

BSD SUICIDE PREVENTION PLAN

Original: Fall 2020

Updated: September 2025

[Suicide First Aid Behavior Chart](#)

[Suicide First Aid Thoughts Chart](#)

[At a Glance Overview of the Plan](#)

INTRODUCTION

Senate Bill 52, also known as "Adi's Act", was passed in Oregon in 2019. This legislation required school districts to develop and publicly post the school district's plan for suicide prevention, intervention, and postvention response activities, beginning no later than the start of the 2020/2021 school year. This plan was originally published in 2020 and was updated in September 2025.

Suicide is the second leading cause of death for Oregon youth ages 5-24. Any firearm death is the leading cause of death for Oregon Youth ages 10-24. Youth face a barrage of pressures and stressors that, if uncared for, can amplify the mental health risk factors most commonly associated with suicide. When youth feel connected to their schools, friends, and caring adults, they are better equipped to cope with life's challenges. (CDC Wonder, 2024)

The purpose of this plan is to protect the health and well-being of all students by having procedures in place to prevent, intervene in, and respond appropriately to suicide. Beaverton School District's current Strategic Plan identifies the importance of physical and mental health outcomes academically and beyond within the "safe and thriving" strategic direction. BSD also recognizes the importance of students feeling a sense of "belonging" in their school communities in order to achieve success. This sense of belonging is also a strong protective factor for suicide.

Given the complexities of suicidal thought and behavior and its impact on others, suicide prevention programming includes prevention (elements that lower the likelihood of thoughts of suicide developing), intervention (the response we have when someone presents as having suicidal thoughts or behaviors), and postvention (how we respond to prevent future thoughts and behaviors for those impacted by someone's thoughts and behaviors). Comprehensive efforts in a school district include components for youth, staff and for parents/guardians/community for the above mentioned categories. BSD utilizes data and best practices whenever possible such as the Oregon Health Authority's recommended [Big River Suicide Prevention Programs](#) to inform the suicide prevention plan.

SUICIDE AND SCHOOLS

School staff are uniquely positioned as a first line of contact with students who may be having thoughts of suicide or who exhibit suicide behavior. However, school staff are not expected to provide the in-depth assessment or mental health treatment for a suicidal student. They are responsible for taking reasonable and prudent actions to help students by providing suicide first aid. All school staff need to know how to recognize suicide behavior and thoughts and that protocols exist to refer students to suicide first aid trained staff and/or for a suicide assessment in the community.

Students and parents/guardians can also help prevent suicide by learning how to recognize suicidal thoughts and behavior and referring the person to someone who is trained in suicide first aid. Asking someone if they are feeling suicidal, will not put the idea in their head or cause them to suicide. Rather, talking responsibly about suicide and having comprehensive supports in place lessens stigma and thoughts and behaviors while it also increases resilience for everyone. Advanced planning is critical to providing an effective crisis response to suicide. Internal and external resources must be in place to address student suicidality and to foster a sense of belonging in the learning environment for everyone.

Confidentiality

School employees are bound by laws of The Family Education Rights and Privacy Act of 1974; commonly known as FERPA. There are situations when confidentiality must NOT BE MAINTAINED; if at any time, a student has shared information that indicates the student is in imminent risk of harm/danger to self or others, that information MUST BE shared. 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 and known as “minimum necessary disclosure”.

In BSD every conversation about suicide where there was an initial suspicion of suicide thought or behavior with students must be shared with parents/guardians or Child Welfare if there are abuse concerns. Parents/guardians need to know about suicide first aid provided to a student and its outcome. If students are anxious about this, staff can remind them that they have shared information so far because a part of them wants help and wants to stay alive. Staff are recommended to give the student as many options as possible in sharing the news with parents/guardians.

There is a possibility that parents/guardians may have a strong reaction to the news of suicide first aid with their student. Given both the stigma and high level of prevalence of suicidal thought and behavior amongst the general population, most people have had some type of experience with suicide. This can lead to parents/guardians having varying reactions to the news that a loved one is potentially thinking about suicide. One way to deal with strong reactions is to “divide and accomplish” and have another staff person address the parent/guardian concerns. A strong reaction may even indicate they themselves are thinking about suicide and need suicide first aid. This allows for both the student’s and parent/guardian’s needs to be addressed.

Parents/guardians need to know about a student's suicide first aid unless a result of parental abuse or neglect is possible. In this case, staff need to make a DHS Child Welfare report and plan with DHS Child Welfare regarding next steps to support the student.

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. Beyond parents/guardians or DHS Child Welfare, the building administrator will be informed and sometimes additional school staff may need to know or get involved in order to support the student. The protocol form at the end of this document school staff fill out after providing suicide first aid is kept strictly confidential at the district office. Any support plans are kept in the student's working file at the school building, not in the cumulative file.

