Multnomah Education Service District

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SUICIDE PREVENTION, INTERVENTION, & POSTVENTION PLAN

Multnomah Education Service District

Adapted from Suicide Prevention: Step by Step
created by Lines for Life and the Willamette Education Service District and previous MESD plan
last updated December 2021.

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If there is an immediate and pressing suicide threat, please call 911 and then notify Joni Tolon.

PURPOSE OF PROTOCOLS AND PROCEDURES

The U.S. Surgeon General promotes the adoption of suicide prevention protocols by local school districts to increase safety to the entire school community. Additionally, in Oregon, Adi's Act is also in place to support suicide prevention, especially in regards to LGBTQ2SIA+ youth and others at higher risk for juvenile suicide. This document is intended to help school staff understand their role, provide information to parents/guardians and community partners, and to provide accessible tools.

This document recognizes and builds on the skills and resources inherent in school systems. Schools are exceptionally resilient and resourceful organizations whose staff members may be called upon to deal with crises on any given day. Schools can be a source of support and stability for students when a crisis occurs in their community. School Boards and school personnel may choose to implement additional supportive measures to fit the specific needs of an individual school community. The purpose of these guidelines is, additionally, to assist school administrators in their planning.

QUICK NOTES: WHAT SCHOOLS NEED TO KNOW

- School staff are frequently considered the first line of contact with students who are potentially experiencing suicidal thoughts/ideation.
- School staff are responsible for taking reasonable and prudent actions to help students with suicidal ideation, such as notifying designated mental health point person who will contact parents/guardians, make appropriate referrals, and secure outside assistance when needed.
- All school personnel need to know that protocols exist to refer students with suicidal ideation to trained professionals so that the burden of responsibility does not rest solely with the individual "on the scene".
- Research has shown that talking about suicide, or asking someone if they are feeling suicidal, will not put the idea in their head or cause them to kill themselves.
- School personnel, parents / guardians, and students need to be confident that help is available when they raise concerns regarding suicidal behavior. Students often know, but do not tell adults, about peers that may be experiencing suicidal thoughts/ideation suicidal peers. Having support in place may lessen this reluctance to speak up when students are concerned about a peer.
- Advanced planning is critical to providing an effective crisis response. Internal and external resources must be in place to address student issues and to normalize the learning environment for everyone.

CONFIDENTIALITY

HIPAA and FERPA

School employees are bound by laws of The Family Education Rights and Privacy Act of 1974 (FERPA). Some employees may also be bound by the Health Insurance Portability and Accountability Act (HIPAA).

When a student shares information that indicates the student is at imminent risk of harm / danger to self or others, that information MUST BE SHARED. The details regarding the student can be discussed with those who need to intervene to keep the student safe. This is in compliance with the spirit of FERPA requirements regarding legitimate educational interest and HIPAA coordination of care.

Exceptions for Parental Notification: Abuse or Neglect

Parents need to know about a student's suicidal ideation unless there is a risk of parental abuse or neglect. The mental health staff or designated mental health point person is in the best position to make the determination of student safety. The staff who has been disclosed should let the student know that mental health staff will be notified on a need to know basis.

If a student makes a statement such as "My dad / mom would kill me" as a reason to refuse, the mental health staff will ask questions to determine if parental abuse or neglect may be involved.

SUICIDE PREVENTION PROTOCOL OVERVIEW

Senate Bill 52, Adi's Act (ORS 339.343 and OAR 581-022-2510) requires each school district in the state of Oregon to adopt a comprehensive suicide prevention policy for grades K-12. Suicide can be prevented. Following these steps will help ensure a comprehensive school-based approach to suicide prevention for staff and students.

RECOMMENDATION: All school employees who have direct contact with youth to receive QPR training once a year. Preview prevention, intervention, and postvention protocols.

RECOMMENDATION: All site mental health professionals should be ASIST trained and be the "go-to" people within the school. All staff should know who the "go-to" people are within the school and are familiar with the intervention protocol.

