



Azusa Unified School District

564 S. Citrus Ave. Azusa, CA 91702

626.967.6211

SUICIDAL RISK/IDEATION PROCEDURES

- 1) Report is made to principal, assistant principal, school counselor or school psychologist, or administrative designee
- 2) Administrator or staff member maintains student under observation at all times until information is gathered and an assessment has been conducted
- 3) Two to three crisis team members are identified and collaborate throughout the process
Team members can include: Principal, Assistant Principal, Counselor, Psychologist, Administrative Designee, Teachers, or other school staff
**Elementary Schools can also contact Mental Health Specialist for support if needed.
Jamaica Murphy (ext. 4387) or Cheryl Nord (ext. 4386)
- 4) Complete Suicide Risk Assessment Checklist
 - a) Determine Risk Level using Risk Table
 - b) If Risk is Severe or Extreme, then call PMRT or 911
 - c) If Risk is Mild or Moderate, then complete Safety Plan and Release to Parent
- 5) Call parent
- 6) In collaboration decide next steps
 - a) Release to parent (Complete Release of Student Form and Authorization Release of Info)
 - b) Call 911 (Imminent danger)
 - c) Contact local law enforcement or SRO for transport (H.S.)
 - d) Call PMRT-626.258.2004
- 7) School re-entry guidelines
 - a) Schedule re-entry meeting with parent, student, and crisis team members
 - b) Hold re-entry meeting **immediately** upon students return to school
 - Obtain hospitalization discharge information
 - Develop safety plan to support the student
 - Discuss counseling service options
- 8) Documentation procedures
 - a) Crisis team member informs all student's teachers of situation
 - b) Aeries documentation- Guidance, Visitation, Note: "Student has yellow file in designated location. Contact school site administrator for more information."
 - c) Complete Progress Note and file with other documentation in yellow file



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SUICIDE RISK ASSESSMENT—CHECKLIST

Student Name: _____

Date: _____

Interviewer/Title: _____

1. PAST ATTEMPTS, CURRENT PLANS, & VIEW OF DEATH

Does the student have frequent thoughts of suicide?	Y	N
Has there been previous suicide attempts by the student?	Y	N
Has there been previous suicide attempts by significant others in the student's life?	Y	N
Does he/she have a detailed, feasible plan?	Y	N
Has the student made special arrangements such as giving away possessions?	Y	N
Does the student fantasize about suicide as a way to make others feel guilty or as a way to end their pain and unhappiness?	Y	N

2. REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? (i.e. gross disturbances in daily functioning, currently experiencing hallucinations overwhelmed with hopelessness, sadness and feelings of helplessness)	Y	N
Have there been major changes in recent behavior along with negative feelings/thoughts? (**Negative thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and/or inwardly directed anger)	Y	N
Has the student experiences sexual or physical or substance abuse?	Y	N

3. PSYCHOSOCIAL SUPPORT

Is there a lack of resources and significant others available to provide support to the student?	Y	N
Does the student feel alienated from significant others?	Y	N

4. HISTORY OF RISK TAKING BEHAVIOR

Does the student take life-threatening risks?	Y	N
Does the student display poor impulse control that can result in serious injury?	Y	N

**Use this checklist as an exploratory guide with students about who you are concerned. Each Yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts can be a sufficient reason for action. High risk also associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time and a location where it unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about critical, recent loss.



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Levels of Suicide Risk Table *(Bryan & Rudd, 2003)*

1. NONEXISTENT	<input type="checkbox"/> No identifiable suicide ideation
2. MILD or LOW	<input type="checkbox"/> Suicidal ideation of limited frequency <input type="checkbox"/> No plans <input type="checkbox"/> No intent (degree to which the student has planned suicide behavior) <input type="checkbox"/> Few risks <input type="checkbox"/> Good self-control <input type="checkbox"/> Presence of protective factors
3. MODERATE	<input type="checkbox"/> Frequent suicidal ideation with limited intensity and duration <input type="checkbox"/> Some plans, not specific <input type="checkbox"/> No intent <input type="checkbox"/> Some risk factors <input type="checkbox"/> History or previous suicide threat/attempt
4. SEVERE	<input type="checkbox"/> Frequent suicidal ideation <input type="checkbox"/> Intense suicidal ideation <input type="checkbox"/> Enduring suicidal ideation <input type="checkbox"/> Specific plans <input type="checkbox"/> Some intent or method (call PMRT)
5. EXTREME	<input type="checkbox"/> Frequent suicidal ideation <input type="checkbox"/> Intense suicidal ideation <input type="checkbox"/> Enduring suicidal ideation <input type="checkbox"/> Specific/concrete plans <input type="checkbox"/> Clear intent or method <input type="checkbox"/> Limited self-control <input type="checkbox"/> Severe depression symptoms <input type="checkbox"/> Sense of hopelessness <input type="checkbox"/> Reports writing suicide note <input type="checkbox"/> Many risk factors <input type="checkbox"/> No protective factors <input type="checkbox"/> Low level of rescue & reversibility of plan (call PMRT)

SAFETY PLAN

I, _____, agree that I will not attempt to cause harm to others or myself.

