intervention

  - **Required for unfounded risk:**
    - The SPD or alternate mental health professional must meet with the parent/ guardian

  - **Required for Low Risk:**
    - The SPD or alternate mental health professional must meet with the parent/ guardian
    - Ensure student is medically safe
    - Never leave the student alone
    - Give emergency/ crisis numbers and information
    - Safety and Support Plan
    - The SPD informs administration of the outcome and any supportive steps that are being done for the student

  - **Required for Moderate Risk:**
    - The SPD or alternate mental health professional must meet with the parent/ guardian
    - Ensure student is medically safe

- Never leave the student alone
- Give emergency/ crisis numbers and information
- Safety and Support Plan
- The SPD informs administration of the outcome and any supportive steps that are being done for the student
- Referral to the school's Collaborative Problem- Solving Team (CPST)
- Referral to Family Counseling, School Social Worker, and/ or Behavioral Health Provider

- **Required for High Risk:**
  - The SPD or alternate mental health professional must meet with the parent/ guardian
  - Ensure student is medically safe
  - Never leave the student alone
  - Give emergency/ crisis numbers and information
  - Safety and Support Plan
  - The SPD informs administration of the outcome and any supportive steps that are being done for the student
  - Referral to the school's Collaborative Problem- Solving Team (CPST)
  - Referral to Family Counseling, School Social Worker, and/ or Behavioral Health Provider
  - Contact SRO, law enforcement, or Mobile Crisis team (Document Baker Act if initiated)

❑ **Additional Responses**

- In addition to the mandatory action steps, please identify responses that can help support this student and make positive outcomes more likely. The actions you select will comprise the Student Safety and Support Plan (SSSP). The resources and supports the student needs will differ depending on the information gathered during the assessment.
- Supports can range from holding a parent conference to creating a safety plan for the student. It is recommended that the original SRA team members help develop the student support plan with the inclusion of the parent/guardian. Some actions may need to be taken immediately (e.g., safety plan) while others (e.g., IEP meetings) may need to occur later.

❑ **Meeting Participants**

- Identify meeting participants and their role in the assessment. It is required that the SPD/Alternate mental health professional participates in the meeting
- Administrator participation is recommended but not required.

❑ **Next Steps**

- Attach the Signed SRA document
- Create Student Safety and Support Plan for Low, Moderate, and High Suicide Risk
- Has there also been a threat to others? If there is a threat to others, proceed to the BTA process.

CONSIDERATIONS FOR DETERMINATION OF RISK

Having the ability to accurately assess suicidality has been compromised by a lack of well-defined terminology and understanding as to what constitutes suicidal behavior. Consequently, behaviors that are not suicidal are labeled as such, while individuals who display suicidal behaviors may be missed, which leads to misinterpretation. Non-suicidal self-harm behaviors, such as "self-mutilation," done for reasons other than ending one's life, and suicidal acts are frequently mistaken for one another[8].

Suicide risk is not easily calculated with a quick algorithm or formula. Many factors can influence a student's risk of suicide at any given point in time. Assessment of risk level is based on clinical judgment. LOW risk does not mean NO Risk. Think of risk as a continuum to better understand how to intervene with a student in a given moment[8]. Two students may present with the same exact stressors, but after further assessment and interview, it is discovered that due to other risk factors, such as genetic predispositions, family structure, socio- cultural factors, or adaptiveness to stress, one student may be at higher risk for suicide than the other. Considering the same two students, one may have robust social supports, such as athletic coaches, healthy friendships, and a strong connection with a specific teacher at school that significantly reduce the risk of suicide. The other may have a single moment such as a loss, a breakup, a move, or another "last straw" that causes the student to cross a threshold and act on suicidal thoughts. It is important to not only consider the here and now, but also the history of the student and the factors that surround the student at school and outside of school. Suicide risk assessment is not absolute and clear, the manual serves to provide guidance and knowledge of suicide risk definitions and interventions, but it cannot overrule clinical decisions. SRA Teams should consider this additional information when determining level of risk:

Unfounded Suicide Risk- School staff should consider the circumstances surrounding a suicide assessment that is determined to be unfounded. The student may be demonstrating the need for intervention in other areas of behavioral health.

Low Risk- Students with low risk suicidality have passing ideations. These ideations do not interfere or create problems in the student's daily living. They do not have an intent or desire to die and there is no specific plan to die. They may have a few risk factors, but they also have enough protective factors that outweigh the risk factors or stressors that the student is experiencing[8].

Moderate Risk- Students with moderate risk suicidality have more frequent and more intense suicidal ideations. The student may have a method of suicide identified and begin to plan out the method. However, they report no immediate intent or true desire to die. They may have some risk factors and some protective factors, including ambivalence of suicide[8].

High Risk- Students with high risk suicidality have frequent and intense suicidal ideations and an intent to die. They have identified a plan of how they would die by suicide and availability/ access to the stated means. They have many risk factors and struggle to identify protective factors. Even if protective factors seem to exist, this student does not relate to them as protective factors[8].

