STUDENT MENTAL HEALTH CRISIS

Guide & Resources

This guide is intended as a resource to Turlock Unified School District administrators and staff in student crisis prevention and response.

Table of Contents

I. Suicide Risk Warning Signs
II. TUSD Suicide Response Protocol
    A. Risk Screener (Elementary and Secondary)
    B. Columbia Suicide Severity Rating Scale (C-SSRS)
III. Family Notification and Involvement
    A. Family Notification Acknowledgement Form
    B. Family Guide: Educational Handout, Resources, Warning Signs
IV. Re-Entry Guidelines
    A. SST for Safety Plan Template
    B. SST for Re-Entry Meeting Template
V. Student Re-Entry
VI. Appendixes
    A. Mental Health Referral Form
    B. Student Self Harm Resources
    C. Self-Care Considerations for Staff

Warning Signs for Suicide

Seek immediate help from a mental health provider, 9-1-1 or your local emergency provider, or the **National Suicide Prevention Lifeline at (9-8-8)** when you hear or see any of these behaviors:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves; seeking access to pills, weapons, etc.
- Talking or writing about death, dying, or suicide (including via social media posts)

9-8-8 Has been designated as the three-digit dialing code that will route callers to the National Suicide Prevention & Mental Health Crisis Lifeline and increase the accessibility of the Lifeline for individuals. The National Suicide Prevention Lifeline provides confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States.

Other red flags (warranting increased supervision / oversight), and referral to services:

- Hopelessness-expresses no reason for living, no sense of purpose in life
- Rage, anger, seeking revenge
- Recklessness or risky behavior, seemingly without thinking
- Expressions of feeling trapped-like there's no way out
- Increased alcohol or drug use
- Withdrawal from friends, family, or society
- Anxiety, agitation, inability to sleep, or constant sleep
- Dramatic mood changes
- Family history of suicide or suicidal behavior
- Problems in family, and/or conflict in parent-child relationship
- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students, perceived lack of acceptance of differences
- Expression and acts of hostility
- Discussion of access to lethal means, such as weapons in the home
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or other physical characteristics

TUSD Suicide Risk Response Protocol

The following is a summary checklist of general procedures for the administrator/designated school site crisis team member to respond to any reports of students exhibiting suicidal behavior/ideation. The urgency of the situation will dictate the order and applicability in which the subsequent steps are followed.

☐ **1. RESPOND IMMEDIATELY AND SECURE THE SAFETY OF THE STUDENT**

- ❏ Report concerns to administrator/designee immediately.
- ❏ Do not leave the student unsupervised.
- ❏ Remove any items or access to means to hurt themselves.

☐ **2. COMPLETE SCREENER**

- ❏ Complete the screener (4 questions) to determine risk level (completed by any knowledgeable staff member).

☐ **3. ASSESS FOR SUICIDE RISK**

- ❏ Complete the C-SRRS to determine risk level (completed by a mental health clinician or school psychologist).

☐ **4. DETERMINE APPROPRIATE ACTION PLAN**

- ❏ If appropriate, contact or consult with on-site clinicians, school psychologists, SRO or Turlock PD.
- ❏ If appropriate, develop a safety plan. (Refer to screener protocol risk level).

☐ **5. CONTACT FAMILY/GUARDIAN (Except in situations of suspected abuse where local law enforcement becomes point of contact or student over the age of 18★)**

- ❏ Contact family with documentation of incident for low risk or
- ❏ Complete Family Contact Acknowledgement Form for medium to high risk level.
- ❏ Provide family education handouts and discuss supports.

★ **In Situations With Suspected Child Abuse or Neglect:** If child abuse or neglect by a parent/guardian is suspected or there is reasonable suspicion that contacting the parent/guardian may escalate the student's current level of risk, or the parent/guardian is contacted and unwilling to respond, report the incident to Child Protective Services.

☐ **6. DOCUMENTATION OF INCIDENT**

- ❏ Secure TUSD Risk Assessment Forms in a confidential locked file on site. Different screener for elementary and for secondary levels.
- ❏ Notify the Student Services Department and site administration for data tracking purposes.
- ❏ Notify casemanager or Program Specialist if a student is in Special Education.
- ❏ Document SST/504/IEP for Safety Planning or Re-Entry Meeting.
- ❏ Information should immediately be documented in Aeries.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent

Version 1/14/09 m9/12/17

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

Disclaimer:

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

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

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

© 2008 The Research Foundation for Mental Hygiene, Inc.

