THE JASON FOUNDATION

SUICIDE INTERVENTION IN SCHOOLS TOOLKIT: 10 RULES & TOOLS FOR SCHOOLS

The Jason Foundation

SCOTT POLAND & RICHARD LIEBERMAN WITH DONNA POLAND

INTRODUCTION

ABOUT THE JASON FOUNDATION

The Jason Foundation (JFI) began in October of 1997 after our president, Clark Flatt, lost his son, Jason, to suicide. Clark describes Jason as being an "average 16-year-old," who made Bs and Cs on his report card, loved football, had a solid friend group, and was actively curious and excited about the world around him. Before Jason's death, Clark was not aware just how big of an issue youth suicide was in the United States. This lack of awareness that Clark had and that many other people in the nation continue to have to this day is why JFI refers to youth suicide as "the silent epidemic." Because of the stigma surrounding mental health issues, many people may not feel comfortable discussing suicide with others, which contributes to a general silence surrounding the issue. Despite the fact that people may be hesitant to talk about suicide, it still occurs at a high rate. Currently, we lose approximately 120 young people aged 10-24 to suicide each week nationwide.[1]

The Jason Foundation strives to replace this silence with awareness. All of our programs aim to get people talking about the problem of youth suicide and to inform people of the warning signs that could indicate a loved one is considering suicide. We believe that once a person is familiar with the signs of concern that often accompany suicidal thoughts and knows about the crisis resources available in their area and nationally, they will be properly equipped to assist a young person in crisis get the help they need.

JFI's programs build what we call a "triangle of prevention." This triangle includes the main groups of people who come into contact with a young person on a regular basis, so their parents, educators or other youth workers, and friends and peers. For parents, we offer community presentations as well as a library of sources about helping children through suicidal ideation and mental health struggles. For educators and youth workers, we provide professional development training modules through our online training platform as well as staff-led in-service presentations. For students, we have a curriculum designed to be shown in a classroom setting that teaches young people how to look out for friends who may be struggling.

Though we offer a variety of resources for many different demographics, the largest demographic utilizing our programs is teachers due in part to our efforts to encourage state legislatures to pass the Jason Flatt Act. In 2007, The Jason Flatt Act was first passed in our home state of Tennessee and became the nation's most inclusive mandatory youth suicide awareness and prevention legislation pertaining to teacher's in-service training. It requires all educators in the state to complete two hours of youth suicide awareness and prevention training each year in order to be licensed to teach in Tennessee. Since then, 21 states have passed the Jason Flatt Act.

We hope this toolkit will make a useful addition to our library of resources for educators and school staff. For more information about our programs, see **References/Resources**, or visit us online at **www.jasonfoundation.com.**

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024.

ABOUT
THE INTERVENTION TOOLKIT

The Jason Foundation, Inc. (JFI) is a national leader in youth suicide prevention and an advocate for all schools to have comprehensive suicide prevention policies and procedures to guide key school personnel to prevent student death by suicide. This comprehensive guide blends both the current research and the experiences of practitioners to inform best practices for suicide intervention in schools.

This Suicide Intervention in Schools Toolkit provides 10 Rules and Tools for Schools to help guide school staff in developing policies and procedures for intervening with students potentially exhibiting suicidal ideation or behavior.

The 10 Rules are summarized here:

Rule 1: Recognize the need for comprehensive suicide prevention and intervention policies and procedures.
Rule 2: Prepare to intervene with students exhibiting potentially suicidal ideation and behaviors.
Rule 3: Assure the student's safety and protect the school mental health professional from liability through supervision and collaboration.
Rule 4: Screen for suicide risk.
Rule 5: Notify parents/guardians or child protective services.
Rule 6: Provide interventions at school and collaborate with community mental health resources.
Rule 7: Document all actions of the crisis team.
Rule 8: Develop a safety plan.
Rule 9: Develop a reentry plan.
Rule 10: Follow up with the student.

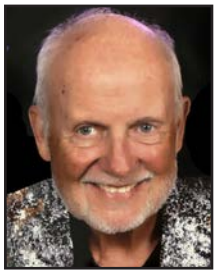
The 10 Tools included in this kit are:

Tool 1a: Role Play of Suicide Screening and Safety Planning Scenario
Tool 1b: Role Play of Parent or Caregiver Notification
Tool 2: Documentation of Suicide Screening and Steps for Student Safety
Tool 3: Brief Screening CSSR-S
Tool 4: SAFE-T**:** Suicide Assessment Five Steps Evaluation and Triage
Tool 5: The Parent Conference
Tool 6a: Sample Parent Notification Form for Student At-Risk of Suicide
Tool 6b: Suicide Proofing the Home
Tool 7: Stanley-Brown Safety Plan
Tool 8: Reentry Planning Following Mental Health Hospitalization
Tool 9: Screening Community-Based Mental Health Providers
Tool 10: Release of Information Form

If you are looking at this toolkit for the very first time, a student at your school is likely at risk for suicide, and you are being asked to intervene. The following 10 Rules and Tools for Schools guide you through best practices for suicide intervention. Key school mental health professionals (SMHP), which include school psychologists, counselors, and social workers, are the most trained and knowledgeable personnel to intervene with students at risk for suicide. However, it is recognized that there may be a time when an SMHP is not available, and a school administrator might need to initially intervene with a student at risk for suicide until an SMHP or emergency personnel are available.

It is our hope that key school personnel, such as school administrators and school mental health professionals, will join to review this toolkit and use it to assist in developing policies and procedures for intervening with students exhibiting suicidal ideation and behavior in their schools and districts.

ABOUT
THE AUTHORS



Scott Poland, Ed.D.
Professor at Nova Southeastern University's College of Psychology

Director of The Suicide and Violence Prevention Office at Nova Southeastern University

I worked in schools as a psychologist or director for 26 years and am still very involved in school crisis response and consultation. I have provided on-site assistance after suicides in many school districts and consulted with many other school leaders after the loss of a student to suicide. As a survivor of the suicide of my father, my family and I are an example of those who never believed a suicide could happen. After being promoted to the Director of Psychological Services in Cypress-Fairbanks ISD in Texas and being faced with the suicides of several students, I became dedicated to suicide prevention. The district superintendent asked me in 1982 what I was going to do about these suicides. At the time, I answered that I did not know. Figuring out how to prevent youth suicide has been my highest professional priority ever since, and I have presented more than 1,500 times on the topic of school crisis and suicide intervention. I am a licensed psychologist and an internationally recognized expert on youth suicide and school crisis, and I have authored or co-authored six books on the subject. Additionally, with my wife, Donna, we have authored the Suicide Safer School Plan for the state of Texas, the Montana CAST-S (Crisis Action School Toolkit on Suicide), and the Florida STEPS (School Toolkit for Educators to Prevent Suicide). I am a past President of the National Association of School Psychologists and a past Prevention Division Director of the American Association of Suicidology. Richard Lieberman and I contributed to the After a Suicide Toolkit for Schools for the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, and we developed numerous suicide prevention, intervention, and postvention training modules for The Jason Foundation.

Richard Lieberman, MA NCSP
Lecturer at the Graduate School of Education at Loyola Marymount University

Lead Suicide Prevention Consultant for the Suicide Prevention Ongoing Resilience Training Program (SPORT)[2]

I am a school psychologist with 50 years of experience in schools. I began my career as an advocate for suicide prevention in schools in 1986 after learning that suicide was the third leading cause of death for high school students. I co-authored the Youth Suicide Prevention Program that provided guidance to over 1,200 schools, covering the one million students of the Los Angeles Unified School District (LAUSD). For many years, the LAUSD program was one of the only suicide prevention efforts in schools, which brought scrutiny and many opportunities for my personal growth. Along the way, I have co-authored numerous book chapters, articles, and curricula on suicide prevention in schools. I have contributed to SAMHSA's Preventing Suicide: A Toolkit for High Schools, the SPRC and AFSP's After a Suicide: A Toolkit for Schools toolkit, and the AFSP and California Department of Education's Model School District Policy on Suicide Prevention. Perhaps a highlight of my career was serving on the founding Steering Committee for the Suicide Prevention Resource Center. I have joined Scott Poland in many projects for The Jason Foundation, and together we have presented internationally and consulted nationally with districts and communities experiencing suicide clusters, intervention, and postvention training modules for The Jason Foundation.

[2] SPORT resources have been accessed by over 70 school districts of the Los Angeles County Office of Education and many counties throughout California.

ABOUT
THE AUTHORS

Donna Poland, Ph.D.
Lifetime teacher certification in several subject areas, educational supervision certification, and educational principal certification

I have been a professional educator for 37 years, of which 27 years were in public schools in the great state of Texas, where everything is big! Imagine my surprise, as a first-year teacher, when I discovered that my middle school classes averaged 30+ students, and I had six classes each day! I very quickly discovered that I needed to get to know my students and build a respectful and nurturing environment before I could even consider teaching the curriculum. Having that vital connection with each student was the reason I walked joyfully into the building every day. After 17 years in the classroom, I began my administrative journey as a director of instruction, an at-risk coordinator, an associate principal, and finally, a principal. Immediately upon taking a leadership role, I was faced with the tragedy of a scholar-athlete taking his life by suicide just days before he was due to enter 9th grade, and at that time, there was not a toolkit to follow. I felt a lot of responsibility to provide leadership and support to the affected school community and relied on the school mental health personnel to guide me. I also provided extensive support for the school crisis team that provided front-line help to affected staff and students. I would like to say it was the only student suicide I experienced.

Unfortunately, every year resulted in working with parents, staff, and children in the aftermath of a death by suicide or accidental death. It would have been very helpful to have a memorial policy in place, as with each loss, we struggled with appropriate ways to memorialize the student. For the next 10 years (at a small private college preparatory school in Florida), I continued to need the skills for developing programs, educating staff, and working with parents regarding the signs of depression and suicide. After experiencing a death by suicide, especially of a young person, one never forgets the details of a life that ended too soon and the haunting questions of “What did I not see?” and “What could I have done?” I hope the information contained in this toolkit will help you in your work with our young people.

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Recognize the need for comprehensive suicide prevention and intervention policies and procedures.

It is important that schools are aware of the most current data on the incidence of youth suicide. Data from the most recent 2023 Youth Risk Behavior Surveillance Survey (YRBSS) of high school students is included below.[3] The figures represent an increase in each question concerning suicide and feeling sad or hopeless from the study released in 2019 (pre-COVID). There was an increase in results in all areas from 2019 to 2021.

The 2023 results were closely aligned with the 2021 statistics, with depressive symptoms and suicidal ideation still above 2019 statistics while suicide plans and attempts decreased slightly to 2019 statistics. However, over time, trends in all areas are increasing. High school students nationally in **the last 12 months**:

- 40% reported feeling sad or hopeless two or more weeks in a row.
- 20% reported seriously considering suicide.
- 16% made a plan for suicide.
- 9% made one or more suicide attempts.

