SUICIDE PREVENTION PLAN AND PROCEDURES

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INTRODUCTION

The U.S. Surgeon General promotes the adoption of suicide prevention protocols by local school districts to protect school personnel, and to increase the safety of at-risk youth and entire school community. In 2019, the Oregon legislature passed Senate Bill 52, also known as "Adi's Act", which requires school districts to develop and implement a comprehensive student suicide prevention plan.

PURPOSE

This document recognizes and builds on the skills and resources inherent in school systems. Schools are exceptionally resilient and resourceful organizations, whose staff members may be called upon to deal with a crisis on any given day. Schools can be a source of support and stability for students and community members when a crisis occurs in their community. Accordingly, this guide is intended to help school staff understand their role and to provide accessible and effective tools.

EUGENE SCHOOL DISTRICT 4J:

- ❏ Recognizes that physical and mental health underpin all learning. Physical and mental health and wellness are integral components of student outcomes, both educationally and beyond graduation.
- ❏ Further recognizes that suicide is a leading cause of death among young people aged 10 - 24 in Oregon.
- ❏ Has an ethical responsibility to take a proactive approach in preventing deaths by suicide.
- ❏ Acknowledges the school's role in providing a culture and environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience.
- ❏ Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components.
- ❏ Will publish its policy and plan on the district website and will revisit and refine the plan as needed.

DEFINITIONS

AT-RISK

Risk for suicide exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention. A high-risk student may have thoughts about suicide, including potential means of death, and may have a plan. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset of potential mental health conditions or a deterioration of mental health.

CRISIS RESPONSE TEAM

The 4J Crisis Response Team is a group of people (school psychologists, school counselors, and the director of public safety) who that work in collaboration with school administrators to address crisis preparedness, intervention, response and recovery.

MENTAL HEALTH

A state of mental health, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders. Mental health can be impacted by the home, school, social environment, early childhood adversity or trauma, physical health, and genes.

PARENT

As used in this plan, the term parent means a parent of a student and includes a natural parent, a legal guardian, or an individual authorized in writing to act as a parent in the absence of a parent or a guardian.

RISK ASSESSMENT

An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated staff (e.g., school psychologist, school social worker, school counselor, nurse, or in some cases, trained school administrator). The Columbia-Suicide Severity Rating Scale (C-SSRS) is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

RISK FACTORS FOR SUICIDE

Characteristics or conditions that increase the chance that a person may attempt to die by suicide. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological, and/or social factors in the individual, family, and environment. The likelihood of an attempt is highest when factors are present or escalating, when

protective factors and healthy coping techniques have diminished, and when the individual has access to lethal means.

SELF-HARM
Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm increase the long-term risk of a future suicide attempt or accidental suicide.

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

SUICIDE ATTEMPT
A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of unresolved mindset, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, unresolved mindset is not reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.

SUICIDAL IDEATION
Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one's life is still considered suicidal ideation and will be taken seriously.

SUICIDE CONTAGION
The process by which suicidal behavior or a death by suicide influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.

POSTVENTION
Suicide postvention is a crisis intervention strategy designed to assist with the grief process following a death by suicide. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school's healthy postvention effort can act as prevention and save lives.

QUICK FACTS - WHAT SCHOOLS NEED TO KNOW

Take suicidal behavior SERIOUSLY EVERY time. Take IMMEDIATE action!
Contact the School Screener and a building administrator to inform her/him/they of the situation. NO student expressing suicidal thoughts should be sent home alone or left alone during the screening process. You must provide supervision!
If there is a reason to believe a student has thoughts of suicide, do not send the student home to an empty house.

- ❑ School staff are frequently considered the first line of contact with potentially suicidal students. Most school personnel are neither qualified, nor expected, to provide the in-depth assessment or counseling necessary for treating a suicidal student. They are responsible for taking reasonable and prudent actions to help at risk students, such as notifying parents, making appropriate referrals, and securing outside assistance when needed.

- ❑ All school personnel need to know that they are required to refer at-risk students to trained professionals; the burden of responsibility does not rest solely with the individual "on the scene."

- ❑ **Research has shown talking about suicide, or asking someone if they are feeling suicidal, will not put the idea in their head or cause them to kill themselves.**

- ❑ School personnel, parents/legal guardians and students need to be confident that help is available when they raise concerns regarding suicidal behavior. Students often know, but do not tell adults, about suicidal peers. Having supports in place may lessen this reluctance to speak up when students are concerned about a peer.

- ❑ Advanced planning is critical to providing an effective crisis response. Internal and external resources must be in place to address student issues and to normalize the learning environment for everyone.

CONFIDENTIALITY

School employees are bound by laws of The Family Education Rights and Privacy Act of 1974; commonly known as FERPA. FERPA generally precludes schools from disclosing student information without first obtaining consent, but there are exceptions, including health and safety emergencies and communication with district staff who have a legitimate educational interest. Further, there are situations when confidentiality must NOT BE MAINTAINED, meaning that staff have a legal obligation to share information.

If at any time, a student has shared information that indicates the student is in imminent risk of harm/danger to self or others, that information MUST BE shared immediately. The details regarding the student can be discussed with those who need to intervene to keep the student safe. This is in compliance with FERPA.

GROUPS AT INCREASED RISK FOR SUICIDAL BEHAVIOR

ALSO TERMED OPPORTUNITY YOUTH

Eugene School District 4J acknowledges the needs of these groups and plans to work actively to create and increase affinity groups and use restorative practices to better serve all students.

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. An estimated one in four to five children have a diagnosable mental condition that will cause severe impairment, with the average onset of depression and dysthymia occurring between ages 11 and 14 years; therefore, school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk and enhance overall performance and improve long-term outcomes.

YOUTH WHO ENGAGE IN SELF-HARM OR HAVE ATTEMPTED SUICIDE

Risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Whether or not they report suicidal intent, one study found that 70 percent of adolescents admitted into inpatient psychiatric treatment who engage in self-harm report attempting suicide at least once in their life. Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. One study found that as many as 88 percent of people who attempt suicide for the first time and are seen in the Emergency Department go on to attempt suicide again within two years. Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources, 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. According to a study released in 2018, nearly a quarter of youth in foster care had a diagnosis of major depression in the last year. Additionally, a quarter of foster care youth reported attempting suicide by the time they were 17.5 years old.