RECOMMENDATIONS:

- (1) Use curriculum in line with Oregon State Standards for health such as RESPONSE. Students should be made aware each year of the staff that have received specialized training to help students at risk for suicide.
- (2) Consider engaging students to help increase awareness of resources (ie – handing out resources, advocating for mental health, being a leader).

RECOMMENDATIONS:

- (1) List resources in the school handbook or newsletter.
- (2) Partner with community agencies to offer parent information nights using research based programs such as QPR or RESPONSE.
- (3) Ensure cross communication between community agencies and schools within bounds of confidentiality.

RECOMMENDATIONS: Develop a site specific suicide response flow chart for staff to access. One model is the PPS model: https://docs.google.com/drawings/d/1YMZuP2M7kzQ8oBiHo1S9yCYXJQ19pd0fKOZVn_8vnJw/view

MESD SUICIDE PREVENTION PROTOCOL

MESD Staff:

All staff receive training (or a refresher) once a year on the policies, procedures, and best practices for intervening with students and / or staff at risk for suicide. The RESPONSE curriculum and / or the Question, Persuade, and Refer (QPR) Suicide Prevention model provide training on best practices.

MESD has trained QPR trainers to provide ongoing training to MESD staff. These trainers were selected based on their experience as school nurses, mental and / or behavioral health specialists, counselors and as other specialized support. Trainers collaboratively meet to review training materials to ensure that training provides culturally responsive and culturally specific information as it pertains to suicide prevention.

In the 2020-2021 school year, all MESD staff who work directly with students were trained in QPR. Beginning in fall 2021, staff will participate in a refresher training each year. For new staff, QPR is part of the onboarding training sessions.

QPR training covers:

- How to Question, Persuade and Refer someone who may be suicidal
- How to get help for yourself or learn more about preventing suicide
- The common causes of suicidal behavior
- The warning signs of suicide
- How to get help for someone in crisis
- Level of appropriate response based on training and credentials

Additional information about QPR can be found on their website at https://qprinstitute.com .

Specific staff members, who are trained and / or credentialed in mental and / or behavioral health receive specialized training to intervene, assess, and refer students at risk for suicide. MESD utilizes the internationally recognized ASIST: Applied Suicide Intervention Skills Training. This training is evidence based and specific to suicide.

Additional support for staff may be found in the MESD Behavioral Health Recovery Plan found here:
https://www.multnomahesd.org/uploads/1/2/0/2/120251715/bhrp_final_9.27.17.pdf

MESD Students:

All students K12 will receive direct instruction on social emotional learning/mental health promotion.

All MS/HS students will receive up to 3 lessons per year on suicide prevention (defining depression, dispelling suicide myths, encouraging help seeking behaviors, and building resilience) taught in partnership between teachers and counselors/social workers.

Additionally, students receive information about suicide and suicide prevention in classes where health and wellness standards are taught. The purpose of this curriculum is to teach students how to access help at their school for themselves, their peers, or others in the community. Curriculum used is reviewed and delivered with an Equity Lens. Specific materials and curriculum are provided that support the unique needs of those youth:

- bereaved by suicide,
- with disabilities, mental illness or substance abuse disorders,
- experiencing homelessness or out of home settings, such as foster care, and/or
- identifying as LGBTQ2SIA+, Native American, Black, Latinx, and Asian students.

A list of suicide prevention resources are periodically included in the school newsletter, depending on the site. Resources include those offered by culturally specific and culturally responsive providers.

Safety planning and connections to community resources will be provided for students by school mental health professionals.

MESD Parents:

Schools provide parents/guardians with informational materials to help them identify whether their child is at risk for suicide. Information should include how to access school and community resources to support students or others in their community that may be at risk for suicide.

MESD staff will connect parents/guardians to QPR trainings in Multnomah County upon request.

A list of suicide prevention resources are periodically included in the school newsletter, depending on the site. Resources include those offered by culturally specific and culturally responsive providers.

MESD also maintains a website with suicide prevention information and support.

MESD Community:

MESD mental and behavioral health staff meet with regional suicide prevention teams on a monthly basis to discuss and strategize supports and increase communication flow and trust.

MESD also maintains a website with suicide prevention information and support.

