

Suicide Prevention Process and Procedural Manual

Pleasant Hill School District #1

Acknowledgements

This manual was assembled by the Pleasant Hill School District Crisis Response Team. Its original development was guided by Grace L'Orange, Ed.S. It was then overseen by Whitney Connolly, Special Education Director; Stephanie Black, Pleasant Hill Elementary School Counselor; Jolene Hill, Pleasant Hill Middle School Counselor; and Susanna Williams, Student Support Advocate. Its final development was completed in consultation with Roger Brubaker and Del Quest from Lane County.

The contents of this manual have been adapted from: the Model School Policy developed through the partnership of the National Associaton of School Psychologists, American School Counselor Association, American Foundation for Suicide Prevention, and the Trevor Project; SAMSHA Suicide Prevention Toolkit; Willamette ESD School Based Suicide Policies and Procedures; and HEARD Alliance Toolkit.

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Introduction

Purpose

The purpose of this manual is to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide. Pleasant Hill School District:

- Recognizes that physical and mental health are integral components of student outcomes, both educationally and beyond graduation.
- Further recognizes that suicide is a leading cause of death among young people.
- Has an ethical responsibility to take a proactive approach in preventing deaths by suicide.
- Acknowledges the school's role in providing an environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience.
- Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components.

This document recognizes and builds on the skills and resources inherent in our school district. 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 and community members when a crisis occurs in their community. This is meant to be paired with other policies supporting the overall emotional and behavioral health of students.

Scope

The procedures in this manual cover actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school-sponsored out-of-school events where school staff are present. It applies to the entire school community, including educators, school and district staff, students, parents/guardians, and volunteers. This also covers appropriate school responses to suicidal or high-risk behaviors that take place outside of the school environment.

Definitions

At-Risk: Suicide risk is not a dichotomous concern, but rather, exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention by the school and the district. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset of potential mental health conditions or a deterioration of mental health. The student may have thoughts about suicide, including potential means of death, and may have a plan. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures.

The type of referral, and its level of urgency, shall be determined by the student's level of risk, according to district protocol.

Crisis Response Team: A multidisciplinary team of administrative staff, mental health professionals, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention, response,

and recovery. These professionals have been specifically trained in areas of crisis preparedness and take a leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports. Crisis team members who are mental health professionals may provide crisis intervention and services.

Pleasant Hill School District's Crisis Response Team	
Jim Crist, Superintendent	Whitney Connolly, Director of Special Programs
Brenna Fairchild, PHES Principal	Stephanie Black, PHES School Counselor
Alan Stearns, PHHS Principal	Paul Griffith, PHMS School Counselor
Pat Jarman, PHHS Assistant Principal/AD	Clarrissa Anderson, PHHS School Counselor
Caleb Salmond, PHMS Assistant Principal	Katie Jensen, school nurse

Mental Health: A state of mental, emotional, and cognitive health that can impact perceptions, choices, and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders. Mental health can be impacted by the home and social environment, early childhood adversity or trauma, physical health, and genes.

Postvention: Suicide postvention is a crisis intervention strategy designed to assist with the grief process following suicide loss. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school's healthy postvention effort can lead to readiness to engage further with suicide prevention efforts and save lives.

Risk Assessment: An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated school staff (e.g., school psychologist, school social worker, school counselor, or in some cases, trained school administrator). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

Risk Factors for Suicide: Characteristics or conditions that increase the chance that a person may attempt to take their life. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. The likelihood of an attempt is highest when factors are present or escalating, when protective factors and healthy coping techniques have diminished, and when the individual has access to lethal means. (For more information, see ***Risk Factors for Suicide*** section.)

Self-Harm: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm should receive mental health care. Treatment can improve coping strategies to lower the urge to self-harm, and reduce the long-term risk of a future suicide attempt.

Suicide: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

NOTE: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death. Additionally, parent or guardian preference shall be considered in determining how the death is communicated to the larger community.

Suicide Attempt: A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, ambivalence is not a reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.

Suicidal Behavior: Suicide attempts, injury to oneself associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

Suicidal Ideation: Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one's life is still considered suicidal ideation and shall be taken seriously.

Suicide Contagion: The process by which suicidal behavior or a suicide completion influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.

Considerations

- School staff are frequently considered the first line of contact with potentially suicidal students.
- Most school personnel are neither qualified, nor expected, to provide the in-depth assessment or counseling necessary for treating a suicidal student. They are responsible for taking reasonable and prudent actions to help at-risk students, such as notifying parents, making appropriate referrals, and securing outside assistance when needed.
- All school personnel need to know that protocols exist to refer at-risk students to trained professionals so that the burden of responsibility does not rest solely with the individual "on the scene".
- Research has shown 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 suicidal peers. Having supports 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.

Risk Factors and Protective Factors

Risk Factors for Suicide

Risk factors are characteristics or conditions that increase the chance that a person may try to attempt suicide. Suicide risk tends to be highest when someone has several risk factors at the same time, or has long standing risk factors and experiences a sudden or devastating setback. These factors interact, and the more there are and the more they intensify, the greater the risk.