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** Recent - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	___	___
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	___	___
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	___	___
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	___	___
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	___	___

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**	**Yes** ☐ **No** ☐ Total # of Attempts _____ **Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐ Total # of Attempts _____ **Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____

Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____	**Yes** ☐ **No** ☐ Total # of preparatory acts _____

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

This screening tool can also be found for free download at: https://cssrs.columbia.edu/

Training modules for staff can be viewed online at:
https://www.youtube.com/channel/UCWmboGLJ8gI_L3YOkteZ2zA/playlists

Family Notification and Involvement

In situations where a student is assessed or screened for suicide risk or has made a suicide attempt, the student's family/guardian will be informed as soon as possible by the administrator or designee. If the student has exhibited any kind of suicidal behavior or reports having an active plan, the family/guardian should be counseled on "means restriction" to limit access to mechanisms for carrying out the attempt. (See Family Guide.)

Through discussion with the student, the administrator/designee, or mental health staff member will also assess whether there is risk of harm due to family / guardian notification. If, in their professional capacity, the administrator/designee believes that contacting the family or guardian would endanger the health or well-being of the student, they may delay notification as appropriate. If contact is delayed, the reasons for the delay should be documented C-SRRS and Suspected Child Abuse Report, as appropriate.

Family Notification Acknowledgement

School: _____

Grade: _____ Teacher: _____

Student Name: _____ DOB: _____

Student ID: _____

This is to verify that I have spoken with school staff member:

_____ on _____,
(Name, Title) (Date)

concerning my child's suicidal risk and the school is fulfilling its duty to notify me pursuant to Education Code Section 49602

I have been advised to seek the services of a mental health agency or therapist immediately. I understand that the school staff will follow up with me, my child, and the agency to whom my child has been referred for services within one to two weeks.

Parent Name (Print)_____

Parent Signature: _____ Date: _____

Staff Name (Print); _____

Staff Member Signature: _____ Date: _____

Original Copy: School Site Copy: Parent

Family Guide

This handout is designed to support you with the information you need as you and your child work together toward wellness. You are not alone. It is not uncommon for young people to consider suicide as a possible solution to their difficulties. The reasons for this are many and varied. What is most important, for you and your child, is knowing there is help available.

Focus on listening, not lecturing. Resist any urge to criticize or pass judgment once your child begins to talk. The important thing is that your child is communicating. You'll do the most good by simply letting your child know that you're there for them, fully and unconditionally.

Be gentle but persistent. Don't give up if they shut you out at first. Talking about suicidal thoughts and depression can be difficult. Even if they want to, your child may have a hard time expressing what they're feeling. Be respectful of your child's comfort level while still emphasizing your concern and willingness to listen.

Acknowledge their feelings. Don't try to talk your child out of depression, even if their feelings or concerns appear silly or irrational to you. Well-meaning attempts to explain why "things aren't that bad" will just come across as if you don't take their emotions seriously. Simply acknowledging the pain and sadness they are experiencing can go a long way in making them feel understood and supported.

Trust your gut. If your child claims nothing is wrong but has no explanation for what is causing the depressed behavior, you should trust your instincts. If your child won't open up to you, consider turning to a trusted third party: a family member, a favorite teacher, or a mental health professional. The important thing is to get them talking to someone.

Attached are "Warning Signs" that a suicidal person may be experiencing. This is included to help you identify specific behaviors related to depression and suicidal ideation.

Local Resources:

Your child should never be left alone during the crisis. If your child has a physician or therapist, call to alert them of the situation.

Crisis Hotlines:

Community Emergency Response Team (CERT) and
Warmline
(209) 558-4600
24-crisis response for psychiatric emergencies, peer to peer
support and referrals for mental health services

Suicide Prevention Hotline
(800) 273-8255
www.suicidepreventionlifeline.org

California Youth Crisis Line
(800) 843-5200
www.youthcrisisline.org
24-hour confidential hotline for youth 12-24 and adults
supporting youth

National Runaway SafeLine
(800) 786-2929
www.1800runaway.org

Trevor Lifeline
(866) 488-7386
www.the trevorproject.org

Grief Support

Jessica's House
1225 W Christoffersen Pkwy,
Turlock, CA 95382
(209) 250-5395
www.jessicashouse.org

StopIt App- Report to school site

National Suicide Prevention Lifeline at (9-8-8)

Counseling Centers

AspiraNet
420 Canal Dr. Turlock, CA 95380
(209) 669-2583
Individual, group, and family counseling.

Sierra Vista Child and Family Services
2925 Niagra St #3, Turlock, CA 95382
(209) 669-6771
Individual, group and family counseling.