STUDENT POPULATIONS AT ELEVATED RISK

Surveillance/data collection for continuous improvement and progress monitoring is also necessary for a comprehensive approach to suicide prevention. BSD utilizes data collected through our protocol process to recognize trends to best focus prevention activities where possible. For example, in the 2023-2024 school year the majority of our suicide screens were of students ages 5-14 with over one third of them being ages 5-11. This led to some focused efforts at the elementary level for the national suicide hotline 988 awareness during suicide prevention month 2024. BSD also recognizes state and national trends for suicide and youth in order to best serve those populations at increased risk within our school district.

Youth Living with Mental and/or Substance Use Disorders

People with diagnosed mental disorders (including substance use disorders) have a higher suicide risk than people without such diagnoses. However, the vast majority of people with mental disorders will not die by suicide (Brådvik, 2018; Holmstrand et al., 2015; Inskip et al., 1998; Nordentof et al., 2011). Suicide rates vary by how common (e.g., mood disorders) and how impairing (e.g., anorexia) the disorder is. Risk also varies based on the age of onset, the age of diagnosis, how many disorders are present, and based on demographic characteristics more generally, such as age and sex. With the average onset of depression and dysthymia occurring between ages 11 and 14 years, 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.

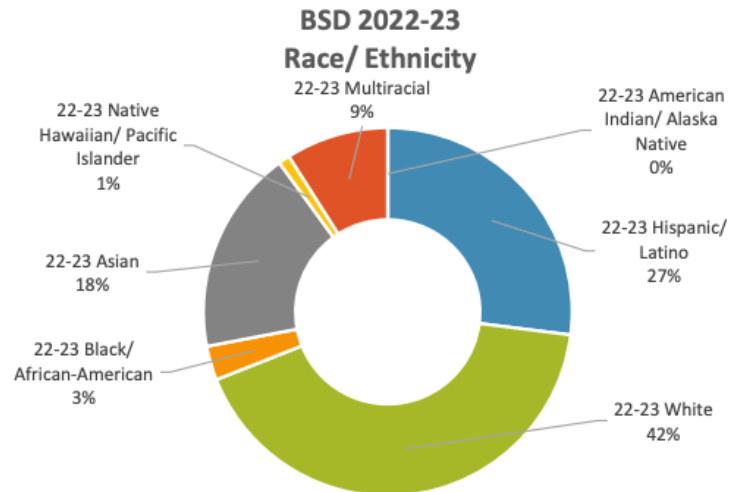
In BSD 12.4 % of the students are receiving special education services. We do not always know which students have a formal mental health or substance use disorder diagnosis. However, we do know that 203 interventions out of 639 total for school year 2023-2024 were with students who are receiving special education services and 54 were with students on a 504. So it is important that we pay extra attention to students receiving special education services or have a 504 since they are more likely to participate in an intervention than students in general education.

Youth Who Engage in Suicide Behavior

Many more people think about and/or attempt suicide than those who die by suicide, and most people who think about or attempt suicide never go on to die by suicide (Wenzel et al., 2011). Understanding these patterns can help ensure timely prevention services are received. Data on suicide thoughts and attempts in the population come from self-reported survey data and from emergency departments and hospital records (called nonfatal self-harm in medical records). Thirteen percent of female high school students and 7% of male high school students reported making a suicide attempt in 2021 (CDC, 2023g). Non-Hispanic AI/AN students and non-Hispanic Black students reported the highest percentage of attempts, 16% and 14%, respectively (CDC, 2023g). More than 30% of students with same-sex sexual contacts and 22% of LGBTQ+ students reported an attempt as compared with 6% of heterosexual students (CDC, 2023g).

Trends in suicide attempts over time between 2011 to 2021 indicate (CDC, 2023g): Suicide attempts among female students increased significantly from 10% in 2011 to 13% in 2021. Attempts among non-Hispanic Black students increased significantly from 8% in 2011 to 14% in 2021 and rates among non-Hispanic White students increased significantly from 6% in 2011 to 9% in 2021. Black students experienced an increase in suicide attempts requiring medical treatment from 2% in 2011 to 4% in 2021.

In BSD in school year 2023-2024, the race/ethnicity of students are in the chart below. In the second chart are the race/ethnicity for each of the 639 screenings in the 2023-2024 school year. Of note is that 5.95% of the screenings were for students who identify as Black/African American and they make up only 3% of our student body.



Ethnicity	Students	Percent
American Indian	4	0.63 %
Asian	48	7.51 %
Black	38	5.95 %
Hispanic	176	27.54 %
Multiple	56	8.76 %
Native Hawaiian	5	0.78 %
White	312	48.83 %
Total	639	100.00 %

Youth in Out-of-Home Settings

Youth involved in the juvenile justice and child welfare systems have a high prevalence of many risk factors for mental, emotional, and behavioral disorders associated with suicide. Juveniles in confinement and foster care have life histories that put them at higher suicide risk. Suicide among youth in contact with the juvenile justice system occurs at a rate about four times greater than the rate among youth in the general population. In one study, children in foster care were almost four times more likely to have considered suicide and almost four times more likely to have attempted suicide than those who had never been in foster care. Because of the heightened vulnerability that youth in the foster care and juvenile justice systems have to engage in suicidal ideation or behavior, specific preventative measures are crucial and can save the lives of youth in need.