Looking closer at the gender differences within the 2023 data, over the past year, girls reported depressive episodes at almost twice the rate of boys and suicide attempts at over twice the rate of boys.

Looking through a developmental lens, suicide rates have increased for youth, particularly minority and marginalized groups, and suicide is the second leading cause of death for 10–14 year-olds and the third leading cause of death for 15–24 year-olds. Suicide rates have almost doubled for middle school-aged children in the past decade.[4]

Alarmingly, increasing numbers of elementary-aged students, particularly African American youth, are expressing suicide ideation, and there may be a need to include upper elementary-age students in the YRBSS in the future. It is noted that it is difficult to screen for suicide risk regardless of age, but it is especially challenging with elementary-age students. The referral for intervention with a student who is experiencing suicidal ideation or behavior might come from school staff, parents, a peer, or the student themselves. If a student is suspected of being at risk of suicide, there is an immediate need to screen for risk.

As we look through a cultural lens, suicide rates are extremely high for students who identify as LBGTQ+.[5] There are national advocates for LGBTQ+ youth, and they provide extensive data on suicidal behavior and resources for this at-risk population. For more information, see the resource section at the end of this toolkit.

[3] Centers for Disease Control and Prevention. [2023] Youth Risk Behavior Survey Data. Available at: www.cdc.gov/healthyyouth/data/yrbs. Accessed on December 5, 2024.
[4] Center for Disease Control and Prevention (2022). Web-based inquiry Statistics Query and Reporting System (WISQARS). https://wisqars.cdc.gov/. Accessed on May 18, 2024.
[5] Erbacher, T. & Poland, S. (2023). Suicide intervention in the schools. In P. Harrison, S. Proctor & A. Thomas (Eds.), Best practices in school psychology VII. Washington, DC: National Association of School Psychologists.

In the US, the highest rates of suicidal behaviors are among American Indians/Alaskan Natives, and the largest increase in suicidal ideation and action over the past 20 years is among African American youth. Latinx students lead all other ethnicities in the reporting of suicidal thoughts and behaviors, and Asian American students report the highest rates of depression and suffer from the recent harassment and bullying around COVID. The disproportional impact of the pandemic on Black and Brown communities cannot be understated. Many marginalized students suffered from isolation, loss, economic strife, and a lack of access to mental health services. In working with multicultural populations, potential barriers include language, socioeconomic status, stigma, historical trauma, and varied views on grief, death, and suicide.[6]

It is important to recognize the strong association between bullying and suicide. A student known to be a victim of bullying should be asked about hopelessness and thoughts of suicide at the appropriate time during screening.[7] In recent years, there have been several lawsuits filed on behalf of parents against the school after the suicide of their child. They charged that bullying at school was a proximal cause of the suicide of their child. Many of these suits were settled out of court. Two groups most often victimized by bullying and in need of supervisory protections are LGBTQ+ and youth with disabilities.[8]

It is also important to recognize that students engaging in non-suicidal self-injury (NSSI) may also be at risk for suicide, particularly those who harm themselves repetitively. NSSI is a puzzling, complex behavior that provides episodic relief to distressing thoughts. It is a behavior that can become addictive with repetition. Those engaging in a variety of NSSI methods over long periods are at the highest risk for a suicide attempt. Joiner emphasized that individuals engaging in NSSI become comfortable harming their bodies and use the term “habituating.”[9] SMHPs should not hesitate to ask those students known to be engaging in NSSI about suicidal thoughts and plans.[10]

School personnel are encouraged to review their state’s high school YRBSS data when advocating for suicide prevention services in their community. Some states have even begun to gather data for middle school students as well. YRBSS data is gathered every two years and can be found on the CDC YRBS page.[11]

[6] Erbacher, T., Singer, J. & Poland, S. (2024) Suicide in schools: Practitioner’s Guide to multi-level prevention and intervention, 2nd Edition. New York: Routledge Publishing.
[7] Poland, S. & Lieberman, R. (2018). Bullying and suicide revisited: What schools can do now. NASP Communique. 46(5).
[8] Erbacher, T. & Poland, S. (2023). Suicide intervention in the schools. In P. Harrison, S. Proctor & A. Thomas (Eds.), Best practices in school psychology VII. Washington, DC: National Association of School Psychologists.
[9] Joiner, T. (2011). Myths about suicide. Cambridge: Harvard Press
[10] Erbacher, T. & Poland, S. (2023). Suicide intervention in the schools. In P. Harrison, S. Proctor & A. Thomas (Eds.), Best practices in school psychology VII. Washington, DC: National Association of School Psychologists
Lieberman, R., & Poland, S. (2006). Self-mutilation and schools. In G. Bear & K. Minke (Eds.), Children’s Needs III: Development, Prevention & Intervention. Bethesda, MD: National Association of School Psychologists
[11] Centers for Disease Control and Prevention. [2023] Youth Risk Behavior Survey Data. Available at: www.cdc.gov/healthyyouth/data/yrbs. Accessed on December 5, 2024.

Prepare to intervene with students exhibiting potentially suicidal ideation or behaviors.

Many Jason Foundation training modules advocate for school districts to collaborate with community stakeholders to establish youth suicide prevention task forces. These would include the critical personnel who can make decisions to update district policies that follow best practices revealed in literature. The essential guide to school districts for developing suicide prevention policies is A Model School Policy on Suicide Prevention: Model Language, Commentary and Resources.[12] This document was developed to ensure that local policies are in line with the latest research in the field of suicide prevention and identify best practices for a national framework. The model is comprehensive, with modular language that may be adapted to draft policies based on the unique needs of individual districts.

An essential component of preparedness is training, and many states mandate or recommend annual training of school site crisis teams, SMHPs, staff, parents, and students on their roles in youth suicide prevention. A school site crisis team is comprised of administrators, SMHPs, nurses, and security, and each plays a critical but distinct role when an at-risk student is referred. Often, the student says, does, writes, or draws something that comes to the attention of a third party. That third party, who may be a teacher, parent, student, or other trusted adult at school, is known as a gatekeeper. Gatekeeper training empowers all school personnel with the knowledge of risk factors, warning signs, and how to keep a student safe until a screening by an SMHP can be performed.

SMHPs perform many significant roles in addition to training teams, staff, parents, and students. During the intervention process they screen students to determine their level of risk (**Rule 4**), notify parents/guardians or protective services when appropriate (**Rule 5**), generate interventions (**Rule 6**), create safety plans for all referred students (**Rule 8**), and create reentry plans (**Rule 9**) when students return to school from a mental health hospitalization.

Within the hectic pace of the typical school, screening for suicide risk and contacting and notifying parents are challenging tasks for the SMHP. Ideally, all SMHPs, either through their graduate work or professional development, will have observed or participated in various roleplays.

Tool 1a provides a sample role-play for SMHPs to practice conducting a suicide risk screening with a student utilizing direct language. A parent notification conference that results in a partnership between the school and the parent or caregiver is essential for student safety. A sample role play of parent or caregiver notification is provided in **Tool 1b**.

[12] American Foundation for Suicide Prevention, American School Counselor Association, National Association of School Psychologists & The Trevor Project (2019). Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources (2nd ed.). New York: American Foundation for Suicide Prevention. https://afsp.org/model-school-policy-on-suicide-prevention/

Assure the student's safety and protect the school mental health professional from liability through supervision and collaboration.

Throughout the referral process, the safety of the student and the SMHP must be assured. Safety for the student is achieved through adult supervision every step of the way. Safety for the SMHP is achieved through active collaboration with other crisis team members.[13]

Supervision

Supervising a student is not as easy as it sounds. What is the bus driver to do if a student shares suicidal thoughts during the ride to or from school? What is the teacher to do if she reads a concerning passage or views a drawing in a student's journal and she is the only adult in the classroom? During staff training, it is imperative that all school personnel learn to maintain supervision of a student exhibiting potentially suicidal ideation or behavior and follow procedures to safely hand off the student to an SMHP or crisis team member to conduct the necessary screening. Such staff should then be strongly encouraged to collaborate with the crisis team and provide valuable feedback to the SMHP during the screening phase (**Rule 4**) where the level of risk must be determined.

Collaboration

Intervening and interacting with students exhibiting potentially suicidal ideation or behavior can be quite anxiety-provoking for school personnel. Safety for the SMHP is achieved through collaborating with other school crisis team members so that all decisions regarding student welfare are team decisions.[14] The school administration must be informed when there is a student at risk of suicide. Therefore, all SMHP should collaborate with the site administrator or designee when initiating a referral. It is strongly recommended that the SMHP add another consultant, preferably a member of the school site crisis team that knows the student, perhaps another SMHP. Occasionally, the SMHP will require another adult to supervise the student while conferences with teachers, other staff, community resources or searches for the parent are made. All team actions must be documented per district policy. **Tool 2** provides a sample documentation form, which is discussed with documentation (**Rule 7**). It is always prudent for the SMHP to maintain separate and personal documentation of all professional actions.

[13] Lieberman, R., Poland, S., & Kornfeld, C. (2014). Suicide intervention in the schools. In A. Thomas & P. Harrison (Eds.), Best practices in school psychology VI. Washington, DC: National Association of School Psychologists.
[14] Lieberman, R., Poland, S., & Kornfeld, C. (2014). Suicide intervention in the schools. In A. Thomas & P. Harrison (Eds.), Best practices in school psychology VI. Washington, DC: National Association of School Psychologists.

Screen for suicide risk.

In a perfect world, the SMHP would have the luxury of a quiet space and sufficient time to gather information and conduct a suicide screening, but this is rarely the case. More often, this kind of referral comes at what may appear to be the most inconvenient time, such as first thing Monday morning or around dismissal time on a Friday. Fortunately, the SMHP brings compassion, knowledge, counseling, and listening skills to the screening component to support students through the initial anxious screening moments. It is crucial for the student not to feel that they are in trouble or the first student to have suicidal thoughts. Connecting with the student is essential not only to build trust but also to guide them to know there are trusted adults at school and help is available.