The most frequently cited risk factors for suicide are:

- Mental Health Issues/Conditions:
  - Major depression (feeling down, withdrawn, or agitated in a way that impacts daily life)
  - Bipolar disorder (extreme mood swings)
  - Psychosis (marked change in behavior, unusual thoughts, and behavior or confusion about reality)
  - Substance abuse and dependence (alcohol, prescribed and illicit drugs)
  - Anxiety disorders (excessive worry, obsessions, or panic attacks)
  - Eating disorders
  - Past suicide attempt(s)

- Personal Characteristics:
  - Hopelessness
  - Low self-esteem
  - Loneliness
  - Social alienation and isolation, lack of belonging
  - Stress and frustration tolerance
  - Impulsivity
  - Risk taking, recklessness
  - Poor problem-solving or coping skills
  - Perception of self as very underweight or very overweight
  - Capacity to self-injure
  - Perception of being a burden (e.g., to family and friends)

- Adverse/Stressful Life Circumstances:
  - Interpersonal difficulties or losses (e.g., breaking up with a girlfriend or boyfriend)
  - History of early childhood trauma, abuse, neglect, or loss
  - Disciplinary or legal problems
  - Bullying, either as victim or perpetrator
  - Chronic physical illness or disability and/or pain
  - History of head trauma
  - School or work problems (e.g., actual or perceived difficulties in school or work, not attending school or work, not going to college)
  - Physical, sexual, and/or psychological abuse
  - Exposure to suicide or other violent death (e.g. car accident, gun violence)

- Family Characteristics:
  - Family history of suicide or mental health problems, especially within immediate family
  - Parental mental health issues
  - Parental divorce or other serious family stress/transition
  - Death of parent or other relative
  - Problems in parent-child relationship (e.g., feelings of detachment from parents, inability to talk with family members, interpersonal conflicts, family financial problems, family violence or abuse, parenting style either underprotective or overprotective and highly critical)

- Social, Cultural, and Physical Environmental Factors:
    - Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students
    - Lack of acceptance of differences
    - Expression and acts of hostility
    - Lack of respect and fair treatment
    - Lack of respect for the cultures of all students
    - Limitations in school physical environment, including lack of safety and security
    - Limited access to mental health care
    - Access to lethal means, particularly in the home
    - Exposure to other suicides in the community, leading to suicide contagion
    - Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as weight. (See ***Student Populations at Higher Risk for Suicidal Behavior*** for more information)

Protective Factors for Suicide

Protective factors are characteristics or conditions that may help to decrease a person's suicide risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them. These factors do not eliminate the possibility of suicide, especially in someone with risk factors. Protective factors help to create resilience, or an ability to "bounce back" from setbacks encountered throughout life.

The most frequently cited protective factors for suicide include:

- Access to or currently receiving effective care for mental, physical, or substance abuse issues
- Development of coping mechanisms, safety plans, and self-care strategies
- Personal Characteristics:
    - Psychological or emotional well-being, positive mood
    - Emotional intelligence (the ability to perceive, integrate into thoughts, understand, and manage one's emotions)
    - Adaptable temperament
    - Internal locus of control (attribute their success and failures to their own efforts)
    - Strong problem-solving skills
    - Prosocial coping skills, including conflict resolution and nonviolent handling of disputes
    - Healthy degree of self-esteem
    - Attitude of resilience (ongoing or continuing sense of hope in the face of adversity)
    - Frustration tolerance and emotional regulation
    - Healthy body image, care, and protection
    - Cultural, spiritual, or faith-based beliefs that promote connections and help-seeking
- Positive Connections to Family and Other Social Support:
    - Family support and connectedness, close/strong relationship with parent, and overall parent involvement
    - Parental prosocial norms that disapprove of antisocial behavior such as beating someone up or abusing alcohol/drugs
    - Access to welcoming and affirming institutions, supportive social groups, and clubs (faith-based or secular)
    - Presence of healthy role models

- Limited Access to Means:
    - Restricted access to firearms: guns locked or unloaded, ammunition stored or locked
    - Safety barriers for bridges, buildings, and other jumping sites
    - Restricted access to medications (over-the-counter and prescriptions)
    - Restricted access to alcohol (since there is an increased risk of suicide by firearms if the victim is drinking at the time)

Note that protective factors do not entirely remove risk, but can mitigate against risk. There are brief periods when students with strong protective factors can have them temporarily dismantled by an acute stressor or sudden increase in other risk factors (e.g., if depression worsens, a student's usual positive coping skills and resilience may diminish).

Actions by school staff to enhance protective factors are an essential element of a suicide prevention effort. Strengthening these factors also protects students from other risks, including violence, substance abuse, and academic failure.

- **Positive school experiences**
- **Part of a close school community**
- **Safe environment at school (especially for lesbian, gay, bisexual, and transgender youth)**
- **Adequate or better academic achievement**
- **A sense of connectedness to the school**
- **A respect for the cultures of all students**

Some examples of school-based prevention activities in Pleasant Hill School District include:

- Second Step/counseling lessons in K-5
- Billie Spirit activities
- RTI systems (data teams and SST teams)
- Elementary classroom buddies
- ROMP/mentoring program
- Peer mentoring
- Parent outreach/activity nights

Student Populations at Higher Risk for Suicidal Behavior

It is important for school staff to be aware of student populations that are at elevated risk for suicidal behavior based on various factors. Much of this has to do with stigma and discrimination which can lead to victimization by others, lack of support or rejection by family and peers, school failure/dropout, and lack of access to opportunities.

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 health 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 youth 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 Homelessness

For youth experiencing homelessness, 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.

Youth from Culturally and/or Linguistically Diverse Backgrounds

Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture can lead to family conflict and rejection.

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. For more information about historical trauma and how it can affect AI/AN youth, see ihs.gov/suicideprevention.

LGBTQIA2S+ Youth

The CDC finds that LGB 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 LGBTQ 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 LGBTQ 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. Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay can lead to low self-esteem, social isolation, and decreased help-seeking.

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.

