Suicide Prevention Across the Educational Continuum Series
Part 1: Suicide Assessment and Response for K12 Populations

Video Transcript:

>> Welcome to today's presentation, Suicide Prevention Across the Educational Continuum. If we could go to the next slide please. Thank you.

>> So this disclaimer notes that the work of the Mountain Plains Mental Health Technology Transfer Center and Mountain Plains Prevention Technology Transfer Center is supported by SAMHSA as well as DHHS. We would like to note that today's presentation is provided free of charge and all of this information is available in the public domain. Also the information presented today are the views and the opinions of Erin Briley and do not reflect the official position of DHHS or SAMHSA. If you have any questions about this information please feel free to contact us. And, let's go to the next slide please. Thank you.

>> So it's my pleasure to introduce our presenter today. Miss Erin Briley is a nationally certified school Psychologist. She recently began working for WICHE's Behavioral Health Program as a Research and Technical Assistant Associate. She earned her Bachelor's Degree in Human Development and Family Studies at Colorado State University, her Master's Degree in Counseling and School Psychology, as well as a Certificate in Applied Behavioral Analysis at California State University Los Angeles. She's also working on her PhD in Clinical Psychology. Miss Briley's work with the WICHE Behavioral Health Program includes a variety of behavioral health projects. But, her primary role is currently assisting in the creation and implementation of psychology internship consortiums in rural western states as well as involvement with school behavioral health projects. Prior to coming to WICHE, Miss Briley worked for about 20 years in schools serving primarily as a school psychologist in school districts in California, Hawaii, and Colorado where she provided direct care and then direct supports for children ages 2 through 22 of all developmental levels. While in Hawaii, Miss Briley also served, temporarily, as a Special Education Administrator and as a Program Manager for the school based Behavioral Health Program for Hawaii's Department of Education. She also trained and supervised professionals providing individualized supports to children with special needs.

>> I'll need turn things over to Erin Briley for our presentation today. And, thank you so much for joining us.

>> Hi good morning. Thank you for joining us today. Before we get started, I just want to let you know that in no way does this replace Advanced Training in Suicide Response and Risk Assessment. If anything, I you are one of the lucky few that does have to respond to potentially suicidal youth, I do highly recommend advanced training. I've

done it myself, and it results in a lot more confidence and skill sets to approaching youth with this sort of difficulty. I did provide some resources at the end of the training for that sort of thing.

>> In order to get started, I think, it's really important to clarify the differences. And, I'm sure many of you already know this. And, I apologize if I'm sort of going back to the basics. The difference between suicide, suicide attempt, and suicide ideation. Now, suicide results in actual death via self-directed injurious behavior. So there is an intent to die. It is not, it is not an unintentional death. Okay? So it is, there's definitely an attempt there. A suicide attempt is a nonfatal self-directed injurious behavior. There's an intent to die. But, it was a nonfatal attempt. Suicidal ideation is when people have thoughts of suicide. They might think that, you know, I wish I were dead. I wish I weren't alive anymore. But, it may or may not include a plan of action.

>> Looking at some statistics, it is really important to understand how serious this problem is with the youth of our nation. So 17% of high schoolers have reported seriously considering suicide in 2017. And, those rates increase significantly for other populations such as those that are LGBTQ and other ethnic groups. So you can see those with LGBTQ, the rates actually jump to 47.7%. That is huge. Suicide is, ranges the 10th leading causes of death in 2017 for all age ranges. But, for youth age 10 to 24 is the second leading cause of death. Okay. So that's pretty extreme. In 2017, suicide nearly tripled for youth age 10 to 14, increased 76% for ages 15 through 19, and increased 36% for ages 20 through 24 as compared to 2007. So the rates are increasing for suicide. For those that are American Indian or Alaska Native youth, ages 15 to 34 suicide rates are 1.5 times that of the national average. And, rates for males is nearly 3 times as high as compared to females ages 15 to 19.

>> I just wanted to give you a little bit of the visuals so you could understand the severity or the frequency rate of those who have committed suicide for our youth ages 5 through 21. And, you can see that it is really elevated for our centralized states here.