IMMINENT RISK

Once it has been determined that a student is in imminent danger, Suicide Prevention Designee/Alternate Mental Health Professional will immediately inform the principal or administrative designee to determine and implement the next steps:

- ❑ Imminent risk is evident when a child is in immediate danger of harming themselves.
- ❑ Ensure the student is medically safe first.
- ❑ Maintain adult supervision. Never leave the student alone.
- ❑ Contact the Suicide Prevention Designee or another mental health professional.
- ❑ Contact the SRO, Local Law Enforcement or the Mobile Crisis Response Team at 954-463-0911.
- ❑ Notify parent of the at-risk student and attempt to enlist their support in creating a safety and support plan.

BAKER ACT PROCEDURES

The Florida Mental Health Act

F.S. Chapter 394, Part I Information

- **PURPOSE**
  - The Florida Law recognizes that some mentally ill persons (adults and children) may need to be involuntarily admitted to a mental health facility for evaluation and short-term treatment. In such instances a person can be admitted involuntary **only if there is a reason to believe they are mentally ill and without care and treatment, they are likely to suffer from substantial harm or are more likely than not to inflict serious, unjustified harm to another person.**

- **INVOLUNTARY EXAMINATION CRISIS**
  - A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he/she is mentally ill (See F.S. 394.463) and because of his/her mental illness:

  - He/She has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination:

OR

  - He/She is unable to determine for him/herself whether examination is necessary:

AND

  - Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his/her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services:

OR

  - There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

- **RULES**
  - The Baker Act Process is to be considered a resource of last resort.
  - This procedure is applicable only to children and adults who display "mental illness" as defined in Florida Statutes and who refuse voluntary examination or admission to a mental health facility. **F.S. 394.455 (18) states** *"mentally ill" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purpose of this part, the term does not include a developmental disability as defined in Chapter 393, intoxication, or conditions manifested only by anti-social behavior or substance abuse impairment.*
  - The Baker Act procedure must not be considered or implemented as a regular school behavioral intervention such as "time out" or "isolation". Neither may it be used only for removing the child or adult from the school campus or for disciplinary reasons. This civil procedure is intended to protect children from harm to themselves or others, and to obtain emergency mental health treatment.

- **PROCEDURES**
  - The principal, or administrative designee has primary responsibility for the Baker Act process. The principal will receive information about the Baker Act process from a suicide prevention designee trained in a mental health field and assigned to the school on a full-time basis (such as a school counselor).
  - To help determine if a student is in danger of hurting himself/herself or others, the principal or administrative designee will involve appropriate school-based personnel (e.g. suicide prevention designee, school social worker, school counselor, family counselors) to conduct a Suicide Risk Assessment. These individuals, other school personnel (e.g.,ESE specialist, school resource officer, behavior specialist, and/or peer counseling coordinator), and parent may need to assist in de-escalating the student. If de-escalation is not successful, the principal or designee will, based on their own observation and input from involved personnel, determine if there is a need to proceed with contacting the Mobile Crisis Response Team, School Resource Officer (SRO) or local law enforcement.
  - The principal or administrative designee will discuss behavioral interventions with school-based student services staff and will together decide the appropriate course of action
  - The principal or designee will call the parent, if parent contact has not yet been made. Parent contact must be completed except in extraordinary circumstances. (i.e. student is of age of majority, student is alleging abuse/or neglect by legal guardians). Multiple efforts to contact parents must be documented.
  - While in the process of assessment for lethality (meeting Baker Act criteria), the student must remain under the care and supervision of designated school personnel and is not to be released to guardian/caregiver.
    - Only after an assessment has been completed and documented by qualified school personnel, ascertaining said student does not appear to pose an immediate danger to themselves or others is the student to be released to the custody of their guardian/caregiver.
    - In the event a guardian/caregiver wishes to remove the student from school before an assessment has been completed, school personnel will utilize the assistance of the School Resource Officer (SRO), School Special Investigation Unit officer (SIU), or other law enforcement officials to ensure the assessment is completed before the guardian/caregiver removes the student from the school grounds.
    - After the above interventions, if it is determined the child is a danger to him/herself, the school's designee may:
      - Request the SRO or other law enforcement official transport the student to the nearest receiving facility.
      - Alternatively, the designee may contact the Mobile Crisis Response Team at 954-463-0911. This service offers mobile crisis intervention support 24/7 for youth and families throughout Broward County. If the Mobile Crisis team determines the student meets the criteria for an involuntary evaluation under the Baker Act and possible placement is needed, they will complete the necessary Baker Act documentation and can arrange for transport of the student to a Baker Act receiving facility if needed.
  - School personnel can assist in requesting transport of students to a receiving facility. Transport may be requested from the Broward Sheriff's Office (BSO) by calling the dispatcher at (954) 764-

4357 and selecting the option for situations requiring the involvement of a law enforcement officer. Alternative transport options include local municipal police or SRO/SRD.