SMHPs are strongly encouraged to seek supervision and collaboration (**Rule 3**) when screening students for suicide risk and not to rush screening even if it is late in the school day. It is prudent to remember two factors generally combine to elevate risk in youth. The first is a chronic factor, such as a history of depression or other mental illness, that becomes ignited by a second factor, a significant precipitating event. Suicide is the result of a psychological process that takes months to develop.[15] Still, a precipitating event may cause someone to act on their earlier thought-out suicide plans. The most common precipitating events to a youth suicide, enumerated in the most recent National Association of School Psychology best practice publications[16] are the following:

- loss as exemplified by a break-up of a relationship, death of a loved one by suicide, or a loss of dignity through severe humiliation
- family issues such as a severe argument with parents or witnessing/suffering domestic violence, such as intimate partner violence (IPV)
- school issues such as an academic or disciplinary crisis

In the past, the term “suicide assessment” had been widely used to describe the evaluation process for a student who is at risk. However, in recent years, the thinking has evolved, particularly with gains in clinical suicide assessment. Today, we consider the more appropriate term “suicide risk screening” to describe the best practice for schools. The level of risk determined at the end of the screening process should be viewed as a snapshot of a student’s life at the time of the screening. The actual value of both suicide assessment and screening should be to identify points of prevention rather than as tools for prediction.[17]

Many SMHPs have remarked that levels of risk have the potential to change frequently, even within school hours, as students are generally lower in risk when trusted adults appear to advocate for their welfare. “Points of prevention,” such as supervision, removal of lethal means at home, and creating a circle of care of trusted adults around the student, can be very helpful in reducing immediate risk.

[15] Joiner, T. (2011). Myths about suicide. Cambridge: Harvard Press
[16] Erbacher, T. & Poland, S. (2023). Suicide intervention in the schools. In P. Harrison, S. Proctor & A. Thomas (Eds.), Best practices in school psychology VII. Washington, DC: National Association of School Psychologists. Lieberman, R., Poland, S., & Kornfeld, C. (2014). Suicide intervention in the schools. In A. Thomas & P. Harrison (Eds.), Best practices in school psychology VI. Washington, DC: National Association of School Psychologists.
[17] Pisani, A.R., Murrie, D.C., & Silverman, M.M. (2016) Reformulating suicide risk formulation. From prediction to prevention. Academic Psychiatry, 40(4), 623-629.

It is noteworthy to discuss differential levels of suicide risk regarding best practice interventions (See **Rule 6**). To simplify here, a low-risk student has current thoughts of suicide but no plan, no previous attempts, and several protective environmental factors, such as cooperative parents, intact family, and hopes for the future. This could be a child easily returned to class following a parent notification, a safety plan that includes resources, and a list of trusted adults at home and school. A moderate-risk student not only has current thoughts of killing themselves but may also have a history of previous attempts or chronic mental illness. While they do not report having a plan or access to means now, the best practice interventions at school are to proceed as if they did. Moderate and high-risk students (those with a plan and access to the means) should only be handed off by school personnel to law enforcement, psychiatric mobile response teams, or a parent or guardian until a more comprehensive suicide assessment can take place.

Seminal publications in suicide prevention[18] have been reluctant to recommend one brief assessment tool for schools. Instead, as with many state departments of education, they offer a wide variety of evidence-based instruments from which to choose. Some states have identified specific evidence-based tools. Nebraska, for example, recommends and provides extensive training in the Suicide Behavior Questionnaire (SBQ). We recommend the reader check with their state departments of education for guidance.
Early publications emphasize the importance of gathering extensive information from the at-risk student about the challenges they are facing, their emotional well-being, and the importance of asking students directly about suicide plans.[19]

These questions are essential to a brief screen of risk:

- Have you been thinking about killing yourself recently?
- Have you ever tried to kill yourself before?
- Do you have a plan to kill yourself today? If so, how would you end your life?

Tools for Brief Suicide Assessment
There are three evidence-based screening tools, initially developed for medical settings but commonly used in schools: The Columbia Suicide Severity Rating Scale (CSSRS Short & Long versions); the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T); and the Ask Suicide Screening Questions (ASQ).[20] The SAFE-T pocket card and the ASQ should only be used by healthcare and mental healthcare professionals and those who have otherwise been trained to work clinically with those at risk for suicide.

[18] Substance Abuse and Mental Health Services Administration (2012). Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012.
[98] Poland, S. (1989). Suicide intervention in the schools. New York: Guilford. Lieberman, R. (1992). Youth suicide prevention program. Los Angeles Unified School District Los Angeles, California
[20] Erbacher, T., Singer, J. & Poland, S. (2024) Suicide in schools: Practitioner's Guide to multi-level prevention and intervention, 2nd Edition. New York: Routledge Publishing.

It is recommended that The Columbia Suicide Severity Rating Scale (**Tool 3**) be used for several reasons:

- It is evidence-based and standardized on many different populations.
- It is available in short and long forms, with the short version meeting the SMHP's need for a brief assessment tool and the long version being the preferred option for training SMHPs.
- It is culturally responsive and available in a myriad of languages.
- It is developmentally responsive by offering a version for elementary-aged children.

The Columbia-Suicide Severity Rating Scale (C-SSRS) supports suicide risk screening through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, determine the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the tool ask people:

- whether and when they have thought about suicide (ideation)
- what actions they have taken — and when — to prepare for suicide
- whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition

The SAFE-T pocket card (**Tool 4**) guides clinicians through five steps that address the patient's level of suicide risk and suggests appropriate interventions. It is intended to provide an accessible and portable resource for the mental health professional whose clinical practice includes suicide risk assessment. The card lists key risk and protective factors that should be considered while completing the five steps and addresses adult and adolescent populations.

The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) pocket card[21] provides protocols for developing treatment plans and interventions responsive to patients' risk levels. It also includes brief triage and documentation guidelines.

The ASQ is a four-question screener developed for hospitals that have been expanded for use in community settings. The Ask Suicide-Screening Questions (ASQ) tool is a brief validated tool for use among both youth and adults. The tool is not provided here as an option for schools but as an example of a brief assessment in hospital or clinical settings. Additional materials to help with suicide risk screening implementation are available in The Ask Suicide-Screening Questions (ASQ) Toolkit, a free resource for use in medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help providers successfully identify individuals at risk for suicide. The ASQ toolkit consists of youth and adult versions, as some of the materials take into account developmental considerations.[22]

The authors of this toolkit have gleaned extensive information from presenting and interacting with school personnel all around the country concerning increased risk and suicidal statements being made by younger and younger children. It is especially challenging to screen a young child for suicide risk. SMHPs will need to utilize all their skills and understanding of child development in conducting a screening for suicide. It is advised with a young child to ask questions like: "Have you thought of going away and never coming back?" or "Do you not want to be here anymore?"

[21] Substance Abuse and Mental Health Services Administration. SAFE-T Pocket Card: Suicide Assessment Five- Step Evaluation and Triage for Clinicians. https://store.samhsa.gov/sites/default/files/sma09-4432.pdf

[22] National Institute of Mental Health. Ask Suicide-Screening Questions Toolkit https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

The challenge of screening students for suicide risk regardless of age is yet another reason why there should be a referral from the school to a community-based mental health professional for a comprehensive suicide assessment.

Some relevant court cases highlight the challenge of establishing best practices in schools:

Case Study 1: In 2023, a contributing author discussed a case in Virginia where one of the issues raised was that a peer notified the SMHP that an individual was exhibiting potentially suicidal ideation and behavior. The SMHP met with the 18-year-old high school student, who denied having suicidal thoughts or plans. The student's parents were not notified, and he died by suicide three weeks later. The parents filed a lawsuit against the SMHP. The case was settled out of court for an undisclosed amount. If a student is suspected of being at any level of risk for suicide, regardless of their age, their parents or caregivers should be notified even if the student denies having suicidal thoughts or plans.

Case Study 2: In 2023, the same author cited another case where a student being recommended for expulsion died by suicide the same afternoon that she was removed from school. The school district prevailed in the lawsuit filed by her parents against the school district. However, SMHPs and administrators are encouraged to be alert for precipitating events, especially severe discipline scenarios. It is recommended that a student faced with being expelled from school be screened for suicide risk and provided counseling support if appropriate.

Notify parents/guardians or child protective services.

An overview of suggestions for Conducting the Parent or Caregiver Notification Conference is provided in **Tool 5**. Notification to the parent or caregiver, regardless of the suicide risk level, is essential. It is particularly important to consider cultural factors that may impact the reactions of the parent or the caregiver. The goal of the conference is to receive a cooperative response and ensure the safety of the student who is at risk of suicide. The parent or caregiver will look for reasons to deny the seriousness of the situation and counselors cannot guarantee the safety of the student. The school and parent or caregiver need to partner for the safety of the student and obtain the needed community-based mental health services for the student.[23] School districts have been found liable in civil court after a student suicide when the school had reason to believe the student was potentially experiencing suicidal ideation and behavior but failed to notify their parents/guardians in a timely fashion, if at all (see Case Study #1).[24] It is highly recommended that parent/guardian notification be provided face-to-face and that the notification be documented regardless of the age of a high school student. Carolyn Stone the ethics co-chair for the American School Counselor Association, stated that counselors have always known that notification to the parent or caregiver of a student at risk for suicide is a ministerial and required duty, not a discretionary duty.[25]

There is only one exception to notifying a parent/guardian. That is, if school personnel, in collaboration, have reason to believe or suspect that notifying the parent/guardian would place the child in a more dangerous situation. All school employees are mandated reporters of suspected child abuse, and at this point in the intervention component, local child protective services need to be notified immediately instead.

Parent notification is not just a mandated act; it is critical to the screening process. The parent can offer invaluable information related to recent history, family dynamics, traumatic events, and mental health background. As mentioned, a major goal of the conference is to obtain the parents' cooperation in generating interventions at school and in the community and following through with counseling recommendations.

The SMHP must prepare for the possibility that a parent or guardian might refuse to sign the notification form (**Tool 5**). If this occurs, the SMHP should ask another staff member to witness the refusal to sign. If the parent or guardian refuses to seek a community-based assessment for their child, the principal should be informed, and protective services should be consulted.

Firearms are the #1 environmental risk factor for youth suicide. It is especially important to discuss with the parent the importance of removing any lethal means from any home where their child could use to harm themselves. It is particularly important for the SMHP to discuss the availability of firearms and other lethal means in homes other than their primary residence, as some students may be going back and forth between more than one home or frequently visiting the homes of peers. It is noted that SMHPs may be uncomfortable discussing with the parent the availability of lethal means in their home, and the Suicide Prevention Resource Center provides a one-hour training on Counseling Access to Lethal Means (CALM).[26]

Tool 6a provides a parent or caregiver notification form that includes language about the importance of removing access to lethal means in the home and emphasizes the importance of sharing information between the school and community-based providers. **Tool 10** provides a separate release of information form. **Tool 6b** provides the parent or caregiver with very specific guidance on suicide-proofing the home.

[23] Stone, C. (2017). School Counseling Principles: Ethics and law (4th edition). Alexandria, VA: American School Counselor Association
[24] Erbacher, T. & Poland, S. (2023). Suicide intervention in the schools. In P. Harrison, S. Proctor & A. Thomas (Eds.), Best practices in school psychology VII. Washington, DC: National Association of School Psychologists.
[25] Stone, C. (2017). School Counseling Principles: Ethics and law (4th edition). Alexandria, VA: American School Counselor Association.
[26] Suicide Prevention Resource Center (2018). CALM: Counseling on Access to Lethal Means. https://sprc.org/online-library/calm-counseling-on-access-to-lethal-means/

INTERVENTION TOOLKIT

RULE 6

Provide interventions at school and collaborate with community mental health resources.