>> So let's just move on to risk factors. What are risk factors? Risk factors are characteristics associated with increased risk. And, risk does increase with multiple factors. Just because you have a risk factor does not mean that you are suicidal. But, the more risk factors you have, the more we want to kind of keep an eye on things. Okay? So some of the things we want to look at are. Have there been previous attempts? Does the child engage in non-suicidal self-injury such as cutting? And, I want to make a little note that just because you cut does not make you suicidal. But, if you have suicidal ideation and you cut at the same time, it's going to elevate our concerns. Is there a history of mental illness, hopelessness, or low self-esteem? Is a child impulsive or have risk taking tendencies? That's a huge concern right there. We'll get into that in a little bit. Is there poor problem solving or coping skills? Does a child have low stress and frustration tolerance? Is there social alienation or isolation or nonconforming? Essentially, if a child feels a sense of connectedness, it's a really, it's a great protective factor. But, if they feel they don't fit in, it can be a big concern. Okay? Other risky behaviors include alcohol or drug use, delinquency, aggressive or violent behavior, risky sexual behavior, exposure to suicidal behavior of others via media or other. You know, with our media, it's really out there. And, there are some communities

where there is a higher suicidal rate than other communities. So that's always a concern if you have a high suicide rate in your community. Family characteristics we want to consider include a family history of suicide, parental mental health problems, family stress and dysfunction. Experiencing stressful life event or a loss or a situational crisis. One thing in there that adults sometimes don't tend to take seriously are breakups. Breakups are catastrophic for our adolescents. It's a big deal. So you never want to brush off a breakup, tell them there's other fish in the sea. You really want to be compassionate to their experience that they're having. And, of course, other types of stressors include abuse, divorce, deaths of loved ones, and the list can go on and on.

>> Environmental factors that we want to consider include, once again, exposure to suicidal behaviors of others, a negative social and emotional environment at school. And, that goes back to really wanting to promote school connectedness is always a good thing to have. Expression and acts of hostility, lack of respect and fair treatment, limitations in school physical environments including lack of safety and security, access to lethal means, and exposure to stigma and discrimination. And, once again, that goes back to feeling as if one doesn't conform to their, you know, to their immediate surroundings.

>> I wanted to also talk about signs of depression in young children as well as youth. Because, sometimes they're manifested differently than adults. And, it's important for us to be attentive to signs of depression in our youth. Some of the things that we're looking for in young children include intense irritability and frequent tantruming. Often talking about fears or worries. Somatic complaints, somatic complaints meaning complaining about stomach aches or headaches or things of that nature that have no medical cause. Being very active except when watching TV or playing video games. Sleeping too much or too little, having frequent nightmares or seems sleepy during the day. No interest in playing with others or they have difficulty making friends. Struggling academically or having a recent decline in their grades. Repeating actions or checking things many times out of fear that something bad might happen.

>> Now, when we're looking at our older children and teenagers, some of the things we want to look at when we're considering signs of depression include: Loss of interest in things they used to enjoy. That's a big one. Sleeping too much or too little or seeming sleepy throughout the day, having low energy. Increased isolation, avoiding social activities. A fear of gaining weight or dieting or exercising excessively. Self-harm behaviors such as cutting or burning their skin, things of that nature. Riskier destructive behaviors including substance use. Periods of higher elevated energy or activity or requiring much less sleep than previously. Or sometimes we have youth that think that someone is trying to control their minds or they hear things that others cannot here. So those are, those can all be signs of depression in our older youth.

>> Besides looking at risk factors, the other thing we want to consider are warning signs. Now warning signs are observable behaviors that signal suicidal thinking. So when we see warning signs it's, we're going to, our concern is going to elevate. Okay? When we're looking at warning signs, these are going to be changes in behaviors, feelings, and beliefs about oneself. We, they generally last about two or more weeks. But, they can occur impulsively. So there is no hard and set rule which is what makes

this difficult. Right? Because sometimes we have to fly off the seat of our pants when making decisions. Some of the warning signs include anxiety, agitation, dramatic mood changes, reckless or engaging in risky activities, unable to sleep or sleeping all the time, increased alcohol or drug use, withdraw from friends, family, and society. Feeling trapped like there's no way out, rage, uncontrollable behavior and seeking revenge.