- The principal or administrative designee will ensure interventions/outcomes are documented, and the Suicide Prevention Designee or alternate mental health professional submits an entry within EdPlan within 24 hours.
- For each student admitted to a receiving facility under the provisions of the Baker Act, the SPD will provide follow up contact with the parent/caregiver and facilitate the student's transition from the receiving facility back to the school. Upon return to school, the SPD and other school staff must be available to help support the student. School staff can not prohibit a student returning to school because of a Baker Act.
- Schools cannot require any documentation from the hospital for any reason. Although, clinical staff at schools can discuss with the legal guardian the possibility of signing a consent to communicate with the Baker Act receiving facility.

❑ **CASE MANAGEMENT**

- SEDNET Case Manager will receive Baker Act notification from the District and track entries in EdPlan. The SEDNET Case Manager offers supports in the following ways:
  - Contact Suicide Prevention Designee (SPD) to ensure that information is documented in EdPlan, including the supports offered to the student and family.
  - Contact the family to ensure that supports have been offered and accessed, as well as discuss any other family needs.
- If a Baker Act is initiated for a student who is a threat to others, refer to The District Threat Assessment Procedures Manual[3].

NOTE: The exception to the Baker Act guidelines is that any licensed clinician providing services in any Broward County Separate Day School (this means SED and IND Centers) can initiate a Baker Act if:

- ❑ the clinician has taken the required Baker Act training course and
- ❑ the clinician believes the student meets criteria under the Baker Act and
- ❑ the clinician feels that they are equipped based on their training and skills.

No administrator can require a clinician or officer to initiate a Baker Act. The clinician or officer will use their professional skills to assess the needs of each individual.

CHAPTER 4: SAFETY PLANNING AND POSTVENTION

Once it is determined that a student is having suicidal ideations or behaviors, it is necessary for the Suicide Prevention Designee or other Mental Health Professional to establish a Safety and Support Plan with the student. This may include interventions such as having a mentor, identifying places to go or people to call when feeling overwhelmed and/ or identifying individual coping strategies. The Safety and Support Plan is completed in EdPlan with collaboration from the student and/ or family. It may be printed out for the student to take with them and have on hand.

Remembering that suicide risk is a fluctuating continuum, it is important that school staff continue to monitor and check in with the student throughout the implementation of the Safety and Support Plan. A Safety and Support Plan must be implemented for all Low Moderate and High Suicidal Risk.

SAFETY AND SUPPORT PLAN

- ❑ Forms are to be entered into EdPlan. If printed forms are utilized, the information must be entered into EdPlan.
- ❑ **Actions with Student**
  - Complete a checklist of the mandatory action steps that were completed following the SRA and any additional responses completed.

- ❑ **Safety and Support Plan Steps**
  - The safety and support plan should be completed with the student. Complete 6 steps that summarize the warning signs, coping strategies, and interventions or actions that the student will take when needing distraction or support. The forms provide general strategies for intervention; however, it is not an all-inclusive list or mandated list of interventions. The mental health professional, student, parent, or other meeting participants may add strategies not provided on the form by using the "other" option.

- ❑ **Step 1: Warning Signs for the Student**
  - Identify all warning signs from the list below:
    - Substance abuse
    - Hopelessness
    - Helplessness
    - Overwhelming guilt/ shame/ self- hate
    - Themes of death
    - Agitation
    - Recklessness/ aggression
    - Behavioral changes
    - Altered sleep/ eating
    - Statements/ ending it all
    - Threats
    - Researching/ rehearsing methods
    - Feeling trapped
    - Giving possessions away

- **Step 2: Internal Coping Strategies**
  - Identify things the student can do to take their mind off problems without contacting another person from the list below.
    - Affirmations
    - Belly breathing/ Using imagination
    - Journaling
    - Counting
    - Positive problem solving
    - Positive self- talk
    - Progressive Muscle Relaxation
    - Talking about feelings
    - Mindfulness activity/ app
    - Visualization
    - Other (please explain)

- **Step 3: People and Social Setting that Provide Distraction**
  - Identify people and places that provide distraction, such as the gym, a local park, a parent, a friend, etc. Write the name and either phone number or address.

- **Step 4: People I Can Ask for Help**
  - Identify people that you can ask for help, such as a teacher, neighbor, coach, or religious figure. Write their name and phone number.

- **Step 5: Professional or Agencies I Can Contact During a Crisis**
  - Identify any professionals or agencies, either new or already working with, that can be contacted during a crisis. Always include the Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), the Crisis Text Line (Text "FL" to 741741, 211, and the Mobile Crisis Response Team: 954-463-0911.

- **Step 6: Making the Environment Safe**
  - What do I need to change in my environment to help me be safe when I am in distress?

