Suicide Prevention, Intervention, and Postvention Protocol Development: A Toolkit for Maine Schools

2019

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Protocol for Suicide Prevention, Intervention, and Postvention Development: A Toolkit for Maine Schools 2019

INTRODUCTION TO THE TOOLKIT
Suicide Prevention, Intervention, and Postvention Toolkit for Maine Schools

A School's Legal Responsibility to Provide Suicide Prevention:
LD 609: An Act to Increase Suicide Awareness and Prevention in Maine Schools, was signed into law by Governor Paul LePage on April 25, 2013, following unanimous passage in the legislature. The statute requires a 1-2 hour Suicide Prevention Awareness Education training be completed by ALL school personnel in each school administrative unit (SAU), island, charter, CTE Region and public school that is not in a school administrative unit. It also requires all school administrative units and each island, charter, approved private and public schools that are not in a school administrative unit to have at least two staff trained in a one-day course in suicide prevention and intervention training commonly referred to in Maine as "Gatekeeper Training." A CTE Region must have at least one school personnel member on site who has successfully completed Gatekeeper training. The second school personnel member could be either on site or the CTE Region could have a legal agreement with one of the sending schools assigned to their region. In addition, beginning in 2019-2020 school year, the law requires that schools develop and implement protocols for suicide prevention and intervention.

As part of a comprehensive suicide prevention and intervention program, it is essential that schools have written protocols for responding to:

A. Students presenting with warning signs of suicide (suicide risk).
B. A suicide attempt.
C. A death by suicide.

In crafting LD 609: Act to Increase Suicide Awareness and Prevention in Maine Public Schools, Maine was following an evidence-based approach to suicide prevention called the "Lifelines Program." The Lifelines model sets out to support the development of a comprehensive safety net to identify and respond to students seen as having increased risk for suicide. The underpinnings of the Lifeline model are to develop a system of competent, confident and caring adults within the school community so that, when a student comes forward (or is brought forward) acknowledging suicide risk, the system of care is in place to address their needs and prevent a suicide act from occurring. The provision of suicide prevention awareness education to ALL school staff, the provisions of the law requiring a minimum number of trained suicide prevention Gatekeepers, and the requirement that school districts develop and implement protocols supporting suicide prevention, intervention and postvention are all key components of the Lifelines model.

The Lifelines seeks to support the development of a safety net within a school community composed of many layers and many people prepared to recognize the signs of suicide and

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intervene to get someone at risk the help they need. It recognizes that a troubled youth will approach an adult based on their comfort and fit with that adult rather than on their professional training and competence as a clinician. The list of caring adults includes bus drivers, custodial staff, food service personnel, teachers and ED Techs, and coaches, among others. With a basic understanding of suicide and increased comfort and confidence to intervene, these adults can act as the bridge to connect an at-risk youth to the professional help she or he needs. With a comprehensive suicide protocol in place, a school district can be assured that staff understand what is required of them and what resources are available to engage for needed help.

The Purpose of this Toolkit:

This toolkit is designed to be used to support a school system in the development of a comprehensive suicide protocol:

A. Address the issue of suicide from prevention and intervention to postvention (in the aftermath of a suicide in the school community) and demonstrate how protocols can support each component.
    a. **Prevention**: Educate school staff to be prepared to recognize and respond to signs of suicide risk. The protocols will dictate how and when this training will happen and which staff receive which training. This section will also address crisis teams and their roles in the school.
    b. **Intervention**: Promote the importance of intervention with youth at risk and connect them with the needed help. This protocol will address the process taken by staff when concerned about a student. This includes how to support the student, where to bring them for support, staff roles in a crisis, internal and external communication, referrals and follow up.
    c. **Postvention**: Information about supporting a school community after suicide loss. This portion of the protocol will address supporting the school community (including staff) and the families in the aftermath of a suicide death. It includes addressing communication with staff, students, outside providers and families, identifying other potentially at risk students, and difficult issues such as memorials.

B. Ensure school staff are familiar with training offered in support of a comprehensive suicide program in schools, and what training they need.
C. Provide sample policies and protocols that schools can use as a template in the development of policies and protocols that best support their community.
D. Provide sample documents that may be edited and used in support of a comprehensive suicide program in schools.

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The following documents included in this toolkit are to be used in support of developing a comprehensive suicide protocol that's inclusive of prevention, intervention, and postvention efforts.