Youth Who Identify as Male

In adolescents and young adults, suicide rates are 2-4 times higher in males than in females, while suicide attempts are 3-9 times more common in females. In developed countries, suicide mortality has been estimated to be 2-3 times higher in young males than females. Gender differences in suicidal behavior may be explained by differences in emotional and behavioral problems. The higher rates of suicide deaths among male youths may be associated with a higher prevalence of externalizing disorders (e.g., conduct disorder, substance abuse disorder, deviant behavior), while females are more prone to show internalizing disorders (e.g., anxiety, mood disorders).

Prevention

District Implementation

A district-level suicide prevention coordinator shall be appointed by the superintendent or designee. The district suicide prevention coordinator and building principal shall be responsible for planning and coordinating implementation of this manual for the school district. All staff members shall report students they believe to be at-risk for suicide to the school suicide prevention coordinator or appropriate school mental health professional if the coordinator is unavailable.

<table>
<tr><th colspan="2">Pleasant Hill School Distrit Suicide Prevention Staff</th></tr>
<tr><td colspan="2">District-Wide Suicide Prevention Coordinator: Whitney Connolly, Director of Special Programs</td></tr>
<tr><td colspan="2">QPR Training Staff: Susanna Williams, and Whitney Connolly</td></tr>
<tr><td>Pleasant Hill Elementary School
<u>School Suicide Prevention Coordinator</u>
Brenna Fairchild, PHES Principal

<u>Additional Staff</u>
Stephanie Black, PHES School Counselor</td><td>Pleasant Hill High School
<u>School Suicide Prevention Coordinator</u>
Alan Stearns, PHHS Principal

<u>Additional Staff</u>
Pat Jarman, PHHS Assistant Principal/AD
Caleb Salmond, PHMS Assistant Principal
Paul Griffith, PHMS School Counselor
Clarrissa Anderson, PHHS School Counselor</td></tr>
</table>

The school suicide prevention coordinator or other designated staff will be responsible for assessing a student's risk once referred, as outlined in the ***Suicide Prevention Response Protocol*** section.

Staff Professional Development

All staff shall receive, at minimum, annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention. The professional development shall include additional information regarding groups of students at elevated risk for suicide, including those who:

- Live with mental and/or substance use disorders
- Engage in self-harm or have attempted suicide
- Live in out-of-home settings (e.g., youth in foster care, group homes, incarcerated youth)
- Experience homelessness
- Are American Indian/Alaska Native
- Are LGBTQIA2S+ (Lesbian, Gay, Bisexual, Transgender, Queer and Questioning)
- Are bereaved by suicide
- Have medical conditions or certain types of disabilities

Additional professional development in risk assessment and crisis intervention shall be provided to school-employed mental health professionals and school nurses.

In Pleasant Hill School District, staff will receive suicide prevention and awareness training in the following manner:

- All staff will receive suicide prevention training modules every year during back-to-school inservice training.
- Crisis Response Team members will receive ASIST refresher training and/or updated training every three years.
- Crisis Response Team members will receive CALM and Connect training at least once during their time on the team.
- All staff will review the Pleasant Hill Suicide Prevention Process and Procedural Manual annually as a part of back-to-school training. As a part of this annual review, staff will also be trained on handling confidential student information.
- New staff will receive appropriate suicide prevention or ASIST training within six months of hire.

Training implementation and status tracking will be the responsibility of the District-Wide Suicide Prevention Coordinator.

Youth Suicide Prevention Programming

Developmentally appropriate, student-centered education materials shall be integrated into the curriculum of all K-12 health classes and other classes as appropriate. The content of these age-appropriate materials shall include the importance of safe and healthy choices and coping strategies focused on resiliency building, and how to recognize risk factors and warning signs of mental health conditions and suicide in oneself and others.

The content shall also include help-seeking strategies for oneself or others and how to engage school resources and refer friends for help. In addition, schools shall provide supplemental small-group suicide prevention programming for students. It is not recommended to deliver any programming related to suicide prevention to a large group in an auditorium setting.

Examples of youth suicide prevention programming in Pleasant Hill School District include:

- Second Step/counseling lessons in K-5
- Health classes in grades 6-12
- Counseling/class lessons on growth mindset
- Parent outreach opportunities

Publication and Distribution

This manual shall be distributed annually and be included in all student and teacher handbooks, and on the school website. All school personnel are expected to know and be accountable for following all policies and procedures regarding suicide prevention.

Intervention

Suicide Prevention Response Protocol

Suicide Concern is Reported

- Something a student has written or said, or something another student has reported, is concerning to a peer or staff member.
- Notify the school counselor AND administrator for a warm hand-off (phone call or face-to-face hand off).
- Team identifies school personnel to conduct the safety assessment.

Conduct Safety Assessment with Student

- Conduct screening assessment (C-SSRS screener with ASIST protocol).
- Ensure the student is in a safe location while conducting additional fact-checking.
- Complete required forms (see below).
- Check the student's file for history of behaviors.
- Conduct a parent interview (if relevant).
- Determine level of risk (based on C-SSRS screener).

Low Level of Risk	Medium Level of Risk	High Level of Risk

***Next Steps** for **Medium Level of Risk** is determined by parent feedback and professional discretion.*

Next Steps (by end of day) ● Plan to send student home on bus ● Notify building admin ● Call parent ● Plan for follow-up interventions and conversation ● Complete documentation ● Send home copy of documentation with student for parent ● Send copy of documentation to parent via email	**Next Steps** (immediate) ● Plan to retain student for pick-up ● Notify building admin ● Call crisis line or 911 if imminent risk ● Call parent/emergency contact ● Direct parent/contact to take student to ER or call crisis response ● If no parent response, call DHS for immediate support ● Discuss current services, plan new referrals, provide community resources ● Complete documentation ● Provide copy of documentation to parents at pick-up

Paperwork to Complete: ● Cover Sheet (Response Doc and Record of Action Taken) ● Report of Risk/Warning Signs ● C-SSRS Screener ● Student Interview Form ● Personal Safety Plan	**Paperwork to Complete**: ● Cover Sheet (Response Doc and Record of Action Taken) ● Report of Risk/Warning Signs ● C-SSRS Screener ● Student Interview Form ● Personal Safety Plan ● Parent Notification & Release (email or in-person)	**Paperwork to Complete**: ● Cover Sheet (Response Doc and Record of Action Taken) ● Report of Risk/Warning Signs ● C-SSRS Screener ● Student Interview Form ● Personal Safety Plan ● Parent Notification & Release ● School-Home Re-Entry Plan

All documentation must be filed in the student's cumulative file in a red confidential folder.