- **Meeting Participants**
  - Identify meeting participants and their role in the safety and support plan. It is required that the SPD participates in meetings, administration and parent involvement is recommended but not required.

RE-ENTRY CONSIDERATIONS

For students who have experienced a crisis or hospitalization, a mental health professional should meet with the student, parent/guardian, and any community or other health care providers (with consent from parent) to plan and discuss supports needed for transition back into the school environment.[1] If the Student Safety and Support Plan has not been finalized, enlist the support of the parent and any additional staff to create an appropriate plan

for the student. The team may consider supporting the student with potential questions or reactions from peers who may be privy to the crisis. The school mental health professional will be available to discuss any concerns and/or questions from teachers. It is important to note that the school may not deny a student re-entry to the school environment or place any conditions on re-entry.

POSTVENTION

The *Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources*[1] publication describes postvention as "a crisis intervention strategy designed to assist with the grief process following suicide loss." Postvention activities are critical to helping the school community cope with distress and prevent possible suicide contagion. Schools must identify those students who are most vulnerable following a death by suicide. This may include students with physical proximity, emotional proximity, and pre-existing mental health concerns or trauma. Postvention activities should also address the social stigma associated with suicide and disseminate factual information after the death of a member of the school community [1,2].

When a student dies by suicide, school staff must refer to the *BCPS Crisis Response and Recovery Handbook*, which can be accessed by clicking here. This handbook covers required procedures for administration and the SPD, letters that can be sent to families, and tip sheets, as well as activities that staff can do to engage students in appropriate conversation and understanding of suicide.

While the Suicide Prevention Designee and other Mental Health Professionals are engaged in supporting others, it is especially important to remember to practice self-care during a period of postvention. Remember:

Physical self-care: Maintain healthy eating habits and drink plenty of water; limit the use of alcohol or other substances; adequate sleep; exercise.

Emotional self-care: Know your limitations; recognize that your reactions are normal and occur frequently among caregivers, including many well-trained crisis professionals.

Social care and connection: Maintain normal daily routines; connect with trusted friends or family; process or debrief the events at the end of each day with other caregivers or colleagues.

FREQUENTLY ASKED QUESTIONS

GENERAL

What is a SEDNET referral?

SEDNET referrals are generated by hospitals and treatment facilities at the discretion of their clinical team during discharge planning. Not all students who are hospitalized under the Baker Act will receive a SEDNET referral. Hospital clinical staff determine if a SEDNET referral is warranted based on review of available information. If the student's emotional well-being and academic functioning may be significantly impacted by the student's condition, a SEDNET referral is generated. For more specific information please contact the SEDNET office at 754-321-3421.

SUICIDE PREVENTION

How can school staff receive training on Suicide Prevention?

Schools requesting suicide prevention training for staff should contact 754-321-3421. The SEDNET office has presentations available on suicide prevention and will collaborate with school-based or District assigned personnel for staff training. Staff training should include all staff who work on the campus.

BAKER ACT

How should we respond to reports of a Baker Act that took place outside of school hours?

If a student was Baker Acted for suicidal risk outside of school hours and there is a continuing concern for safety or suicide risk, upon receiving the report of the Baker Act, the SPD or alternate mental health professional should to conduct the SRA using information from the parent/guardian and the student in order to gain information for safety planning. The screener questions in these cases may be answered N/A, unless there is a concern for imminent danger, in which case the screener questions should be asked to determine intervention.

How should we respond to reports of a suicidal threats that happen off campus?

It is the responsibility of the school to respond to all reports of a threat, regardless of the location of the event. If there is any concern about a student's potential harm to self, the mental health professional or SPD must complete an SRA to determine the level of risk and interventions. If there is imminent danger, call 911.

PROCEDURES

Can other school counselors at the school complete a suicide risk assessment in EdPlan besides the SPD? What if the SPD is not present at school the day an incident occurs?

Yes, alternate mental health professionals, may complete a Suicide Risk Assessment. Considerations, such as which professional has the best rapport with or most historical knowledge of a student should be taken in account when deciding who should complete the assessment. There is not a one size fits all method for determining who completes the interview and assessment. Mental health professionals who see

How many adults should be with the student while completing an SRA?

School teams must use your professional discretion to determine what is best for the student in any given situation without compromising safety. Every situation is unique, and a student may feel more or less comfortable with another adult in the room depending on their relationship with you and others. If a student requests a specific teacher, counselor, or administrator be present, the mental health professional should do their best to accommodate the request. However, it will not always be possible to do so.

How involved should students be when creating the safety and support plan in EdPlan?
The student should be an active participant in their own safety and support planning to the maximum extent possible. However, the level of participation and language use during the discussion may vary based on the age and capacity of the student. The mental health professional or SPD should have a dialogue or brainstorm with the student about what strategies work best for them.

Is a parent required for safety planning?
While it is best practice to involve a parent in safety planning at school for their child, parents are not required to participate. However, it is the responsibility of the school to keep students safe. If a parent chooses not to participate in safety planning, we must do our best to educate, keep an open dialogue, and provide resources.