A. Comprehensive School Protocol Rubric
B. Trainings offered by NAMI Maine and the Maine Suicide Prevention Program
C. Report of Suicide Risk
D. Student Contact Form
E. Collaborative Safety Plan
F. Guidelines for Effective Referrals
G. Referral and Follow-up form
H. Parent Involvement form
I. Suicide Intervention Flowchart
J. Suicide Postvention Flowchart

Getting Started

The development of good school protocols benefits from a team approach. Consider who should form a core development committee and how to get input from the other sectors of the school in the process of development. Minimum core team members:

- District Administrator
- Educator
- School Principal/administrator
- School Clinician (Counselor and/or nurse)
- School Resource Office if the school has one
- School Based Health Centers if the school has one

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The following rubric can be used to develop your school's protocols. The intent is to use this rubric as a guide: using components that are most useful to your school's needs and your community's available resources. The below rubric is based on the most comprehensive protocol that addresses prevention intervention, and postvention. Further, it addresses issues such as staff roles, response to struggling student based on their level of risk (low, moderate, and high), internal suicide assessments, communication amongst staff, students, outside providers, and with families, referrals and follow up and documentation needs. Complete this rubric during your first committee meeting.

A. Comprehensive School Protocol Rubric

	Yes	No	Partial
A. Prevention			
This protocol is for ___________ School or ___________ District.			
Is there a written protocol for suicide *prevention*?			
If yes: Does it address the following:			
Staff training			
A1. All staff to receive basic 1-2 hour suicide prevention awareness training.			
A2. Prioritized staff roles to be Gatekeeper trained.			
A3. Clinicians, including mental health clinicians, to be trained in clinical assessment, treatment and referral.			
A4. Prioritized staff roles for additional training such as Collaborative Safety Planning, Non-Suicidal Self Injury, and Training of the Trainer.			
A5. All trainings to be renewed every 5 years or sooner			
A6. New staff to receive training within 6 months of hire			
A7. District maintains TOT staff to deliver awareness sessions within district.			

	Yes	No	Partial
Staff roles and responsibilities			
A8. Identifies staff roles to serve on internal crisis team A9. Identifies staff representatives to district-wide crisis team A10. Designates a staff member to lead suicide prevention coordination A11. Designated individual is gatekeeper and TOT trained A12. Identifies staff responsible for assessing student risk A13. Identifies process for will follow up with students after initial assessment and referral A14. Protocol flow charts (that indicate staff roles) to be on hand for quick reference			
Referral networks/resources			
A15. Identifies key external community resources A16. Includes names and phone numbers of community resources A17. List of external community resources is kept up-to-date A18. Identifies school resources by position and specific role A19. Provides for student education and outreach A20. Describes distribution of brochures, resources, posters, and crisis cards A21. Identifies process for Suicide Awareness curriculum implementation A22. Plan for supporting students during and after educational events (classroom or school-wide)			
Assessment (Universal)			
A23. Ensures that all SBHC users complete a health risk assessment (HRA) within their first two visits to the SBHC A24. Requires additional screening if student answers affirmatively to initial HRA screening questions for depression or suicide risk A25. Specifies process and tools for assessment A26. Specifies criteria for suicide assessment using approved tool A27. Describes actions (triage, referral, additional care) based on results of additional screening			

	Yes	No	Partial
B. Intervention			
Is there a written protocol for suicide *intervention*? *If yes:* Does it address the following:			
Collaboration			
B1. Describes expectation for collaboration and information sharing between school clinical staff and contracted school providers (e.g. school based clinicians). B2. Describes process for accessing outside resources including law enforcement officers.			
Assessment (indicated)			
B3. For risk assessment within schools, identify: • Which school clinical staff are responsible for assessing risk? • What assessment tool will be used? (e.g. C-SSRS) • Triage guidance based on level of assessed risk			
Safety			
B4. Criteria and reasons for calling 911, police, EMS, crisis B5. Process (who, how, when) for calling 911, police, EMS, crisis B6. When a collaborative safety plan is needed B7. What a collaborative safety plan should entail B8. Who develops the collaborative safety plan B9. Inquire about the availability of lethal means in the home B10. Develop plan to remove/limit access, as appropriate B11. Other steps for ensuring student safety?			
Plan for low risk students includes:			
B12. Referral for support services within the school or community B13. Focus on modifiable risk factors and protective factors B14. Offer resources (crisis numbers etc…) B15. Develop follow-up plan B16. Develop a collaborative safety plan			