Assessment and Referral

When a student is identified by a peer, educator, or other source as potentially suicidal - i.e., verbalizes thoughts about suicide, presents overt risk factors such as agitation or intoxication, an act of self-harm occurs, or expresses or otherwise shows signs of suicidal ideation - the student shall be seen by a school-employed mental health professional, such as a school psychologist or school counselor within the same school day to assess risk and facilitate referral, if necessary.

Educators shall also be aware of written threats and expressions about suicide and death in school assignments. Such incidences require immediate referral to the appropriate school-employed mental health professional. If there is no mental health professional available, a designated staff member (e.g., school administrator) shall address the situation according to the **Pleasant Hill School District Suicide Prevention Response Protocol** until a mental health professional is brought in.

For Youth Determined to be At-Risk for Suicide - Summary Guidance

- School staff shall continuously supervise the student to ensure their safety until the assessment process is complete.
- The principal and school suicide prevention coordinator shall be made aware of the situation as soon as reasonably possible.
- ASIST-trained personnel (i.e. school counselor or building administrator) shall conduct the screening assessment. This may include reviewing the Warning Signs Checklist (either completed by teachers or by counselor), but must include a conversation centered on the C-SSRS Screener (supported by the questions on the Student Interview Form).
- After completing C-SSRS Screener and reviewing relevant information (Warning Signs Checklist, file review, other student or parent conversation), staff will determine appropriate level of suicide risk.
    - Based on level of suicide risk, staff will complete required documentation and make contact with additional school staff (as necessary).
    - Based on level of sucide risk, staff will follow additional "Next Steps" as outlined on **Pleasant Hill School District Suicide Prevention Response Protocol**.
    - The school-employed mental health professional or principal shall contact the student's parent or guardian, as described in the ***Parental Notification and Involvement*** section and in compliance with existing state law/district policy (if applicable), and shall assist the family with urgent referral.
        - Urgent referral may include, but is not limited to, working with the parent or guardian to set up an outpatient mental health or primary care appointment and conveying the reason for referral to the healthcare provider; in some instances, particularly life-threatening situations, the school may be required to contact emergency services, or arrange for the student to be transported to the local Emergency Department, preferably by a parent or guardian.
        - If parental abuse or neglect is suspected or reported, the appropriate state protection officials (e.g., local Child Protection Services) shall be contacted in lieu of parents as per law.
- Staff will ask the student's parent or guardian, and/or eligible student, for written permission to discuss the student's health with outside care providers, if appropriate.

When School Personnel Need to Engage Law Enforcement

When responding to a student expressing suicidal ideation, there may come a time when school personnel need to engage law enforcement.

When a student is actively suicidal and the immediate safety of the student or others is at-risk (such as when a weapon is in the possession of the student), school staff shall call 911 immediately. The staff calling shall provide as much information about the situation as possible, including the name of the student, any weapons the student may have, and where the student is located. School staff may tell the dispatcher that the student is a suicidal emotionally disturbed person, or "suicidal EDP", to allow for the dispatcher to send officers with specific training in crisis de-escalation and mental illness.

Notify the building principal **immediately** when a call to law enforcement needs to be placed. Building administration plays a key role in coordinating emergency response and must be included in this decision-making.

Parental Notification and Involvement

The principal, designee, or school mental health professional shall inform the student's parent or guardian on the same school day, or as soon as possible, any time a student is identified as having any level of risk for suicide or if the student has made a suicide attempt (pursuant to school/state codes, unless notifying the parent will put the student at increased risk of harm).

Following parental notification and based on initial risk assessment, the principal, designee, or school mental health professional may offer recommendations for next steps based on perceived student need. These can include but are not limited to, an additional, external mental health evaluation conducted by a qualified health professional or emergency service provider. Document this conversation using the **Parent Notification and Release Form**.

When a student indicates suicidal intent, schools shall attempt to discuss safety at home, or "means safety" with parent or guardian, limiting the student's access to mechanisms for carrying out a suicide attempt (e.g., guns, knives, pills, etc.). In addition, during "lethal means counseling," which can also include safety planning, it is imperative to ask parents whether or not the individual has access to firearms, medication, or other lethal means.

Lethal Means Counseling shall include discussing the following:

Firearms

- Inquire of the parent or guardian if firearms are kept in the home or are otherwise accessible to the student.
- Recommend that parents store all guns away from home while the student is struggling (e.g., following state laws, store their guns with a relative, gun shop, or police).
- Discuss parents' concerns and help problem-solve around offsite storage, and avoid a negative attitude about guns. Accept parents where they are, but let them know offsite storage is an effective, immediate way to protect the student.
- Explain that in-home locking is not as safe as offsite storage, as children and adolescents sometimes find

the keys or get past the locks.