Suicidal Behavior Risk + Protective Factors

Risk factors are events or experiences that increase the chance of a student developing suicidal ideation and / or behavior.

- Family history of suicide
- History of maltreatment / abuse
- Exposure to violence
- Witnessing / experiencing family abuse
- **Previous attempt(s)**
- Isolation
- Hopelessness
- History of substance abuse
- History of mental health diagnoses
- Trauma
- Limited access to behavioral health
- care
- Chronic illness
- Lack of social support
- **Access to lethal means**
- LGBTQ2SIA+
- American Indian/Alaskan Native
- Perceived burdensomeness
- Multiple losses in the family
- Major disruptions in the family
- Learning difficulties

For more information about how traumatic experiences can impact your students, refer to the Adverse Childhood Experiences (ACEs) study via The Center for Disease Control and Prevention (CDC):

http: //www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

Protective factors are parts of someone's life experience that might increase their ability to cope with stressors.

- Effective clinical care for mental health diagnoses
- Social support
- Self esteem
- Sense of purpose
- Problem solving skills
- Healthy coping tools
- Cultural and religious beliefs
- Social competence
- Access of multiple intervention / support avenues for help
- Sense of purpose and future orientation
- Academic success
- School Climate
- Secure housing and food
- Pets - responsibilities / duties to others
- Reasonably safe and stable environment
- Connectedness
    - Family
    - Peers
    - School
    - Trusted adults
    - Community

KEEP IN MIND: A person with an array of protective factors in place can still struggle with thoughts of suicide. It is important to consider this when conducting a risk assessment.

SUICIDE INTERVENTION PROTOCOL

Warning Signs for Suicide

Many signs of suicide are similar to the signs of depression. However, keep in mind that depression is a risk factor for suicide, not a cause. Usually these signs last for a period of two weeks or longer. Many youth behave impulsively and may choose suicide as a solution to their problems quickly, especially if they have access to firearms or other lethal means. Although you may see the following externalizing behaviors there may be no observable signs. Youth may have mostly internalizing signs that are not noticeable to others.

Older Youth:

- Feeling like a burden
- Being isolated
- Increased anxiety
- Feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Bullying / being bullied
- Risk-taking behavior
- Newly truant
- Talking or posting about wanting to die
- Making plans for suicide

Younger Youth (12 and under):

- Excessive somatic complaints
- Anxiety / worry
- Sleep problems / nightmares
- Constant fidgeting / movement
- Expression in writing or art
- Withdrawal
- Crying spells
- Increased anger, frustration, temper tantrums
- Becoming less verbal
- Attempting self-harm
- cutting skin / rubbing objects repeatedly to break skin
- Marked decline in school work
- Absenteeism
- Bullying / being bullied

At-Risk Student Populations

It is important for school districts to be aware of student populations that are at elevated risk for suicidal behavior based on various factors.

Youth Living with Mental and/or Substance Use Disorders

Mental health conditions, in particular depression/dysthymia, attention-deficit hyperactivity disorder, eating disorders, intermittent explosive disorder, and conduct disorder are important risk factors for suicidal behavior among young people. An estimated one in four to five children have a diagnosable mental condition that will cause severe impairment, with the average onset of depression and dysthymia occurring between ages 11 and 14 years; therefore, school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk and enhance overall performance and improve long-term outcomes. Though mental health conditions are a risk factor for suicide, the majority of people with mental health concerns do not engage in suicidal behavior.

Youth Who Engage in Self-Harm or Have Attempted Suicide

Suicide risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Whether or not they report suicidal intent, one study found that 70 percent of adolescents admitted into inpatient psychiatric treatment who engage in self harm report attempting suicide at least once in their life. Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. One study found that as many as 88 percent of people who attempt suicide for the first time and are seen in the Emergency Department go on to attempt suicide again within two years. Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources, transportation, insurance, copays, parental consent, etc.

Youth in Out-of-Home Settings

Youth involved in the juvenile justice or child welfare systems have a high prevalence of risk factors for suicide. As much as 60 to 70 percent of young people involved in the juvenile justice system meet criteria for at least one psychiatric disorder, and youth in juvenile justice residential programs are three times more likely to die by suicide than the general youth population. According to a study released in 2018, nearly a quarter of youth in foster care had a diagnosis of major depression in the last year. Additionally, a quarter of foster care youth reported attempting suicide by the time they were 17.5 years old.

