Suicide Prevention Practices 5141.5 R

1) Crisis Team – should meet within the first ten school days of each school year.

2) Crisis Team (or another established committee) should include a subcommittee that addresses Suicide Prevention & Wellness; it should be established and active in each school.

   Suicide Prevention & Wellness Committee in each school should be interdisciplinary. Goals of the committee include:
   a. Addressing Suicide Awareness and Prevention Recommendations
   b. Promoting integration of "wellness" across the curriculum

3) The Counselor or Principal is the Site Level Incident Coordinator.

4) The Suicide Prevention and Wellness Committee continue to review the health curriculum to determine the points at which suicide should be directly addressed, given national trends indicating suicide is impacting younger students. Review any changes with Suicide Response Committee.

5) Suicide Response Committee: Will serve as a resource to the schools to provide guidance in time of crisis in addition to district and site coordinators. The Suicide Response Committee will meet and train all staff annually.
   a. Suicide Response Committee in each school shall meet annually to ensure consistency throughout the region.

6) Time should be designated annually for review of this document with staff, no later than October 31st of each year
   a. Guidelines for suicide prevention are provided to all new staff members.
   b. Time and opportunity should be provided within each building to meet with new staff regarding crisis intervention and "wellness."

7) Parent forums to promote positive mental health should be part of an ongoing proactive prevention program.

8) All contracted staff in the region who are not in one school district shall be responsible for obtaining training annually.

Suicide and Crisis Intervention Procedures at Sharon Center School

When an employee of Sharon Center School is confronted with an individual who presents as at risk of suicide, appears to have attempted, or expresses suicidal thinking the employee will adhere to the following protocol:

Sharon Board of Education
Sharon, Connecticut

In the event that a student has acted in a manner which creates a medical emergency, the building principal or designee are to be notified and emergency medical procedures initiated.

1) If the designated professionals conduct an assessment and determine that hospitalization is required, the student will be transported immediately to an area hospital. The Principal or designee will make every attempt to contact the parent and ask that they go to the hospital.
   OR
   If an assessment is not able to be conducted or hospitalization is not required, 211 will be immediately called. The Principal or designee will make every attempt to contact the parent and ask that they go to the hospital.

When an employee of Sharon Center School is confronted with an individual presenting with suicidal thinking and that student has taken no action resulting in self-harm, these procedures are to be followed*:

1) Psychologist, school counselor, or nurse ensures that the student is not left alone at any time.
2) The Psychologist or School Counselor verbally notifies/consults with other staff as necessary (e.g., administration, school counselor, teachers, and nurse).
3) The parents or guardian will be notified by the school designee of the referral.
4) The Psychologist, school counselor, or nurse will utilize the C-SSRS model for risk assessments to determine further steps for referral.
5) The Psychologist or School Counselor notifies/consults with the student's private therapist, if appropriate. The School Counselor should have a release of information for the student's after care provider.
6) Psychologist or School Counselor plans follow-up procedures for the student with parent per clinical recommendations.
7) Psychologist or School Counselor notifies the principal and/or designee of the situation and informs him/her of the recommendations to be made to the parents.
8) Psychologist or School Counselor will contact DCF for all students under 18 years of age, if parent does not follow the recommendations of the professional assigned to the student.
9) Psychologist or School Counselor documents the course of events.
10) The Psychologist, School Counselor, or Administrator will follow-up with the student and parent the next school day, and then as needed.
11) The Psychologist or School Counselor will also follow up by documenting ~~documents with written notes~~ all contacts/discussions with student, parent, and staff. The Suicide Intervention Form is completed and submitted to the Principal ~~with a copy going to the Counselor or Psychologist~~. This form will be stored in student confidential files in the Pupil Services Office.
12) A re-entry meeting will be held and a PPT may be held prior to the student returning to school.
13) Check box on cumulative file indicating that Pupil Services has additional information.

*All staff listed above are expected to be trained in the use of the Columbia Suicide Severity Rating (C-SSRS)

Postvention Policy & Procedure at Sharon Center School in the event that a student dies by suicide or sudden death

Sharon Board of Education
Sharon, Connecticut

Before the opening of the next school day, Crisis Team meets to:

1) Verify suicide
2) Assess the potential impact on the school
3) Estimate level of response resources required
4) Advise administrative team how to proceed
   a) Develop a list of impacted students and staff to be notified prior to larger student body.
   b) Assign trained staff to each of the deceased student's classrooms.
   c) Assign highly visible, accessible trained staff to be available throughout the day.
   d) Collect the deceased student's personal possessions before school begins.
5) Contact the family to: offer support, obtain information regarding funeral arrangements, family wishes, and information to be released.

At the start of the school day and throughout, mobilize the postvention plan and enact the following:

1) A faculty staff meeting is immediately held before the start of the school day to communicate information and protocol.
2) Media contact is made through the administrator, as appropriate.
3) An end-of-day team/staff meeting should be held to review the day's events and identify unmet needs and further procedures.
4) Assign one staff member to follow-up with each at-risk student, as well as each staff member impacted by a student's death.
5) Consider a letter or another form of communication to the school community regarding the incident, to be sent by the administrator.
6) Consider careful discussion of memorials and tributes given the potential for possible glamorization of the death.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric - Since Last Contact – Communities and Healthcare

Version 6/23/10

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

Disclaimer:

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

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

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

Sharon Board of Education
Sharon, Connecticut

SUICIDAL IDEATION

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

Since Last Visit

1. Wish to be Dead
Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Have you thought about being dead or what it would be like to be dead?
Have you wished you were dead or wished you could go to sleep and never wake up?
Do you wish you weren't alive anymore?

If yes, describe:

Yes ☐ **No** ☐

2. Non-Specific Active Suicidal Thoughts
General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.
Have you thought about doing something to make yourself not alive anymore?
Have you had any thoughts about killing yourself?

If yes, describe:

Yes ☐ **No** ☐

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."*
Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?

If yes, describe:

Yes ☐ **No** ☐

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan
Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?
This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.

If yes, describe:

Yes ☐ **No** ☐

5. Active Suicidal Ideation with Specific Plan and Intent
Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?
What was your plan?
When you made this plan (or worked out these details), was any part of you thinking about actually doing it?

If yes, describe:

Yes ☐ **No** ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

Most Severe Ideation: _____ _____

Type # (1-5) ***Description of Ideation***

Most Severe

Frequency
How many times have you had these thoughts? ***Write response*** _____
(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable

____

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

Actual Lethality/Medical Damage: 1. No physical damage or very minor physical damage (e.g., surface scratches). 2. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 3. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 4. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 5. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 6. Death	*Enter Code*
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code*