In BSD in 2023-2024, 3.1% of our students were eligible for McKinney-Vento Act services. The McKinney-Vento Act defines homeless children and youth as individuals who lack a fixed, regular, and adequate nighttime residence. This definition also includes children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason. We also have students involved with Juvenile Justice and DHS Child Welfare. Unfortunately, that data is not available to cross reference this with suicide ideation or behavior.

American Indian/Alaska Native (AI/AN) Youth

Suicide rates among American Indian/Alaska Native (AI/AN) individuals are the highest among any racial or ethnic group in the United States, thus suicide rates among AI/AN youth are significantly higher than that of youth overall. Where the overall U.S. suicide rate in 2019 was 13.2 per every 100,000, the rate for AI/AN individuals was 22.2 per every 100,000. Following a similar trend to the adult population, 34 percent of AI/AN high school youth had seriously considered suicide within the past year compared to the overall U.S. population's 18 percent, and the percentage of AI/AN youth who made a suicide plan was 9 percent higher than that of non-native U.S. youth. Suicide rates for this population peak in adolescence and young adulthood, particularly between the ages of 15-34. Although suicide rates vary widely among individual tribes, it is estimated that 14 to 27 percent of AI/AN adolescents have attempted suicide.

These statistics underscore how crucial it is that AI/AN youth receive increased access to high-quality, culturally responsive mental health services and suicide prevention interventions. Due to the rural residential settings of many AI/AN adolescents surveyed in current research, there is a strong need for increased implementation of suicide prevention strategies and interventions in rural areas. Increased access to mental health services and therapy must also occur in rural areas and those areas with high AI/AN populations in order to identify and diagnose youth struggling with mental disorders that put them at higher risk for suicide early on. Financial incentives such as loan forgiveness for mental health practitioners have been suggested by some as a possible avenue to address provider shortages in these rural areas.

In BSD the American Indian/Alaska Native population is so small it shows up as 0% of our student body. 0.63% of the suicide interventions in the 2023-2024 school year were students who identify as American Indian/Alaska Native. BSD has a position dedicated to supporting American Indian/Alaska Native students in the district and during the 2023-2024 school year there were efforts to coordinate and share resources specific to this population with this staff person and their programming.

LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) Youth

Youth who are not heterosexual and/or express their gender in diverse ways are nearly one and a half to three times more likely to have reported suicidal ideation and nearly one and a half to seven times more likely to have reported attempting suicide than heterosexual and cisgender youth. Rates of "suicidal ideation, suicide plans, attempts, and attempts requiring medical treatment were highest among sexual minority youth, those who identified as LGB, and youth

who reported having had sexual contact with the same or with both sexes during 2019.” Some groups of LGB youth are at particular risk: those who experience homelessness or have run away from home, are living in foster care, and/or are involved in the juvenile justice system. Surveys show high rates of suicidal behavior in the transgender population, with transgender boys, transgender girls, and nonbinary adolescents assigned female at birth showing significantly higher suicidality outcomes than cisgender adolescents, including higher suicidal ideation and suicide attempts.

In BSD, the data available is not very specific in terms of identity either at the district level or in terms of suicide interventions. At the district level the data points are only male or female, 51.3% Male and 48.7% Female. For suicide interventions, females were 53.21%, males 44.29% and non-binary 2.5%. There has been promotion of professional development on this topic for those that provide suicide first aid for students in the district, particularly the concerns regarding high rates of suicidal behavior for students in the transgender population.

Gender	Students	Percent
Female	340	53.21 %
Male	283	44.29 %
Non Binary	16	2.50 %
Total	639	100.00 %

Those 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. Suicide and suicide attempts affect the health and well-being of friends, loved ones, co-workers, and the community. When people die by suicide, their surviving family and friends may experience prolonged grief, shock, anger, guilt, symptoms of depression or anxiety, and even thoughts of suicide themselves. While we pay close attention to those bereaved by suicide if we are aware of the suicide. Often we are not aware until the point of the suicide first aid that the student is struggling with this issue. We do not collect data regarding this in BSD.

Citations for this section

Oregon Health Authority, Behavioral Health Division. Youth Suicide Intervention and Prevention Plan Annual Report. Oregon Health Authority, Portland, OR. June 2024.

U.S. Department of Health and Human Services (HHS), National Strategy for Suicide Prevention. Washington, DC: HHS, April 2024.