Youth Experiencing Houselessness

For youth experiencing houselessness, the rate of self-injury, suicidal ideation, and suicide attempts is over two times greater than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorder, and post-traumatic stress disorder. One study found that more than half of runaway and homeless youth experience suicidal ideation.

American Indian/Alaska Native (AI/AN) Youth

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

LGBTQ2SIA+ Youth

The CDC finds that LGBTQ2SIA+ youth are 4.5 times more likely, and questioning youth are over twice as likely to consider attempting suicide as their heterosexual peers. One study found that 40 percent of transgender people attempted suicide sometime in their lifetime — of those who attempted, 73 percent made their first attempt before the age of 18. Suicidal behavior among LGBTQ2SIA+ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental health condition), these experiences can place them at increased risk. It is not their sexual orientation or gender identity that place LGBTQ2SIA+ youth at greater risk of suicidal behavior, but rather these societal and external factors: the way they are treated, shunned, abused, or neglected, in concert with other individual factors such as mental health history.

Youth Bereaved by Suicide

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

Youth Living with Medical Conditions or Disabilities

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive delays that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

Warning signs that indicate an immediate danger or threat:

- Signs that indicate the youth has a plan to kill themself
- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves – seeking access to pills, weapons, or other means
- Someone talking, joking, or writing about death, dying, or suicide

If suicidal attempts, gestures, or ideation occur or are recognized, report it to mental health staff. If there is imminent danger, such as an active attempt, also call 911. A suicide assessment will be performed by a trained school staff member. The assessment will do the following:

- Interview student using a standardized suicide rating scale
- Develop a School Support Safety Plan (aka Safety Plan) if needed
- Contact parent / guardian to inform and obtain further information.
- Determine need for further assessment
- Consult with another mental health staff before activating a crisis response
- Inform administrator of screening results
- Consult with the student's team

See following School-Based Suicide Intervention Process flowchart for additional information.

MESD SCHOOL-BASED SUICIDE INTERVENTION PROCESS

Overview

- Suicidal attempt, gestures, or ideation occurs & is recognized.
- Event is reported to mental health staff.
    - Initiate crisis response if there is an active attempt (ex. call 911)

    — OR —

    - Proceed with suicide risk assessment
        - Mental health staff determines appropriate next steps
            - Team initiates school support safety plan*
            - Psychoeducation on suicidality
            - Contact parent / guardians
            - refer to outside services

*School team (mental health staff and administrator) with parent and student initiates a support plan which may include:

- School, family, community components
- Monitoring, supervision
- Confidentiality
- Personal safety plan
- Referral
- Precautionary removal of lethal means from
- student's environment
- Review

Guidelines for When the Risk of Suicide Has Been Raised

The risk of suicide is raised when any peer, teacher, or other school employee identifies someone as potentially suicidal because the person has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated other warning signs. It is critical that any school employee who has knowledge of a suicide threat reports this information immediately and directly to a School Screener (counselor, school social worker, psychologist, or Administrator) so that the student of concern receives appropriate attention. Every effort should be made to interview the student the same day that concerns are reported.

Take suicidal behavior seriously every time. Take immediate action. Contact the school screener and a building administrator to inform that person of the situation. No student expressing suicidal thoughts should be sent home alone or left alone during the screening process. If there is reason to believe a student has thoughts of suicide, every effort should be made to avoid sending the student home to an empty house.

LEVEL 1 SCREENING—STUDENT INTERVIEW

1. Lethal Means. A concern for risk of suicide is brought to the attention of the School Screener and school administrator by a staff member, student's peers, or from direct referral by the student. If the student is in possession of lethal means (razor, gun, rope, pills, etc.), secure the area and prevent other students from accessing this area. Lethal means must be removed without putting anyone in danger. Call law enforcement to remove lethal means.