What should I do when a student requests the parent not be informed?
While some information is confidential, we cannot make promises that we won't inform the parents about a student who is at-risk for suicide. If a student discloses any suicidal ideation, plans, or actions, we must inform the parent and document this notification in EdPlan. We should be transparent with the student about the requirement for notification.

What should an SPD do if they hear of a threat from another student?
It is the responsibility of the school to respond to all reports of a threat. If there is any concern about a student's potential harm to self, the mental health professional or SPD must complete an SRA to determine the level of risk and interventions.

EDPLAN

Should I document a suicide risk assessment in the Suicide Database or in EdPlan?
All suicide risk assessments will be completed within EdPlan only.

Who can initiate a Student Risk Intake Form for threat to self?
A school administrator or mental health professional conducting the assessment may initiate an intake form for the SRA. Ensure that everyone on the SRA Team has been added using the BTA/SRA Team tab in EdPlan*.

Can I save my work in EdPlan without finalizing the SRA document if I am still collecting information to complete the SRA?
Yes, there are situations that you may not have all the information that you need to finalize the in EdPlan in one sitting and you can save without finalizing. However, you must finalize within 24 hours of learning of the incident and starting an SRA.

*For any additional questions regarding EdPlan procedures, please refer to EdPlan Guide on the Main Menu under Resources/SRA Tab (at the bottom of the page).

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APPENDIX A: DISTRICT RESOURCES AND CONTACT INFORMATION

BCPS Mental Health Portal (Manual)

www.bcps-mentalhealth.com

Behavioral Health Partnership

http://www.bcps-esls.com/html/BHP_Provider_List.php

SEDNET/ESE Counseling/Suicide Prevention

754-321-3421

Psychological Services

754-321-3440

School Counseling & BRACE Advisement Department

754-321-1675

Family Counseling Program

754-321-1590

SBBC Privacy Office (FERPA concerns)

754-321-1914

School Social Work Services

754-321-1618

School Climate & Discipline

754-321-1655

Broward County Public Schools Mental Health Hotline

754-321-HELP (4357)

APPENDIX B: RESOURCES

Crisis Resources

- **211 Broward: Dial 2-1-1 For Help https://211-broward.org/service/crisis-suicide-intervention/**
- **National Suicide Prevention Lifeline: is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. http://www.suicidepreventionlifeline.org**
- **Crisis TEXT Line: Text HOME to 741741 for free 24-7 crisis support**
- **Trevor Project Lifeline: LGBTQ Trained Counselors- 1-866-488-7386** http://www.thetrevorproject.org

Local Community Support

- Henderson Behavioral Health
  Mobile Crisis Response Team (954-463-0911)
  https://www.hendersonbh.org/services/crisis/

- Memorial Healthcare-Children and Adolescent Treatment Services (CATS) (954-276-3422)
  https://www.mhs.net/services/mental-health/conditions/children-adolescents

Awareness/Prevention for Professionals

- American Foundation for Suicide Prevention: www.afsp.org
- American Association of Suicidology: www.suicidology.org
- Attic Youth Center for gay, lesbian, bisexual and transgender: www.atticyouthcenter.org
- Crisis Connections: www.crisisconnections.org
- Florida Department of Education: www.fldoe.org/safe-schools/suicide-prevent.stml
- Florida Suicide Prevention Coalition: www.floridasuicideprevention.org/
- National Hopeline Network: www.hopeline.com
- National Organization of People of Color Against Suicide: www.nopcas.com
- National Institute of Mental Health: www.nimh.gov
- QPR Institute: www.qprinstitute.com
- Suicide Awareness/Voices of Education: www.save.org
- Suicide Prevention Resource Center www.sprc.org
- Yellow Ribbon Youth Suicide Prevention Program: www.yellowribbon.org
- Minding your Mind: www.mindingyourmind.org
- Jason Foundation Suicide Prevention Program: www.jasonfoundation.com
- Children & Trauma: www.apa.org/pi/families/resources/children-trauma-update.aspx

Websites for Youth

- Facts for Teens: Teen Suicide: http://www.safeyouth.org/scripts/teens/docs/suicide.pdf
- Go Ask Alice!: A web-based health question-and-answer service produced by Alice!, Columbia University's Health Education Program. It provides information to help young people make better decisions concerning their health and well-being. http://www.goaskalice.columbia.edu
- Jason Foundation: Nationally recognized leader in youth suicide with a section for students. http://www.jasonfoundation.com/student.html