The goals of an intervention plan include:

- creating a collaborative approach that unifies the home, school, and community resources
- striving to ameliorate distress at home and school through enhancing coping strategies
- providing developmentally and culturally sensitive interventions with the overarching goal of creating a circle of care around each child

When responding to a student at risk for suicide, one size does not fit all. The SMHP guides the crisis team to consider a myriad of factors before generating interventions:

- Screened level of risk
- Parent/guardian support
  - Review **Rule 5**
  - Encourage support in monitoring online behaviors and social media
- Resources available at school
  - Modifications to the regular program
  - Counseling at school
- Counseling through community mental health providers/partners
- Resources in the community and online
- Developmental & cultural factors
- Safety planning (**Rule 8**)
- Reentry planning (**Rule 9**)

Levels of risk

When developing intervention policies, the authors recommend keeping things simple for districts, particularly those with large numbers of students and personnel. Districts should identify procedures for responding to two levels of student suicide risk: low and moderate-high.

We have already described a low-risk screen, but to review here, this is a student who has current thoughts of suicide but no plan, no history of mental illness or previous attempts, and numerous protective factors that exist, such as cooperative parents, intact family and hopes for the future.

Interventions for low-risk students include:

- Return the student to class and their regular activities following parent notification.
- Enlist parent support in monitoring their child's online behaviors and social media and following up on any community mental health services.
  - Always obtain a parental release of information (**Tool 10**).
  - Review information regarding firearms in the home.
- Modify school protocol for that student, such as implementing a check-in/check-out with a trusted staff member.
- Provide mental health services at school.
- Generate a safety plan that includes identifying trusted adults at school and at home, as well as developmentally and culturally responsive community mental health and online resources.
- Provide ongoing follow-up by an SMHP.

A moderate-risk student not only has current thoughts of killing themselves but may have a history of previous attempts or chronic mental illness. While they do not report having a plan or access to means now, the best practice interventions at school are to proceed as if they did. A high-risk student has active ideation, a desire to die, a specific plan, and access to the means, and can identify few, if any, reasons for living. These students require a comprehensive formal clinical suicide assessment done by a community-based mental health provider.

Interventions for moderate and high-risk students:

- Supervise the student throughout the referral process.
- Hand off the student only to the parent (moderate risk only), law enforcement, or psychiatric mobile response team.
  - It is never recommended that any one individual, either a parent or crisis team member, transport a student to a local ER alone.
  - Always obtain a parental release of information (**Tool 10**).
  - Review **Tool 6a**.
- Refer the student and parent/guardian to a community-based provider for a comprehensive assessment.
- Develop a safety plan.
- Develop a reentry plan the day following discharge from mental health hospitalization.

Parents can present as cooperative, ineffective, or completely resistant to the SMHP. Certain cultural views may result in the parent or caregiver being resistant to seeking community-based mental health services for their child. They may view obtaining mental health services for a family member as a sign of weakness or embarrassment for the family. A student at risk for suicide must be referred to a community-based provider who is skilled in culturally responsive suicide risk assessment and management. It may take many contacts on behalf of the SMHP to build trust and cooperation from parents who initially appear ineffective in following through on any intervention, particularly those that involve community resources. The prudent SMHP seeks ways to mitigate barriers for marginalized families in obtaining mental health services, such as having materials in native languages, having access to a computer or smartphone internet connection, and being aware of cultural traditions, rituals, and beliefs around grief, death, and suicide.

Key questions to ask community-based mental health providers are summarized in **Tool 9**, Screening Community-Based Mental Health Providers. This tool will help SMHPs to identify those skilled in suicide risk and assessment and result in more effective treatment for the at-risk student. It is recommended these skilled community-based providers be identified before making a referral. It is noted that some school districts have not only identified skilled community providers in advance who collaborate well with the school district but have also entered contractual relationships with community-based providers. This includes identifying community-based providers that utilize a sliding scale for services and the school district funding a community-based assessment. A task force from the American Association of Suicidology found that few mental health professionals were trained in suicide risk and management in their graduate program, nor was a competency usually required for licensure.[27] Hence, finding the right community mental health professional can be challenging.

A release of information is also important for schools to utilize when making referrals so that SMHPs and community or hospital-based mental health professionals can communicate about the treatment and needed support for the student at risk for suicide. A release of information form is provided in **Tool 10**.

[27] Schmitz, M., Allen, B. & Felman, B. (2012). Preventing suicide though improved training in suicide risk assessment and care. Suicide Life Threatening Behavior. Jun;42(3).

Document all actions of the crisis team.

For a multitude of reasons, all school districts should have protocols for tracking and record keeping of student information and chief among them is to protect from litigation. All employed SMHPs should be keenly aware of how to create and record all actions on behalf of the crisis team when intervening with students exhibiting potentially suicidal ideation or behavior. School have been sued and lost for not notifying parents in a timely fashion and for not supervising a student who is at potential risk of harming themselves or others. These are significant actions that must be documented.

Notes, forms, and records related to the referral, both written or electronic, are confidential information and remain privileged to authorized personnel. These notes should be kept in a confidential file separate and apart from the student's cumulative records. Many districts utilize a centralized and computerized system. Questions related to confidentiality are common with regard to suicide risk, but it is important to note that while all efforts are made to protect students' privacy, there are exceptions to the Family Educational Rights and Privacy Act (FERPA) when student safety is at risk. This provision permits disclosure "when it is necessary to protect the health or safety of the student or others."[28]

A particular challenge in assuring student safety occurs when a student for whom a suicide screening has been recently conducted transfers to a school either within or outside the district. In this case, the transferring school may contact the receiving school to share information and concerns, as appropriate, to the extent necessary to ensure the health and safety of the student. To ensure a continuity of care within the district, a safety plan (**Rule 8**) with the new school's crisis team should be developed upon enrollment.

In addition to following district procedures for documentation, the prudent SMHP should maintain personal documentation as well. It is recommended that all steps taken in collaboration with the administration during the referral process, regardless of the level of parent or caregiver cooperation, be documented. **Tool 2** is provided as a template.

[28] Erbacher, T., Singer, J. & Poland, S. (2024) Suicide in schools: Practitioner's Guide to multi-level prevention and intervention, 2nd Edition. New York: Routledge Publishing.

Develop a safety plan.

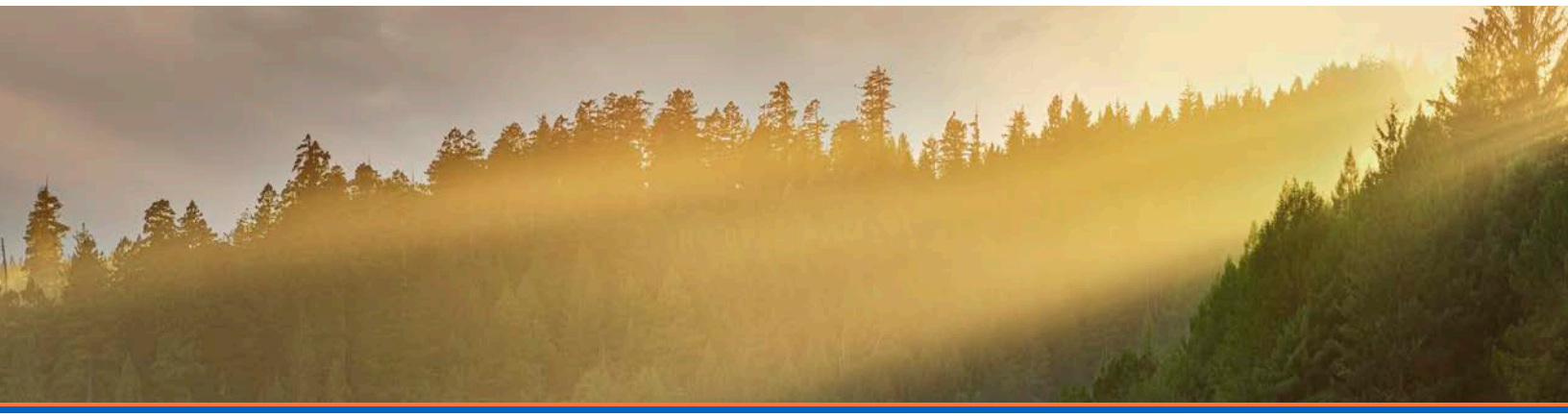
Safety planning is an evidence-based brief intervention designed to reduce suicide risk. They are most effective when personalized and developed collaboratively with the student. The plan should be developmentally, culturally, and linguistically appropriate to the student and family. In general, safety plans identify warning signs or activators of suicidal thoughts, contain the names of trusted adults at home and at school, provide individualized strategies for coping with feelings of distress or isolation, and provide relevant resources online or in the community that the student can rely on. Reducing access to lethal means should be an integral component of the plan.

The SMHP and the at-risk student should both sign the safety plan, and the student should take a photo of it to store on their phone in addition to receiving a hard copy. The SMHP keeps a copy and provides copies to parents, caregivers, and community-based mental health providers. The safety plan includes both local and national 24-hour crisis resources. Include a backup plan, such as calling the 988 Suicide & Crisis Lifeline or texting the Crisis Text Line. A Safety Planning tool is provided in **Tool 7**.

The Suicide Prevention Resource Center offers a free one-hour course on Safety Planning for Youth.[29] The training can be accessed at **www.sprc.org**, and also includes a Safety Planning Guide.[30]

Safety plans can be developed using a smartphone app or a paper template. If you use a paper template, consider encouraging the student to take a picture of the plan on their phone so that they don't lose it.

Commonly used safety planning tools, the Stanley Brown Safety Planning Tool (template and app) can be accessed through the Suicide Prevention Resource Center.[31] The Virtual Hope Box can be accessed through the Apple App Store or Google Play.[32]



[29] https://healtheknowledge.org/course/index.php?categoryid=114
[30] https://sprc.org/wp-content/uploads/2023/01/SafetyPlanningGuide-Quick-Guide-for-Clinicians.pdf
[31] https://sprc.org/online-library/stanley-brown-safety-plan/,
[32] https://sprc.org/news/the-virtual-hope-box/, https://apps.apple.com/us/app/virtual-hope-box/id825099621, https://play.google.com/store/rch?q=virtual+hope+box&c=apps

Develop a reentry plan.

Reentry planning is another evidenced-based intervention to assure the safety of a student who is returning to school following mental health hospitalization. Ideally, the parent will escort the student back to school on the first day after discharge and meet with the original SMHP and crisis team members who collaborated on the initial referral. All records, reports, and recommendations from the hospital should be provided, and if necessary, begin the process anew by having the parent sign a release of information form (**Tool 10**).