2. Supervision. A school staff person must stay with the identified student in a quiet, private setting to provide supervision and appropriate support until the School Screener meets with the student. If possible, this should be the person who identified the student at risk.

3. Use the Suicide Screening Form. The School Screener interviews the student and conducts a Level 1 Suicide Screening to determine immediate suicide risk. If the student admits that s/he is thinking about harming someone else, refer the student to the school administrator per the Behavior Student Threat Assessment Team (BSTAT). The Suicide Screening Form is used by the School Screener to document the Level 1 suicide screening and to ensure that the Suicide Intervention Procedures are followed.

4. Parents/guardians must always be notified when there appears to be any risk of self-harm.

- If the student discloses thoughts of suicide or if the School Screener has reason to believe there is a current risk for suicide, the School Screener will request that a parent/guardian come to school to participate in the screening process and safety plan. This can be completed over the phone, though it is not preferred.
- If the student denies experiencing thoughts of suicide and the Suicide Screener does not have reason to believe there is a current risk of suicide, it is still recommended that the Suicide Screener notify parent/guardian to share concerns.
- If the School Screener has exhausted all methods to reach the parent/guardian (including Emergency contacts and sibling schools), call the County Crisis Line to consult regarding next steps. It may be necessary, after consultation, to contact the Department of Human Services (Child Protective Services) or 911 if the risk of self-harm may be imminent.

5. Child abuse and/or neglect. When the School Screener or other staff person knows, or has reasonable cause to suspect that an identified student has been, or is likely to be abused or neglected if/when parents/guardians are contacted, he or she must make a report to the Child Welfare Hotline through the Department of Human Services at 503-681-6917 and complete the mandatory Child Abuse form.

6. Consultation. Upon completion of the Level 1 Suicide Screening, the School Screener will consult with another School Screener team member to determine if a Level 2 Suicide Assessment is appropriate. Sharing decision-making with another professional is best practice. The outcome of the consultation will be one of the following:

- If Level 2 Assessment is not warranted. School Support Plan is completed with the student (and parent/guardian if possible).
- If Level 2 Assessment is warranted. After consultation, if concern about suicidal ideation is sufficiently high, the School Screener refers student to a Level 2 Suicide Assessment by a Qualified Mental Health Professional. A School Support Plan is developed upon the student's return to school.

8. Home safety. If there is reason to believe a student has thoughts of suicide, every effort should be made to avoid sending the student home to an empty house.

LEVEL 2 SUICIDE ASSESSMENT (by a Qualified Mental Health Professional)

After consultation with another staff person who has been trained in the Suicide Screening Procedures (Counselor, Psychologist, Administrator), the School Screener determines that it is appropriate to proceed with a Level 2 assessment by a Qualified Mental Health Professional.

A Level 2 Assessment requires parental permission unless the student is 14 years of age or older. If a parent/guardian is unavailable or unwilling to consent to a suicide assessment by a Qualified Mental Health Professional, the School Screener collaborate with the Screener team to consult regarding next steps. It may be necessary, after consultation, to contact the Department of Human Services (Child Welfare Hotline: 503-681-6917), or 911 if the risk of self-harm may be imminent and parents/guardians are unwilling to seek services. The School Screener facilitates a connection to one of the following Qualified Mental Health Professionals (listed in order of preference):

1. Student's primary mental health therapist: The School Screener calls the therapist, provider, or agency. The therapist or agency makes an immediate plan with the student and family to conduct the Level 2 Suicide Assessment. If the School Screener cannot reach the therapist, the Screener will utilize other options listed below. It is not sufficient to simply leave a voicemail message for the therapist.

2. Hospital: Arrange student transportation to the hospital. Transportation options:

- Parent/Guardian
- Ambulance

Child/adolescent psychiatric units in the Portland metro area are located at:

- Unity Center for Behavioral Health, 1225 NE 2nd Ave, Portland, OR 97232, 503-413-2200
- Providence Willamette Falls Medical Center, 1500 Division Street Oregon City, OR 97045, 503-722-3730

Developing the School Support Plan After a Level 1 or Level 2 Suicide Screening

After every suicide screening, the School Screener must complete a School Support Safety Plan. The School Support Safety Plan provides a structure for intentional support, designates the responsibilities of each person, and includes a review date to ensure follow-through and coordinated decision-making. A Plan Manager should be designated to serve as the school point person for follow-up communication with parents/guardians and community providers for students who have been screened for suicide (Level 1 AND 2).