- If there are no guns at home:
  - Ask about guns in other residences (e.g., joint custody situation, access to guns in the homes of friends or other family members).
- If parent won't or can't store offsite:
  - The next safest option is to unload guns, lock them in a gun safe, and lock ammunition separately (or don't keep ammunition at home for now).
  - If guns are already locked, ask parents to consider changing the combination or key location. Parents can be unaware that the student may know their "hiding" places.

Medications

- Recommend that the parent or guardian lock up all medications (except rescue meds like inhalers), either with a traditional lock box or a daily pill dispenser.
- Recommend disposing of expired and unneeded medications, especially prescription pain pills.
- Recommend the parent maintain possession of the student's medication, only dispensing one dose at a time under supervision.
  - If the parent will not or cannot lock medication, advise they prioritize and seek specific guidance from a doctor or pharmacist regarding the following:
    - Prescriptions, especially for pain, anxiety or insomnia
    - Over-the-counter pain pills
    - Over-the-counter sleeping pills

Staff will also seek parental permission, in the form of a **Release of Information** form, to communicate with outside mental health care providers regarding the student's safety plan and access to lethal means.

In-School Suicide Attempts

In the case of an in-school suicide attempt, the physical and mental health and safety of the student are paramount. In these situations:

1. First aid shall be rendered until professional medical services and/or transportation can be received, following district emergency medical procedures.
2. School staff shall supervise the student to ensure their safety.
3. Staff shall move all other students out of the immediate area as soon as possible.
4. The school-employed mental health professional or principal shall contact the student's parent or guardian (see ***Parental Notification and Involvement*** section).
5. Staff shall immediately notify the principal or school suicide prevention coordinator regarding the incident of in-school suicide attempt.

6. The school shall engage the Crisis Response Team as necessary to assess whether additional steps should be taken to ensure student safety and well-being, including those students who may have had emotional or physical proximity to the victim.

7. Staff shall request a mental health assessment for the student as soon as possible.

Since self-harm behaviors are on a continuum of level and urgency, not all instances of suicidal ideation or behavior warrant hospitalization. A mental health assessment, including a suicide risk assessment, can help determine the best treatment plan and disposition.

Out-of-School Suicide Attempts

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member shall:

1. Call 911 (police and/or emergency medical services)

2. Inform the student's parent or guardian

3. Inform the school suicide prevention coordinator and principal

If the student contacts the staff member and expresses suicidal ideation, the staff member shall maintain contact with the student (either in person, online, or on the phone) and then enlist the assistance of another person to contact the police while maintaining engagement with the student.

Re-Entry Procedure

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), whenever possible, a school-employed mental health professional, the principal, or designee shall meet with the student's parent or guardian, and if appropriate, include the student to discuss re-entry.

This meeting shall address next steps needed to ensure the student's readiness for return to school and plan for the first day back. Following a student hospitalization, parents may be encouraged to inform the school counselor and/or school psychologist of the student's hospitalization to ensure continuity of service provision and increase the likelihood of a successful re-entry.

Possible questions to assess appropriate re-entry:

- How are things going for you now?
- Are you still having suicidal thoughts? If so, how often and how intense?
- Have you received help from a mental health or substance abuse practitioner?
- Have your parents signed a release of information so that we can speak to your practitioner?
- Has this treatment been of help to you? If so, how?
- Are you receiving on-going treatment?
- What have you learned?

A school-employed mental health professional or other designee shall be identified to coordinate with the student, their parent or guardian, and any outside health care providers. The school-employed mental health professional shall meet with the student and their parents or guardians to discuss and develop a re-entry plan, including a plan for what would help to ease the transition back into the school environment (e.g., whether or not the student will be required to make up missed work, the nature of check-in/check-out visits, etc.). Any necessary accommodations shall also be discussed and documented. This will be documented on the **School-Home-Student Support and Re-entry Plan**.

While not a requirement for re-entry, the school may coordinate with the hospital and any external mental health providers to assess the student for readiness to return to school.

The designated staff person shall periodically check-in with the student to help with readjustment to the school community and address any ongoing concerns, including social or academic concerns.

The school-employed mental health professional shall check-in with the student and the student's parents or guardians at an agreed upon interval depending on the student's needs either on the phone or in person for a mutually agreed upon time period (e.g. for a period of three months). These efforts are encouraged to ensure the student and their parents or guardians are supported in the transition, with more frequent check-ins initially, and then fading support.

The administration shall disclose to the student's teachers and other relevant staff (without sharing specific details of mental health diagnoses) that the student is returning after a medically-related absence and may need adjusted deadlines for assignments. The school-employed mental health professional shall be available to teachers to discuss any concerns they may have regarding the student after re-entry.

Postvention

Suicide Postvention Response Protocol

Immediate Response (1 Hour to 1 Week)

Suicide Death is Reported

- Work with sheriff's office and Lane County Suicide Prevention leads to confirm facts.
- Notify school leadership and confirm building and district leaders and roles.
- Principal or designee contacts the family to express condolences and gather information.
- Convene Crisis Response Team:
  - Topics: care rooms, triage, safety planning, resource identification and distribution, Tragedy Response Network, communication
- Administrative staff call all building staff to disclose news and clarify plans for an all-staff meeting the following day.

Prepare to Disclose Information to Staff and Students

- Crisis Response Team continues to communicate and coordinate actions.
- Develop a communication plan to share with staff. Plan for additional supports for targeted staff, as needed.
- Ensure siblings have been notified by family first. Be prepared to provide supports.
- Identify students closest to the individual and prepare to notify them together.
- Identify other possible impacted students (based on identity) and prepare additional supports.

Prepare Communication and Ongoing Supports

- Crisis Response Team continues to communicate and coordinate actions.
- Prepare statements to share with the community and media, if needed.
- Develop memorial plans.