- ❑ The ME Project: Talking about mental emotions with teens. http://meproject.org
- ❑ National Institute of Mental Health: What to Do When a Friend Is Depressed-Guide for Students. http://www.nimh.nih.gov/publicat/friend.cfm
- ❑ Reach Out: Information support service to help teens facing tough times. All content is written by teens and young adults, for teens and young adults, to meet them where they are. www.reachout.com
- ❑ Samariteens: A free, confidential, helpline staffed by teenage volunteers who are trained to be compassionate and supportive listeners. http://www.samaritansofboston.org/samariteens.html
- ❑ Teens Health Answers & Advice: Offers information for teens on physical and emotional health, food and fitness, and other issues. http://kidshealth.org/teen

For Suicide Loss Survivors

- ❑ AFSP: https://afsp.org/find-support/ive-lost-someone/find-a-support-group
- ❑ Survivors of Suicide (SOS): www.survivorsofsuicide.com or www.phillysos.tripod.com
- ❑ STAR-Center: https://www.starcenter.pitt.edu/Adult-Survivors-of-Suicide-(SOS-/- Bereavement-Group)-Sessions/38/default.aspx
- ❑ Parents of Suicides: www.parentsofsuicide.com
- ❑ Friends and Families of Suicides: www.friendsandfamiliesofsuicide.com
- ❑ Suicide Memorial Wall: www.suicidememorialwall.com
- ❑ Dougy Center for Grieving Children and Families: www.dougy.org
- ❑ Compassionate Friends for Parents who Have Lost Children: www.compassionatefriends.org
- ❑ Grief Loss Recovery: www.recover-from-grief.com
- ❑ Online Healing for Grief: www.journeyofhearts.org

Other Online Resources

- ❑ American Academy for Child and Adolescent Psychiatry: www.aacap.org
- ❑ American Association of Suicidology: http://www.suicidology.org
- ❑ Depression and Bipolar Support Alliance (DBSA): www.dbsalliance.org
- ❑ Light for Life Program: http://www.yellowribbon.org/
- ❑ National Institute of Mental Health Suicide Prevention Resources: http://www.nimh.nih.gov/suicideprevention/index.cfm
- ❑ National Mental Health Association: www.nmha.org
- ❑ S.O.S High School Suicide Prevention Program: http://www.mentalhealthscreening.org/highschool/
- ❑ Suicide Awareness/Voices of Education (SAVE): www.save.org
- ❑ U.S. Department of Health and Human Services: National Strategy on Suicide Prevention, http://www.mentalhealth.samhsa.gov/suicideprevention/

APPENDIX C: STUDENT RISK INTAKE FORM

STUDENT RISK INTAKE FORM

Forms are to be entered into EdPlan. If printed forms are utilized, the information must be entered or uploaded as an attached source into EdPlan. Ensure that the SPD is added to the SRA Core Team prior to completing the SRIF.

Incident Information

Student Name: _____ DMS Incident Number: _____

_____ (Incident Type) _____ (Today's Date) _____ (Date Reported) at _____ (Time Reported) ☐ am ☐ pm

_____ (Who reported this initial concern?) _____ (Contact Number) _____ (Affiliation to School)

_____ (Who was this concern reported to?) _____ (Contact Number) _____ (Affiliation to School)

_____ (Date Administrator Learned of Incident) _____ (Location of Incident) _____ (Date of Incident) at _____ (Time of Incident) ☐ am ☐ pm

Incident Narrative:

If a threat to others has been made, has the target been identified? (Circle one) YES NO

Witnesses:

Witness 1 Name	Affiliation to School	Contact Number
Witness 2 Name	Affiliation to School	Contact Number
Witness 3 Name	Affiliation to School	Contact Number

Intake Outcome:

☐ Threat to Self ☐ Threat to Others

Name of Baker Act Assessment Initiator	Outcome of Baker Act	Date of Baker Act Initiated	at	Time of Baker Act Initiated	☐ am	☐ pm

APPENDIX D: SUICIDE RISK ASSESSMENT FORMS

SUICIDE RISK ASSESSMENT

If printed forms are utilized, the information must be entered into EdPlan.

INFORMATION ABOUT THE EVENT

What was the context for the suicidal actions, behaviors, statements or thoughts?
What was happening at the time and/or just before?

Initial Screener

_____ _____ at _____ ☐ ☐

Name of Interviewer | Date Interviewed | Time Interviewed | am | pm

1. In the past month, have you wished you were dead or wished you could go to sleep and not wake up?
2. In the past month, have you had any actual thoughts of killing yourself?
3. If yes to 2, in the past month have you thought about how you might do this? (If no to 2, enter "N/A")
4. If yes to 2, in the past month have you had any intention of acting on those thoughts?
5. If yes to 2, in the past month, have you started to work out or worked out the details of how to kill yourself?
6. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?
7. In the past 3 months, have you done anything, started to do anything, or prepared to do anything to end your life?

MENTAL HEALTH RECORDS REVIEW

Mental Health Records Review

_____ _____ at _____ ☐ ☐

Suicide Prevention Designee/ Mental Health Professional | Date of Review | Time of Review | am | pm

1. Has the student previously presented with suicidal behaviors this academic year?

2. Prior to this academic year, has the student presented with suicidal behaviors?

3. Has the student previously been hospitalized under the Baker Act this academic year?

4. Prior to this academic year, has the student been hospitalized under the Baker Act?

5. If you indicated yes to any of the questions above (including screener questions), please provide additional information.

