



GUIDELINES FOR IN-SCHOOL SUICIDE OR SELF-HARM THREAT CRISIS INTERVENTION

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Suicidal ideation, suicidal behavior, and self-harm threats are to be taken seriously by all staff members. The following procedures must be followed with all suicide and self-harm threats:

- Interview from trained member of crisis intervention team: school counselor, social worker, or psychologist
- Contact parent or guardian to inform and obtain necessary answers to Indicators/Interview
- Inform school nurse
- Inform principal/administration
- Contact law enforcement or medical personnel if needed
- Never leave a student unsupervised; escort them to suicide threat assessment intake location

The following forms are to be filled out for all instances in which a student has expressed suicidal ideation or behavior and at the interviewer's discretion in self-harm instances:

- Self-harm Indicators (copy to school only)
- Action Plan (copy to school only)
- Parent Statement of Understanding/Release of Liability (copies to home and school)
- Safety Assessment Referral (copies to home and school)
- Authorization for Request/Release of Information (copies to home and school)
- Student Safety Plan (to be completed upon student's return to school in reentry meeting)
- Personal Safety Contract (to be completed upon student's return to school)

The principal or their designee may remove a student from classes or from school premises for health, safety, or welfare reasons. This includes students suffering from any condition that threatens their welfare or the safety of others. Any student who is removed is to be released only to the student's parent/guardian, a representative of the parent/guardian, or other proper authority, including but not limited to law enforcement officers and medical personnel.

When a student is removed from school for self-harm or suicidal ideations or actions, the Parent/Guardian Statement of Understanding may be used, at the school's discretion, in an effort to encourage the parent/guardian to seek professional mental health care for a student outside of the school. In these cases, failure to seek outside mental health consultation may constitute neglect, and the school is legally obligated to report the situation to Child Protective Services. The State of California defines neglect as "treatment which threatens the child's health or welfare."

FACULTY/STAFF REFERRAL FORM

Student Name: _____ Date: _____

Referred By: _____ Parent Contacted? Yes ___ No ___

What are the primary ways the student could use additional support? _____

Personal/Emotional Support

- Emotional regulation skills
- Feel more confident
- Manage stress or anxiety
- Cope with feelings of sadness
- Improve ability to seek out social support
- Manage feelings of anger
- Develop self-acceptance & self-compassion
- Address self-harm/suicidal behavior

Social/Relational Support

- Develop empathy skills
- Improve friendship/relationship skills
- Build self-assertion/self-advocacy skills
- Develop conflict resolution skills
- Feel safe at school
- Develop healthy boundaries
- Increase sense of belonging

Reason for Referral

Student's Strengths/Interests

Specific Observable Behaviors

Academic/Classroom Support

- Complete and hand in homework
- Pay better attention in class
- Improve study habits
- Arrive at school wellrested
- Complete classroom assignments
- Be on time or improve attendance
- Participate more in class
- Develop organizational skills
- Improve communication skills

Home/Family Support

- Illness or death in the family
- Parents divorced/separating
- Changes in the family context
- Incarceration of a family member
- Foster Care
- Other

QUESTIONS TO ASK WHEN ASSESSING RISK IN SUICIDAL STUDENTS

Risk-Level I (low risk): *Notify parents verbally and in writing*

Thoughts, suicidal ideation, but no previous attempts, no plan, no immediate suicides of friends/family. There could be signs of depression, direct or indirect threats, change in personality, or evidence of self-harm in written work. Acknowledges helping resources.

Risk-Level II (moderate risk): *Notify parents verbally and in writing*

Suicidal ideation, plan, but no time frame. Destructive/high-risk behavior, previous attempts, or recent suicides among family/friends. Possible high-profile suicide in media or community, alcohol/drug use, diagnosed or undiagnosed mental illness, recent traumas, or change in medication.

Risk-Level III (high risk): *Student transported to hospital (Warm handoff) by a parent, student resource officer (SRO), police, or ambulance*

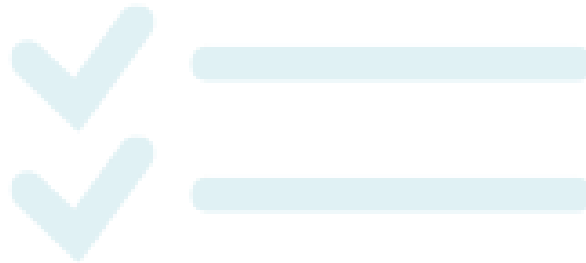
Ideation, plan, means, cannot commit to being safe, previous suicide attempts, previous hospitalization for mental health, recent trauma, depression signs, diagnosed or undiagnosed mental illness, recent suicide in family or friend, recent suicide/good-bye letter, alcohol/drug use, repetitive self-injurer, access to lethal methods (guns, etc.), changes in medication, lack of support system, nonacceptance of helping resources.