Beaverton School District Suicide Screening Data 2023-2024

<https://youth.gov/youth-topics/youth-suicide-prevention/references>

<https://www.cdc.gov/suicide/facts/index.html>

BSD's SUICIDE PLAN

Prevention

Suicide prevention are the intentional steps that schools take to create a culture that encourages positive coping skills, reaching out for help with suicidal thoughts or behaviors and talking about suicide in a safe and healthy way. BSD is in the third year of implementation for universal SEL curriculum Kindness in the Classroom at elementary and Character Strong at secondary. We also use Purposeful People at the elementary level as a curricular enhancement and teach Adi's Act lessons at secondary. We are also in the process of aligning with the new Transformative Social and Emotional Framework and Standards from the Oregon Department of Education with our SEL work in BSD. All schools have "safe and thriving" goals as part of their school strategic plans which directly impact the climate and culture of their buildings and their students' sense of belonging and connectedness with others. Progress will be measured with a universal SEL screener (SAEBRS) and a staff survey. Information about how to recognize warning signs and risk factors for suicide is shared with staff and parents/guardians/community through QPR (Question, Persuade, Refer) trainings each year. We have begun an ambitious plan to have a QPR trainer in every building and have them each provide one all-staff training and one parent/community training each year to increase awareness. We are also in the process of implementing Sources of Strength, the peer led resilience building program at every secondary. We have two schools participating and one ready to start this year.

Intervention

Intervention refers to BSD's responsibility to respond immediately to concerns about suicide thought or behavior with an evidence based practice to reduce suicide behavior; this is suicide first aid. The suicide first aid intervention model BSD uses is Applied Suicide Intervention Skills Training or ASIST. ASIST is one of the Oregon Health Authority's "Big River" suicide intervention trainings as are QPR and Counseling on Access to Lethal Means, CALM. Those trained in ASIST every four years will also receive CALM every three years.

Immediate Response and Supervision: The risk of suicide is raised when any peer, teacher, or other school employee identifies someone as potentially suicidal because they have directly or indirectly expressed suicidal thoughts (ideation) or demonstrated other warning signs or suicide behavior. It is critical that any school employee who has knowledge of a suicide threat reports this information immediately and directly to an administrator, school counselor, school social worker, school psychologist or youth services officer so that the student of concern receives appropriate attention. These roles are trained in Applied Suicide Intervention Skills Training (ASIST) and can apply suicide first aid. We have one staff person who is certified as an ASIST trainer and are working to have another trainer trained this school year from a community partner agency, Beaverton Police Department. Then we will strive to offer 1-3 trainings for BSD and BPD staff each year.

Every effort should be made to intervene with the student the same day that concerns are reported. A staff person must stay with the identified student in a quiet, private setting to provide

supervision and appropriate support until first aid can be conducted. If possible, this should be the person who first identified the concern about suicide.

In the ASIST model of suicide first aid, a plan to “keep safe for now” is developed in the assisting phase of the model after the person with thoughts of suicide has confirmed they are having thoughts of suicide (the connecting phase) and made a choice to keep their “life side” safe from suicide behavior (the understanding choices phase). If someone with thoughts of suicide is unwilling or unable to agree to make a plan to keep themselves safe from suicide for now then they need to go immediately for a suicide assessment in the community.

The staff person providing suicide first aid will need to fill out the form associated with the first aid. This form can be found at the end of this plan. This can be after the bulk of the intervention is complete when they are in the assisting phase of the first aid. This form is used by ASIST trained staff to document the first aid provided and to ensure that the Beaverton School District Suicide Intervention Protocol is followed.

If the student is willing and able to make a plan to keep themselves safe for now then the staff person’s role is to help the student develop a support plan. It is best if the student has as much say as possible in creating this plan as then they are much more likely to follow through on the plan. Parents/guardians are also important resources when developing a support plan.

When a student is unwilling or unable to participate in creating a support plan and they instead receive a suicide assessment in the community, upon return to school the parent/guardian and student need to have a re-entry meeting with an administrator, school counselor, school social worker or school psychologist to create a support plan for school to support the student in keeping safe from suicide.

A re-entry meeting and creation of a support plan is also necessary if the student returns from a hospitalization, in-patient treatment, intensive out-patient or other suicide behavior and treatment that the school was previously not aware of.

Consultation: Sharing decision-making with another ASIST trained staff either on-site or via a crisis line is best practice. Upon completion and/or at any point during the suicide first aid intervention, consultation can be sought. In particular, the decision to proceed with support planning or send the student for a suicide assessment in the community should be made in consultation.

Threats to Others: If the student discloses any threats of harm or there is reason to believe there is a possibility of harm to others through targeted violence then the staff person will complete suicide first aid and then refer the threat concern to their administrator for a possible Student Threat Assessment Team process.

Postvention

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 are very important as anyone associated with the event are at increased risk for suicide themselves and communities can be vulnerable to suicide contagion. Therefore it is important to have a tragedy response system in place that incorporates best practices for supporting school communities after a suicide. From communication to memorialization to acknowledging cultural differences regarding death and dying to considering equity issues in types of responses—all aspects of a response are important to consider.

The purpose of tragedy response generally is to assist schools in regaining stability in the wake of a crisis by supporting students and staff experiencing loss, grief or trauma. Grieving together is part of belonging to a community. In the case of suicide postvention, providing support after a suicide is also part of prevention for future suicide behavior. In any response, this work helps move school communities from a place of grief and tragedy to one of hope and resiliency.