YOUTH EXPERIENCING HOMELESSNESS

For unhoused youth, 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. One study found that more than half of runaway and unhoused youth experience suicidal ideation.

Racial and Ethnic Minority Youth

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. For more information about historical trauma and how it can affect AI/AN youth, see ihs.gov/suicideprevention.

Black Youth

Among Black populations, suicide rates peak during adolescence and young adulthood, then decline. This is a different pattern than is seen in the overall U.S. population, where suicide rates peak in midlife. A particularly important risk factor associated with suicide behavior among Black youth is exposure to racism and trauma. Black youth who experience racism often feel alienated, rejected by society, ignored, marginalized, depressed, and anxious.

Latinx Youth

Suicide and suicide attempts are especially concerning among Latinx adolescent girls, who have the highest suicide rates among all adolescent groups nationwide. Statistics reveal that in the United States, 15.6% of Latinx adolescent girls have attempted suicide one or more times and 25% have thought about it. Risk factors include alienation - including disconnection from family or family origin, acculturative stress and family conflict, hopelessness and fatalism, discrimination, and racism.

Asian Youth

For Asian Americans and Pacific Islanders between the ages of 15 and 19, suicide was the leading cause of death in 2016, according to CDC data, accounting for 31.8 percent of all deaths. Asian youth may be susceptible to different risks than other racial/ethnic groups, such as ethnic and cultural socialization or orientation, poverty, education related stress, familialism, discrimination, and acculturation that can take root at a young age, affecting mental health outcomes.

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. One study found that 40 percent of transgender people attempted suicide sometime in their lifetime — of those who attempted, 73 percent made their first attempt before the age of 18. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental health condition), these experiences can place them at increased risk. 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 can be treated, shunned, abused, or neglected, in connection 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.

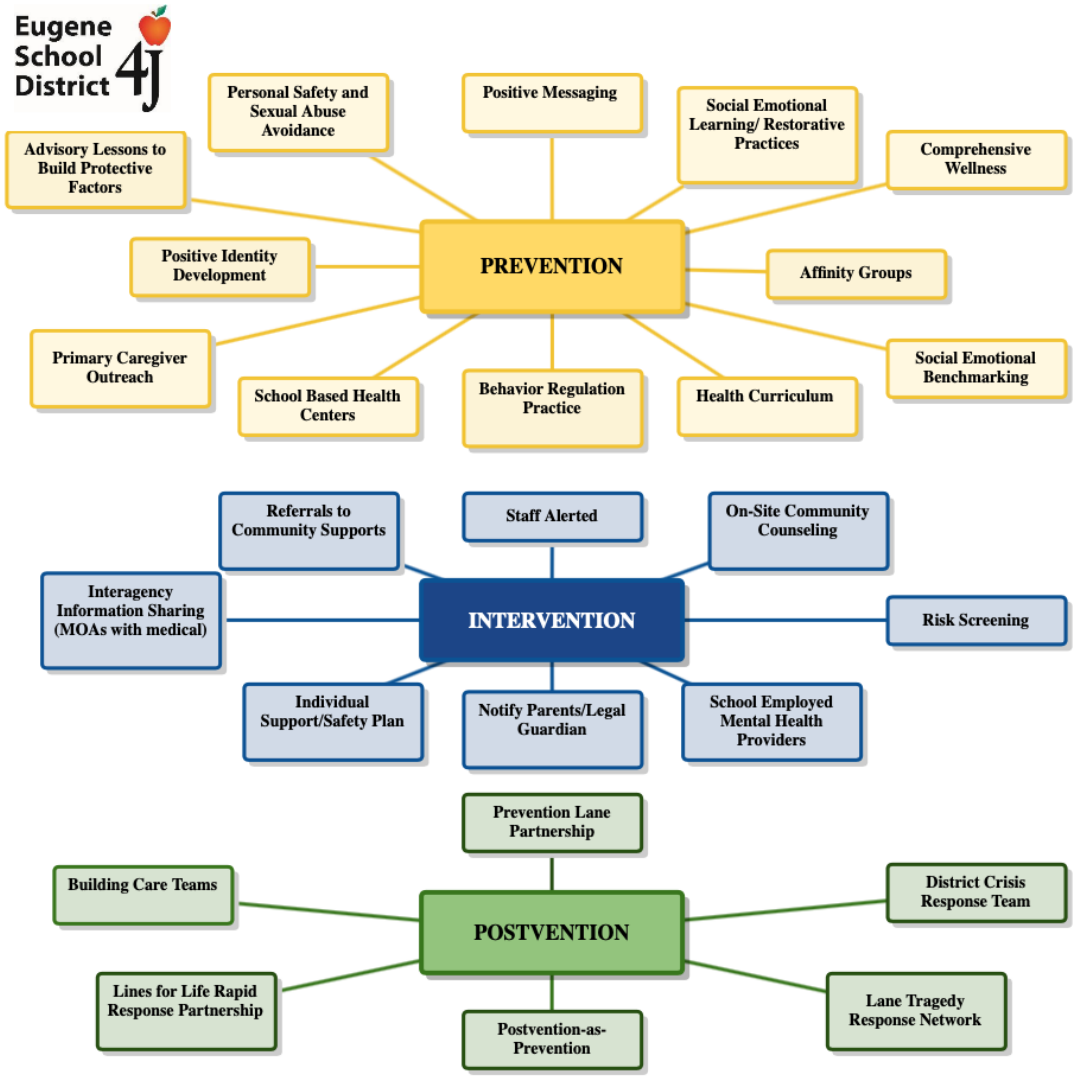
Youth Living with Medical Conditions or Disabilities

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. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

COMPREHENSIVE SUICIDE PREVENTION PLAN COMPONENTS

Eugene School District 4J takes a multifaceted strategic approach to preventing suicide. It includes specific components implemented in a particular sequence: prevention, intervention, and postvention (PIP). Although each section has important independent elements, prevention efforts work best, just like 4J students, when they are connected or interconnected. This plan will outline each of the three components and 4J's commitment to each one of them. 4J is dedicated to developing a suicide prevention program using a culturally competent approach that considers cultural factors, such as the role of the family, level of acculturation, language acculturation, language preferences, and religious beliefs. This process includes staff and student awareness surrounding identity, human dignity, and connection.