6. Please describe the student's mental health history, if known, in both the school and/ or community environment.

ANALYSIS, RISK LEVEL, AND INTERVENTIONS (SRA CLINICAL INTERVIEW)

Risk Factors and Warning Signs

1. Do you have a family member or know someone close to you that died by suicide or attempted suicide?

2. Have you experienced situation where others have been violent towards you?

3. Have you witnessed violence in your home?

4. Tell me if you have had any experiences with bullying.

5. Do you feel that the problems you are experiencing can get better over time?

6. Do you feel that you have control over the situations in your life?

7. Do you feel that you are a burden or a bother to others?

Protective Factors

1. What family support do you have? Do you feel connected to your family?

2. Who are your group of friends and people that you feel close to?

3. Do you feel a sense of connection to your school and to your community?

4. What are your cultural beliefs that discourage suicide and promote healthy living?

5. Do you have any healthy coping skills or problem-solving skills that help you when you feel frustrated or overwhelmed?

6. What in life makes you happy?

7. What makes you feel good about yourself?

8. Are you aware of medical and mental health resources available to you? If so, what are they?

9. Who do you feel safe to talk with about your feelings? And are those people available to you at any times?

Key Observations from this Interview:

Additional Contributing Risk Factors

1. What circumstances might increase the risk or suicide for this student?

2. Other people concerned about student's potential for suicide? Please explain:

3. Is the student experiencing hopelessness, desperation, and/ or despair?

4. Does he/ she perceive him/ herself as a burden to others?

Capacity to Carry Out Harm to Self

Method and Accessibility:

☐ Fire	☐ Pill	☐ Asphyxiation	☐ Hanging
☐ Poison	☐ Self-Injury/ Cutting	☐ Jump	☐ Razor of Glass
☐ Drug/ Alcohol	☐ Knife	☐ Drowning	☐ Gun
☐ Other:			

What access does the student have to the method indicated above?

Type of Suicide Risk

(select the highest risk level only)

☐ Ideation	☐ Threat	☐ Self- Harm	☐ Attempt

Reason for Suicide Risk

(select all that apply)

☐ Family Complications	☐ Child Abuse	☐ Loss of Relationship	☐ School Problems
☐ Bullying	☐ Peer Issues	☐ Loner	☐ Low Self Esteem
☐ Depression	☐ Sexual Identity	☐ Hearing Voices	☐ Returning to School after Hospitalization
☐ Returning to School after School Break	☐ Other:		

Risk Level

☐	Unfounded Risk	No evidence of suicidal actions, behaviors, statements or thoughts could be identified
☐	Low Risk	Modifiable risk factors, strong protective factors; thoughts of death, no plan, intent or behavior
☐	Moderate Risk	The student presents with multiple risk factors with few protective factors. There may be suicidal ideation with a plan, but no intent or behavior.
☐	High Risk	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant, few protective factors; potentially lethal suicide attempt or persistent ideation with strong intent or suicidal rehearsal, plan

Parent Notification

_____ _____ at _____ ☐ ☐

Parent Name | Date Notified | Time Notified | am | pm

Outcome of Contact and Parent Input:

Mandatory Actions

Intervention Selected	Person Responsible/ Date Initiated
☐ Ensure student is medically safe	
☐ Never leave student alone	
☐ Contact SRO, LE or Mobile Crisis Response Team	
☐ Give emergency/ crisis numbers and information	
☐ Student Support Plan	
☐ SPD informs administration of outcome	
☐ Referral to CPST	
☐ SPD meets with family	
☐ Referral to Family Counseling, School Social Work and/ or Behavioral Health Provider	

Was a Baker Act initiated? ☐ Yes ☐ No

Name of Baker Act Assessment Initiator	Outcome of Baker Act	Date of Baker Act Initiated	at	Time of Baker Act Initiated	☐ am	☐ pm

Meeting Participants

Name	Mental Health Professional	Participation Type
Name	Role	Participation Type
Name	Role	Participation Type
Name	Role	Participation Type

APPENDIX E: SAFETY AND SUPPORT PLAN

SAFETY & SUPPORT PLAN

Forms are to be entered into EdPlan. If printed forms are utilized, the information must be entered or uploaded as an attached source into EdPlan.

Interventions

Plan ID: _____ Begin Date: _____

Actions with Student

Were the mandatory action steps from the SRA Checklist Completed?