>> Now, warnings become acute, meaning we want to act immediately, when these three things are present. Threatening to hurt or kill themselves or talking about wanting to die. Looking for ways to kill themselves by seeking access to lethal means. Talking or writing about death, dying, or suicide. So at that point we want to find out if there's a detailed plan for the, for the potential attempt. How are they planning to do it? Where are they planning to do it? When are they planning to do it. The other thing I want to add in here, sometimes, with the younger kids that I've worked with or children who are developmentally disabled, I see a lot of artwork related to this. One thing that I found, however, is that children who play a lot of violent video games or watch a lot of violent media tend to produce a lot of violent themed artwork as well. So sometimes you need to kind of discriminate between the two. But, I have seen artwork as a potential warning sign for suicide as well. One note, if you see a kid or actually anybody, and they sudden, they have a sudden improvement after a period of being very sad or withdrawn, that could be a warning sign as well. Because, there could've been a decision been made, been made to escape their problems by ending their life. The thought of that alone releases a lot o that anxiety causing them to have a sudden improvement in behavior. So that is one thing we don't want to discount.

>> Other warning signs for youth specifically. So the warning signs we talked about before are warning signs in general for everybody. This is for youth. Talking about or making plans for suicide. Being hopeless about the future, hopelessness is a huge sign, a very big predictor of suicide. Having severe or overwhelming emotional pain or distress or exhibiting worrisome behavioral cues or marked behavioral change. For example, there's been withdraw or changes in social connections. There's changes in sleep. They're either sleeping too much or they have insomnia or they're not sleeping enough. They have anger that seems out of their character or out of context. Levels of agitation irritability have increased recently. Those are all things that are going to spark a concern for youth.

>> The other thing that increases the risk for suicide is when warning signs are new and or increased, and possibly related to an anticipated or actual painful event, loss, or change.

>> Now, protective factors are great. Protective factors don't necessarily shield a child from risk if they're already actively suicidal. But, they can help us with safety planning. Some of the individual characteristics we'd want to consider are the child's emotional well being and emotional intelligence. Are they adaptable and flexible to changes? Are they resilient? Do they have internal control over their environment? Or, do they point the finger at external controls? Do they have strong problem solving and coping and conflict resolution skills? Do they engage in frequent and vigorous exercise or do they participate in sports? Do they have a connection to spiritual faith? Cultural beliefs that affirm life? Do they have a health frustration tolerance and emotional regulation? We

want to consider, do they have a positive body image, care of their body, protecting themselves?

>> Some of the social supports that are considered to be protective factors would be connections. We talked about connections a little bit. Connectedness is absolutely huge. We want children to feel they have supportive bonds not only with their family and caring adults and their peers but also with their school environment as well. Is there parental involvement? Is there peer involvement? Do parents have prosocial norms as their family supports the school?

>> In terms of school supports, we want to make sure that there are positive school environments. Is the climate safe and respectful? That's one of the first things we want to do with our schools is making sure that the overall climate is safe. We want our children to feel that they're self in their schools and that it's a respectful place to be despite maybe not being nonconforming with the typical climate or the typical community. The other thing is we want to make sure that the children have adequate or better improved academic achievement. And, once again, connectedness. It's really all about relationships, about being connected. They want to be part of the school community. We do want to consider a child's internal resources. We want to look at their ability to cope with stress, religious beliefs, and frustration tolerance. The other thing we want to, want to look at is their external factors. We want to look at their responsibility to others, their positive therapeutic relationships, and their social supports. So you can see here that relationships and social supports and connectedness plays a very, very, very big role in attending to youth and supporting them.

>> Now, research does show that a brief screening tool can identify individuals at risk for suicide more reliable lead and a lead in identification of the clinician's personal judgment over asking about suicidal thoughts using big or soft in language. So we're going to talk about being specific in a little bit. I was very uncomfortable doing that at first too. But, it's changed my life as a school psychologist in being able to identify kids a lot more readily once I started being very, a lot more specific. We'll talk about that more.