At this initial meeting, modifications to the student's program are discussed with the parent and can include adjusting the academic program and easing expectations; identifying on-going counseling resources at school or in partnership with community mental health; monitoring any medications that may have been prescribed and discussing any teachers or staff to be notified that the student is returning from hospitalization.

The parent or even the student, may be sensitive to or even opposed to the school personnel being aware of the hospitalization and the treatment. The SMHP should stress how the information shared will be confidential, but it is important for the school personnel to be alert for further warning signs of suicidal behavior and how the school can support the community-based treatment the student is receiving. Hopefully, the school is referring at-risk students to community-based professionals who see the value in sharing information with the school. Notifying trusted adults and strategic staff at school can ensure a safe space for the student who may become a target of bullying as rumors might spread through the halls or social media. A tool for reentry is provided in **Tool 8**.

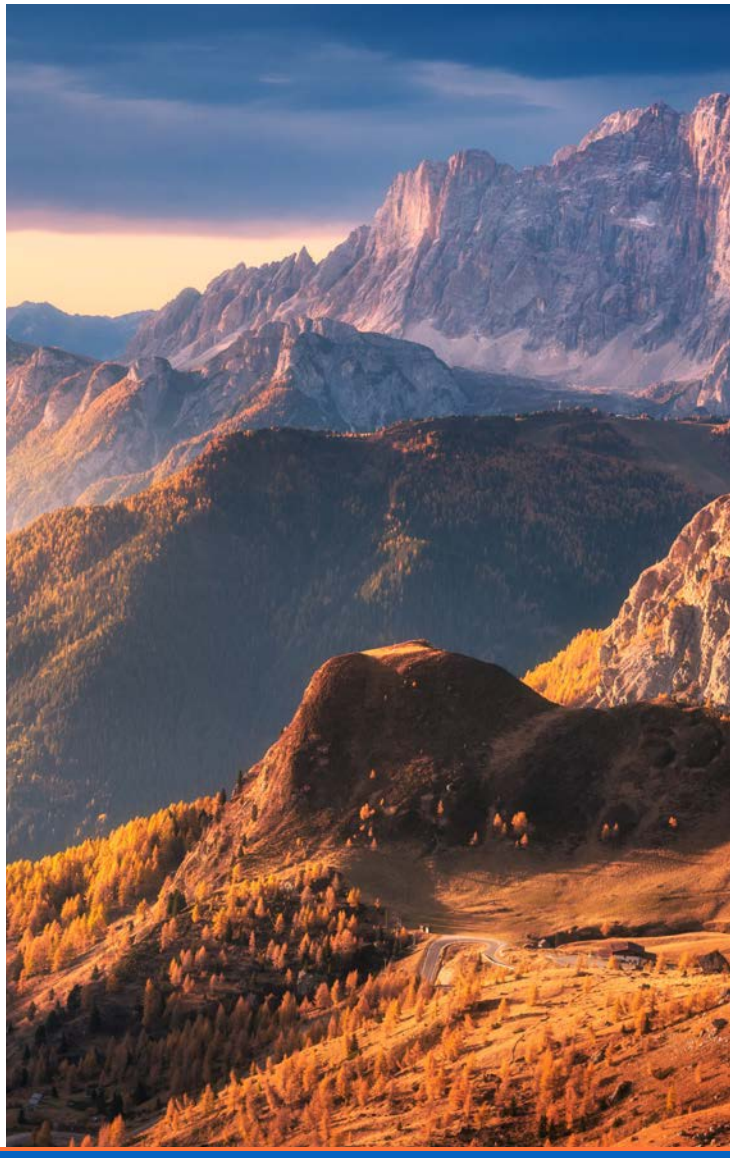
Following reentry planning, the SMHP should check in frequently with the student in the days and weeks following hospitalizations. Follow-up suggestions are reviewed in **Rule 10**.

Follow up with the student.

Following up with students exhibiting suicidal ideation or behavior can be very demanding on an SMHP's time and energy, yet it is a critical component of intervention. The recent pandemic has left schools with a sea of vulnerable youth. Yet, there is a national shortage of SMHPs, resulting in much higher ratios of students to SMHPs than recommended by their professional associations. Nonetheless, following up with students, particularly those returning from hospitalization, is imperative. Relevant follow-up actions by the SMHP/Crisis team include:

- assessing the student's overall stress and functioning levels
- reminding students of their written safety plan, updating trusted adults, resources, and coping strategies
- updating community-based mental health treatment
- monitoring attendance and modifications made to the student's regular activities and schedule, checking in with appropriate trusted staff as needed
- keeping in contact with parents on several issues:
  - student's overall stress and functioning at home
  - updating medication issues in collaboration with the school nurse
  - assessing the current availability of lethal means in the home
  - ensuring current releases of information between the school and home to create a circle of care around the student
  - documenting all SMHP/Crisis team follow-up actions professionally and personally

These rules for schools have all been developed based on many decades of suicide prevention, intervention and postvention work in K to 12 schools and are designed to guide school personnel with their planning. The rules have been provided as a foundation for the implementation of all the following tools. Our experience has been that school personnel are extremely appreciative of being provided with tools that they can utilize. All the information provided is designed to enhance existing suicide protocols in schools.



Role Play of Suicide Screening and Safety Planning Scenario

Note: Columbia Suicide Severity Rating Scale CSSR-S is recommended for use during this role play. Mary, a 13-year-old middle school student who is new to school, has written on her English paper, "Hannah Baker Rocks," and she showed it to others. "I can do it too!" Mary is referred to the counseling office and presents herself as unkempt and shy, with very little eye contact and a lack of affect. She initially does not want to talk, but when asked about 13 Reasons Why, she opens up as she is fascinated by the show and how Hannah got even and watched over everyone who mistreated her and escaped a horrid life!

Mary shares serious family issues at home. She had not seen her mother since she was 8, and her father never even answered Mary's questions about her mother. Mary wonders why her mother does not want to be involved in her life. Her father's live-in girlfriend, Babs, yells at her frequently, and Mary thinks Babs has a drug problem, as her behavior towards Mary and her brother is so erratic. Her father works all the time in his new position in a Tallahassee law firm and has a significant commute to work each day. The father's girlfriend does not work and is always home when Mary returns from school. She is consistently on Mary about her chores. Mary had been close to her 19-year-old cousin, but she killed herself last year.

Mary did not want to move to the new school and misses her dog, Buddy, that her father left behind as they moved to a condo that does not allow dogs. Her father says they may get a house, and Buddy could come to live with them, but Mary does not think that will happen. She misses her old friends in St. Louis and tries to stay in touch via texting and social media, but her father and his girlfriend have told her repeatedly to move on and to make new friends. Mary had enjoyed participating in a church youth group in St. Louis but has no plans to attend one in Tallahassee. Mary reports that all the 8th grade girls at the new school are already matched up in groups and no one has really welcomed her. Mary played basketball last year on the school B team but does not think she is good enough to make the team in her new school, which is much larger than her previous one.

Her 6th-grade younger brother John has already made new friends, and Babs is not so hard on him. Mary wonders what is wrong with her; she is so unhappy here. Mary reports that few things are going well, that she sleeps a lot, spends most of her time at home in her room, and has little appetite or energy. She is also behind on school assignments, even though it is only the second week of school.

Mary admits that she has thought of cutting herself the way Hannah did and reports she has watched the show three times. Mary admits to researching suicide online, and she has also thought that if she couldn't cut herself, she could pull the trigger on a gun, and her father has one. She is unsure where it is but has thought of looking for it when no one is home.

Discussion Questions

- How many protective factors do you see for Mary?
- How many risk factors?
- Was the Columbia CSSR-S used, and if not, then was Mary asked direct questions about previous attempts, current thoughts of suicide, and if she had a specific plan to die by suicide?
- What actions need to be taken to intervene and support Mary?
- How was the need to notify her father introduced, and what was Mary's reaction?
- Did the role-play of the assessment ask all the key questions?
- Was rapport established with Mary?
- Was eye contact maintained with Mary, and was suicide discussed calmly with no sign of disapproval from the SMHP?
- Was Mary assured she was not the first student to experience suicidal ideation?
- Was a safety plan jointly developed?
- Did the SMHP sit side by side with Mary while developing the safety plan with her?
- What did the safety plan emphasize?
- What level of suicide risk is Mary?
- What level of intervention support do you feel is warranted currently?

Role Play of Parent or Caregiver Notification

Uncooperative Parent Role Play Scenario for Student Mary Smith: The father or mother of Mary Smith, a new 8th-grade student in your school, has very reluctantly come to school for a conference with the school counselor, who gave Mary's parent very little information on the phone as to why a face-to-face conference had to take place immediately this morning. It was long drive from his office to the school.

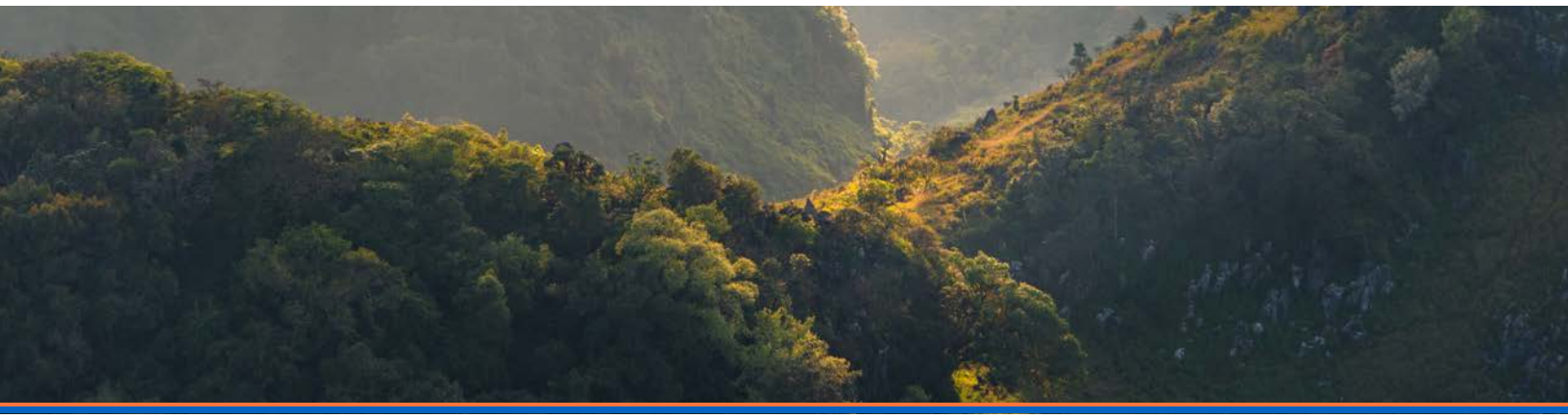
Mr. or Mrs. Smith arrives very frustrated and immediately indicates they did not appreciate being called to the school. They are extremely busy attorneys, and being away from the office costs them client billable hours and, therefore, money.