Haven Women's Center
301 Starr Ave, Turlock, CA 95380
(209) 664-9131
www.havenwcs.org
24 - Hour Crisis Line
(209) 577-5980
Free counseling services to adults, teens and children who are survivors of domestic violence, sexual abuse, and human trafficking. Emergency shelter services are also available.

Golden Valley Health Centers
(866) 682-4832
Provides medical, dental, and behavioral health care.

Substance Use Recovery and Support

Prodigal Sons & Daughters
352 E Olive Ave, Turlock, CA 95380
(209) 634-3538

Alcoholics Anonymous
(209) 572-2970

Narcotics Anonymous
(209) 526-181

Warning Signs for Suicide

Learning the warning signs of suicide is a huge part of preventing a crisis. Although emotional ups and downs are normal, sometimes a person who is suicidal gives certain signs or hints that something is wrong. Knowing these major warning signs can help you seek support when it is needed most.

Has your child felt…?

- Unimportant
- Trapped
- Hopeless
- Overwhelmed
- Unmotivated
- Alone
- Irritable
- Impulsive
- Suicidal

Have you discovered your child…?

- Not cared about their future: “It won’t matter soon anyway.”
- Put themselves down – and think they deserve it: “I don’t deserve to live. I suck.”
- Expressed hopelessness: “Things will never get better for me.”
- Said goodbye to important people: “You’re the best friend I’ve ever had. I’ll miss you.”
- Had a specific plan for suicide: “I’ve thought about how I’d do it.”
- Talked about feeling suicidal: “LIfe is so hard. Lately I’ve felt like ending it all.”
- Using drugs or alcohol more than usual
- Acting differently than usual
- Giving away their most valuable possessions
- Losing interest in their favorite things to do
- Admiring people who have died by suicide
- Planning for death by writing a will or letter
- Eating or sleeping more or less than usual
- Feeling more sick, tired or achy than usual

Student Re-Entry

Safety Plan Template

Student Safety Plan

Name:

Date:

School Site:

Stressors/Triggers	Warning Signs
Certain situations or circumstances which make me feel uncomfortable or overwhelmed: 1. 2. 3.	I should use my safety plan when I notice these warning signs (e.g thoughts, images, moods, situations, behaviors): 1. 2. 3.

Coping Skills/Healthy Behaviors	Places I Feel Safe
Things I can do to calm myself down or feel better in the moment (e.g. favorite activities, pets, friends, hobbies, relaxation techniques): 1. 2. 3.	Places I feel better and/or places I feel safe (e.g. a physical location, an imagined safe place, or place in the presence of safe people): 1. 2. 3.

School Support

Adult/Peer Support

Ways school staff can provide support and/or helpful school staff with whom I can trust or feel safe: 1. 2. 3.	People in my home or community whom I trust and can ask for help during a crisis (include phone number): 1. 2. 3.

Parent/Guardian Support

Hopes/Future Goals

Actions my parent/guardian can take to help me stay safe: 1. 2. 3.	Goals, dreams, factors that give me hope for my future or to live: 1. 2. 3.

During a crisis, I can also call:

- **911** for emergency or immediate support
- Stanislaus WarmLine and Mental Health Referral **(209) 558-4600**
- Suicide Prevention Lines (24 Hours)
    - *National Suicide Prevention Lifeline* **(800) 273-TALK or (800) 273-8255**
    - *Suicide Prevention Crisis Line* **(877) 727-4747**
    - *National Hopeline Network* **(800) SUICIDE or (800) 784-2433**
- California Youth Crisis Line (24 hours, bilingual): **(800) 843-5200**
- TEEN LINE: a teen-to-teen hotline with community outreach services from 6pm-10pm PST daily **(310) 855-HOPE or (800) TLC-TEEN.** Text, email and message board also available, with limited hours-visit **http://teenlineonline.org** for more information.
- The Trevor Project: a 24 hour crisis line that provides crisis intervention and suicide prevention services to young people ages 13-24 identifying as lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) **(866) 4-U-TREVOR or (866) 488-7386.** Text and chat also available, with limited hours-visit **www.thetrevorproject.org** for more information.
- Crisis Text Line: **Text HOME to 741741**

- Suicide Prevention Chat: **https://suicidepreventionlifeline.org/chat/**
- **National Suicide Prevention Lifeline at (9-8-8)**

Student (print and sign)	Date
_____	_____
Parent/Guardian (print and sign)	Date
_____	_____
School Staff (print name, title, signature)	Date

Re-Entry Guidelines

If a student has been out of school for any length of time, including for a mental health evaluation or mental health hospitalization, including psychiatric and drug or alcohol inpatient treatment, a re-entry meeting should be held either prior to, or on the day the student returns. Request that the family provide discharge documents from hospital or medical provider.