Diagram 1: Prevention, Intervention, and Postvention Web of Interconnection



Prevention Procedures

Eugene School District 4J takes intentional steps to create a school culture that encourages positive coping skills by building protective factors while communicating about suicide in a safe and healthy way. Suicide prevention includes mental and physical wellness education, accessible resources, staff training, mental health awareness campaigns, restorative practices, and building a culture of belonging. The district has adopted the staff and student training programs set forth below:

Staff Training and Education

Program	Who	Time
QPR Question, Persuade, Refer Gatekeeper Training for all student-facing staff members. Contacts: Angi Meyer (4J), Karen Apgar (4J)	All student-facing staff.	2 hours First responders
Columbia Suicide Severity Rating Scale (C-SSRS) Evidence-based first responder to gauge risk and response level needed during a potential suicidal engagement. Includes protocols for both initial and follow-up screening and documentation. Contacts: Karen Apgar (4J), Angi Meyer (4J),	First responders with some mental health training (but can be a universal gatekeeper with basic training for anyone)	30 minutes for initial gatekeeper training online to 3.5 hours in person (2 hours online) for clinical training
PREPaRE Universal School Crisis Prevention, Intervention and Crisis Response Training Curriculum Contact: Karen Apgar (4J), Level 2 PREPaRE Trainer	Level 2 for Crisis Team responders Level 1 for any school personnel	Level 1, 7 hours Can be done virtual (synchronous); locally, only Level 2, 13 hours, can be done in person.
Sources of Strength Secondary level peer-based suicide prevention program Research supported Grant funded starting Fall 2020 High school pilot Contacts: Liz Thorne, Matchstick Consulting & Dan Gallo (Lane ESD)	Peer-based with adult facilitators	Varies 4-6 hours initial adult training 4-6 hours peer leaders Meeting times throughout the year
Connect Postvention Training (NAMI) Training around the planned response after a suicide to identify protective factors and reduce risk of those impacted by suicide.	School counselors, school psychologists, other interested staff	6 hours

Contact: Kris Bifulco (she/they), Connect Postvention Coordinator		
FastBridge SAEBRs Risk Screener (or another comparable tool) 4J will take a culturally conscious approach to using this screening tool. It is systematic brief risk screening survey tool that can be quickly completed by teachers for each student (1-3 minutes per student) to identify risk levels and prioritize services accordingly Contacts: Jessica Hunt (4J) and Drew Maves (4J)	Teachers	Minimal and online training available.

Suicide prevention activities are best conducted in the context of other prevention efforts such as health and wellness curriculum, sexual violence prevention, drug awareness, unhoused youth, wraparound services, social-emotional learning, trauma-informed education, disability identification and services, and supports for underrepresented populations such as positive identity development and affinity groups. Prevention efforts are best characterized as being part of a multi-tiered system of support (MTSS) where universal practices across domains are employed, increasingly intensive training and supports are engaged as screening, and intervention outcomes are evaluated.

ONLY TRAINED SCHOOL STAFF MEMBERS MAY ACT AS SCHOOL SCREENERS WHO PERFORM LEVEL 1 SUICIDE RESPONSE PROTOCOLS AND SAFETY PLANNING. TRAINED SCREENERS IN YOUR SCHOOL CAN BE:
❑ School Counselors
❑ School Psychologists
❑ School Nurses
❑ School Social Worker
❑ School Administrator(s)
* If you are uncertain who the specific trained screeners are in your building, ask your building administrator.

Student Training and Education

All students K - 12 will receive direct instruction on social emotional learning/mental health and wellness promotion using restorative practices.

School Program	
Social/Emotional Learning curriculum (SEL) including regulating emotions.	K - 5
Mental health as a part of physical health; Second Steps curriculum.	K - 5
Social, Academic, Emotional Behavior Risk Screener SAEBRS (Fall 2021) to provide a mental health baseline and progress monitoring of all students.	K - 5
Additional curriculum supplied: Oregon Department of Education and the Oregon Health Authority recommend Sources of Strength Elementary curriculum, and 5 Radical Minutes. 4J's plan in the next year is to assess the current curriculum and see if these recommendations can be adopted and implemented.	K - 5
Wellness, community and strength-building (protective factors) embedded throughout classes such as advisory.	6 - 8
Social, Academic, Emotional Behavior Risk Screener SAEBRS (Fall 2021) to provide a mental health baseline and progress monitoring of all students.	6 - 8
Suicide prevention direct instruction in health classes in collaboration with Lines for Life. (soft introduction Fall 2021)	7 & 9
Wellness, community and strength-building (protective factors) embedded throughout classes such as Advisory, i.e., Character Strong.	9 - 12
Use Social, Academic, Emotional Behavior Risk Screener SAEBRS (Fall 2021) to provide a mental health baseline and progress monitoring of all students.	9 - 12
Sources of Strength club/classes (Fall 2021).	6 - 12
Digital Device Program	
All school issued student devices will have an app with easily accessible crisis resources (Fall 2021).	K - 12
A student safety device screening software program will be purchased and placed on all devices to detect high risk searches (Fall 2021).	K - 12

INTERVENTION PROCEDURES

The risk of suicide is raised when any peer, teacher, caregiver, or school employee identifies someone as potentially suicidal because s/he/they has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated other warning signs. It is critical that any school employee who has knowledge of a suicide threat **reports** this information immediately and directly to a trained School Screener (school counselor, school psychologist, school nurse, or administrator) and school administrator so that the student of concern receives appropriate attention. A suicide risk screening will need to be completed for every student expressing comments and/or thoughts of suicide. Every effort should be made to conduct a screening the same day staff members are made aware of the risk for suicide.