	Yes	No	Partial
Plan for medium risk students includes:			
B17. Ensure student safety. Do not leave them alone.			
B18. Develop a collaborative safety plan			
B19. Determine referral type (ER, crisis intervention, therapist, etc.,)			
Plan for high risk students includes:			
B20. Activate safety precautions			
B21. Check personal belongings			
B22. Do not leave alone			
B23. Do not allow to leave school property alone			
B24. Contact parents and complete student contact form			
B25. Establish who will transport to ER/crisis service			
B26. Debrief staff and any affected students			
B27. Debriefing to occur within a prescribed time period			
B28. Plan for follow-up with student and family			
Communication			
B29. Criteria and reasons for contacting school resource officer			
B30. Process (who, how, when) for contacting school resource officer			
B31. Criteria and reasons for contacting parent/guardian (e.g., re risk concerns, recommendations for safety, treatment and follow-up)			
B32. Process (who, how, when) for contacting parent/guardian			
B33. Involvement of/feedback to referral source, ie: concerned friend, family member or school staff			
B34. Process for sharing information between SBHC and appropriate school staff (within bounds of student confidentiality)			
B35. Process for sharing information between crisis and outside providers			
B36. Follow up of any student referral to an external provider			
B37. Obtain release of information in compliance with patient confidentiality, HIPPA, FERPA			

	Yes	No	Partial
Referral			
B38. Criteria for which referral should be used and when B39. Regional mental health crisis team B40. Mental health/substance abuse agencies B41. Student's primary care provider or other private provider B42. Specify documents to be sent with student, provided consent to release			
Follow up			
B43. Specifies timeframe for follow-up communication with student/family (to ensure student has received the recommended assessment, treatment and support) B44. Communication and coordination with appropriate school staff and administration (for transition and ongoing support) B45. Procedures for ongoing follow-up appointments and support (recognizing that student will have ongoing risk) B46. Debriefing with staff, as appropriate			
Documentation			
B47. Document all screenings, assessments, referral recommendations and follow-up efforts in the student's medical record. B48. Document any record release			

	Yes	No	Partial
C. Postvention			
Is there a written protocol for suicide *postvention*? *IF YES:* Does it address the following:			
Collaboration – Role of the School Crisis Team			
C1. Collaboration with school in support of postvention efforts C2. Plan for use of available staff resources (mental health or other clinical staff) C3. Plan for accessing clinical supports (crisis, other schools, etc.) C4. Contact with and support for family			
Debriefing			
C5. Identify the most impacted students. C6. Debrief staff internally C7. Debrief with external partners, e.g., crisis team or other school staff C8. Conduct community outreach.			
Follow Up			
C9. Review procedures for assessing, supporting, and referring students at risk C10. Communicate with school C11. Increase assessment and support for students who access the health center			

B. Trainings offered by NAMI Maine

Training Title	Description	Who should attend
Suicide Awareness: Basic Suicide Prevention	This training focuses on identification of and response to those at-risk and how to connect them with help	People who want to understand the basics about suicide and how to connect someone to support
Gatekeeper	Full-day training-basic intervention skills response to suicidal behavior while identifying helpful resources	People who want a deeper level of information about the issue of suicide and how to help someone in need
Advanced Gatekeeper for School Personnel	For school staff who must renew their Gatekeeper training every five years, this training deepens suicide prevention skills in the school setting.	Gatekeepers
Curriculum Training for Teachers	Full-day training to prepare educators to provide lesson plans to students about suicide and how to help a friend	Gatekeepers who want to teach: Middle School Lessons, Lifelines (8th-10th graders).
Training for Trainers	Equip trainers with the tools, resources and skills necessary to present an effective Awareness Training session	Gatekeepers
Assessment for Clinicians: focus on the Columbia Suicide Severity Rating Scale (C- SSRS)	This training prepares a clinician to assess risk and manage care needs	Clinicians including in health and mental health
Suicide Prevention Protocol Workshop	Create and implement a protocol using best practices with guidance and structure to safely assist in a suicidal situation.	A team of staff with diverse perspectives from schools and service agencies
Collaborative Safety Planning	Teaches the ability to articulate a rationale for collaborative safety planning within a system of care and describe the components of a safety plan.	A team of staff with diverse perspectives from schools and service agencies
Non-Suicidal Self Injury	Training covers definitions, patterns of occurrence, and the relationship between self injury and suicide. Will discuss risk factors and signs to look for.	Anyone in the community