Safety and Support Plan Steps

Step 1: Warning Signs for the Student

☐ Substance abuse	☐ Hopelessness	☐ Helplessness	☐ Haplessness
☐ Overwhelming guilt/ shame/ self- hate	☐ Themes of death	☐ Agitation	☐ Recklessness/ aggression
☐ Behavioral changes	☐ Altered sleep/ eating	☐ Statements/ ending it all	☐ Threats
☐ Researching/ rehearsing methods	☐ Attending to important papers	☐ Feeling trapped	☐ Giving possessions away

Other (please explain):

Safety and Support Plan Steps (cont.)

Step 2: Internal Coping Strategies

☐ Affirmations	☐ Belly breathing/ Using imagination	☐ Journaling	☐ Counting
☐ Positive problem solving	☐ Positive self- talk	☐ Progressive Muscle Relaxation	☐ Talking about feelings
☐ Mindfulness activity/ app	☐ Visualization		

Other Internal Coping Strategies (please explain):

Step 3: People and Social Settings That Provide Distraction

Name	Phone/ Address
Name	Phone/ Address
Name	Phone/ Address
Name	Phone/ Address

Step 4: People I Can Ask for Help (examples: teachers, neighbors, coaches, religious figures)

Name	Phone
Name	Phone
Name	Phone
Name	Phone

Safety and Support Plan Steps (cont.)

Step 5: Professional or Agencies I can Contact During a Crisis

Name	Phone
Name	Phone
Name	Phone
Name	Phone
Name	Phone
Name	Phone

Step 6: Making the Environment Safe

What do I need to change in my environment to help me be safe when I am in distress?

Meeting Participants

Name	Role	Participation Type
Name	Role	Participation Type
Name	Role	Participation Type
Name	Role	Participation Type

Meeting Date	Review Date

APPENDIX F: RISK FACTORS AND WARNING SIGNS HANDOUT

Risk Factors	
Family Factors	
Changes in family structure	Lack of support from parents
Loss of job by parent	Death of a family member or abandonment
Life threatening/ chronic disease	Constant arguments/ violence in the family
Separation /divorce or marital instability	New family, blended or stepfamily
Physical/ sexual/ emotional abuse or neglect	Parent alcohol/ drug abuse
Overprotecting/ overindulging/ being isolated from parents	Poor communication between parents and children
Excessive responsibility for sibling care	Family history of suicidal behavior and/or mental illness
School Factors	
Unreasonable expectations (pressures to excel from parents, school and self, straight A's, part-time job, play sports, etc.)	Loss of status (e.g., failure to make the team, drop in grades)
Unsafe environments (gangs, bullies, runaway)	Bullying/ lack of connections at school
Personal/Social Factors	
Previous suicide attempt or self- harming behaviors	Exposure to suicidal behaviors of friends/ acquaintances, or in the media
Loss of a close friend through rejection, moving away, death/ suicide	Loss of romantic relationship
Being homeless or having run away from home	Loneliness/ isolation/ embarrassment/ humiliation
Peer pressure (drugs, truancy, sex)	Poor coping skills
Unintended pregnancy	Victim of sexual assault
Alcohol and drug abuse	Aggressive/ impulsive/ disruptive behaviors
Demographic Factors	
Being male (for death by suicide)	Being female (for suicide attempts)
Lesbian, Gay, Bisexual, Transgender Questioning (LGBTQ)	American Indian/ Alaska Native

WARNING SIGNS

Elementary Students	
3 to 5 Years	**4 to 10 Years**
Sudden withdrawal	Reckless acts
Sad face/Somber affect	Angry outbursts
Cries often without obvious reason	Preoccupation with death
Sudden behavior changes	Morbid artwork
Withdrawal from peers and family	Frequent, unexplainable accidents
Talking about joining family members who have passed away	
Somatic complaints to avoid school or fun activities	
Secondary Students	
Significant Changes in Student's Behavior/Personality	
Hopelessness or Feeling Trapped	Helplessness - unable to alter their situation
Low self-esteem	Neglect of personal appearance
Serious mood changes	Not tolerating praise or rewards
Abuse of alcohol and/ or drugs	Self-injurious behavior or accident prone
Change in eating and/ or sleeping patterns	Giving away prized possessions
Sudden happiness following prolonged depression	Out of character outbursts such as violent actions, rebellious behavior, or running away
Withdrawal from family and friends	Getting into trouble with the law
Difficulty concentrating	Loss of interest in things one cares about
Serious medical issues (intense pain associated with condition)	A desire to end one's life may show up in artwork, poetry, essays, etc.
Change in eating and sleeping pattern	Irritable
Verbal Warning Signs	**Significant Changes in Academic Performance**
Talks about death and/ or asks questions about suicide	Skipping classes - chronic tardiness
Complaining of being a bad person or feeling "rotten inside"	Assignments done carelessly or neglected
Reports previous suicide attempts	Falling asleep in class
Talks openly about suicide or a suicidal plan	Noticeable drop in grades
Expresses a desire to join someone who has died	Over achiever - under achiever
Expresses feeling like a burden	Lack of interest or participation in class
	Sudden withdrawal from extracurricular activities