I promise to not to verbally or physically abuse others.

I will express my feelings and needs with words and in a respectful way.

When I am upset, frustrated, angry, or sad, I will do the following (choose)

- Take space in a calm and relaxing place
- Talk to a trusted person
- Listen to music
- Write in a diary
- Take deep breaths
- Read something positive
- Other: _____

If I am ever having thoughts of hurting myself or others I will contact the following people:

- 1.
- 2.
- 3.

I will call **911 immediately** if I feel that I could hurt myself or others. My family will also contact 911 if I become aggressive or threatening.

My address is: _____

If I need additional support, I can call the following numbers:

TeenLine Hotline Help Center	1-714-639-8336
TeenAdviceOnline	1-877-968-8454
USA National Hotline	1-800-273-8255
Aurora Charter Oak Hospital	626-966-1632 Support Groups 800-654-2673
National Suicide Prevention Lifeline	1-800-273-8255
Suicide Hotline	1-800-SUICIDE (1800-784-2433)
PMRT- DMH mobile assessment unit	1-626-258-2004 OR 1-626-258-2005

I agree to the above mentioned contract to ensure the safety of myself and others.

Signed _____

Date: _____

Signed _____

Date: _____

Signed _____

Date: _____

My family supports this safety plan:

Family Member: _____ Date: _____



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Release of Student to Parent/Guardian

Student Name: _____

DOB: _____

School: _____

Grade: _____

I have been notified that my child has been expressing suicidal thoughts. School staff members are concerned and want to support my child and I understand that I have a part in keeping my child safe. In collaboration with school personnel, I have agreed to take the following steps:

- Provide supervision for my child at all times and to safety proof my home.
I will not allow my child to be left alone at this time or allow them access to drugs or medication.
- I should immediately take my child to a hospital to be evaluated.
- Contact professionals that can assist me and my child with counseling services.
I have received a list of mental health resources from the school staff.
- I will share with the school the names of other professionals helping my child.
If the student is currently receiving counseling services, have parent/guardian sign the *Authorization for Use/Disclosure of Information form* so the school staff and other professionals may share information to benefit the student.
- In case of emergency, I should:
 - 1) Call 911
 - 2) Call the Crisis Hot Line at 1-877-7Crisis/PMRT 626-258-2004
 - 3) Take my child to a hospital emergency room.

If student is hospitalized or seen by a therapist, documentation will be provided stating that student has been cleared to return to a school setting.

Parent Signature

Date

School Staff Signature

Date



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546 South Citrus Avenue . P.O. Box 500 . Azusa, CA 91702-0500

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable information as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

PATIENT/STUDENT NAME _____
Last First Middle Date of Birth

I, the undersigned, authorize the Release Exchange Request

RECORDS/INFORMATION FROM:

SEND RECORDS/INFORMATION TO:

Person/Agency: _____

Person/Agency: _____

Address: _____

Address: _____

City/State/Zip: _____

City/State/Zip: _____

Telephone #: _____

Telephone #: _____

FAX#: _____

FAX#: _____

- Psychiatric/Mental Health Records/ Information (CA W & I Code Section 5328)
- Diagnosis
- Medication Records
- Discharge Summary
- Medical Records (Civil Code 56.10, Title 17)
- Lab Results Specify: _____
- Alcohol/Substance Abuse Treatment Records/Information (Section 42, CFR, Part 2) - Cannot be combined w/ any other categories
- DCFS Records (please specify): _____
- School Records (i. e., academics, attendance, immunizations. IEP, 504, etc.)
- Psychological/DIS Test Results

Duration:

This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature if no date is entered.

Revocation:

I understand that I have the right to revoke this authorization in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization.

Re-disclosure:

I understand that the requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent educational record. The information will be shared with individuals working at or with the School District for the purpose of providing a safe, appropriate, and least restrictive educational setting and school health services program.

Health Information:

I understand that authorizing the disclosure of health information is voluntary and I have the right to receive a copy of the authorization. Signing this authorization may be required in order for this student to obtain appropriate services in the educational setting.

A copy of this authorization is as valid as an original.