C. Report of Suicide Risk

Student Name:

Date:	Name of School:

MALE FEMALE	Date of Birth: Age:	Grade:

Parent Notification Date/Time:

Response:

Who initiated the referral:

Friend/Student:______________________ ☐ Parent:_______________ ☐ Teacher: ______

Other School Personnel:___________________________ ☐ Administrator: _______________________

Self-Referral:__________________________ ☐ Other: ____

Reason for Referral

Suicidal Behavior (Check One):

Suicide Attempt – Having taken action with intent to die

Suicide Threat – Saying or doing something that indicates self-destructive desires

Suicide Ideation - Having thoughts about killing self

Action Taken (check those that apply)

Student seen by school personnel: (Name/Agency) ____

Student transported to a hospital/other: (Name/Agency) ____

Student referred to Crisis Services: (Name/Agency) ____

Parent notification and/or advised to seek the services of a mental health agency or service. ☐

Results of Follow-Up Contact: Date:

Form Completed By: ______________________________________

Date: ____________________

Position: ____

Signature:____

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D. My Plan for Safety/Recovery/Support

Name: Grade: Date:

Step 1: Warning signs (thoughts, images, mood, situations, behavior) that a crisis may be developing: How does your body feel? What are the thoughts in your head?	
1.	
2.	
3.	
Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):	
1.	
2.	
3.	
Step 3: People, social settings, and activities that provide distraction:	
Name:	Phone:
Name:	Phone:
Place:	Place:
Activity:	Activity:
Step 4: People whom I can ask for help: At Home, At School, and In the Community	
1. Name:	Phone:
2. Name: (Adult)	Phone:
3. Name: (Adult)	Phone:
Step 5: Professionals or agencies I can contact during a crisis:	
Therapist, Name: ___________________________________	Phone: _________________________
Emergency Contact, Name: _______________________________	Phone: _________________________
Maine Crisis Hotline—1-888-568-1112	
Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)	**Police: 911**
Other: ____	
Step 6: Making the environment safe:	
1.	
2.	

Step 7: What in your life is worth living for?____

____

Staff Signature: ____**Date**_____ **Follow up Meeting:**
(MH/Counselor)
Student Signature: ____**Date**_____ **Date ______ Time _______**
Parent/ Guardian: ____**Date**_____ **Review Date:____________**

E. Guidelines for Making Effective Referrals

School personnel often have to refer students to other community services for a wide variety of problems that commonly surface among their students. In fact, any community consists of a *network* of services and agencies that constantly refer clients to each other. While making referrals is a common activity, it is done with varying degrees of success. That is, it is not easy to make a referral that is equally acceptable to the person making the referral, the person being referred, and the person receiving the referral. Accomplishing this involves not only obtaining the right services for the student, but also maintaining open communication and smooth working relationships with other agencies.

Referring an adolescent for counseling or other mental health services is one of the more difficult "hand offs" to accomplish. Research has shown that few of these referrals are followed up on, or, if the adolescent does complete an initial appointment, s/he often fails to return for subsequent appointments.

There are probably many reasons, aside from the manner in which the referral was initiated, why this is so. However, we have found that there are some ways of making such referrals that increase the likelihood of a successful hand-off. These techniques can be roughly divided into three categories:

1. Involving the student in the referral.
2. Involving the parents in the referral.
3. Considerations involved in the actual referral process.

The first category contains guidelines that have relevance for school administrators or other designated officials to whom troubled students are referred within the school, as well as for classroom teachers or any other school personnel who have contact with students. The last two categories are mainly administrators or officials who make contact with parents and other community agencies.

For our purposes here, an effective referral is defined as one that seems acceptable or appropriate to the person making the referral, the person or agency receiving the referral and, at least to some degree, to the student and parents who are being referred.

Involving the Student in the Referral

1. **Clarify the Problem**
   This may sound obvious, but it is not uncommon for referrals to be made before the nature of the problem has been clarified. This results in inappropriate referrals that annoy the student, the referral source, and you. By taking the time to listen and clarify the concerns, you accomplish at least four things:

- Obtaining the information that you need to support your decision to refer and to make a correct referral.
- Showing the student that you understand his/her concerns and thus have some basis for your recommendation.
- Sending the student to a valuable resource and not just out of your care.
- Showing acceptance and understanding and establishing some rapport without which suggestions or directions are unlikely to be accepted.