>> Now what's a screener, what's a suicide assessment? I worked in the schools, you know, my whole professional life until now. A screener is a, it can be a protocol it doesn't always have to be standardized. But, it can be a standardized instrument or protocol to identify suicide risk. We can do it universally meaning it can be done with all students in the school, or selectively. So let's say a teacher comes up to you, hey I have a concern about so and so. I'm their art teacher. There's a lot of dark themes, they're moody, they're not, you know, socializing with the other peers. And, at that point I'm going to pull the child out and do a screening. Right? So we're going to do a screening when a child either informs us of an attempt, plot, or plan. Or if we learn of an attempt through a peer or staff member. Or simply because we believe to student to be at risk ourselves. Now suicidal assessment is a comprehensive eval done by a clinician to confirm the risk. And, at that point, not only are they confirming risk, they're estimating immediate danger and they're determining the course of treatment. So in the schools, my job was primarily doing the suicidal screening. I may have gone a little bit into estimating immediate danger. But, I was lucky enough to have some mobile crisis units

that'll come in to do an additional assessment on top of the screener that I just performed.

>> In terms of basic guidelines, always, always, always refer to your school's crisis protocol. If you don't know your crisis protocol, find out what it is. Okay? So if you are, I'm not sure the, who exactly is attending. I'm sure we have people who are responders and have been trained to be responders. I'm sure we have people here who are simply trying to acquire more skills to figure out when to refer out. You always want to refer if you have a child with a concern refer them out to somebody who's been trained to recognize and respond to this. People in your school that might fall into this role could include school counselors, behavior health specialist, school psychologist, school based clinical psychologist, and school social workers. If you are unable to locate that person, so if you're not this person, you are unable to locate this person, we do want to alert administration and determine that a crisis team needs to be called to assess for eminence. And, if that is true, we want to alert the parents. In emergencies, we want to alert administration, call 911 and the parents. Only, by the way, I've only had to call 911 maybe two times. We do want to insure school staff are aware of the referral response protocol and basic guidelines. Now my recommendation would be that your office staff is aware of response protocol. Sometimes there's situations when all behavioral health staff at the school are away for training for example, this has happened before. And, a student is presenting with suicide ideation and they require a screening. And, people need to know who to go to, what to do. So your administrators need to know what the protocol is and your office staff need, definitely need to know what the protocol is. And, I would recommend that your teachers know what the protocol is. At least know who to refer to, at least knowing what that first step is.

>> When we are doing a risk assessment, the things that we want to do is, first of all, we want to identify the risk factors. We want to pay attention to the things that can be reduced and definitely explore if there's been past attempts of suicide or if there's a family history. Next, what we want to do is we kind of want to identify and mobilize protective factors. Is there anything that can stop them? Consider pets too. Pets is one thing that we don't often concern. Do you have a dog in your life that you're crazy about? Let's talk more about that dog. Oh you have a baby brother that you take care of a lot and you think is really adorable and you spend a lot of time about. Let's talk about your baby brother. We want to kind of bring them back to things that bring them some joy.

>> In terms of the suicidal inquiry, the things that we want to look at, number one, is ideation. So if you guys remember, ideation are thoughts of suicide. It may or may not mean that the student has a plan. We don't know. So we want to find out how long they've been thinking about suicide. How frequently? How intense? Of course we want to make sure we are developmentally appropriate when you're asking these questions. Some of the prompt questions we can say is are you thinking of suicide? Have you thought about suicide in the last two months? Have you ever attempted to kill yourself? Notice I'm being very specific about my language. I am not using a vague terminology like are you thinking of hurting yourself. Because some youth or some people either are about, they didn't technically ask me if I'm going to, you know, I'm thinking about killing

myself. So I'm going to say no because technically speaking, that's not true. The moment I became very specific in my questioning, the moment that I started asking students, when I started noticing incongruencies, right, between what they're telling me in their facial affects. Hey, you know, I'm really concerned here. You're mentioning this and that. It sounds like it's a lot to be dealing with this right now. I have to ask. Have you ever thought about killing yourself? Yes. Yes I have. Wow that's really tough. When was the last time you thought that? This morning. Last week. Three days ago. These are questions that I never would have asked early in my career because I was trained that we don't ask unless we have specifics. Now I know it's very important to be specific about your terminology. So it is okay to say suicide. It is okay to ask if they're planning to kill themselves. It's uncomfortable, but it's necessary to be specific.