Risk-Level Notes:

- The risk levels described are designed to assist you in determining suicide risk but are not an absolute measure.
- Access to lethal means potentially increases the risk level. If a student cannot commit to safety and has access to guns, the level is automatically high.
- Anytime there is an indication of a previous suicide attempt, suicide in family/friends, recent hospitalizations, alcohol/drug use, change in medication, diagnosed mental illness, abrupt changes in behavior, or recent traumas, the student will be automatically a moderate to high-risk level.

Suicide Screening Questions (to be used to complete the Self-Harm Indicators page)

Current Situation: On a scale of 1-10, with 1 being as bad as it ever has been and 10 being as good as it ever has been, how would you rate your life right now? What is going on in your life that makes you feel that way? (Determine current stressors, home, school, friends, family, etc.)



QUESTIONS TO ASK WHEN ASSESSING RISK IN SUICIDAL STUDENTS (CONT.)

Somatic Questions: Have you had or are you having any recent health concerns (headaches, stomachaches, illness, physical pains, etc.)? Are you taking any medications now or in the past? If so, which medications? Have you ever been hospitalized? If so, when and for what?

Reality Check: (Determine how aware the student is with time and space presently. Can they keep a train of thought? Are they disoriented?) How long have you lived in ____? Tell me what you did this morning when you woke up? What is today's date? What school do you attend? What is your name?

Drug Use: Are you using any drugs or alcohol? If so, what? How often do you use? When was the last time you used?

Emotional: Have you ever felt depressed or very sad for more than a couple of weeks? Do you ever feel lonely or empty inside? Do you feel as if nobody loves or likes you? Have you ever been so depressed that you feel hopeless, like things are not going to get better? Where do you see yourself in 10 years? Do you feel in control of your life now?

Behavior: (Determine coping mechanisms) How do you deal with your stress, anger, sadness? Have you ever attempted suicide? If so, when and how? (Determine change in behavioral patterns, such as eating, sleeping, or concentrating.)

History: Have you ever thought about hurting yourself or deliberately hurt yourself? Have you had any recent hospitalizations? Have you experienced any trauma recently (breakup, death of a loved one, abuse, etc.)?



SUICIDE RISK ASSESSMENT C-SSRS

ASK THE QUESTION!

Suicide Thoughts:

Are you thinking about suicide?

How often do you think about suicide?

Have you been researching suicide online?

Have you shared your thoughts about suicide with anyone?

Who can you talk to that can help you cope with suicidal thinking?

Suicide Plan:

Do you have a suicide plan?

How would you kill yourself?

Do you have the means to carry out your plan?

When will you carry out your plan?

Prior Suicide Thoughts and Behaviors:

Have you had thoughts of suicide in the past?

How long ago?

Have you ever tried to kill/hurt yourself in the past?

If yes, when?

Was there anyone that helped you cope with your prior suicidal thinking?

Parent/Guardian/Caregiver Interview:

Has your child displayed abrupt behavior changes?

What is your child's current support system?

Is there a history of mental illness?

Is there a history of recent losses, trauma, or bullying?

*(Provide parent with Parent Suicide Prevention Information sheet)

INDICATORS

Student: _____ Grade: _____ Date: _____

Interviewer: _____ Position: _____

Referral From: _____ Reason for Referral: _____

Intent:

INDICATOR	YES	NO	?	DESCRIPTIONS / NOTES / QUOTES
Verbalization of self-harm/suicide				
Responses indicating hopelessness				
There is a plan				
There are means available				
Referrer is confident the threat is credible				

History:

INDICATOR	YES	NO	?	DESCRIPTIONS / NOTES / QUOTES
Any previous mental health intervention?				
Previous threats of self-harm/suicide?				
Previous self-harm/suicidal attempts?				
Self-harm behavior in family or friends?				
Are you currently taking any medications? List.				
How many families have you lived with?				