Mid-Term Services for Students and Families (1 Week to 2 Months)

- Provide grief/mental health support groups or facilitated discussions with targeted groups.
- Plan for possible academic accommodations.
- Plan for and administer universal screening and safety planning.
- Ensure increased supports and follow-up services are available for at-risk students.

Long-Term Planning and Services (2 Months to 1 Year)

- Identify anniversaries and special events as potential times of increased risk and need.
- Plan for and administer additional universal screening and safety planning.
- Evaluate the need for additional or ongoing training and education.
- Identify existing suicide prevention activities or resources. Implement new programs, as needed.
- Continue to communicate frequently about mental health and suicide with students, staff, and community.

Immediate Response - 1 Hour to 1 Week

Get the Facts First

The crisis response coordinator or other designated school official (e.g. the school's principal or superintendent) shall *confirm the death and determine the cause of death* through communication with the Lane County Postvention Response Lead, the student's parent or guardian, the medical examiner's office, local hospital, or sheriff department. If the death has been ruled a suicide, the school can proceed with communication as described in the ***Crisis Response*** section.

If the manner of death is unconfirmed: Before the death is officially classified as a suicide by the coroner's office, the death shall be reported to staff, students, and parents or guardians, with an acknowledgement that its cause is unknown.

- When a case is perceived as being an obvious instance of suicide, it shall not be labeled as such until after a manner of death ruling has been made.
- Acknowledge that there are rumors (which are often inaccurate), and remind students that rumors can be deeply hurtful and unfair to the missing/deceased person, their family, and their friends.
- If there is an ongoing investigation, schools should check with local law enforcement before speaking about the death with students who may need to be interviewed by the authorities.

If the family does not want the manner of death disclosed: While the fact that a student has died may be disclosed immediately, information about the manner of death should not be disclosed to students until the family has been consulted. The school may release a general statement without disclosing the student's name (e.g., *"We had a ninth-grade student die over the weekend"*).

- If the parents do not want to disclose manner of death, an administrator or mental health professional from the school who has a good relationship with the family shall be designated to speak with the parents to explain the benefits of sharing mental health resources and suicide prevention with students.
    - If the family still refuses to permit disclosure, schools may state *"The family has requested that information about the cause of death not be shared at this time."* Staff may also use the opportunity to talk with students about suicide. *"We know there has been a lot of talk about whether this was a suicide death. Since the subject of suicide has been raised, we want to take this opportunity to give you accurate information about suicide in general, ways to prevent it, and how to get help if you or someone you know is feeling depressed or may be suicidal."*

Crisis Response

The Crisis Response Team shall meet to prepare the postvention response according to the crisis response plan. The team shall consider how the death is likely to affect other students, and determine which students are most likely to be affected. The Crisis Response Team shall also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. The team and principal shall triage staff first, and all teachers directly involved with the victim shall be notified in-person and offered the opportunity for support.

Another consideration related to communication after a suicide death involves educating parents and other adults on suicide grief, since adult behavior following a suicide death can have a great impact on students, particularly elementary school-aged students.

The Crisis Response Team Leader (Special Education Director in coordination with the building principal) has overall responsibility for the duration of the crisis. They should immediately assemble the Crisis Response Team, which will be responsible for implementing the various elements of the crisis response.

Pleasant Hill School District's Crisis Response Team	
Jim Crist, Superintendent	Whitney Connolly, Director of Special Programs
Brenna Fairchild, PHES Principal	Stephanie Black, PHES School Counselor
Alan Stearns, PHHS Principal	Paul Griffith, PHMS School Counselor
Pat Jarman, PHHS Assistant Principal/AD	Clarrissa Anderson, PHHS School Counselor
Caleb Salmond, PHMS Assistant Principal	Katie Jensen, school nurse

Crisis Response Team Leader's Checklist

- ❑ Inform the school district superintendent of the death.
- ❑ Contact the deceased's family to offer condolences, inquire what the school can do to assist, discuss what students should be told, and inquire about funeral arrangements.
- ❑ Call an immediate meeting of the Crisis Response Team to assign responsibilities.
- ❑ Establish a plan to immediately notify staff of the death via the school's crisis alert system (usually phone or email).
- ❑ Schedule an initial all-staff meeting as soon as possible (ideally before school starts in the morning).
- ❑ Arrange for students to be notified of the death in small groups such as homerooms or advisories (not by overhead announcement or in a large assembly) and disseminate a death notification statement for students to homeroom teachers, advisors, or others leading those groups.
- ❑ Designate clerical staff to prepare materials (handouts for staff, care room supplies)
- ❑ Draft and disseminate a death notification statement for parents.
- ❑ Disseminate handouts on Facts About Suicide in Adolescents and Talking About Suicide to faculty.
- ❑ Speak with the district superintendent and building principal throughout the day.
- ❑ Determine whether additional grief counselors, crisis responders, or other resources may be needed from outside the school.
    - ❑ Contact the Tragedy Response Network for additional support.
    - ❑ Recruit trusted community members (religious leaders, sports coaches, etc.).

Safety

- ❑ Keep to regular school hours.
- ❑ Ensure that students follow established dismissal procedures.
- ❑ Assign personnel to assist parents and others who may show up at the school and to keep media off of school grounds.
- ❑ Pay attention to students who are having particular difficulty, including those who may be congregating in hallways and bathrooms, and encourage them to talk with counselors or other appropriate school personnel.

Operations

- ❑ Assign a staff member to follow the deceased student's schedule to monitor peer reactions and answer questions.
- ❑ If possible, arrange for several substitute teachers or "floaters" from other schools within the district to be on hand in the building in case teachers need to take time out of their classrooms.