Even if you know that the student needs additional help before s/he walks into your office, take the time to listen. Referrals work best if they are the end of a process, not the beginning.

2. Address the Reluctance

Give the student a chance to talk about his/her reluctance to accept the referral. A simple way to address this is to ask, “How does this sound to you?” or “How do you feel about my suggesting this?” or “How do you feel about talking to _ (name)?” Pay attention to

nonverbal cues such as tone of voice and body language as well as to what the student says. Some feelings that may interfere with the student’s acceptance of the referral include:

- Rejection: “Why can't you help me?”
- Hopelessness: “If you can't help me, nobody can!” “Going for counseling means I'm sicker than I thought”
- Anger: “I thought you were supposed to help me” “I'm tired of telling my story” “You're just trying to get rid of me”
- Concern about parental reaction: “My parents will kill me if they find out I told someone all of this” “They told me if I cause one more problem then I'm out on my ear” “You're crazier than I am if you think my Dad would pay for a shrink”.

It's very important to address any expressed concern that reflects reluctance to follow up on your referral. Ignoring the teen's feelings doesn't make them go away. Addressing them provides the opportunity to clear up misconceptions and speak to the teen's fears about mental health treatment. In addition to acknowledging his/her concerns, you may also offer to accompany the student on the next step in order to smooth the transition.

Sometimes, despite your best efforts, the student remains unconvinced about the need for a referral. At this point, it may be best to acknowledge the disagreement, indicate that you would rather be safe than sorry, and invite the student to share his/her concerns again with the person to whom s/he is being referred. Once rapport has been established and the student at least feels s/he has been listened to, many educators have developed ways of "framing" the hand off with the student. For example, some may have an agreement with the student that the student is following up to make the school official feel better.

Involving the Parents in the Referral

Once you have determined that a referral is indicated, the student's parents must be contacted. Your school may have different procedures for contacting parents. Some schools require that all such contacts are made by one person such as the principal, vice-principal, or other designated official. It may be a good idea to find out if any faculty member or staff person has had some prior contact with the parents and could best make the contact.

Regardless of who makes the contact, a phone call to let them know that you are concerned about their child and to ask them to come in for a discussion is an appropriate first step. Make sure you have as much objective evidence as possible to support your concerns. Parents sometimes see their child's problems as a reflection of their parenting and may be defensive about accepting the idea that their child needs professional help. Or, they may hold stereotypic or negative ideas about mental health treatment that affects their response to your suggestions. It is best to briefly state what you have *seen* that causes you concern (rather than make an inference about what the causes for the behavior might be); then ask the parents if this fits with anything they have seen or know that has been going on with the student. This invites the parents to join with you in a discussion about their child, rather than receiving a "report" from you. As with the student, explore the reasons for their reluctance to the referral, then address them directly. As most school officials know, many parents will accept a referral suggestion. Here, we are considering those parents who may be resistant. You may find that you need to restate your concerns several times before they sink in. With some parents, you may need to appeal to their "good" parenting, "I know you want to do what's best for your child". Unfortunately, with others you may have to resort to pointing out possible consequences of not taking action at this time.

As with the student, your best efforts may leave the parents unconvinced of the need for a referral. This presents a substantial dilemma when you feel that the risk of a suicide attempt is high or, as in some cases that we have seen, where there has been an actual attempt.

The issue has arisen in all of our consultations with school officials, and there is usually a discussion about involving a child protection agency in such situations. We have found that states have different laws regarding the involvement of a child protection agency, and that there is even greater variance in their application to suicidal risk, as opposed to physical abuse. At this point, then, we recommend that superintendents, in consultation with lawyers and/or legislators develop a policy for this situation.