Stressors:

INDICATOR	YES	NO	?	DESCRIPTIONS / NOTES / QUOTES
Family violence/abuse				
Death, loss, or separation				
Girlfriend/boyfriend breakup				
Caregiver/child conflict				
School pressures				
Long-term illness or pain				
Parent to-parent conflict				
Substance abuse				
Other				

Support:

INDICATOR	YES	NO	?	DESCRIPTIONS / NOTES / QUOTES
Student feels supported at school. From whom?				
Students feels supported at home. From whom?				
Student feels supported by community. From whom?				
Appropriate adult supervision while not at school?				

Symptomatic Behavior:

INDICATOR	YES	NO	?		YES	NO	?
Changes in eating or sleeping habits				Substance abuse			
Neglect of personal appearance				Increased risk-taking			
Neglect of school work				Sexual acting out			
Problems internalized/self-blaming				Tying up loose ends or giving away			
Withdrawn/unwilling to communicate				important items			
Self-mutilation				Anger issues			
Triggering Event				Rebellious behavior			

ACTION PLAN

Student: _____ Grade: _____ Date: _____

Person Completing Form: _____ Position: _____

Summary of Concern: (check one) Risk-Level I _____ Risk-Level II _____ Risk-Level III _____
Comments:

Required Actions Taken	Date/Time	Who Was Notified	Notified by Whom
School Nurse Notified			
School Principal Notified			
Parent/Guardian Notified & Involved in Assessment			
Other:			

Other Possible Actions Taken	Date/Time	Who Was Notified	Notified by Whom
Mental health provider notified/ Warm Handoff			
Police notified 911 Wellness Check			
State/tribal services notified (if applicable)			
Parent Statement of Understanding Signed			
Intervention/counseling; 24/7 resources given			
Authorization for release of information signed			
Parent/guardian informed that they are financially responsible for treatment			
Mobilized support system (school & home)			
Access to lethal means removed			
Line of sight supervision (Caregiver)			

PARENT/GUARDIAN STATEMENT OF UNDERSTANDING/RELEASE OF LIABILITY

Date: _____ Regarding _____ (student name) of _____ (school),
I _____ (parent/guardian name) have been notified by _____ of
_____ school district personnel of my child's threats or ideations to harm themselves.

I have been asked to seek help for them within 24 hours from a mental health professional licensed by the State of California (see note). If I do not, I understand that my child's school considers this a failure to provide appropriate mental health care and is required by statute to report suspected neglect to California Child Protective Services (CPS). California defines neglect as "negligent treatment which threatens the child's health or welfare." Penal Code 270 PC-California Child Neglect Laws.

___ I understand there may be a risk of severe harm to my child without further medical assessment and/or treatment.

___ I decline the recommendations and offers of school personnel to assist me in obtaining medical transport for further assessment of my child.

My child's school personnel have made community health/mental health referral information available to me. I agree, as indicated by my signature below, to release the _____ School District and School District Personnel of all liability for any harm to my child as a result of my failure to act upon the suggestions and recommendations made to me regarding the concerns expressed and documented above.

I also understand that my child may be suspended from attending school or any extracurricular activity until appropriate mental health care has been received and the child possesses no suicidal tendencies and is not a threat to himself or others.

Student reentry meeting must take place upon student's return to school.

Contact _____ (name/#) _____

Referred School Member:

Printed Name

Signature

Date

Parent/Guardian:

Printed Name

Signature

Date

SAFETY ASSESSMENT REFERRAL

Note: Mental health professionals licensed by the state of California includes psychiatrists, psychologists, Licensed Clinical Social Worker (LCSW or LISW), Licensed Professional Clinical Counselor (LPCC), Licensed Professional Counselor (LPC), Licensed Mental Health Counselor, Psychiatric Nurse Practitioner, or Clinical Nurse Specialist.

Student: _____ Date: _____

Referring School: _____

Contact Person: _____

The above-listed student has threatened/attempted self-harm or suicide. Please complete this form so the parent/guardian may confirm that a mental health assessment by a licensed independent-level mental health professional was completed.

Thank you for your assistance.

For psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW or LISW), Licensed Professional Clinical Counselor (LPCC), Licensed Professional Counselor (LPC), Licensed Mental Health Counselor, Psychiatric Nurse Practitioner, or Clinical Nurse Specialist:

___ The student has been evaluated

The student has been evaluated and referred for additional mental health services at _____

Mental Health Professional:

Name (print): _____ License Type: _____

Signature: _____ Date: _____

Recommendations for safety at school:

Note: Please make sure the Authorization for Request/Release of Information form is completed and signed so that information can be exchanged between the mental health agency and the school.