If imminent danger exists, call **911** immediately. This is especially important if the student of concern is not in class or left the campus and a plan to suicide is discovered. All threats of self-harm must be taken seriously.

SCREENING PROCESS

If imminent danger to the student is present (such as where a suicide attempt is in progress or the student is having an acute mental health crisis), the trained school screener or other staff member is to call 911.

If the student is not in immediate but a concern about suicide risk exists, the trained school screener initiates the screening process.

1. Suicide screening is conducted by a school-employed provider trained in screening (school counselor, school psychologist, school social worker, or school nurse), or a school administrator.
2. The trained school screener conducts a Level 1 interviews of the student using the Columbia - Suicide Severity Rating Scale (C-SSRS) screening tool.
3. After the assessment, the trained school screener will consult with another trained school screener (another counselor, psychologist, social worker, administrator, or mental health specialist) or Lines for Life (Student Suicide Assessment Line - 503-575-3760, line is open Monday-Friday, 8:30AM-4:30PM for Remote Suicide Risk Assessment and Safety Planning (RSRASP) support) to determine if a Level 2 Suicide Assessment is appropriate. Sharing decision-making with another professional is best practice. The outcome of the consultation will be one of the following:

    a. When a Level 2 suicide assessment **is NOT** warranted:

        1. Inform the parent or legal guardian the same day that a screening was conducted and why. Parents are a critical part of the student's care team and possess information that the school may not have access to.

2. If low risk, schedule follow up meetings with the student 14 and 30 days after the comments or ideation are scheduled and the person doing the follow up is determined. If necessary, create a Support Plan with the student (and parent or legal guardian, if possible) by the end of the next school day.

3. If moderate risk, schedule follow up meetings and create a Safety Plan with the student (and parent or legal guardian, if possible) by the end of the next school day. Schedule a minimum of two follow ups 14 days and 30 days after the screening.

b. When a Level 2 external assessment **IS** warranted.

1. After consultation, if concern about suicidal ideation is sufficiently high, the trained school screener will contact and assist the student's parent or legal guardian in referring the student to an in-depth suicide assessment by an external licensed and qualified Mental Health Professional. A Level 2 Assessment of students aged 13 or under will require parental consent.
2. A School Safety Plan should be developed and updated upon the student's return to school prior to or the morning of re-entry. Schedule a minimum of two follow ups 14 days and 30 days after the screening.

***Follow up dates of 14 and 30 days after assessed risk are minimum scheduled contacts. It should be understood that Student Support and Student Safety Plans may include daily, bi-weekly, or weekly follow ups with the student.**

DOCUMENTATION

- ❑ Document when the parents or legal guardians were notified. (If applicable, document contacts with DHS).
- ❑ The trained school screener will complete a confidential Google Form in compliance with the 4J District reporting process.
- ❑ The trained school screener will make a copy of the mental health alert form to place in the student's cumulative file.

SCREENING PROCESS FOR ONLINE STUDENTS ONLY

1. The trained school screener will retrieve the parent or legal guardian's contact information and determine the student's location. The school screener will contact the parent or legal guardian and notify them of the need for screening.
2. Retrieve student's contact information and confirm their exact physical location.
3. Contact the student and obtain assent to conduct the Level 1 risk assessment.
4. Contact the parent or legal guardian if a student could not be contacted or refused assent.
    i. Contact Eugene Police Department to deploy CAHOOTS or Lane County Sheriff's Office for a well check if previous methods to contact the student fail.
    ii. Call 911 if there is a direct and imminent suicide threat.
    iii. Call 911 if the student terminates the remote assessment without reason or warning.
5. Conduct a Level 1 suicide risk assessment interview using the C-SSRS. Determine student risk level.
6. The trained school screener will consult with another trained school screener (another counselor, psychologist, social worker, nurse, administrator, or mental health specialist) or Lines for Life to determine if a Level 2 Suicide Assessment is appropriate. Sharing decision-making with another professional is best practice. The outcome of the consultation will be one of the following:
    iv. Level 2 Assessment is not warranted. A School Support Plan is completed by the end of the next school day.
    v. Level 2 Assessment is warranted.
7. Communicate risk assessment results to parents or legal guardians, and conduct a post C-SSRS parent or guardian interview, if possible.
8. Determine updated risk level, if including results from the parent or legal guardian interview.
9. Notify the school administrator of the results of the Level 1 screening. and/or Level 2 referral.
10. Provide parents or legal guardians with school and community crisis intervention resources.
11. Complete 4J district reporting process.
    i. Google Form
    ii. Mental Health Alert Form in cumulative (cum) file

Process Following Suicide Attempt or Acute Mental Health

1. Collaborate with parents and legal guardians, if possible, to select interventions, and develop a school support or safety plan, as needed.
2. Provide parents and legal guardians with school and community crisis intervention resources.
3. Schedule minimum follow up meetings 14 days after and 30 days after comments, ideation and/or attempt. Designate a trained school screener (counselor, psychologist, social worker, or nurse) or administrator to serve as the school point person for follow up communication and ongoing support/safety plan organization.

Developing a School Support/Safety Plan

After every suicide screening, the trained school screener consults with another mental health professional or administrator to determine if a School Support/Safety Plan is necessary and schedules follow up meetings.

The School **Support Plan** provides a structure for intentional support, designates the responsibilities of each person, and includes a review date to ensure follow-through and coordinated decision making. A designated staff member will serve as the school point person for follow-up communication with parents and, legal guardians and community providers for students who have been screened for suicide.

The School **Safety Plan** provides a more extensive structure for support, designates responsibilities of each person, supervision, and includes a review date to ensure follow-through and coordinated decision making. A designated staff member will serve as the school point person for follow-up communication with parents and legal guardians, and community providers, for students who are moderate to high risk or who have attempted suicide. If the child is transitioning after a hospital stay a re-entry meeting to develop a plan should take place prior to re-entry.