The Suicide Prevention Resource Center describes postvention goals in the case of suicide as, supporting the grieving process, preventing contagion, reestablishing a healthy school climate, providing long-term surveillance and integrating and strengthening protective factors (community, positive coping skills, resiliency). This includes using best practices for communication about a suicide, not using the word “commit,” instead use “died by suicide” or suicided, and providing crisis line and warning signs information.

Schools should also treat all student deaths in the same way. For example, having one approach for a student who dies of cancer and another for a student who dies by suicide reinforces the negative association that often surrounds suicide and may be deeply painful to the deceased student’s family and close friends. Schools should also not romanticise or glorify suicide deaths. Memorials following a suicide should also not glamorize, romanticize, or stigmatize the act of suicide. Memorial activities can be an important opportunity for students and staff to grieve and for the community to bring closure to the formal period of grief. We can support participation by excusing abscess for attendance at a community memorial. Memorial activities at school should support healthy bereavement such as: pictures, notes, flowers, can be displayed until a service or for a set period of time and then given to the family. Supporting a cause, hosting educational opportunities, such as about mental health or some other active community event, are also best practice options.

Students are vulnerable to the risk of suicide contagion. Contagion is the process by which one suicide death may contribute to another. Although contagion is relatively rare (accounting for between 1 and 5 percent of all youth suicide deaths annually), adolescents and teenagers appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. It is also important to recognize the impact of highly publicized suicide deaths, such as those of celebrities, which may contribute to contagion. Adolescents are also resilient. With the proper information, guidance, and support

from school staff, students can learn to cope with the suicide of a fellow student, process their grief, and return to healthy functioning.

[After A Suicide Toolkit](#)

[Suicide Prevention Messaging](#)

[Tips for Talking to Students about Suicide](#)

BSD uses an equitable trauma-informed lens to plan and implement tragedy responses for both the schools receiving the services and the responders. BSD uses evidence based or best practice interventions where possible in our responses to tragedy and we train staff annually accordingly. Staff who volunteer as responders will receive specialized training in how to respond to suicide through the Connect training which will be offered every three years. In addition to this, new responders receive a tragedy response training which includes tips for suicide postvention every year.

BSD has a Planning Team Model which includes the disciplines needed to adequately plan and implement all parts of the response: Administrator, Executive Administrator, Tragedy Response Coordinators, Communication Director, Human Resources Administrators, Multilingual Department Administrators. The Planning Team deploys trained volunteer responders. These responders are volunteer administrators, educators on special assignment, school nurses, school counselors, school psychologists and school social workers. Responses may also require trained substitute teachers and trained roving substitutes. Responders receive formal training or a refresher annually. Responding to tragedy is not for everyone. BSD uses only those who volunteer to respond. BSD provides professional development on resilience building and coping strategies to mitigate the impact of vicarious trauma.

[Tragedy Response Best Practices Document](#)

BSD Suicide Prevention Plan Overview			
	Prevention	Intervention	Postvention
Students	• Inclusive Climate and Culture • Universal Tier 1 SEL • Kindness in the Classroom • Character Strong • Universal SAEBRs Screener • Sources of Strength Peer Led Prevention Group at Secondaries • Adi's Act Lessons at Secondaries	• Functioning BH&W and SPED Teams • Tier 2 Interventions • Referrals to community mental health providers • Suicide First Aid (ASIST) and Support Plans	• Tragedy Responders meet with students • Appropriate communication and protocols to reduce contagion risk • Dougy Center Grief Journals and Library Book Lists available for Grief Groups at Secondary • Grief Book Kits for Elementary Classrooms

BSD Suicide Prevention Plan Overview			
	• Referrals to community mental health providers • Restorative Practices • Behavioral Health CTE Program at Sunset HS		
Staff	• PD/Support for SEL • Safe and Thriving Goals in Strategic Plan • Vector Training on Suicide Prevention • District-Wide Equity Professional Development	• ASIST: Admin and School Mental Health Professionals • QPR • CALM: Admin and School Mental Health Professionals every 3 years • Protocol Training • Involvement in Support Plans	• Tragedy Responders provided to support staff • District Level Response Planning Team (meets at least twice per year to review data/process improvement) • Connect Training for volunteer Tragedy Responders every three years • Training about Tragedy Response Process every year • Appropriate communication and protocols to reduce contagion risk
Parent/Guardian/Community	• QPR • Referrals to community mental health providers	• QPR • Provision of crisis line information • Provision of safe means storage • Involvement in Support Plans, Re-entry meetings • Referrals to community mental health providers	• Tragedy Responders provided to support parents/guardians/community • Appropriate communication and protocols to reduce contagion risk • Youth Suicide Loss funds for eligible families
Connection to County/State Efforts	• Participate in SEL Collaborative/BAS E Behavior Attendance Social Emotional Committee • Attendance at Oregon Suicide Prevention Conference	• Collaboration regarding QPR and ASIST trainings	• Participate in County-Wide Tragedy Response meetings to share training, data and talk about continuous improvement • Can access Suicide Rapid Response Team through County Coordinator • Can access response assistance through County-Wide Tragedy Response Group