Level 1 Assessment- Safety Support Plan needs to be completed with student (involve parent/guardian as appropriate) immediately.

Level 2 Assessment– School screener or designated Plan Manager schedules a re-entry meeting with student, parent, and administrator to complete the Support Plan. The Counselor or Psychologist/Case Manager should be involved in this meeting as appropriate. The Support Plan needs to be completed upon the student's return to school (prior to attending classes).

*** A Reentry meeting is also necessary when students are returning to school following a suicide attempt, even if the school did not complete a suicide screening. ***

CONFIDENTIALITY

Privacy is of utmost importance, and every effort will be made to respect the confidentiality of the student while attending to the safety needs of the student and school building. The student and parent/guardian should be informed of the limited information sharing that the district requires:

- For safety reasons, the designated building administrator will be notified of every suicide concern.
- Depending on the Support Safety Plan , specific school staff might receive certain information about concerns as part of a plan to maintain safety and provide support to the student. Student and parents/guardians are invited to help develop this plan.
- The Suicide Screening Form will be kept strictly confidential in the student's working file in the school office in a locked file cabinet, separate from the cumulative file. .
- A data tracking spreadsheet will be updated each time there is a suicide screening. This will be completed by the school staff who completes the screening. Information will be anonymous, and will include: school name, date of screening, grade of student

SUICIDE POSTVENTION PROTOCOL OVERVIEW

Schools must be prepared to act and provide postvention support and action in the event of a suicide attempt or completed suicide. Suicide Postvention has been defined as "the provision of crisis intervention, support, and assistance for those affected by a suicide" (American Association of Suicidology). Postvention strategies after a suicide attempt or completion are very important. Schools should be aware that youth and others associated with the event may be vulnerable to increased risk or suicide. Families and communities can be especially vulnerable after a suicide.

The school's primary responsibility in these cases is to respond to the suicide attempt or completion in a manner which appropriately supports students and the school community. MESD has systems in place that work with and support those affected by the attempt or death; such as students, staff, parents / guardians, community, media, law enforcement, etc.

Postvention Goals:

- Support the grieving process
- Prevent suicide contagion
- Reestablish healthy school climate
- Provide long-term supports
- Integrate and strengthen protective factors
    - i.e., community involvement in school, parent engagement, mental health supports, etc.

How do we reach these goals?

- Activate Flight Team for further support.
- Do not glorify or romanticize the suicide but treat it sensitively when speaking about the event, particularly with the media
- Address all deaths in a similar manner. For example, having one approach for a student who dies in a car accident and a different approach for a student who dies by suicide reinforces the stigma surrounding suicide.
- Research and identify the resources available in your community.

Resources

- School-based: Mental Health Therapist, Counselor, School Psychologist, and Behavior Specialist
- Community: YouthLine
- County Supports: Multnomah County, Clackamas County, & Washington County Crisis Lines
- Grief Support: The Dougy Center

Generally, postvention response includes, but is not limited to, the following actions:

- Verify the suicide attempt or completion
- Estimate level of response resources required
- Determine what and how information is to be shared (do NOT release information in a large assembly or over the intercom)
- Mobilize the Flight Team.
- Inform staff
- Identify at-risk students and staff (see "risk identification strategies")
- Refresh information for faculty and staff on prevention protocols and be responsive to signs of risk. Be aware that persons may still be traumatized months after the event.

Key Points to Emphasize to Students, Parents/Guardians, and Media:

- Prevention (warning signs, risk factors)
- Survivors are not responsible for the death
- Mental illness etiology
- Normalize anger
- Stress alternatives
- Help is available

SAFE REPORTING

The way that media outlets, reporters, and others can safely share news that someone has died by suicide. Safe reporting can help reduce the risk of suicide contagion and / or clusters in a community. Examples of safe reporting practices include not sharing the means of death, avoiding sensationalizing the death, and including resources for community members to get help if needed.