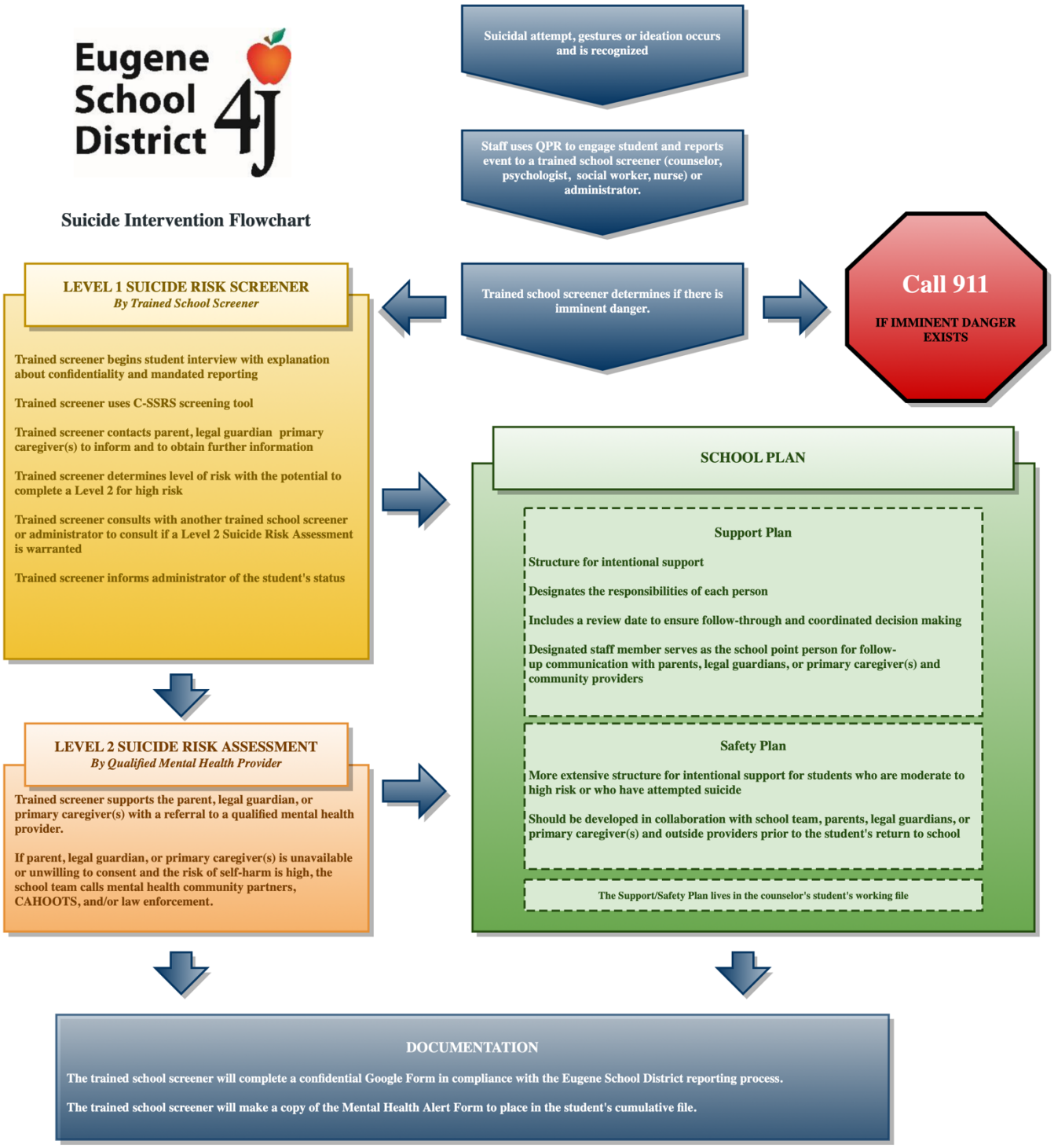
Developing a Re-Entry Plan

The re-entry process occurs after a student has been hospitalized for an attempt or has been out of school for a mental health crisis. Students who have made a suicide attempt are at a higher risk of re-attempting during the first 90 days after the attempt unless the parents and school staff work together utilizing evidence - based prevention protocols. It is important for the student to be monitored by parents or guardians, mental health professionals, and designated school professionals in order to establish a support system. It is critical to connect the student, his/her/their parents or legal guardians, the mental health team working with the student, as well as the school counselor so that pertinent information flows, and a safety net is created.

The Re-Entry Meeting and/or School Safety Plan is scheduled by the designated school counselor or mental health specialist with the student, parent or legal guardian, nurse (if necessary) and administrator. The district suicide prevention specialist, district social worker, student case manager (if SPED), The Child Center Crisis and Transition Services counselor (if applicable) may be available to help, as needed, to complete the Safety Plan.

1. A re-entry meeting should occur when students are returning to school following a suicide attempt, even if the school did not complete a suicide screening. This is a best practice approach contributing to student safety.
2. The Safety Plan should be completed upon the student's return to school (prior to attending classes).

Diagram 2: Suicide Intervention Flowchart of Communication and Action



NOTIFYING PARENTS AND OTHERS

PARENTS MUST ALWAYS BE NOTIFIED WHEN THERE APPEARS TO BE ANY RISK OF SELF-HARM.

a. Whenever a student has directly or indirectly expressed suicidal thoughts or demonstrated other warning signs, the student's parent is to be informed the same day. Such notice shall made by the trained School Screener.

b. If the student discloses thoughts of suicide or if the trained School Screener has reason to believe there is a current risk for suicide, the trained School Screener will request that a parent/ legal guardian come to school to discuss the screening results and will help develop the safety plan, usually in collaboration with the parent or legal guardian and student. This can be completed over the phone, or via zoom, though it is not preferred.

c. If the student denies experiencing thoughts of suicide and the trained School Screener does not have reason to believe there is a current risk of suicide, it is still 4J policy that the trained School Screener notify the parent to share that a screening was conducted and why.

d. If a student is in crisis and the trained School Screener has exhausted all methods to reach the parent or legal guardian (including Emergency contacts and sibling's schools), call The Child Crisis Response Program 1-888-989-9990 or Lines for Life 503-575-3760 to consult regarding next steps. It may be necessary, after consultation, to contact the Department of Human Services (Child Protective Services) (541) 349-4444, 1-855-503-7233, or local law enforcement at 911 if the risk of self-harm may be imminent.