>> The other thing we want to talk about, so we've already talked about ideation. So if we find out about ideation, okay, so they've had thoughts of killing themselves. Is there a plan? Have they talked about or have they considered how they intend to do it if they could? So you want to get specifics. Okay. Oh wow so you, you thought about killing yourself last week. That's rough. Did you think about how you would do it if you could? The next thing we want to ask about is access. Do they have the means to carryout with the plan? Oh so you thought about you would take, you would overdose. Okay. You know, is there, is there any sort of medication that you thought that you would use? Well is there any of that in the home? That sort of thing. I had a student, for example, tell me yeah I thought about killing myself. I thought about it this morning. Wow. So have you thought about how you would do it? Well yeah. I actually walked in front of a car and they swerved around me. Okay. There you, I've hit the plan, I've hit the access. And, they actually told me about their intent which was pretty eminent. The next thing after the access is we're going to talk about have they made plans to follow through with their plan? Yes, I thought about OD'ing, yes I have access to that medication, and yes I plan, I plan to make it happen. I plan to make it happen. If it is eminent, meaning forthcoming, it's happening very soon, you should within the next 24, 48 hours you want to obtain immediate assistance or emergency response. And, typically, we send those students to the ER. Ok We can't let them, those are the students that we can't leave alone. And, the one thing I want to comfort people with is asking about intent to kill oneself is not correlated with suicidality. They have actually done some research related to that and there is no correlation. So I don't want you to think well I'm uncomfortable asking that because if I ask that I'm going to plant the thought in your head. You don't have to worry about that. It is more important for you to be direct.

>> After we determine eminency, we want to determine the risk level and if the person's team should be contacted. And, of course we want to document all our steps. And, yes this is for legality, definitely for legality. But also to make sure that we followed our protocol.

>> So let's talk about levels of risk. In order to be, we're going to be, first of all, talking about high levels of risk, moderate levels of risk, and low levels of risk. And, when we're looking at high levels of risk, some of the risk protective factors we're looking at are does the youth have psychiatric disorder with severe symptoms or acute precipitating events? Protective factors really aren't relevant at this state. You know, they can have

all the protective factors in the world. But, if they're at high level of risk, we're going to go ahead and act immediately. In terms of suicidality, there really is potential for a lethal suicide attempt or persistent ideation with strong attempt or suicide rehearsal. At this point we really do want to contact the crisis team. So you do, it is helpful for you guys to know who is on your crisis team. The, all the districts that I worked in, in California, Hawaii, and Colorado we did have mobile crisis teams that were, I believe, employed by Department of Health. We'd contact them, they'd come right in, they'd do the assessment. So our protocol was nice and clean, we knew exactly what we had to do. I understand that some districts don't have an outside crisis team. But, sometimes they have established a district level crisis team. If you do not have a crisis team, I would talk to your department head and admin about potentially establishing one.

>> When we're looking at moderate levels of risk, we're, these type of kids usually have multiple risk factors and very few protective factors. And, usually there is suicide ideation with a plan, but there's no intent. Meaning, yeah, you know, life sucks. I wish I was dead. I thought about that if I were to commit suicide, this is how I'd do it. But, no, no ways, I wouldn't go through with it, there's no way I could leave my little brother or I just couldn't do that to anybody. That doesn't mean that we're not going to be concerned about this student. We're still going to develop a safety plan for them. But, we know that their suicidality is not eminent. They're moderate level of risk. Some of the interventions that we might want to do is we may have to contact the crisis team. That really kind of depends on the situation. There's no easy answer for that. We definitely do want to contact a crisis, develop a crisis plan and we want to provide resources.