SPECIFIC PROGRAM IMPLEMENTATION				
	2024-2025	2025-2026	2026-2027	2027-2028
Adi's Act Lessons (Secondary Schools)	In Place	Update Curriculum	In Place	In Place
SEL Tier 1 (Kindness in the Classroom and Character Strong)	In Place	In Place	In Place	In Place
SEL Tier 2	Survey of current Tier 2 practices	Spring: Begin Curriculum Adoption for Tier 2 SEL	Continue and Complete Adoption Process	Implementation of Tier 2 curriculum
QPR (All schools provide all staff and community training once per year, secondaries consider training students)	Train Admins Get List from Admins of Potential Trainers (1 per school) Begin getting trainers trained through Lines for Life Host training in Spring for remaining staff trainers	Full Implementation at each school: 1 training for all staff 1 training for parent/guardian 1 training for students who are old enough Identify and train trainers for all other departments Three times per year learning collaborative for	Trainings in place Learning Collaborative in place Train new staff for schools/departments as needed.	Trainings in place Learning Collaborative in place Train new staff for schools/departments as needed.

SPECIFIC PROGRAM IMPLEMENTATION				
		trainers		
ASIST Applied Suicide Intervention Skills Training (Administrators and all school mental health professionals trained every four years)	Get two more BSD staff trained Offer 1 ASIST for administrators only in June 2025 Sign MOU with NW Regional ESD to provide trainers for their trainings	Provide two trainings through NW regional ESD Promote all ASIST trainings being offered through NW Regional ESD	Promote taking ASIST in the community	Promote taking ASIST in the community
CALM Counseling on Access to Lethal Means (Administrators and all school mental health professionals trained every three years)	Free online training is available at CALM	Free online training is available at CALM	Free online training is available at CALM	Free online training is available at CALM
Sources of Strength (Add one to two secondary schools each year)	In place in 2 of 21 secondaries Add 1-2 programs per year until all 21 have an SOS program	Add 1-2	Add 1-2	Add 1-2 (continue for 7 more years)
Connect Suicide Postvention Training (all tragedy responders every three years)	One staff person trained as a trainer Provide two Connect trainings to	Train one more staff person as a trainer Provide at least one Connect per year	At least one Connect training	At least one Connect training

SPECIFIC PROGRAM IMPLEMENTATION				
	school mental health professionals	Update BSD policies on memorialization per best practice recommendations		

SUICIDE FIRST AID PROTOCOL AND PAPERWORK BSD
SAFETY FIRST RESPONSE: IF THE STUDENT IS ACTIVELY ENGAGING IN SUICIDE BEHAVIOR, CALL 911 AND STOP THE BEHAVIOR IF IT IS SAFE TO DO SO
Suicide behavior indicates the student is in a psychiatric and potentially life threatening crisis that requires immediate community assessment. <i>A Safety First Response should occur when a student is engaging in suicidal behavior that will <u>harm themselves or others is occurring or about to occur</u>, or when a student is <u>unable to participate in a plan to stay safe</u>.</i> Steps for Safety First Response (<i>When suicidal behavior that will harm themselves or others is occurring or about to occur, or student is unable to participate in safety planning intervention</i>): 1. Call 911 and stop behavior if safe to do so. You can request “medical transport” by ambulance when you call 911. 2. Contact your Youth Service Officer (YSO) for assistance. Building a relationship with your YSO ahead of time may be helpful in these situations as they may be able to provide a Peace Officer hold and transport to the hospital. 3. Contact parents/guardians (You do not need parent permission to call 911 when responding to safety concerns.) 4. If it feels unsafe to contact a parent, or after multiple attempts, you are unable to reach guardian or emergency contact, contact DHS Child Welfare about suicide risk. If there is a child abuse or neglect concern, call DHS Child Welfare (855-503-7233). 5. Before returning to school, parent/guardian and student will need to meet with school staff to review information from community-based safety plan to help create a support plan for school. You may also need to consider any new diagnoses or information that would fall under Child Find.

CONFIDENTIALITY AND SUICIDE
We have an ethical obligation to break confidentiality when we believe someone’s safety may be at risk, including when someone is being harmed, they are harming someone else or if they are thinking

about suicide.

CONTACTING PARENT/GUARDIANS

It is mandatory for school staff in BSD to notify parents every time suicide first aid is used with a student.

If parent/guardian cannot be reached, reach out to Emergency Contacts from Synergy. When speaking to an emergency contact, share that you need to urgently speak to the parent; do not disclose details of the situation. Parent/Guardian should be invited to school to participate in the development of the Support Plan, if possible.

CENTERING THE PERSON WITH THOUGHTS OF SUICIDE'S NEEDS AND BIAS CHECK

When we center the person with thoughts of suicide's needs we are more likely to reduce the likelihood of suicide behavior and create the conditions where the person will engage in support planning to keep their life safe. Remember we are responding to the needs of the person with our tasks. In thinking about what they need we are also considering our own biases and any cultural considerations that apply to this unique person.

EXPLORING SUICIDAL THOUGHTS (*Connecting With Suicide*)

What brought the two of you to the conversation (*invitations*) about suicide? What do they mean to the person (*exploring*)?