- ❏ Arrange for crisis counseling rooms for staff and students.
- ❏ Provide tissues and water throughout the building and arrange for food for faculty and crisis counselors.
- ❏ Work with administration, staff, and counselors to identify individuals who may be having particular difficulty, such as family members, close friends, and teammates; those who had difficulties with the deceased; those who may have witnessed the death; and students known to have depression or prior suicidality; and work with school counseling staff to develop plans to provide psychological first aid to them.
- ❏ Prepare to track and respond to student and/or family requests for memorialization.

Community Liaison

- ❏ Several team members will be needed, each serving as the primary contact for working with community partners of various types, including:
    - medical examiner, to ensure accuracy of information disseminated to school community;
    - police, as necessary, to ensure student safety;
    - Lane County Suicide Postvention Response Lead (Roger Brubaker), to facilitate community-wide response to the suicide death;
    - mental health and medical communities, as well as grief support organizations, to plan for service needs; and
    - arranging for outside trauma responders and briefing them as they arrive on scene.

Media Relations

- ❏ Notify staff that the superintendent will field all media inquiries. Refer to the **Media Statement/Responses** document.
- ❏ Advise staff that only the media spokesperson is authorized to speak to the media.
- ❏ Advise students to avoid interviews with the media.

Social Media

- ❏ Oversee school's use of social media as part of the crisis response.
- ❏ Consider convening a small group of the deceased's friends to work with school administration to monitor social networking sites and other social media.

Sharing of Information

Inform the faculty and staff that a student death has occurred, preferably in an all-staff meeting. Use the **Agenda for All-Staff Meetings** to guide this meeting. This meeting is typically conducted by the Crisis Response Team Leader and should be held as soon as possible, ideally before school starts in the morning.

Depending on when the death occurs, there may not be enough time to hold the meeting before students have begun to hear the news through word of mouth, text messaging, or other means. If this happens, the Crisis Response Team Leader should first verify the accuracy of the reports and then notify staff of the death through the school's predetermined crisis alert system, such as e-mail or calls to classroom phones. Remember that information about the manner of death should be withheld until the family has been consulted.

The Crisis Response Team shall provide a written statement for staff members to share with students and also assess staff's readiness to provide this message in the event a designee is needed. *Avoid public address system announcements and school-wide assemblies in favor of face-to-face notifications, including small-group and classroom discussions.* Use the **Death Notification Statement for Students** to guide this communication with

students.

When communicating with students, it is important to remember the following:

- Staff shall respond to questions only with factual information that has been confirmed.
- Staff shall dispel rumors with facts, be flexible with academic demands, encourage conversations about suicide and mental health, normalize a wide range of emotional reactions, and know the referral process and how to get help for a student.

The Crisis Response Team will prepare a letter — with the input and permission from the student's parent or guardian — to communicate with parents which includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available. If necessary, a parent meeting may also be planned. Use the **Death Notification Statement for Parents** to create this letter. Also be prepared to provide additional family resources, such as the **SPRC Resource List for Families** or the **Community Resources** document.

External Communication

The school or district-appointed spokesperson shall be the sole media spokesperson. Staff shall refer all inquiries from the media directly to the spokesperson. The spokesperson shall:

- Keep the district superintendent and school crisis response coordinator informed of school actions relating to the death.
- Prepare a statement for the media, which may include the facts of the death, postvention plans, and available resources — the statement shall not include confidential information, speculation about victim motivation, means of suicide, or personal family information.

The school or district-appointed spokesperson shall answer all media inquiries. If a suicide is to be reported by news media, the spokesperson shall encourage reporters to follow safe messaging guidelines (e.g. not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide, and not to use the phrase "suicide epidemic") to mitigate the risk of suicide contagion. The spokesperson shall encourage media not to link bullying to suicide, and not to speculate about the reason for suicide and instead offer the community information on suicide risk factors, warning signs, and resources available.

Staff shall direct all media inquiries to the superintendent.

Initiate Support Services

Students identified as being more likely to be affected by the death will be assessed by a school mental health professional to determine the level of support needed. The Crisis Response Team shall coordinate support services for students and staff in need of individual and small group counseling as needed. School-employed mental health professionals will provide ongoing and long term support to students impacted by the death of the student, as needed. If long term intensive services by a community provider are warranted, the school-employed mental health professional will collaborate with that provider and the family to ensure continuity of care between the school, home, and community.

Together with parents or guardians, Crisis Response Team members shall provide information for partner community mental health providers, or providers with appropriate expertise, to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs. These discussions may

include debriefing (orientation to the facts), reflection on memories, reminders for and re-teaching of coping skills, and encouraging spending time with friends and caregivers as soon as possible. Students and staff affected by the suicide death shall be encouraged to return to a normal routine as much as possible, understanding that some deviation from routine is to be expected.

Mid-Term Services for Students and Families - 1 Week to 2 Months

Avoid Suicide Contagion

Actively triage particular risk factors for contagion, including emotional proximity (e.g., siblings, friends, or teammates), physical proximity (witness, neighbor) and pre-existing mental health issues or trauma. Explain in an all-staff meeting that one purpose of trying to identify and provide services to other high-risk students is to prevent another death. The Crisis Response Team shall work with teachers to identify students who are most likely to be significantly affected by the death, or who exhibit behavioral changes indicating increased risk. In the staff meeting, the Crisis Response Team shall review suicide warning signs and procedures for referring students who present with increased risk.

For those school personnel who are concerned that talking about suicide may contribute to contagion, it has been clearly demonstrated through research that talking about mental health and suicide in a nonjudgmental, open way that encourages dialogue and help-seeking does not elevate risk.