Cautions:

- Avoid romanticizing or glorifying event or vilifying victim
- Do not provide excessive details or describe the event as courageous or rational
- Do not create memorials to students unless they can be replicated every time a student dies. Ex.: don't put a statue on the front lawn for a death by suicide if you won't do it for every student death at the school.
- Address loss but avoid school disruption as best as possible

Risk Identification Strategies:

IDENTIFY students / staff that may have witnessed the suicide or its aftermath, have had a personal connection / relationship with the attempt survivor or the deceased, who have previously demonstrated suicidal behavior, have a mental illness, have a history of familial suicide, or who have experienced a recent loss.

MONITOR student absentees in the days following a suicide attempt or completion. Groups that may be at higher risk include those who have a history of being bullied, who are LGBTQ+, who are isolated from the larger community, and those who have low levels of social / familial support.

NOTIFY parents/guardians of highly affected students, provide recommendations for community-based mental health services, hold evening meetings for parents/guardians, provide information on community based funeral services / memorials, and collaborate with media, law enforcement and community agencies.

Themes of Responsible Postvention:

- Grief is normal
- Help is available
- Youth and young adults are resilient
- Healthy coping skills can be learned
- Suicide loss survivors are not responsible for the death
- Suicide is preventable

Recommended Resources:

- After A Suicide: A Toolkit for Schools www.afsp.org
- Suicide Prevention Resource Center www.sprc.org
- American Foundation for Suicide Prevention www.afsp.org
- Suicide Rapid Response SRR@linesforlife.org

MESD SUICIDE POSTVENTION PROTOCOL

After a Suicide:

After a suicide, MESD immediately activates the MESD FLIGHT team and follows FLIGHT team protocol. This protocol uses the Crisis Resource Manual developed by Crisis Management Institute and Cheri Lovre. Information about the protocol can be found here: https://cmionline.com/about/

MESD FLIGHT Team includes district Mental Health Therapists, Counselors, School Psychologists, Behavior Specialists and Student Services Administrators.

After a Hospitalization for a Suicide Attempt:

MESD is in a unique position to support youth upon discharge, since MESD provides for the education of hospitalized youth including in the only two behavioral health hospitals in Oregon. Upon discharge, MESD staff collaborate across programs to develop a transition plan for the return to school taking into account educational needs, medical recommendations, parent requests and student voice. Students, parents / guardians, mental and / or behavioral health and educators collaborate to ensure proper support are in place for re-entry. Examples of possible supports include:

- Supervision Plan
- Safety Plan
- Escalation Cycle Plan
- Updated 504
- IEP Accommodations
- Behavior Support Plan (BSP)
- Functional Behavior Assessment (FBA)

MESD COMMUNITY REVIEW PROTOCOL

Staff, students, parents/guardians, and community members may request the district review response to a suicide risk.

Step 1: Request a meeting with the Senior Student Services Administrator to review the request.

Senior Student Services Administrator: Joni Tolon

Email: jtolon@mesd.k12.or.us

Cell: 503-793-3129

Step 2: If not satisfied with review, follow the MESD Board Policy KL: Community

Information about this policy may be found here:
https://policy.osba.org/mesd/KL/KL%20G1.PDF

The KL Complaint form may be found here:
https://policy.osba.org/mesd/KL/KL%20R%202%20D1.PDF

CULTURALLY RESPONSIVE & SPECIFIC RESOURCES

Asian American/Pacific Islander

Asian American Psychological Association: https://aapaonline.org/

Asian & Pacific Islander American Health Forum: https://www.apiahf.org/

National Asian American Pacific Islander Mental Health Association: https://www.naapimha.org/

Immigrant and Refugee Community Organization https://irco.org/

Black/African American

Avel Gordley Center for Healing at OHSU: https://www.ohsu.edu/brain-institute/ohsu-avel-gordly-center-healing-portland