To be completed by trained member of school crisis team during reentry meeting with parent.

Form received on: _____ By: _____

This form must be completed and returned prior to student attending class.

AUTHORIZATION FOR REQUEST/ RELEASE OF PROTECTED HEALTH INFORMATION

Today's Date: _____

Student Name: _____ DOB: _____

Address: _____

Home/Cell Telephone: _____ Work Telephone: _____

I hereby authorize the release of records for the following area(s) indicated:

- ☐ Complete medical record ☐ Psychotherapy notes ☐ Mental health records
☐ Lab test results ☐ Consultation ☐ Conversational rights

To the extent my records contain information about drug and/or alcohol abuse or treatment, I agree to the release of this information: ☐ Yes ☐ No

To the extent my records contain information about sexually transmitted diseases, Hepatitis B & C testing and/or treatment, or HIV/AIDS testing and/or treatment, I agree to the release of this information:
☐ Yes ☐ No

Identify dates of service of records to be used/disclosed:

- ☐ All dates of service ☐ Specific dates: From _____ To _____

From: _____

To: _____ School _____

Person Requesting Records: _____

Requested records will be used for the determination of student's mental health capacity for normal educational attendance. This authorization shall remain in effect for 1 year from the date of signature unless revoked in writing by the student or the student's parent, guardian, or conservator.

AUTHORIZATION FOR REQUEST/ RELEASE OF PROTECTED HEALTH INFORMATION (CONT)

Revocation. I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the agency and that the revocation will be effective, except to the extent that action has already been taken in reliance on this Authorization. Unless revoked, this Authorization will expire 1 year from the date of signature.

Redisclosure. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy requirements unless otherwise prohibited by law. The agency, its affiliates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

No denial of treatment/payment. I understand that I do not have to sign this Authorization and that my treatment or payment for services will not be denied if I do not sign this Authorization unless such treatment is solely for purposes of providing health information to a third party (e.g., my employer). I also understand that I may review and copy the information to be disclosed and that I have a right to receive a copy of this Authorization form.

I hereby consent to the release of the records indicated above:

Person giving consent signature _____ Date _____

If signed by legal guardian, describe legal authority to act on behalf of patient/client:

Check one: ☐ Parent ☐ Guardian ☐ Court Appointed ☐ Conservator

DISCLOSURE OF HIGHLY SENSITIVE INFORMATION

To the extent the information disclosed along with this form concerns sexually transmitted diseases, HIV/AIDS, or drug/alcohol abuse or treatment, such information has been disclosed to you from records protected by federal confidentiality rules, including, without limitation, 42 CFR Part 2. These federal rules prohibit the recipient of the records from making further disclosure of such information without written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and applicable California law. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

***THE PERSON GIVING SIGNATURE TO THIS RELEASE HAS
THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION***

STUDENT PERSONAL SAFETY PLAN

Student: _____ Date: _____

School: _____

My triggers or events that cause me to feel upset:

I should use my safety plan when my triggers cause a change in my mood, thought, behavior, such as:

If I start to feel like harming myself or become depressed/hopeless, other things I can do instead of hurting myself are (coping strategies/alternate activities):

If I feel like I cannot control myself or become depressed/hopeless, I will call a designated support adult.
(MY3 App)

NAME	PHONE NUMBER

RE-ENTRY MEETING & FOLLOW-UP PLAN:

Attending Meeting: _____ Date of Meeting: _____

Person responsible for follow-up: _____

Will a Student Safety Plan be completed? Yes _____ No _____

Follow-up:

Signatures:



*Adapted from NASP.org, SCSD

CRISIS INTERVENTION RESOURCES

911

National Suicide Prevention Lifeline (24-hour hotline)
800-273-8255 (800-273-TALK)

California Youth Crisis Line (24-hour hotline, bilingual)
800-843-5200

Trevor Project (24-hour hotline)
(866-488-7386)
text "START" to 678678

Teen Line (6pm-10pm)
800-852-8336 (800-TLC-TEEN)
text "TEEN" to 839863

Parents, Families and Friends of Lesbian & Gays (PFLAG)
Helpline
888-735-2488

LA County INFO Line - 211
www.211la.org

CA Crisis Resources by County
<https://focus.senate.ca.gov/mentalhealth/county-resources>