EXCEPTION - ABUSE OR NEGLECT

Parents and legal guardians need to know about a student's suicidal ideation unless the trained School Screener, after conferring with the school administrator, reasonably believes that child abuse or neglect would result from disclosure and would place the student at an imminent increased risk of harm. In such a case, the trained School Screener or other staff person must make a report to the Child Welfare Hotline through the Department of Human Services at (855) 503-7233 or Eugene Police Department. The trained School Screener will also review with the student that they will be communicating with essential staff members in order to keep them safe.

If a student makes a statement such as "My dad/mom would kill me" as a reason to refuse, the trained School Screener can ask questions to determine if parental abuse or neglect is suspected. If there is no indication that abuse or neglect is suspected, compassionately disclose that the parent needs to be involved.

PRIVACY IS OF UTMOST IMPORTANCE, AND EVERY EFFORT WILL BE MADE TO RESPECT THE CONFIDENTIALITY OF THE STUDENT WHILE ATTENDING TO THE SAFETY NEEDS OF THE STUDENT AND SCHOOL BUILDING. THE STUDENT AND PARENT SHOULD BE INFORMED OF THE LIMITED INFORMATION SHARING THAT THE DISTRICT REQUIRES:
For safety reasons, the school building administrator will be notified of every suicide ideation or attempt and district documentation protocols will be followed.
Depending on the School Support/Safety Plan, specific school staff may receive certain information about concerns as part of a plan to maintain safety and provide support to the student. The student and parent are invited to help develop this plan.
A mental health alert sheet will be kept in the cumulative file with contact information for the counselor and student services department.

POSTVENTION PROCEDURES: AFTER A DEATH OCCURS

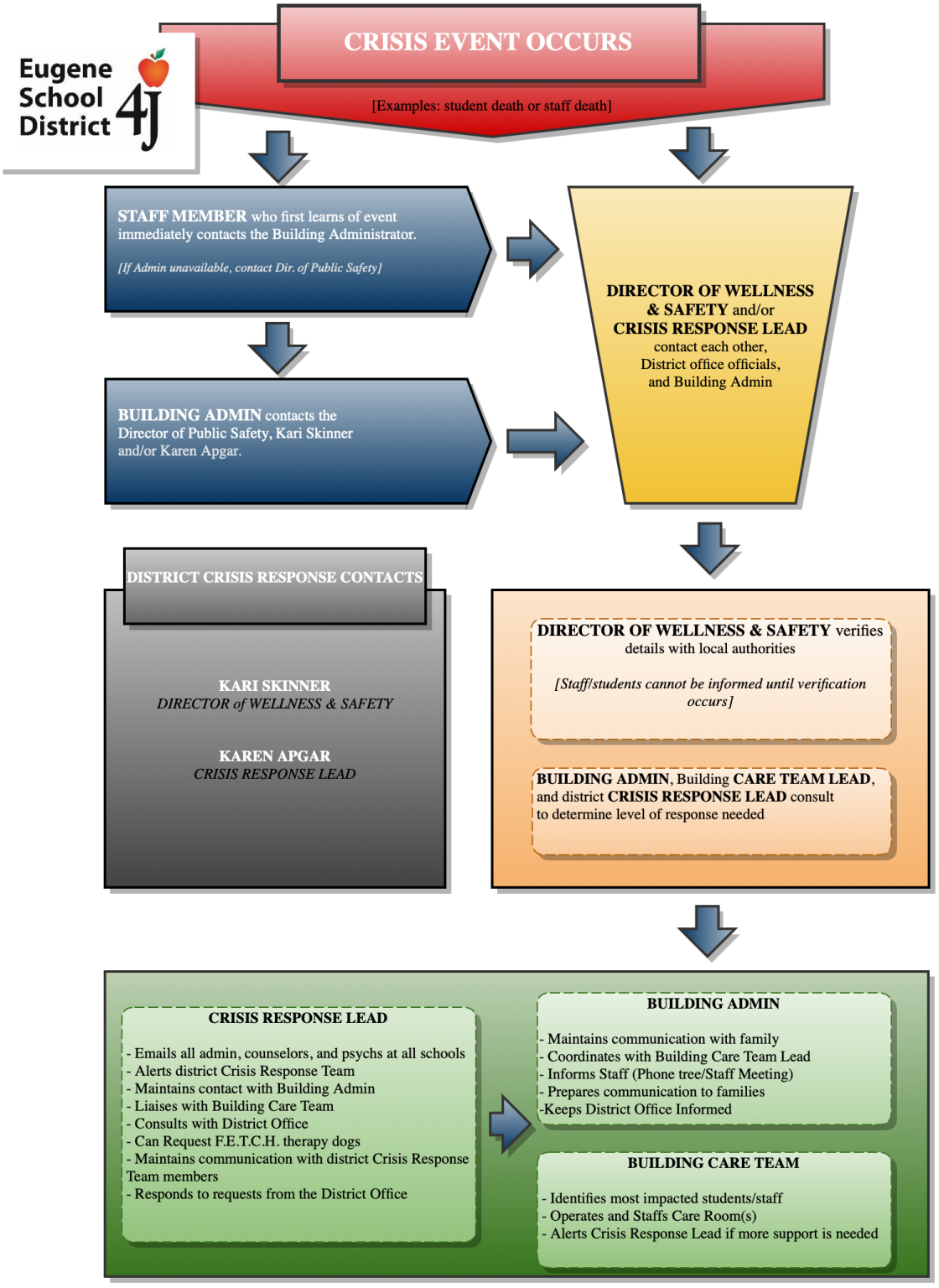
Postvention means any compassionate, honest, and effective "post-intervention" activities conducted after a suicide. Postvention seeks to reduce the risk of imitations or "contagion", supports the needs of those bereaved by a suicide, provides safe messaging to students, families, and the community, and supports the mental health of the entire school community. Appropriate postvention activities serve to enhance future prevention efforts and save lives. Postvention includes procedures and practices addressing immediate, intermediate, and long-term response planning. Postvention also involves active crisis response strategies that strive to treat the loss in similar ways to that of other sudden deaths within the school community and to return the school environment to its normal routine as soon as possible while providing grief support. It includes addressing communication with staff, students, outside providers and families, identifying other potentially at-risk students, and other difficult issues such as memorialization. This includes having a system in place to work with the multitude of groups that may eventually be involved, such as students, staff, parents and legal guardians, community, media, law enforcement, etc. In Oregon, postvention is specifically defined under OAR 309-027-0200(8). Eugene School District 4J works in collaboration with Lines for Life, the Oregon Health Authority and Lane County Public Health per Senate Bills 561, 485 and 981.