- Loss or emotional pain?
- How does the person feel about current situation? (*meaning behind the invitation*)
- What is your spidey sense/intuition telling you?

How did you learn about suicide risk? Share summary of relevant information from invitations and exploration:

Ask clearly and directly about *suicide*:

- Are you thinking about suicide?
- Are you having thoughts about killing yourself?

- ☐ Yes, student is having thoughts of suicide
- ☐ No, student is not having thoughts of suicide

Notes about student's response?

If student responds that they have No Thoughts of Suicide (If you feel unsure of their response, resume exploring invitations)	NEXT STEPS: • Validate student • Provide Crisis Line Number/Identify Supports • Consult with team member
Contact parent/guardian to include them in the conversation about invitations and inform them that you asked about suicide.	Parent/Guardian Contacted? ☐ Yes ☐ No (if no, why not?) Document notification/conversation with parent/guardian (this is required by BSD policy):
Student states no thoughts of suicide. Parent has been notified of the conversation. Sign and Submit screening form completed to this point. Suicide screening intervention complete.	

If the answer is YES, they are experiencing suicidal ideation: PAUSE: CHECK-IN WITH YOURSELF	
Can you be present and focus on being this person's caregiver for a first aid intervention about suicide?	☐ Yes, proceed with suicide screening ☐ No, I am not able to proceed with suicide intervention

No, I am not able to proceed with suicide intervention. Next Steps: • Thank the student for sharing with you. • Do not leave the student alone. • Contact a team member to take over intervention. ☐ School Mental Health Professional ☐ Administrator ☐ Washington County Crisis Line (503-291-9111) ☐ Youth Service Officer (YSO)	
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WHY ARE THEY THINKING ABOUT SUICIDE? WHAT ARE THEIR REASONS FOR LIVING? (Understanding Choices)	
Hear their story:	Student Response:

• Why are you thinking about suicide?	
Support the turning point: • What are reasons for living? • What has kept them here? • Why they have not acted on their thoughts of suicide?	Turning Point:
You are helping the person with thoughts of suicide see their three choices: Suicide, Life, or Safety For Now. <u>Highlight for them</u> what you think you have heard about why they have not engaged in suicidal behavior. Ask: Are you willing to talk about a plan to stay safe for now?	Is the student able to make a plan to stay “safe for now”? ☐ Yes - Ask student if they are ready to talk about making a plan for safety and proceed to Safety Planning (<i>Assisting Life</i>) ☐ No, they are unable or unwilling to make a plan for safety with school staff.

If the answer is NO, they are unable or unwilling to create a plan for safety with school staff NEXT STEPS: Return to hearing the story about why they are thinking about suicide? Consult with team member. If student is unable or unwilling to make a safe plan access one of the following supports: • Immediate contact with the student's mental health therapist agency	What is the plan to keep the student safe today? (Where is the student accessing support to create a safety plan today? Who transported? Parent/Guardian involvement?)
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(two-way interaction needed by phone or in-person). • Contact with Washington County Crisis Line (503-291-9111) for assistance with safety planning with student/parent guardian. • Contacting parent/guardian to transport student to Hawthorn Walk-in Clinic or permission to have Mobile Crisis Team meet with student. • Transporting to emergency department by parent/guardian, request Youth Service Officer (YSO) transport, or by ambulance. 6. If there is a child abuse or neglect concern, call Child Welfare. Before returning to school, parent/guardian and student will need to meet with school staff to review information from community-based safety plan to help create a support plan for school. You may also need to consider any new diagnoses or information that would fall under Child Find.	
Parent/Guardian Contacted?	☐ Yes ☐ No (if no, why not?) Document conversation (this is required by BSD policy) Include Parent/Guardian's perception of student's suicide risk?: ☐ DHS Child Welfare Report Made

Support Planning (Assisting Life)
In this phase you get details about suicide from the person that are putting their life side at risk and support them in creating a safe plan to keep themselves safe. You also confirm actions at the end of this phase to review and begin implementation of the safe plan.
A Safety First response should occur when a student is engaging in suicidal behavior that will <u>harm</u>

themselves or others is occurring or about to occur or when a student is unable to participate in a plan to stay safe. See Safety First Response Outline at the top of this form.

Reviewing Safety Guards (Identifying Risk Factors)	
Is there a suicide plan? Are there means available to carry out this plan?	☐ No suicide plan ☐ Yes, document plan and access to means <i>(Disabling plan will be addressed in “making environment safer” section of support plan)</i>
Previous suicide attempts?	☐ No previous suicide attempts ☐ Yes, How long has it been since previous attempt? Previous means used for suicide attempt? “What have you learned that might help with safety now?”
Are there concerns about alcohol, drugs and/or medication?	☐ No substance use concerns ☐ Yes, document current substance use. <i>(Making a plan for safe or no use in “making environment safer” section of support planning)</i>
Previous mental health concerns/diagnosis?	☐ No previous mental health concerns or diagnosis ☐ Yes, document previous concerns or diagnosis
Are you thinking of hurting other people? If yes: - Is a Safety First Response needed? - Proceed with STAT process	☐ No thoughts of hurting other people ☐ Yes, summary of concerns and plan for next steps:

Safety Aids and Support Planning	
WARNING SIGNS: What are warning signs that a crisis may be developing? What are my triggers?	1. 2. 3.