Black Emotional and Mental Health (BEAM): https://www.beam.community/

Black Mental Health Alliance: https://blackmentalhealth.com/suicide/

Black Safe Spaces: https://www.safeblackspace.org/

The Boris Lawrence Henson Foundation: https://borislhensonfoundation.org/

Bridge Pamoja (Portland): info@bridge-pamoja.org

Loveland Foundation: https://thelovelandfoundation.org/

Therapy for Black Girls: https://therapyforblackgirls.com/

Hispanic/Latinx

Latinx/Hispanic Communities And Mental Health: https://mhanational.org/issues/latinxhispanic-communities-and-mental-health

Latinx Therapy: https://latinxtherapy.com/

Therapy for Latinx: https://www.therapyforlatinx.com/

Latino Network https://www.latnet.org/

LGBTQ2SIA+

National Queer and Trans Therapists of Color Network: https://www.nqttcn.com/

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

Transgender Life Line 1-877-565-8860

Native/Indigenous

One Sky Center: http://www.oneskycenter.org/

Native American Rehabilitation Association https://www.naranorthwest.org/

Native American Youth and Family Center https://nayapdx.org/

For Culturally Specific Portland Based Practitioners

https://www.portlandtherapycenter.com/

DEFINITIONS

Term	Definition
Behavior Student Assessment Team (BSAT)	The Behavior Student Assessment Team is a collaborative group of licensed school and public safety professionals that review behavioral information and provide strategies to support students' success in school.
Behavior Support Plan (BSP)	A Behavior Support Plan (BSP) is a plan that **assists a student in building positive behaviors to replace or reduce a challenging/dangerous behavior**. This plan proactively teaches and reinforces positive behavior.
Escalation Cycle Plan	When students exhibit behaviors that escalate, it can be useful to determine student options and staff responses at each stage of escalation. The information that is cultivated can be used to supplement a Behavior Support Plan that is already in place.
Functional Behavior Assessment (FBA)	Functional Behavioral Assessment (FBA) is **a process for identifying problem behaviors and developing interventions to improve or eliminate those behaviors**. An FBA consists of information-gathering procedures that result in a hypothesis about the function(s) that the behavior is serving for the student.
Individual Education Plan (IEP)	Students who qualify for Special Education have an IEP. An IEP outlines the program of special education instruction, supports, and services students need to make progress and thrive in school.
LGBTQ2SIA+	Lesbian, Gay, Bisexual, Transgender/non-binary, Queer/Questioning, Two-Spirit, Intersex, Asexual, + (recognizes that there are myriad ways to describe gender identities)
Mental Health	Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices (https://www.cdc.gov/mentalhealth/learn/index.htm)
QMHA	A qualified mental health associate is one who meets the following minimum qualifications: bachelor's degree in a

	behavioral sciences field; or a combination of at least three years relevant work, education, training or experience; or a qualified mental health intern as defined in OAR 309-022-0105. QMHA demonstrate the ability to communicate effectively; understand mental health assessment, treatment, and service terminology and apply each of these concepts; implement skills development strategies; and identify, implement, and coordinate the services and supports identified in a service plan.(https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=254417)
QMHP	A qualified mental health professional is one who holds any of the following educational degrees and meets the following minimum qualifications:Graduate degree in psychology, bachelor's degree in nursing and licensed by the State of Oregon, graduate degree in social work, graduate degree in behavioral science field, graduate degree in recreational, music or art therapy, bachelor's degree in occupational therapy and licensed by the State of Oregon, a qualified mental health intern as defined in OAR 309-022-0105. QMHP demonstrate the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services, and criminal justice contacts; assessing family, cultural, social, and work relationships; and conducting a mental status examination, completing a DSM diagnosis, writing and supervising the implementation of a service plan; and providing individual, family, or group therapy within the scope of their training. (https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=254417)
School Support Safety Plan (aka Safety Plan)	The MESD form was developed by the Oregon Pediatric Society and Youth Save. After a suicide screener has been completed, the designated school staff will work with the student and family to complete the School Support Safety Plan which includes a checklist for safety and preventative lists of people and activites.
Section 504	504 plans are formal plans that schools develop to provide students with disabilities equal access to general education, typically in the form of accommodations. Accommodations are changes to the learning environment, but not specialized instruction.