Throughout the conference, they refuse to provide much information about how Mary is doing regarding school, social life, and family. They are very defensive about Mary and her family life and repeatedly ask,"Why is this any business of yours? I did not come here to answer questions. Who are you, and why have you demanded that I come to the school?"

The parent does not take the report of Mary's suicide plans seriously. "She is a 13-year-old girl; what do you expect? They are emotional and say dramatic things! She is new to the school and will make friends soon and be ok! Her younger brother is doing simply fine in the new school and community. Now, are we done here?"

The parent is particularly defensive when questioned about whether Mary has access to a gun in the home. They finally admit, "Yes, there is a gun, but there is no way she would ever touch it!" The parent dismisses all requests to secure the handgun, which is for protection and is kept in the nightstand. When asked about Netflix's 13 Reasons Why program, the parent is unfamiliar with it and states that they could not have watched it because they do not have a Netflix account. The parent is not supportive of the need for any mental health services outside of school and forbids the SMHP to ever talk with Mary again!

When the question is raised that you would like the parent to sign a notification form, they angrily refuse and further indicate that there are no plans to obtain counseling for her.



Discussion Questions

- How did the role-play go?
- Did the counselor begin by thanking Mary's parents for coming to school for a conference and emphasizing that this showed how much they care about Mary?
- Did the SMHP begin by asking for information from Mary's parent about how they thought Mary was adjusting to the new school?
- Did the counselor receive any helpful information?
- How did the parent respond when told that Mary was experiencing suicidal ideation?
- Did the counselor emphasize that it must be difficult information for the parent to hear?
- Was the SMHP clear about what steps needed to be taken to support Mary and instruct them to get her counseling services outside of school and to prevent suicide?
- Was there a discussion of removing lethal means from Mary's access?
- Did the SMHP discuss suicide-proofing the home?
- How did the SMHP manage the conversation about whether a gun is available to Mary?
- Did the SMHP seem judgmental at any time during the parent notification?
- Was Mary's parent requested to sign a suicide notification form?
- Was there a discussion of the need to increase Mary's parental supervision?
- Did the SMHP refer to community services and request that information be shared between the school and the community provider?
- Did the parent agree to obtain counseling services?
- Was follow-up at school outlined?
- If the parent notification did not go well and the parent will not seek outside services for Mary, what steps should the SMHP take?
- Should they notify the principal and/or Protective Services?
- Is there a need to contact a mobile crisis team or consider involuntary hospitalization?
- Should the SMHP document the actions and seek supervisor and/or collaboration?

Documentation of Suicide Screening and Steps for Student Safety
Screened level of risk: Low ☐ Medium ☐ High ☐

Student: _____ School: _____ Grade: _____

Counselor/SMHP:_____ Administrator: _____

Risk Assessment Completed by: _____

Date: _____ Notification of Student's Counselor (circle one): Y / N

Actions Taken:

Date	Action	Members Present	Notes
	Student Conference		
	Notified Principal, key personnel		
	Parent contacted		
	Parent conference		
	Student Safety Plan written		
	Parent Notification Form signed		
	Release of Information signed		
	Mental health referral for community-based services made		

Follow-up documentation:
Student: _____

_____

Parent/caregiver: _____

_____

Community Resource:_____

_____

* Copy for student's counselor or SMHP and designated administrator

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
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?***		
2) ***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.		
3) ***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?***		

6) ***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
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

SAFE-T
SUICIDE ASSESSMENT

Five-Step
EVALUATION AND TRIAGE

1. **IDENTIFY RISK FACTORS**
   Note those that can be modified to reduce risk
2. **IDENTIFY PROTECTIVE FACTORS**
   Note those that can be enhanced
3. **CONDUCT SUICIDE INQUIRY**
   Suicidal thoughts, plans, behavior, method, and intent
4. **DETERMINE RISK LEVEL & INTERVENTION**
   Determine risk. Choose appropriate intervention to address and reduce risk.
5. **DOCUMENT**
   Assessment of risk, rationale, intervention, and follow-up

Suicide assessments should be conducted (1) at first contact; (2) with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; (3) prior to changes in behavioral health treatment; and (4) at inpatient discharge.

SAMHSA
Substance Abuse and Mental Health Services Administration

1. RISK FACTORS[1]

- Prior suicide attempt(s)
- Alcohol or substance use
- History of mental health concerns, particularly depression and other mood disorders
- Access to lethal means, including firearms
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Chronic disease and/or disability
- Lack of access to behavioral health care
- Prolonged feelings of hopelessness

POPULATIONS AT INCREASED RISK FOR SUICIDE

- American Indian, Alaska Native, and Tribal communities
- Black youth
- Rural communities
- LGBTQI + youth and young adults
- Middle-aged men
- Older adults

2. PROTECTIVE FACTORS[1]

Note: Protective factors, even if present, may not counteract significant acute risk

- Connectedness to people, family, community, and social supports
- Effective behavioral health care
- Life skills (including problem-solving skills, coping skills, emotional regulation, ability to adapt to change)
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide
- No access to lethal means

[1] https://sprc.org/risk-and-protective-factors

3. SUICIDE INQUIRY

Specific questioning about thoughts, plans, behaviors, intent

- **Ideation:** Frequency, intensity, duration—in last 48 hours, past month, and worst ever
- **Plan:** Timing, location, lethality, availability, preparatory acts
- **Behaviors:** Past attempts, aborted attempts, rehearsals versus non-suicidal self-injurious actions
- **Intent:** Extent to which the patient (1) expects to carry out the suicide plan and (2) believes the plan/act to be lethal. Explore ambivalence: reasons to die versus reasons to live

For Youth: Ask parent/guardian about history of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition.

4. RISK LEVEL/INTERVENTION

- **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- **Reassess** as patient or environmental circumstances change
- **Develop** a safety plan for all individuals at low, moderate, and high risk levels

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
HIGH	Individuals experiencing severe behavioral health symptoms or acute precipitating event; protective factors not relevant	Suicidal ideation with plan (when and where), method (how), and intent to carry out the suicide plan	Emergency psychiatric treatment in a secure setting may be necessary unless a significant change reduces risk
MODERATE	Multiple risk factors, experiences some elevated behavioral health symptoms, and few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Give emergency/crisis numbers to include the 988 Lifeline
LOW	Manageable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral with a warm handoff, symptom reduction. Give emergency/crisis numbers, 988 Lifeline

Note: This chart is intended to serve as an example of a range of risk levels and interventions, not actual determinations.

5. DOCUMENT

Document: Risk level and rationale; treatment plan to address/reduce current risk (e.g., safety plan, medication, psychotherapy, contact with significant others, consultation, etc.); counseling on access to lethal means; follow-up plan. Patients/clients should receive a copy of their safety plan. For youth, the treatment plan should include roles for parent/guardian/supportive adult.

SUICIDE PREVENTION RESOURCES

988 Suicide & Crisis Lifeline, call or text 988 or chat at 988lifeline.org for 24/7 support
samhsa.gov/find-help/988

- Download this and additional resources at store.samhsa.gov
- SAMHSA's Suicide Prevention webpage: samhsa.gov/mental-health/suicide
- The 2024 National Strategy for Suicide Prevention and Federal Action Plan: hhs.gov/programs/prevention-and-wellness/mental-health-substance-abuse/national-strategy-suicide-prevention/index.html
- Suicide Prevention Resource Center: https://sprc.org
- National Action Alliance for Suicide Prevention: https://theactionalliance.org
- American Foundation for Suicide Prevention: https://afsp.org
- 988 End Cards for Media: samhsa.gov/find-help/988/partner-toolkit/end-cards-media

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The Parent Conference

1. This conference is best held in person if possible, and school procedures may require it to be in person.

2. Begin by asking the parent or caregiver how their child has been doing and if they have noted any changes in their child's behavior.

3. There may be language barriers that necessitate the SMHP utilizing an interpreter during the notification conference.

4. State what you have noticed in their child's behavior and ask how that fits with what they have seen in their child.

5. Provide an overview of your interaction with their child and the importance of safety planning, and give the parent or caregiver a copy of the written safety plan **Tool 7**.

6. It may be difficult and even shocking to hear that their child is exhibiting suicidal ideation or behavior. It will be important to ensure the parent or caregiver understands the seriousness of the situation. It may be necessary to educate them on the scope of the problem of youth suicide and even to share a recent suicide of a student in the district or a nearby school.

7. Emphasize that there are evidence-based treatments for suicide and that suicide can be prevented.

8. Advise parents to remove lethal means from the home as their child is exhibiting suicidal ideation or behavior. You can equate this to how you would advise taking car keys from a youth who had been drinking. Approximately 14 states and the District of Columbia have laws imposing criminal liability when a child gains access because of negligent storage of a firearm. Typically, these laws apply whenever the person "knows or reasonably should know" that a child is likely to gain access to the firearm. Key school personnel such as SMHPS are encouraged to ask the parent or caregiver directly about their child's access to a gun and to recommend strongly that guns and other lethal means be safely stored. Go over **Tool 6b** Suicide-Proofing the Home.

9. Acknowledge the emotional state of the parents. Provide empathy for this situation and comment on its scary nature for parents.

10. Acknowledge that it is essential for schools, parents, and community mental health and medical services to collaborate to help a child who is exhibiting suicidal ideation or behavior, as no one can do this alone.

11. If the parent is uncooperative or unwilling to take specific actions, find out their beliefs about youth suicide risk/behavior and see if there are myths they believe that are blocking them from taking proper action.

12. Acknowledge and explore any cultural, religious, or other concerns that might reduce their acceptance of mental health treatment for their child.

The Parent Conference (Continued)

13. When possible, align yourself with the parent or caregiver. It is essential for them to understand the stress and depression their child is experiencing and to discuss with them ways to alleviate stress for their child and how to obtain the needed community-based mental health assistance for their child.

14. Refer the parent or caregiver to local community mental health providers that the school has previously worked well with and explain what parents can expect in the suicide assessment and the treatment of their child. If finances or insurance coverage are a family concern, share information about a sliding scale for services or any contractual community-based mental health services the school has in place.

15. Assist the parent or caregiver in managing their emotions and encourage them to truly listen to their child, increase supervision, and avoid arguing with them.

16. Clarify the role of the school and the follow-up that will be done at school.

17. Utilize **Tool 10** and persuasively request that parents sign a release of information form so that designated school personnel can speak directly with community mental health professionals. State clearly that you will be checking in with the student and their parents to verify that community-based mental health services were obtained.