Considerations Involved in the Referral Process

The following are some points to keep in mind when initiating the actual referral. Again, they are aimed not only at making better hand-offs, but also maintaining good working relationships with other community services.

a. *Know your local mental health resources.* While some communities have only one agency that provides mental health services, many areas have a variety of agencies that meet these needs (e.g. local community mental health center, family services agency, crisis services, etc.). Some agencies many even have special services for adolescents. An awareness of community resources will help you in making a referral that best meets the student's needs. A personal contact or liaison with a staff member in these agencies can also facilitate the referral process.
b. In cases where your referral requests to have the student evaluated for suicide risk, you need to make sure that the person or agency to whom you refer has the ability to hospitalize the teenager if it seems necessary. Referring to an agency or person without that capacity (e.g. clergy, mental health clinic without psychiatric affiliation) just adds another step to the process at a point when timely action is indicated. So when you're checking out your referral source, make sure to inquire about this.
c. Even if there are a variety of sources who could provide the service that the student needs, it is best to select just one for your referral. More than one referral can be confusing at a time when the family's decision-making ability may already be taxed.
d. Try to match the family with the resource available. Anticipate difficulties if the agency is geographically distant and the family lacks transportation. Check other resources that may provide that service. It will require your spending extra time now, but it could save you time later. If possible, use a referral that is congruent to the family's background and resources (e.g., religious affiliation, cultural background, financial resources). Don't send a low-income family to a private practitioner whom they can't afford.
e. If you feel that the situation is an emergency, set up the referral yourself before the family leaves your office. Call the referral source and let them know you are sending the family immediately for an evaluation. Again, be clear about your reasons for the referral.
f. If you feel comfortable letting the family set up the appointment, make sure to give complete information about the referral. This includes the name of a person at the agency to contact, phone number, address, directions from school or their home, information about cost, etc.
g. Do not commit your referral source to a specific course of action by implying or promising to the student or parents that the agency will definitely work with the teen, hospitalize or not hospitalize, and the like. Your previous arrangements with the referral agency will only ensure that they will see the student. After that, the agency must be free to decide the most appropriate course of action.

h. It is best to not make evaluative comments about other agencies or individuals in your community. Your prior arrangements with your referral sources implies your acceptance of their practices and personnel. Any questions about the competence, responsiveness, etc. of specific agencies or individuals are best deflected with the statement that you are only familiar with those agencies with which you have specific working arrangements. That being said, if a student or parent returns with a complaint or concern about your referral source, it is best to obtain specific details, and follow this up immediately with that agency in order to clarify any misunderstandings about services or procedures.
i. Indicate to the family your intention to follow up with them and the referral source. Ask them to sign a release of information at the referral agency to allow you to receive limited information about the outcome of the evaluation. Explain that it is imperative that the school coordinate its response to their child with the mental health professionals in order to continue to provide a supportive environment for their child. Without the family's specific written consent, this will be impossible. Let them know that you only need information that relates to the treatment plan, not details about the life of the family.
j. Your school has the right to obtain such follow up information in order to ensure the proper responses to the student who is in treatment or has been recently discharged from treatment. Remember that the risk of suicide is very high in adolescents who have made attempts serious enough to be hospitalized (about 1 in 13 for males; 1 in 340 for females). You need information about medication, recommended management, and the amount of academic requirements to be placed on the returning student, just as you would require for a student returning to school while recovering from any illness or injury.

Unfortunately, we have found that some mental health agencies do not provide such vital information to the schools, considering this a breach of their client's confidentiality. When establishing a working relationship between the school and the local mental health provider prior to an actual referral, this issue should be resolved. It is imperative for schools to have some information that allows them to provide appropriate supports for the student and to avoid conflicts with the mental health treatment plan.

Some schools have a policy that they will not accept a student back into the school after an attempt if such information and joint planning is not in place. Again, having clear prior arrangements and solid working relationships with community agencies will generally attenuate the need to call upon such policies.

Schools must assure mental health providers that they have clear policies about sharing such information only with those who have a clear "need to know". It is our experience that many schools do not do an effective job of maintaining confidentiality in regard to students in these situations. Only faculty who will be interacting with the student should be provided information about the student, and this information should be specific to their particular interaction with

the student. For example, a classroom teacher may need to know what schoolwork was completed while the student was out and whether the student can complete regular assignments. The school nurse should know about medications and when they are to be taken. Such information should be shared in private, and "faculty lounge" discussions should be strongly discouraged. If any faculty or other school personnel feel that they need to know something about the student's situation, they should contact the person designated to coordinate transition back to school.