POSTVENTION GOALS	POSTVENTION CAUTIONS
❑ Support the grieving process ❑ Prevent suicide contagion ❑ Reestablish healthy school climate ❑ Provide long-term surveillance ❑ Integrate and strengthen protective factors	❑ Avoid romanticizing or glorifying event or vilifying victim ❑ Do not provide excessive details ❑ Do not eulogize victim or conduct school-based memorial services ❑ Do not release information in a large assembly or over the intercom

4J Postvention Response Procedures

1. Principal or administrator notified of suspected or known student death by suicide. Principal/Administrator notifies the Director of Public Safety.
2. Director of Public Safety or designated personnel confirms the cause of death.
3. Director of Public Safety notifies Superintendent and the District Crisis Response Lead of confirmed death.
4. Suicide Prevention Specialist notifies Lane County Public Health (LCPH) as a courtesy. LCPH will then notify Lines for Life Rapid Response Team.
5. District Crisis Response Team Lead contacts building Principal/Administrator to estimate level of need or response resources required and determines what information is to be shared.
6. Director of Public Safety notifies level directors.
7. Principal or administrator communicates with the family to offer condolences and determines their wishes for communication about the death.
8. Superintendent's office prepares any media statements.
9. The Principal/Administrator mobilizes the building Care Team (and district crisis response team, if needed) and prepares for possible substitutes.
10. Administrator and Care Team Lead (with District Crisis Response Lead, as necessary) meet to assign responsibilities:
    1. Identifies potentially at-risk students and staff, e.g., those knowledgeable about or connected to the deceased.
    2. Creates scripts for teachers to use from provided templates. Provides script and response to line staff (building secretaries, etc.)
    3. Gathers Care Room Box and sets up a Care Room.
    4. Gathers input on concerns from teachers and staff.
    5. Maintains contact with the Director of Public Safety and administrator throughout the process.
11. The Principal/Administrator holds all-staff or stand-up meeting as soon as possible and distributes scripts and other resources for teachers to use.
12. Building staff, as directed by the administrator, notify students, and distributes any needed notifications or resource handouts.
13. The Principal/Administrator crafts and sends a message (using provided templates on Google Site) to parents and others in the school community.
14. The Suicide Prevention Specialist monitors media information, including social media.
15. The Principal/Administrator holds end-of-day meeting with the crisis team, provides communication with staff, and determines any follow-up resources or coordination needed.
16. The Principal/Administrator communicates needs for follow up to the District Crisis Response Lead.
    1. The Suicide Prevention Specialist documents the date of death and will send notifications to school administration of the 3-month, 1 year, and birthday anniversary to promote awareness and sensitivity to students and staff potentially impacted.

Diagram 3 Suicide Postvention Crisis Response Communication Pathway



RISK IDENTIFICATION STRATEGIES BY SCHOOL CARE TEAM
❑ IDENTIFY students/staff that may have witnessed the suicide or its aftermath, have had a personal connection/relationship with the deceased, who have previously demonstrated suicidal behavior, have a mental illness, have a history of familial suicide, or who have experienced a recent loss.
❑ MONITOR student absentees in the days following a student suicide, those who have a history of being bullied, who are LBGTQ, who are participants in fringe groups, and those who have weak levels of social/familial support.
❑ NOTIFY parents and legal guardians of highly affected students, provide recommendations for community-based mental health services, hold evening meetings for parents and guardians, provide information on community-based funeral services/memorials, and collaborate with media, law enforcement and community agencies.

COMMITMENT TO STAFF, STUDENTS, AND FAMILIES

Eugene School District 4J strongly values interpersonal connection and strives to encourage personal growth in a diverse community where ALL students recognize their worth and feel they belong. In this community barriers are removed and resources for growth and resilience are provided, in hopes students are inspired to use their gifts in service to one another. Eugene 4J strives to be culturally responsive by recognizing the inherent dignity of its staff, students, and the broader community it serves. In Eugene School District, we believe we are lifelong learners; therefore, this Suicide Prevention Plan will remain a living document to ensure best practices in suicide prevention and mental health support.

REVIEW AND FEEDBACK PROCESS

Eugene School District 4J believes in lifelong learning. Rooted in this belief, a procedure has been created for a student, parents, and/or legal guardians to request the school district review the actions that a school takes when responding to a suicidal risk. Any parent, or legal guardian, with concerns about the district's actions with regard to suicide prevention and response may contact the Suicide Prevention Specialist to discuss such concerns. A person wishing to make a formal complaint may do so following the district's Uniform Complaint Procedure process.

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ACKNOWLEDGEMENTS AND RESOURCES

This document was produced by Angi Meyer, Suicide Prevention and Risk Assessment Specialist, and adapted from the following sources in collaboration with the Eugene School District 4J Mental Health Work Group:

The Trevor Project
Oregon Health Authority (OHA)
Oregon Department of Education (ODE)
Willamette Educational Service District
Lane Educational Service District
The Ross Center
Lane County Public Health
Center for Disease Control (CDC)
Suicide Prevention Resource Center
Research Gate
Lines for Life
National Association of School Psychologists (NASP)
National Institute of Mental Health (NAMI)

COMMUNITY RESOURCES LINK
4J Community Suicide Prevention Contacts and Resources

FORMS AND CHECKLISTS

WARNING SIGNS FOR SUICIDE

There is no definitive list of warning signs of suicide.