Sample Parent Notification Form for Student at Risk of Suicide

Date: _____
Student: _____
School: _____

As the parent/caregiver of _____ (student name), I have the authority to make decisions on behalf of my child and have the authority to sign this document. I acknowledge that I have been advised by school staff member _____ on _____ (date) that my child has expressed suicidal ideation and may be at risk of suicide. I have been advised that a common method of suicide is a gun, and I have been asked to secure all firearms in my home to ensure the firearms and other common means of suicide, such as pills and ropes, are inaccessible to my child. I understand that the removal of all lethal means is an essential suicide prevention strategy.

I understand that I have been advised to take my child immediately to the appropriate medical and/or mental health providers for evaluation and treatment. I agree to release information to _____ (name of school and/or staff member) regarding any evaluations and/or treatment recommendations from the mental health provider that will prepare the school to support my child's reentry into the academic setting.

_____(name of staff member) will follow up with me and my child within one week from the date of this letter as well as other times that the staff member determines. I understand that any referral information provided to me identifying medical, mental health, or related health providers is meant for my consideration only and does not require me to use these providers. I am free to select other providers of my choice. The school/district is not responsible for evaluation expenses for any service providers.

Parent/Caregiver Printed Name: _____
Parent/Caregiver Signature: _____
Date: _____

Parent/Caregiver current address and phone contact information:

_____

_____

Staff member signature: _____
Date: _____

Witness (if parent/caregiver refuses to sign the form): _____
Date: _____

*Copies provided for parent or caregiver, SMHP, and administrator

Suicide Proofing the Home

School personnel have notified you that your child is at risk of suicide, and they recognize this is very difficult information for you to hear. Please supervise your child closely and find opportunities for your child to talk to you about their suicidal thoughts honestly. One important thing you can do is remove lethal means available in your home, especially those means that your child has already mentioned they would use in a suicide attempt. Removing lethal means for suicide in your home is an essential and very effective strategy to prevent suicide. The following are recommendations for suicide-proofing your home.

- It is desirable that all knives, firearms, and ammunition be removed from the home. If that is not possible, lock up these items securely to deny your child access. If these items are locked in a safe, ensure that your child does not have the key or know the safe combination. Store ammunition in a separate place from the firearm.

- Search your house and your child's room. Look for any items that could be used for suicide. These items include weapons, sharp objects, over-the-counter and prescription medicines, belts, ropes, and cords.

- Lock up or remove all prescription and over-the-counter medicines.

- Your child should not have access to alcohol, cleaning supplies, pesticides, poisons, and power tools.

- Other items in your home may be difficult to remove that also could be used in a suicide attempt, and those include plastic bags, belts, and cords of any kind.

- If your child is old enough to drive, deny them access to a car until your child has received a comprehensive suicide assessment by a community-based mental health professional.

- Encourage open and honest conversations about feelings, mental health, and any concerns your child has. Let your child know it's important to ask for help. Ensure all family members are educated on the signs of depression and suicidal ideation, and know how to respond supportively, and that they are familiar with 24-hour crisis numbers and resources. The parents or the caregiver are encouraged to primarily be there to listen to their child and to avoid getting into an argument with them. The community-based mental health professional, as part of the needed comprehensive suicide risk assessment, will provide directions to the parents or caregivers on how best to further support their at-risk child.

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ Address: _____
4. Place: _____ Address: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR PROFESSIONAL SERVICES I CAN CONTACT DURING A CRISIS:

1. Professional/Services Name: _____ Phone: _____
   Emergency Contact: _____
2. Professional/Services Name: _____ Phone: _____
   Emergency Contact: _____
3. Emergency Department: _____
   Emergency Department Address: _____
   Emergency Department Phone: _____
4. Crisis Line Phone (e.g. 988): _____

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

[33] https://suicidesafetyplan.com/wp-content/uploads/2024/12/Stanley-Brown-Safety-Plan-05-02-2024.pdf

Safety Plan (Continued)

Suicide & Crisis Lifeline Phone: 988
CrisisTextLine.org (24 hours nationwide): text “start” or “help” to 741741 or 988
Have an iPhone? Talk to Siri for connection to help.

Student Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Note: Emphasis is on the safety plan being developed jointly with the student. If the plan is for an older student, have them complete it. School staff and the student should sit side by side to fill it out. The parent or caregiver should be given a copy. Students should be continually asked if they still have their copy and if they have anything to add to it to increase their safety. If a student refuses to sign the safety plan, hospitalization may be warranted. If the student has lost the safety plan, another one should be developed. It is noted that it is not uncommon for a student who is exhibiting suicidal ideation or behavior and receiving community-based treatment, or even one who has received hospitalization services, not to have a written safety plan. If that is the case, the SMHP should develop one jointly with the student, give them a copy, and have the student store a picture of their safety plan on their phone.

Reentry Planning Following Mental Health Hospitalization

- The principal and SMHP meet with the student's parent/caregiver to discuss reentry and the steps needed to ensure the student successfully returns to school.
- Review the student's progress with the mental health provider outside school. Hopefully, a release of information form has been signed. If not, discuss the necessity of sharing information for the student's safety and well-being.
- Review all information from the mental health provider, especially regarding safety planning and needed support services at school.
- Plan the follow-up services within the school community that will be available to the parent/caregiver and the student.
- Discuss any foreseeable social and/or academic challenges the student will experience and plan for easing those challenges.
- The SMHP should meet with the student on the first day of return from the hospital and before the student attends any classes.
- The SMHP should regularly check in with the student to assess the student's adjustment to the academic and social environment.
- Ensure that the student has a written safety plan. If one was not developed while the student was hospitalized, the SMHP must develop one jointly with the student.
- Discuss with the student the progress they have made while under mental health care. Do they feel hopeful for the future? Are they looking forward to getting back to classes? Are they looking forward to meeting up with friends? Who are their friends?
- Help the student identify and know how to find the SMHP (or another adult they express trust in) if they are distressed or have a question.
- Review the plan for staying in touch with the student to ensure they adjust to the academic and social requirements.
- If the student has been out for an extended time, missed assignments may have to be prioritized by importance, and coordination with teachers is advised to set up a manageable schedule for the student. Also, consider postponing interim or final course grades until the student has had time to catch up.
- Provide appropriate information on a need-to-know basis for the student's teachers and any other staff so they can be alert to any further warning signs.
- It is recommended to follow up with the student weekly for a minimum of two months, and if suicidal thoughts and behaviors are noted, conduct a screening using procedures outlined in **Tool 3** or **Tool 4**, document all steps taken in **Tool 2** and conduct another parent conference **Tool 5**.

Screening Community-Based Mental Health Providers

The following questions can be asked of mental health service providers to help you get an idea of whether they meet the needs of students at risk for suicide. These questions were drawn from the authors' professional experiences and adapted from the SAMHSA Toolkit.[34]

Professional Qualifications:

1. Are you able to provide services to children and adolescents?
2. Are there ages that you work more frequently with or have more expertise and training with?
3. What types of services do you provide?
4. Do you do individual, family, couples, or group therapy?
5. Do you have experience working with LGBTQ students and other groups that are disproportionately at risk for suicide?
6. Do you have experience working with the varied cultural, ethnic, and religious groups in our community?
7. Do you have experience assessing suicide risk in youth? If yes, where did you get your training?
8. Do you have experience managing and treating suicide risk in youth? If yes, what treatment approach do you use? Do you have training in any empirically supported treatments for youth experiencing suicidal ideation or behavior (e.g. cognitive behavioral therapy, dialectical behavior therapy, interpersonal psychotherapy, attachment-based family therapy)?
9. Do you have experience working with people who have lost a loved one to suicide?
10. What process do you follow in the event of a suicide crisis?
11. Under what circumstances would you visit the school or visit a home to see a student or parent?
12. Do you work with a psychiatrist?

Business Issues:

13. Where are you located?
14. Are you accessible via public transportation?
15. What is your typical wait time to see a new client?
16. What insurance do you accept?
17. Do you have a sliding fee scale for people who pay out-of-pocket? What is the range of the fee scale?
18. Do you have the necessary clearances to work in schools if you were to come here: child abuse, police, and FBI clearances?

[34] Substance Abuse and Mental Health Services Administration (2012). Preventing suicide: A toolkit for high schools. HHS Publication No.SMA-12 4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Release of Information Form

STUDENT INFORMATION:			
Student Full Name	Student ID#		Date of Report
Name of School	Student Grade	Student Gender	Student Birth Date
Staff Full Name	Staff Job Title		
Parent/Caregiver Full Name	Phone Number		Email Address
RELEASE OF RECORDS:			
Information sharing between schools, parents, caregivers, and care providers can make services faster and easier to access. Student records will only be shared to the extent that the information is helpful for service providers, and with the consent of the caregiver or parent(s).			
INFORMATION REQUEST #1:			
Organization/Provider Name			Organization/Provider Type
Organization/Provider Address			Organization/Provider Contact
Information to Share			
Information to Receive			
INFORMATION REQUEST #2:			
Organization/Provider Name			Organization/Provider Type
Organization/Provider Address			Organization/Provider Contact
Information to Share			
Information to Receive			

I consent to the exchange of confidential information (written and verbal) described above.

Caregiver/Parent Signature: _____ Date Signed: _____
Staff Signature: _____ Date Signed: _____

INTERVENTION TOOLKIT
REFERENCES

American Foundation for Suicide Prevention, American School Counselor Association, National Association of School Psychologists & The Trevor Project (2019). Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources (2nd ed.). New York: American Foundation for Suicide Prevention.

Center for Disease Control and Prevention (2021). Web-based inquiry Statistics Query and Reporting System (WISQARS). https://wisqars.cdc.gov/. Accessed on May 18, 2024.

Centers for Disease Control and Prevention (2023). Youth Risk Behavior Survey Data. Available at: www.cdc.gov/healthyyouth/data/yrbs. Accessed on December 5, 2024.

Erbacher, T., Singer, J. & Poland, S. (2024). Suicide in schools: Practitioner's Guide to multilevel prevention and intervention, 2nd Edition. New York: Routledge Publishing.

Erbacher, T. & Poland, S. (2023). Suicide intervention in the schools. In P. Harrison, S. Proctor & A. Thomas (Eds.), Best practices in school psychology VII. Washington, DC: National Association of School Psychologists.

Joiner, T. (2011). Myths about suicide. Cambridge: Harvard Press.

Lieberman, R., Poland, S., & Kornfeld, C. (2014). Suicide intervention in the schools. In A. Thomas & P. Harrison (Eds.), Best practices in school psychology VI. Washington, DC: National Association of School Psychologists.

Lieberman, R., & Poland, S. (2006). Self-mutilation and schools. In G. Bear & K. Minke (Eds.), Children's Needs III: Development, Prevention & Intervention. Bethesda, MD: National Association of School Psychologists.