F. Referral and Follow-up

Student Name: **Address:** **Phone number:** **Date of birth:** **Language spoken in home:**		
Date of Referral:	**Referral Type/ reason:**	
Receiving agency Name: ______________________ **Phone/ Fax:** ______________________**Contact** **person:** ____________		
FOLLOW UP ATTEMPTS:		
1ST ATTEMPT	**Date of contact:**	**Worker Name:**
Outcome:		
2ND ATTEMPT	**Date of contact:**	**Worker Name:**
Outcome:		
3RD ATTEMPT	**Date of contact:**	**Worker Name:**
Outcome:		
Referral Closing:	**Date:**	**Final outcome:**

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Follow up plan: ____

____

____

Additional Notes: ____

____

____

G. Parental Involvement form

This is a sample form that verifies that the parent/guardian has been informed and advised of a student's behavior that was not directly life threatening but of enough concern for parental/guardian contact. If the meeting is in person, the parent/guardian can sign it, but if the contact is by telephone, mail the form and have the parent/guardian(s) sign it and return it within a specified time frame. Keep record of every additional attempt for follow through with referral made.

School Administrative Unit ________________

Student's Name ________________________

Parent Contact Acknowledgment Form

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

____on__________________________(date), concerning my child's suicidal ideation. I have been advised to seek the following services:

- Crisis Assessment
- Counseling
- Medical Services
- Other ______________________________

I understand a follow-up check by this staff person_________________________________will be made with my child, the treating agency, and myself within two weeks of this date.

Parent Signature

_________________________________Date: __________________________________

Faculty Member Signature

________________________________Date: __________________________________

Additional contacts made with parents/guardians on:

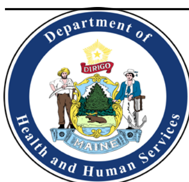
____

____

____

____

____



H. **School Intervention Flowchart**

If a weapon is present, clear the area and call 911 or local police

Suicide Intervention Protocol Chart
For Schools
A student has displayed risk for suicide

Take immediate action; notify a building administrator/designee

Warning signs

Gatekeeper conducts basic assessment, if in doubt, call Crisis:

1-888-568-1112

Low Risk

No plan, no intention to harm self

→ Fill out risk referral form, develop safety plan

→ Forward form to student's guidance counselor or social worker on the same day of the incident and relay information to the necessary staff

Medium to High Risk

(Self-harming behavior, threats, ideation, plan, history of attempt)

→ Consult with crisis services

Notify parents or guardians

Follow crisis recommendations

→ Document actions taken

Debrief with staff

Follow up with parents/guardians

Attempt

On-site

→ Clear the area of other students,

DO NOT LEAVE THE STUDENT ALONE

→ Render first-aid
Life threatening?

- YES → Call 911, & family
- NO → Call crisis 1-888-568-1112 & parents

→ Disposition determined after crisis assessment

Off-site

→ Monitor other at-risk students, provide support

→ Contact parents to set up reentry meeting

→ Document actions taken

Protocol for Suicide Prevention, Intervention, and Postvention:
A Toolkit for Maine Schools

I. School Postvention Flowchart

School Suicide Postvention Protocol Chart
Maine Suicide Prevention Program, 2014

Suicide on site

Immediately contact police (911) and top administration
Secure the area
- Do not move the body or disturb evidence
- Keep others away
- Document names of witnesses

Administrator:
- **Convenes school crisis team**
- **Notifies family, guardian**
- **Notifies staff**

Suicide off site

Administrator:
- **Verifies information**
- **Convenes Crisis Team for planning response.**
- **Notifies staff**

Respect/protect confidentiality

Support the Staff
- Schedule time for debriefing (call local crisis agency, consider using a crisis debriefing team), identify most affected staff
- Review postvention protocols and how to deal with students
- Provide information on counseling services
- Give time off / secure substitutes as needed
- Continue to check in, offer support and debrief and evaluate

Notify and Support Other Students
- In small groups, briefly state relevant publicly known facts, allow questions, discussion, preserving privacy.
- Identify and monitor those who may be particularly vulnerable
- Review self-care skills and help-seeking behavior
- Review school resources for support
- Carefully plan appropriate memorialization
- Continue to check in and support affected youth

Direct media or outside inquiries to top administrator(s)

Document Actions Taken

Communicate with all families
- Briefly state relevant publically known facts
- Provide information on memorial service
- Provide fact sheets on grief and local resources for additional help
- Provide information on the school's response and policies

Contact with Family
- Administrator/designee contacts family and arranges for meeting
- Continue to monitor and provide support for all affected

NAMI Maine
National Alliance on Mental Illness