Ideation - *Thoughts of Suicide*	Expressing suicidal feelings through talking, gesturing, writing, or drawing. Desire to die
Suicide Plan	Having a plan for suicide and/or obtaining the means to follow-through on a suicidal attempt.
Unbearable Pain	Often as a result of a loss/crisis. Expressing they are suffering a great deal and feel there is no hope.
Displaying Signs of Depression	Such as a loss of pleasure in activities they used to enjoy, prolonged sad mood, changes in eating or sleeping patterns.
Making Final Arrangements	Saying good-bye as if they won't be seeing someone again. Giving away favorite possessions.
Self-Destructive Behavior	Such as the start of or increase in alcohol or drug use, risky sexual behavior, reckless driving.
Changes in Behavior	Such as pulling away from family, friends, or social groups; anger or hostility.
Previous Suicide Attempt	This significantly increases the likelihood that someone will complete suicide.
Exposure to Suicide	Friend or family member who attempted or completed suicide.
Abuse	Physical or sexual abuse, being mistreated.
Social Isolation	May lead to feelings of helplessness and depression. Lack of support. Unwilling to seek help.
Depression, Anxiety, Agitation	Primarily Major Depressive Disorder. Feeling trapped.
Access to Lethal Means	Such as guns, weapons, knives, medications in the house.
Perceived Major Trouble	Such as trouble at school, at home, or with the law.
Peer Victimization	Bullying, extreme embarrassment or humiliation.

5 Steps to Help a Suicidal Student

Take all suicidal behavior seriously.

1.	Establish Rapport	Express your concern about what you are observing in their behavior.
2.	Ask the question *It is important that this question is asked directly and it is not asked in a roundabout way.*	"Are you thinking about suicide?"
3.	If "Yes", then do not leave this student alone.	Stay with the student.
4.	Offer comforting things to say	Such as, "Thanks for telling me, I am here to help."
5.	Escort student to a Primary Intervener	Primary Interveners: School Counselors, School Psychologists, School Nurses, and Principals

Suicidal Behavior Risk and Protective Factors

Risk Factors	Protective Factors
○ Current plan to kill self ○ Current suicidal ideation ○ Access to means to kill self ○ Previous suicide attempts ○ Family history of suicide ○ Exposure to suicide by others ○ Recent discharge from psychiatric hospitalization ○ History of mental health challenges ○ Current drug/alcohol use Sense of hopelessness ○ Self-hate or self-injurious behavior ○ Current psychological/emotional pain ○ Loss (relationship, work, financial) ○ Relationship issues (friends/family/school) ○ Feeling isolated/alone ○ Current/past trauma ○ Bullying ○ Discrimination and lived experience with oppression ○ Chronic pain/physical health problems ○ Impulsive or aggressive behavior ○ Unwilling to seek help ○ Members of disproportionately at-risk groups (LGBTQ+, Black, Indigenous, People of Color, etc.)	● Engaged in effective physical and/or mental healthcare ● Feeling connected to others (family, friends, school, at least one trusted adult) ● Positive problem-solving skills • Healthy coping skills ● Restricted access to means to kill self ● Stable living environment ● Willing to access support/help ● Positive self esteem ● Resiliency ● High frustration tolerance ● Emotional regulation ● Cultural and/or religious beliefs that discourage suicide Successful at school ● Has responsibility for others ● Financial stability ● Future planning ● Acceptance of identity (family, peers, school) **KEEP IN MIND**: A person with an array of protective factors in place can still struggle with thoughts of suicide. It is important to consider this when conducting a risk assessment.

SUICIDE RISK FACTORS AND WARNING SIGNS CHECKLIST

Risk Factors

	Mental illness		Local suicide cluster
	Substance use disorder		Lack of social support and sense of isolation
	Hopelessness		Asking for help is associated with stigma
	Impulsive/aggressive tendencies		Lack of healthcare
	Trauma or abuse history		Exposure to a suicide death
	Major physical or chronic illness		Non-suicidal self-injury
	Previous suicide attempt		Cultural/religious beliefs that suicide is an acceptable solution to coping challenges
	Family history of suicide		Other:
	Recent loss of relationship		
	Access to lethal means		

Warning Signs

	Talks about wanting to die/kill self		Acts anxious, agitated, or reckless
	Looks for ways to kill self		Sleeps too little or too much
	Reports feeling hopeless		Withdraws or reports feeling isolated
	Reports feeling having no purpose		Shows rage or talks about seeking revenge
	Reports feeling trapped		Displays extreme mood swings
	Reports feeling in unbearable pain		Other:
	Talks about being a burden		
	Increasing use of alcohol or drugs		

From NASP (2020a)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

SUICIDE IDEATION DEFINITIONS AND PROMPTS		
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
Have you actually had any thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
) Have you been thinking about how you might do this? E.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it….and I would never go through with it."		
4) Have you had these thoughts and had some intention of acting on them? As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		

Have you ever done anything, started to do anything, or prepared to do anything to end your life?	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: Was this within the past three months?		

Low Risk
(i.e., current comments, thoughts of suicide, but no suicide plan, acknowledges helping resources and protective factors)

Moderate Risk
(i.e., prior attempt, thoughts of and plan for behavior or no resources, but no time frame for behavior)

High Risk
(i.e., thoughts of suicide, plan for behavior, time frame for behavior specified, and no helping resources)

POST C-SSRS PRIMARY CAREGIVER INTERVIEW (OPTIONAL)

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?
Has your child ever tried to harm themselves before?
Have they ever attempted to kill themselves before?

NASP (2020)

Intervention Plan Checklist

This is a checklist to document interventions taken.

	Provided 24/7 resource numbers
	Connected(ing) with school/community resources
	Called for a 911 wellness check
	Mobilized prosocial support systems
	Identified specific caring adults
	Promoted communication and coping
	Provided treatment referrals

Primary Caregiver Student Safety Plan Includes

	Increased supervision
	Constant supervision (including when they are in the bathroom)
	Restricted access to possible suicide means
	Provided 24/7 resource numbers
	Made immediate treatment referrals
	Mobilized prosocial support system
	Connected with school/community resources
	Arranged transportation
	Called DHS