Lieberman, R. (1992). Youth suicide prevention program. Los Angeles Unified School District Los Angeles, California.

National Institute of Mental Health Ask Suicide Questions Toolkit. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Pisani, A.R., Murrie, D.C., & Silverman, M.M. (2016). Reformulating suicide risk formulation. From prediction to prevention. Academic Psychiatry, 40(4), 623-629.

Poland, S. & Hall, R. (2023). Suicide and school liability. NASP Communique. 52(3).

Poland, S. & Lieberman, R. (2018). Bullying and suicide revisited: What schools can do now. NASP Communique. 46(5).

Poland, S. (1989). Suicide intervention in the schools. New York: Guilford.

Schmitz, M., Allen, B. & Felman, B. (2012). Preventing suicide though improved training in suicide risk assessment and care. Suicide Life Threatening Behavior. June:42(3).

Stanley, B., & Brown, G. (2008, 2021). Stanley-Brown Safety Planning Intervention. https://suicidesafetyplan.com/forms/

Stone, C. (2017). Ethics and the law (4th edition). Alexandria, VA: American School Counselor Association.

Substance Abuse and Mental Health Services Administration (2012). Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012.

Substance Abuse and Mental Health Services Administration SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians. https://www.samhsa.gov/resource/dbhis/safe-t-pocket-card-suicide-assessment-five-step-evaluation-triage-safe-t-clinicians

Suicide Prevention Resource Center CALM: Counseling on Access to Lethal Means. https://sprc.org/online-library/calm-counseling-on-access-to-lethal-means/. Accessed on December 12, 2024

Other Resources

The Jason Foundation https://jasonfoundation.com/

SPRC https://sprc.org/

AFSP https://afsp.org/

Trevor Project https://www.thetrevorproject.org/

More from the Authors

Modules for The Jason Foundation[35]

Bullying and Suicide
Childhood and Teen Depression
Developing a Comprehensive Suicide Prevention Protocol for Elementary Schools
Non-Suicidal Self-Injury
Suicide Contagion and Clusters
Suicide Postvention: The Critical Role of Educators
Suicide Prevention in Challenging Times
Suicide Prevention in Schools: Contemporary Issues
Supporting LGBT Students in Schools: Suicide Prevention among LGBT Youth
Tools of Suicide Prevention for School Professionals

NSU Florida Suicide and Violence Prevention Office: www.nova.edu/suicideprevention

Suicide Prevention Ongoing Resilience Training (SPORT) Los Angeles County Office of Education: https://preventsuicide.lacoe.edu/.

Survivor Resources

https://afsp.org/find-a-support-group/

https://sprc.org/tools/resources-survivors-suicide-loss/

https://988lifeline.org/help-yourself/loss-survivors/

https://allianceofhope.org/

The Jason Foundation Programs and Resources

A Friend Asks

A Friend Asks is JFI's smartphone app designed to provide users with the information, tools, and resources to help recognize when someone may be struggling with thoughts of suicide and how to help. The app has been very well received since its launch. Recently, we completed an update to the app to include a Spanish translation. Once in the app, a dropdown menu is available in the upper, right-hand corner. The new feature will allow you to seamlessly switch between English and Spanish. All pages have been translated to better serve a variety of communities. If you have not done so already, download the app today. Search "Jason Foundation" on the Apple App Store or Google Play.

[35] All JFI modules can be accessed at no cost through our website at https://jasonfoundation.com/getinvolved/ educator-youth-worker-coach/professional-development-series/.

INTERVENTION TOOLKIT
RESOURCES

The Jason Foundation Programs and Resources

The Jason Foundation Programs and Resources

A Promise for Tomorrow Student Curriculum
The student curriculum "A Promise for Tomorrow" presents a positive look at how students can help friends who may be depressed or having suicidal thoughts. This curriculum aims to provide information and strategies needed to be a lifesaving influence. The program is designed to be used within a school's current health and wellness program for grades 6-12.

It is designed in a two-lesson format for the traditional high school schedule of 50-to-60-minute classes. These can be presented as two separate lessons or back-to-back to accommodate an extended block class of 90 minutes or longer. The curriculum content is delivered digitally with facilitator-led sections to reiterate information and lead discussion.

B1 Project

A friend, especially an informed friend, can help make a difference for someone who may be struggling with thoughts of suicide or self-harm. The B1 Project is designed to be quick, informative, and target the most important aspects of youth suicide prevention.

The purpose of B1 is to give you some of the information, tools and resources to better:

- Respond to a friend who may come to you for help
- Help recognize when a friend might be struggling with thoughts of suicide
- Help you prepare a plan on how you can help that friend

We are not trying to make you a counselor but assist you in guiding a friend to help in your school or community. Working together, we can help our friends find the help they need should they be struggling with life's issues or thoughts of suicide. Share that you have taken the B1 Pledge with others via social media. Encourage your friends to B1, too.

The Jason Foundation offers several materials that you could use to market the B1 Project in your community. Visit the B1 website at **b1.jasonfoundation.com**.

Bee the Friend Elementary Curriculum

Our Bee the Friend program, a unique peer support initiative for elementary schools, is tailored for 3rd-5th graders. Bee the Friend is a positive, engaging program that fosters friendship and prepares our young children to become compassionate, supportive, and responsible middle and high schoolers. It aims to guide children in becoming the best friends they can be through acts of kindness, sharing, observing, showing empathy, and supporting their peers.

Bee the Friend consists of four lessons with accompanying activities. Each lesson aims to educate students about what it takes to be a friend to someone at school, on the bus, on the playground, or in their neighborhood and community.

Students learn how to show the characteristics of a good friend, identify a student who might need a friend or help from an adult, identify adults who can assist them, be mindful of their surroundings and their peers, and identify situations in which they can show empathy and be ready to help their peers. Visit the Bee the Friend website at https://beethefriend.com/

INTERVENTION TOOLKIT
RESOURCES

Crisis Support Team

The Jason Foundation and Acadia Healthcare teamed up to create the Crisis Support Team (CST) as a resource that communities in need can access at no cost. CST is a free resource for guidance and advice when dealing with traumatic events that could affect a young person's emotional health. CST will provide telephonic assistance from a clinical professional who will listen to your situation and share insights on the most appropriate way to respond to these traumatic events. The service is NOT crisis counseling for individuals but intended to offer guidance for administration or leadership responding to groups dealing with adverse events. These events could range from suicide, suicide attempt, auto accident, or school violence. Reading a protocol or watching an informational module does not allow for the opportunity to ask questions or receive clarification for your specific situation. The Crisis Support Team will act as a sounding board where professionals will help guide your efforts to ensure that the youth involved receive proper care and instruction.

This resource provides an excellent opportunity to reach out to your schools, school districts, colleges, places of worship, and anywhere else that awareness of this program could benefit. For more information visit https://www.acadiahealthcare.com/programming-treatment/jason-foundation/cst.

First Responder Training

The Jason Foundation's First Responder Training Module addresses suicide among youth in the community and within the profession. The goal of this training is to provide First Responders with the knowledge, skills and resources to enable them to recognize the signs of concern and elevated risk factors for suicidal ideation in youth within their community, as well as in coworkers and fellow First Responders. As with everything that we do, the first part of the training focuses on statistics, warning signs, and information related to youth suicide. The second part of the module highlights stress, statistics, and how to help fellow First Responders.

Researchers found that elevated levels of PTSD were associated with a higher likelihood of thinking about suicide and/or having a history of suicide attempts. Police officers, firefighters, and EMS workers suffer from PTSD at a rate 2 to 5 times higher than the general population. Some First Responders work around the clock to ensure that medical services are available. Especially now, it is imperative that we provide them with the resources necessary to care for themselves as well.

To access the online training module, visit The Jason Foundation's website and look for First Responders under the How to Get Involved tab. The module was designed for both individual study and group training.

Foster Care Training Module

While suicide is a significant public health crisis for the general population, the risk for suicidal ideation and behavior increases for youth in care because of the complex circumstances they often face.

- At any given time, there are estimated to be approximately 400,000 youth in care.
- Youth in care may have complex medical, mental, and behavioral health concerns stemming from a trauma history.
- Children who are adopted wait an average of almost three years in the foster system.
- Youth in care may struggle with separation anxiety.

Foster Care Training Module (Continued)

This training module discusses facts, myths, and signs regarding suicide risk for youth involved with the child welfare system and specialized topics such as trauma and adverse childhood experiences. Material is presented by a professional speaker and people with lived experience (former foster youth, foster and adoptive families, and experts in the field). Suggested protective factors and recommendations are provided for caregivers.

I Won't Be Silent

#IWONTBESILENT is an awareness campaign by The Jason Foundation to raise the national conversation of the "silent epidemic" of youth suicide. Learn the warning signs associated with suicide and challenge the people you know to learn them as well. Challenge your co-workers, school, social club, friends, or family to join you. Taking a few short minutes to challenge the people you know will help take some of the silence away from the tragedy of youth suicide. Our nation should be familiar with the warning signs, suicide facts and statistics, and how to find help for at-risk youth.

Visit **www.iwontbesilent.com** and learn how you can help raise the national conversation of youth suicide prevention. The site will provide you with ideas on how you can conduct an awareness campaign within your school, business, church, or other organization. Materials are available for download so that you can obtain them within minutes.

Parent Resource Program

The Parent Resource Program site will help provide you with some of the information, tools, and resources to help you identify at-risk youth and know how to assist them in getting help before a tragedy occurs. Prevention begins with education.

This website also offers a Parent and Community Seminar, with basic information on suicide and awareness and prevention strategies for parents and other adults. For more information visit: **https://prp.jasonfoundation.com/**

Professional Development Series

The Jason Foundation's series of online Staff Development Training Modules provide information on the awareness and prevention of youth suicide. These training modules are suitable for teachers, coaches, other school personnel, youth workers, First Responders, foster parents, and any adult who works with or interacts with young people or wants to learn more about youth suicide. This series of programs introduces the scope and magnitude of the problem of youth suicide, the signs of concern, risk factors, how to recognize young people who may be struggling, how to approach the student, and how to help an at-risk youth find resources for assistance. At the conclusion of each training module, an opportunity to print a certificate of completion is provided.

The Jason Flatt Act is legislation that requires teachers and certain school personnel to complete two hours of youth suicide awareness and prevention training in order to maintain or renew their licensing credentials. The requirement for this training does not add additional hours of training, but rather falls within the number of hours already required to continue the professional teaching license. Twenty-one states have taken the initiative to be proactive in preventing youth suicide by passing The Jason Flatt Act. The Jason Foundation Staff Development Training Modules are provided at no cost to those requesting the programs.

SCOTT POLAND & RICHARD LIEBERMAN WITH DONNA POLAND