Approval:

Printed Name	Signature	Relationship to Patient/ Student	Date
Address	City Zip Code	() Phone Number	Copy Received (Initials)



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AUTORIZACIÓN PARA EL USO O DIVULGACIÓN DE INFORMACIÓN

Al completar este documento autoriza la divulgación y/o uso de información personal identificable como se establece a continuación, de acuerdo con la ley de California y la ley Federal relativo a la privacidad de dicha información. El no proporcionar toda la información solicitada puede invalidar esta autorización.

NOMBRE DEL ESTUDIANTE O PACIENTE _____

Apellido Nombre Segundo Nombre Fecha de Nacimiento

Yo, la persona que firma, autorizo La Liberación Intercambio Solicitud

ARCHIVOS E INFORMACIÓN DE:

ENVÍE LOS ARCHIVOS E INFORMACIÓN A:

Persona/Agencia: _____

Persona/Agencia: _____

Dirección: _____

Dirección: _____

Ciudad/Estado/Zona Postal: _____

Ciudad/Estado/Zona Postal: _____

No. de teléfono: _____

No. de teléfono: _____

FAX#: _____

FAX#: _____

- Psiquiátrico/Récords de Salud Mental / Información (CA W & I Código Sección 5328)
- Diagnóstico
- Registro de medicamentos
- Registro fecha dado de alta
- Registros Médicos (Código Civil 56.10, Título 17)
- Resultados del Laboratorio - Especificar: _____
- Alcohol / Registro del tratamiento por abuso de sustancias (Sección 42, CFR, Parte 2) – No se puede combinar con cualquier otra categoría
- Registros de DCFS (Por favor especifique): _____
- Registros Escolares (por ejemplo: académico, asistencia, vacunas, IEP, 504, etc.)
- Resultados de las pruebas psicológicas /DIS

Duración:

Esta autorización entrará en vigor de inmediato y permanecerá vigente hasta _____ o por un año desde la fecha de la firma si no especifica la fecha de vigencia.

Revocación:

Yo entiendo que tengo el derecho de revocar esta autorización por escrito, en cualquier momento mediante el envío de dicha notificación por escrito a la agencia de liberación. La revocación por escrito entrará en vigor al momento de recibirla, pero no se aplicará a la información que ha sido ya dada en respuesta a esta autorización.

Nueva divulgación:

Yo entiendo que el solicitante (Distrito Escolar) protegerá esta información según lo prescrito por la Ley de Protección de la Familia de Igualdad de Derechos (FERPA, por sus siglas en inglés) y que la información se convierte en parte del registro educativo permanente del estudiante. La información será compartida con las personas que trabajan en o con el Distrito Escolar, con el fin de proporcionar un ambiente educativo seguro, apropiado, menos restrictivo y el programa de servicios de salud escolar.

Información sobre la salud:

Entiendo que el autorizar la divulgación de información de salud es voluntaria y tengo el derecho de recibir una copia de la autorización. La firma de esta autorización puede ser requerida para que este estudiante obtenga los servicios adecuados relacionados con el ámbito de la educación.

Una copia de esta autorización es tan válida como la original.

Aprobación:

Nombre (escriba con letra de imprenta)

Firma

Relación al paciente / estudiante

Fecha

Dirección

Ciudad

Zona Postal

() Número de teléfono

Copia recibida (Iniciales)

Education - the Torch that Lights the Path of Knowledge

SUICIDE INTERVENTION AND ADVICE FOR PARENTS/GUARDIANS

- Be patient, show love, and seek help for your child with no strings attached
—Show you care —Listen carefully —Be genuine
“I’m concerned about you...about how you feel. I love you.”
- Take all threats and gestures seriously
- Keep communication open
- Closely supervise your child
- Remove all weapons, sharp objects, medications, and other lethal means
- Seek professional mental health assistance (see referral list, consult with your medical insurance carrier for referrals)
- Notify school staff of any changes as well as concerns you have
- Do not be afraid to ask school staff questions and get their assistance. They are there to help you and your child
- Take care of yourself and seek support

WARNING SIGNS OF SUICIDE

- Verbal references to suicide
- Giving away treasured possessions
- Withdrawal from friends
- Dramatic changes in attendance
- Declining academic performances/failure to complete work
- Frequent talk or writing about death/despair
- Mood swings
- Dramatic changes in personality/appearance
- Increased use of drugs and/or alcohol

How to Support Youth

Avoid	Do
Giving a lot of advise	Learn about the student and their crisis and personal need
Arguing over trivial matters	Be absolutely genuine and truthful
Making moralistic statements about the student in crisis	Encourage talking about feelings and about themselves
Minimizing the crisis situations	Demonstrate respect by being attentive
Discouraging or time-limiting the assessment process	Expect that your presence may be important while talking may be limited (“Silence is Golden”)
	Ongoing monitoring of student
	Listen, no matter what!
	Help identify others to talk to
	Believe in healing and growth