>> Now for our low levels of risk, at this point these kids usually have modifiable risk factors and some strong protective factors. Great. But, there is ideation. These kids usually have thoughts of suicide. But there is no plan. Yeah life sucks and sometimes I wish I was dead. No I haven't thought about how I would go forth with doing that. I have, no, I just, life just really sucks sometimes. But, there's no, there's no intent to follow through and there's no plan. Some of the interventions we're going to do is provide some outpatient referrals. You want them to learn alternative positive coping skills. Right? We want to reduce their symptoms of depression or anxiety or whatever they're going, they're experiencing as well as provide resources. So no matter the level of risk, we're always providing resources, we're always developing a plan of action to help either provide coping resources or more immediate forms of intervention.

>> Now this is everything that I talked about. It's just in a little table to make it easier to access for you. So if you choose to download the presentation, you can go ahead and use this. And, when I was in the schools, this is what I would, I would use to help me figure out when to contact who and what steps to take next. So this I found very helpful to kind of have it in a little table.

>> Now, there is a problem with these levels of risk. One of the problems that some researchers talk about is hey suicidality is dynamic. There's a lot of things in a child's life that can influence the level of severity at any point in time. So you could have a child who, or I shouldn't just say child, you could have anyone who's perfectly fine at one moment and then experience something that they perceive as catastrophic or stressful. And it, and it pushes them up to the next level and you just never know. The other thing

that we want to take into consideration too is children who are impulsive. Right? We want to be very concerned with children who are impulsive. Because, let's say for example they just have ideation. But if they're impulsive and they're experiencing intense feelings of ideation and they're near a potential means, they could make a decision right then and there. So we always want to make sure that we are, we are very cautious when it comes to children who are impulsive. Other factors that should be included when we're determining severity of risk include the patient's current available and accessible resources, foreseeable changes in the future. Are there any events or stressors that might be coming up that we need to take into account that could influence their risk? And comparing their current risk state to their baseline or their worse point of state. So basically, you know, these levels of risk are extremely helpful. But, it's saying you have to be flexible when working with our kids and identifying where we think they are because it really could be fluid.

>> When we are working with our kiddos, we do want to be compassionate and show them that you care. Listen to them. Be genuine. For those of you, the majority of you that work with youth, you already know. If you are not genuine, you've lost the battle. Right? You're not going to be able to connect with them. You want to connect with them. And, they only way we connect with them is trying to build that relationship as soon as we can, as fast as we can. And, sometimes it's difficult. For example, as a school psychologist, I didn't always know these students. Sometimes my VP was walking into my room, hey Erin, this is so and so. Could you talk to them? They've been having these thoughts. And, I have to try and build a trust factor right then and there. And, that's the first step I'm going to do is be as genuine as possible and show them that I care. Ask the question. Be direct. We've talked about this already. Do not use vague terminology. I know it's uncomfortable being direct. But, really you have to become comfortable doing that. So be direct, caring, and non-confrontational. Hey, I'm really concerned, you know, you look like you're really down, I noticed these things, you know, I have to ask. Are you thinking about suicide? Are you thinking about killing yourself? And, even if they say know, you might, have you ever thought about that in the past? You want to follow up with have they ever thought about it in the past. The next thing is you don't want to leave them alone, especially for higher levels of eminence. You don't want to leave them alone. You don't want to leave them in your office as you run out to go get help from somebody else, to go consult with somebody else. If you need to consult with somebody, hopefully there's somebody that you can trust that you can have in the room with them while you go and consult with somebody else. I've actually had professionals just walk outside of the door to talk to somebody and they walked in and the child is carving their arm out with pushpins that they found in the bulletin board, scissors, had to get some scissors away from students that they found in desks. So you know, just people, people can get very resourceful when they are, have made up their mind in terms of what they wanted to do. They're very distraught, do not leave them alone.