Engage family/guardian(s), school support staff, nurse, teacher, and student (as appropriate) in a **Re-Entry Planning SST/504/IEP Meeting**.

Returning Day	Have parent escort student on first day back. Develop a re-entry communication and safety plan in the event of future emergencies.
Hospital Discharge Documents	Request discharge documents from hospital or Medical Clearance for Return to School from parent on first day back. (FORM J) Obtain Authorization or Exchange/Release Information for relevant providers including psychiatrist, treating physician, psychologist etc…Update medication list.
Meeting with Parents	Engage parents, school support staff, teachers, and student, as appropriate in a Re-Entry Planning Meeting. • Identify on-going mental health resources in school and/or in the community. • Modify academic programming, as appropriate. • Consider an assessment for special education for a student whose behavioral and emotional needs effect their ability to benefit from their educational If the student is prescribed medication, monitor with parent consent. • Offer suggestions to parents regarding monitoring personal communication devices, including social networking sites, as needed. • Notify student's teachers, as appropriate.
Identify Supports	Assist the student in identifying adults they trust and can go to for assistance at school and at home (reference Student Safety Plan document)
Address Bullying, Harassment, Discrimination	As needed, ensure that any bullying, harassment, discrimination is being addressed.
Designate Staff	Designate staff (e.g., SAP Counselor, School Counselor, School Psychologist, School Nurse, et cetera) to check in with the student during the first couple weeks periodically.
Release of Information	Obtain consent by the parent to discuss student information with outside providers using the Parent Authorization for Release/Exchange of Information.
Manage and Monitor	Case management and monitoring – ensure the student is receiving and accessing the proper mental health and educational services needed.

Appendixes

A. Responding to Students Who Self Harm

B. Self-Care Considerations for Staff

Responding to Students Who Self-Harm

Non-suicidal self-harm is used to refer to situations in which the self-harm is not intended to result in death. It may be difficult to tell the difference between nonsuicidal self-harm and a suicide attempt. The only way to know is to ask the person directly if they are suicidal.

Warning Signs of Self Harm

Physical signs can include:

- Burning (with matches, cigarettes, or hot objects)
- Carving symbols into skin
- Hitting or punching, broken bones
- Biting
- Head banging
- Piercing
- Pulling out hair
- Picking at wound that interferes with healing

Other related signs/symptoms:

- Scars from cuts or burns
- Claiming to have frequent accidents
- Fresh cuts, scratches, or bruises
- Broken bones
- Keeping sharp objects on hand
- Spending a great deal of time alone
- Wearing long sleeves and pants even in hot weather
- Difficulties with interpersonal relationships
- Emotional instability
- Impulsiveness and unpredictability
- Depressed mood
- Irritability
- Frequent thoughts of helplessness, hopelessness, or worthlessness

When a Student is Self- Harming

- Report concerns to administrator/designee immediately or as soon as possible.
- Do not leave the student unsupervised.
- Conduct an administrative search for access to means.
- Assess for risk using the Risk Screener
- Communicate with family/guardian.
- Complete referrals to mental health services as appropriate.
- Determine and/or develop a safety plan with student.
- Document all actions appropriately.

Self- Harm and Contagion

- Respond individually to students, but try to identify peers that may be engaging in similar behaviors.
- Supervise students in separate locations and assess individually.
- Self-harm should be addressed individually, never in settings such as student assemblies, public announcements, or classrooms/groups.
- Consult with student support and mental health staff as needed.

Self-Care Considerations for Staff

1. Your most urgent task is to ensure that the student in crisis is safe: do not leave the student alone or without appropriate adult supervision until the crisis is resolved.

2. Contact others for help: You can use your team to support you. Write instructions down and pass to another staff member to make calls to others on your team if needed.

3. Know your limits: Involve yourself only to the level you feel comfortable. School Administrators, Counselors, School Psychologists, Mental Health Clinicians, and/or SRO/Police Officer.

4. Listen to the student: Acknowledge their feelings, allow them to express their feelings, avoid giving advice or opinions, and listen for warning signs.

5. Be direct: Ask openly about suicide (follow QPR training guidelines.) Asking about suicide does not put the idea into the student's mind. Complete the TUSD Risk Assessment Form, if applicable.

6. Inform student: At each stage, be sure the student knows what is going on in age appropriate terms.

7. Maintain confidentiality and provide student privacy: Remove other students from the area, or escort the at-risk student to a more secure environment.

8. Debrief: Take time to meet with staff involved in the incident to discuss any emotional response you are having, offer support to others, and problem solve any steps of the process that need refinement.