Develop Memorial Plans

Memorializing a student who has died by suicide can be a difficult process. Staff, students, and the family of the deceased may have different ideas of what is appropriate, inappropriate, or useful. It is important to be prepared to respond to and channel the need of people to grieve into activities that will not raise the suicide risk of vulnerable students or escalate the emotional crisis.

The person designated as the liaison with the family needs to consult the family and be prepared to explain the memorialization policy to the family while respecting their wishes as well as the grieving traditions associated with their culture and religion.

- Avoid planned on-campus physical memorials (e.g. photos, flowers, locker displays), funeral services, tributes, or flying the flag at half-staff, because it may inadvertently sensationalize the death and encourage suicide contagion among vulnerable students.
- Spontaneous memorials may occur from students expressing their grief. Cards, letters, and pictures may be given to the student's family after being reviewed by the school administration.
    - If items indicate that additional students may be at increased risk for suicide and/or in need of additional mental health support (e.g. writing about a wish to die or other risk behavior), outreach shall be made to those students to help determine level of risk and appropriate response.
    - The school shall also leave a notice for when the memorial will be removed and given to the student's family.
- Online memorial pages shall use safe messaging, include resources to obtain information and support, be monitored by an adult, and be time limited.
- School shall not be canceled for the funeral or for reasons related to the death.

- Any school-based memorials (e.g., small gatherings) shall include a focus on how to prevent future suicides and prevention resources available.

It is noteworthy that even articles that are inappropriate to share with families may have been therapeutic for the students to create. Allowing for these memorials to stay in place for a brief period up to the funeral (up to approximately five days), and monitoring memorials while in place, is recommended to avoid hostile and glamorizing messaging and to monitor for at-risk students.

Consider Ongoing Supports

The Crisis Response Team will continue to monitor students' reaction to the crisis and plan for ongoing interventions and supports. These supports may include:

- Grief or mental health support groups
- Academic interventions and accommodations
- Universal screening and safety planning
- Targeted supports for identified and/or at-risk students

Long-Term Planning and Services - 2 Months to 1 Year

Preparing for Significant Dates and Events

The anniversary of the death (and other significant dates, such as the deceased's birthday) may stir up emotions and can be an upsetting time for some students and staff. It is helpful to anticipate this and provide an opportunity to acknowledge the date, particularly with those students who were especially close to the student who died. These students may also need additional support since mourning can be a long-term process, and an anniversary of a loss can trigger the grief and trauma they experienced at the time of the death.

Consider Ongoing Supports

The Crisis Response Team will continue to monitor students' reaction to the crisis and plan for ongoing interventions and supports. These supports may include:

- Grief or mental health support groups
- Academic interventions and accommodations
- Universal screening and safety planning
- Targeted supports for identified and/or at-risk students

Postvention as Prevention

Following a student suicide, Pleasant Hill School District will review and/or revise existing policies. The Crisis Response Team will meet to review existing support structures and programs, as well as plan for the implementation of additional programming to continue to ensure student safety and wellbeing.

Community Support and Referral Resources

Pleasant Hill School District Support Staff

Pleasant Hill School District's Crisis Response Team	
Jim Crist, Superintendent	Whitney Connolly, Director of Special Programs
Brenna Fairchild, PHES Principal	Stephanie Black, PHES School Counselor
Alan Stearns, PHHS Principal	Paul Griffith, PHMS School Counselor
Pat Jarman, PHHS Assistant Principal/AD	Clarrissa Anderson, PHHS School Counselor
Caleb Salmond, PHMS Assistant Principal	Katie Jensen, school nurse

Community Agencies

Crisis Resources

- **Call 911 for any imminent danger to self or others**
- **Whitebird**: 541-687-4000
- **Riverview Center for Growth Crisis Response Line**: 1-888-989-9990 (for parents of children through age 17)
- **Looking Glass Youth & Family Crisis Line**: 541-689-3111
- **Naitonal Suicide Prevention Lifeline**: 988 (call or text)
- **Lane County Crisis Line**: 541-682-1001
- **Springfield Crisis Response**: 541-726-3714

Counseling Resources

- **Center for Family Development**: 541-342-8437
- **Centro Latino Americano**: 541-687-2667 (bilingual Spanish-speaking staff available)
- **Riverview Center for Growth**: 541-726-1465
- **Child & Family Center, University of Oregon**: 541-346-4910
- **Direction Service Counseling**: 541-344-7303 (for youth/families with OHP)
- **Lane County Behavioral Health**: 541-682-3608
    - **Child & Adolescent Program**: 541-682-1915 (youth/families 17 and under with OHP)
- **Looking Glass Counseling Program**: 541-484-4428 (for youth 24 and under)
- **Options Counseling**: 541-687-6983 (youth & adults); 541-997-6261 (Florence)
- **Oregon Social Learning Center**: 541-485-2711
- **PeaceHealth Behavioral Health**: 458-205-6709 (Eugene); 541-502-2890 (Cottage Grove)
- **South Lane Mental Health**: 541-942-3939 (counseling & crisis services for South Lane County)
- **Vet Center**: 541-465-6918 (combat veterans; also offers MST services)
- **VA Mental Health**: 541-242-0440
- **White Bird Clinic**: 541-505-5221
- **Willamette Family**: 541-762-4300

Support Groups

- National Alliance on Mental Illness (NAMI) Lane County: 541-343-7688; www.namilane.org

- 211 Resource line: www.211info.org or dial 211.

Bereavement Services

- **Cascade Health Solutions Grief Education & Support Groups**: 541-228-3050 – Free and open to adults living with the loss of a loved one
- **Courageous Kids**: 458-205-7474 – 8-week Suicide Loss Support Group for youth and their families