	3. Hawthorn Walk-In Clinic Phone: 503-291-9111 5240 NE Elam Young PKWY, Suite 100, Hillsboro, OR 97124 <i>*Call before going to location to verify walk-in hours</i> 4. Local Emergency Department or in an emergency call 911
Which of the following crisis supports would the student like listed on their support plan:	☐ Washington County Crisis Line: 503-291-9111 ☐ National Suicide Hotline: 988 ☐ Oregon Youthline: 877-968-8491; Text “teen2teen” to 839863. 24 hour service, peer support 4pm-10pm ☐ Trevor Project: 1-866-488-7386; Text 678-678 ☐ Trans Lifeline: 877-565-8860 ☐ Blackline: Call or text 1-800-604-5841 ☐ National Sexual Assault Hotline (RAINN): 800-656-4673
MAKING THE ENVIRONMENT SAFER <i>Making a plan for lethal means safety and addressing other concerns related to risk factors from the Safety Guards Section</i>	
Are there firearms accessible that need to be removed or locked and secured?	☐ No accessible firearms ☐ Yes, What is the plan to remove or lock and secure the firearms? Who will support this plan?
Does the student have access to medication in quantities that could be used for overdose?	☐ No access to medication that could be used for overdose ☐ Yes, What is the plan to secure and monitor medication? Who will support this plan?
Are there other items such as sharps, poisons, chemicals, or items related to student’s specific plan for suicide that need to be secured or monitored to disable the suicide plan or increase student safety?	☐ No other items of concern for safety ☐ Yes, What items need to be secured or monitored for safety? What is the plan to secure and monitor these items? Who will support this plan?
Are there concerns about alcohol, drugs and/or medication? - What are there changes that need to be made to reduce risk of harm to safe or no use? - Does student need referral to BSD	☐ No substance use concerns at this time ☐ Yes, What is needed for safe or no use? Include relevant supports or resources student can access.

SUS or other community D&A supports?	
Based on the information above, what changes need to be made to the student's environment to reduce the risk of suicide and who will support those plans?	Include any information that should be listed on the support plan about making the environment safer: 1. 2.
SCHOOL SUPPORTS <i>What changes or supports needs does the student need for increased safety at school.</i>	
Who can I ask for support at school? <i>(This can include both Staff and Students who can access help.)</i>	1. 2.
Consider if the student needs access to any of the following school support options? • <u>Student should be added to BH&W for team consultation and support.</u> • Scheduled check-in with staff • Designated safe place at school • Increased supervision in specific setting • Decrease or eliminate passing time or unsupervised time • Late Arrival/Early Dismissal OR Other schedule changes • Other changes needed?	What is the plan to increase student support and safety at school?
Check in with student and discuss which other staff will need a copy of their support plan. Are there other staff who need to be informed? What information would they like shared?	

PAUSE FOR CONSULTATION	
Before completing the intervention, let the person who is thinking about suicide know that you want to make sure you haven't missed anything and need to do some consultation before you complete the safety plan or next step. Consult with someone else in your building who is trained in ASIST or call the Washington County Crisis Line 503-291-9111 for consultation.	Who did you consult with?

SUPPORT PLAN FOR HOPE AND HEALING (pull answers from Safety Guards and Safety Aids)

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:
4. Place:

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 AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: Phone:
Emergency Contact:
2. Clinician/Agency Name: Phone:
Emergency Contact:
3. Hawthorn Walk-In Clinic Phone: 503-291-9111
5240 NE Elam Young PKWY, Suite 100, Hillsboro, OR 97124
**Call before going to location to verify walk-in available*
4. Local Emergency Department

Crisis Line Information

Washington County Crisis Line: 503-291-9111
National Suicide Hotline 988

STEP 6: MAKING THE ENVIRONMENT SAFER:

- 1.
- 2.

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SCHOOL SUPPORTS AND ENVIRONMENTAL CHANGES:

School Supports

- 1.

2.

Places I can go that I feel safe at school:

REVIEW, PARENT/GUARDIAN CONTACT, AND FOLLOW-UP

Have you reviewed the support plan with student and confirmed actions for next steps?

- ☐ Yes
☐ No (if no, why not?)

Plan for reviewing support plan and follow-up with student?

☐ Date: _____

Did you make contact with the parent/guardian to discuss risk of suicide?

- ☐ Yes
☐ No (if no, why not?)

Document conversation (this is required by BSD policy) Include Parent/Guardian's perception of student's suicide risk?:

SIGNATURES:

Electronic Signature of Screener

Name of Consulting Screener

Select the administrator that needs to be notified:

STAFF SUPPORT: Consider what support you need right now. Think about how you can continue to build your own resilience and process the vicarious trauma you experience.