(Adapted from Main Youth Suicide Prevention School Personnel Resources Guide, 2002)

Mental Health Resources

Suicide Prevention Center Hotline

1-877-7-CRISIS or 1-877-727-4747

National Suicide Prevention Lifeline

1-800-273-TALK or 1-800-273-8255

Trevor Lifeline - LGBTQ

1-866-488-7386

Teen Line

1-800-TLC-TEEN or 1-800-852-8336

Toll free in CA only. 6 pm - 10 pm PT

Community Resources

Aurora Charter Oak Hospital (Psychiatric Emergencies)

HOTLINE # 1-800-654-2673

1161 E. Covina Blvd.

Covina, CA

626-966-1632

BHC Alhambra Hospital (County Mental Health)

4619 N. Rosemead Blvd.

Rosemead, CA

1-800-235-5570

Pacific Clinics Sierra Family Center

1160 S. Grand Ave.

Glendora, CA

626-335-5980

APU Community Counseling Center

918 E. Alostia Ave.

Azusa, CA

626-815-5421

Foothill Family Services

1720 W. Cameron Ave. Ste 100

West Covina, CA

626-338-9200

Los Angeles County Youth Suicide Prevention Project
preventsuicide.lacoe.edu

PSYCHIATRIC MOBILE RESPONSE TEAM
626-258-2004



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Re-Entry Guidelines

1. Have parent escort the student back to school the first morning following hospitalization and conduct re-entry meeting

2. Collaborate with members of the crisis team

3. Obtain any records from the doctor or hospital (discharge paperwork, diagnosis, medication, etc.) and have parent sign a release of information form

4. Develop safety plan and interventions to support the student:
 - Modify academic programming as appropriate
 - Identify on-going counseling resources at school or in the community
 - Notify student's teachers- emphasizing confidentiality
 - Identify personnel available to support the student at school and at home
 - Monitor the student with frequent check-ins during the first two weeks and as needed

5. Ensure that all appropriate documentation has been completed

Suicidal Risk Progress Note

Student's Name

DOB

Date

Statements made by student

Actions Taken

Staff Reporting- Print Name

Signature

Date

Disposition

- No risk determined, caregiver made aware of situation
- Released to caregiver
- PMRT called, student **NOT** hospitalized
- PMRT called, student hospitalized

******This form is to be filed in the designated yellow folder at your school site.**

SUICIDE INTERVENTION AND ADVICE FOR SCHOOL STAFF ONLY

Suicide Intervention DOs and DON'Ts	
DO	DON'T
<ul style="list-style-type: none"> ✓ Talk openly ✓ Show you care and that student is not alone ✓ Ask direct questions ✓ Stay calm ✓ Proceed slowly ✓ Be positive ✓ Know your limits ✓ Consult with colleague ✓ Clarify permanence of death ✓ Emphasize alternatives ✓ Take care of yourself and process/debrief event 	<ul style="list-style-type: none"> ▪ Be shocked ▪ Encourage guilt ▪ Try to physically take away a weapon ▪ Promise total confidentiality ▪ Minimize the problem ▪ Leave student alone ▪ Get overwhelmed ▪ Argue against suicide ▪ Give up hope ▪ Take responsibility for student's life

(Adapted from Main Youth Suicide Prevention School Personnel Resources Guide, 2002)

SUICIDE INTERVENTION AND ADVICE FOR SCHOOL STAFF ONLY

School/Community Risk Factors:

- Exposure to recent suicide in community
- Truancy
- Disciplinary actions (suspensions, expulsion)
- Low scores on achievement tests & perceived failure with pressure to succeed
- Peer rejection or victimization
- Loss of close relationship (e.g. boyfriend or girlfriend)

Family Risk Factors:

- Child sexual abuse
- Use of extreme physical punishment
- Lower family SES
- Changes of parent/family (e.g. divorce, remarriage, recent death of loved one)
- Poor parent-child attachment
- Parent alcohol problems/drug use
- Low parental monitoring
- Family history of suicide or suicide attempt

PROTECTIVE FACTORS

Protective factors are the positive conditions, personal and social resources that promote resilience and reduce the probability for youth suicide as well as other high-risk behaviors. (Bryan & Rudd, 2003)

- Presence of social support
- Problem solving skills and history of coping skills
- Active participation in treatment
- Presence of hopefulness
- Religious commitment
- Fear of suicide or death
- Fear of social disapproval
- Life satisfaction
- Intact reality testing
- Children, pets