>> Some of the things that are not helpful, when working with these kids, are we don't want to ignore them. We don't want to dismiss them. We don't want to make their feelings feel less than. Remember how I talked about the child who had a very painful breakup? They were with their first girlfriend for a week for two weeks and they're

devastated, they got dumped. We don't want to laugh that off. We know that two weeks in the life of an adult can be a disappointment. But, we're going to move on. For kids like this, we want to hear their pain, we want to care about their pain, we want to believe them. This is very real for them. This is their perception, not ours. So we want to, we really want to acknowledge them. Second, we don't want to act shocked or embarrassed. And, that is, that's hard to do sometimes. You can act caring and compassionate but you don't want to act shocked. Sometimes when you get that shocked reaction, they'll shut down. You want them to feel comfortable engaging with you and sharing with you. The other thing is you don't want to panic. You don't want to preach. You don't want to patronize. I know a lot of these things that I'm talking about I'm preaching to the choir. You all know about this. But, clearly this is in the research because people are out there doing that. Most people that I've seen are very appropriate with our kids. But, I've seen some trained people who aren't. You know? And, so let's build our skill sets and be better than before because we all have things that we can learn. Right? We don't want to challenge or debate or bargain. Because you, they're thinking irrationally. You can't bargain with somebody who's thinking irrationally. Please be careful. Do not give harmful advice. And, most of all don't promise to keep a secrete. And, this has happened to me many, many times with my youth. Please don't tell please, please, please don't tell. My mom's going to kill me. Please, please, please, please, please. Right? Now a lot of times, when someone's suicidal and they're sharing this information with you, it's because ultimately they want help easing their pain. They don't know how to go about doing it, even though they can verbally contradict it. They usually want help. But, you don't want to keep their secret. So my suggestion for those who are going to be referring out to somebody else is just say something along the lines of like look, I know sharing something like this with me must have been extremely difficult. And, I feel really honored that you trusted to share this with me. But, the truth is, is that I don't have the training to help you. I want to make sure that you're okay. So I'm going to go with you. So we can do one of two things. I can go with you to talk with somebody else and sit with you. I can sit outside the door with you or whatever it might be. But, don't promise to make that secret. If anything, it is so much more helpful to be transparent in a loving and caring way with kids than to lie and tell them you're not going to tell anybody and tell them anyway. So just be transparent with them. My, I've actually had very good luck except for one case, one case in about 20 years with being transparent. I need to tell somebody, I care about you, I need to call the crisis team. Ultimately, we just want to make sure you're okay.

>> Some of the screeners that are available include the Columbia Suicide Severity Rating Scale. And, I'm just bringing this up. I know that a lot of our schools don't always use actual screeners and they use more of a protocol. I used a protocol, just to let you know. But this screening scale is free. So that's a winner. Right? And, it's very brief. It's about four to six questions that just can help guide your response. So you can do your entire protocol and just make sure that it includes these four questions that assess for ideation severity within this last month as well as the last three months. What we're supposed to do with those questions, of course, as we always should do, is combine the results with clinical judgment to determine the risk levels and to make the clinical decisions about care. So you always want them to use your clinical judgment. Okay?

Sometimes things don't seem right. Sometimes the kids say no I'm fine, but you see all these other behaviors that are prompting you for you to be concerned. I would say heir on the side of caution at all times. The nice thing about this scale is that it can work with children who are, it has, at all age levels beginning at the age of six or developmentally disabled. Excuse me. So it's got your standard scale. And, it's got also a scale for very young children or for those who are cognitively impaired. In terms of administration requirements, any professional can administrate it, so you don't have to have a mental health background. That's the other thing that I like about this. And, it is evidence supported. So if you're looking for a screening scale, I would suggest that you consider this. I've got resources at the back of the training that will tell you where to locate this.

>> This is an example of the severity scale for, this is, for our general population, so our older youth, okay, older youth and adults. Questions are related to have you wished you were dead or wish you could go to sleep and not wake up? Have you actually had any thoughts of killing yourself? And, if the answer to that question is yes, you want to move on to the next one. Have you thought about how you would do this? Have you had these thoughts or some intent on acting upon them? Have you started to work out or work up the details of how you would kill yourself? So you can see here this screen is looking at ideation, plan of action, means, access to means, as well as eminency. Right? So it's hitting all t hose variables that we talked about before. And, the nice thing is, with the color coding, you can kind of eyeball whether they're low risk, moderate, moderate risk, or high risk. So this is really helpful for people that are just starting off in the field. Right? For people that are so very uncomfortable about how to proceed with the screening. But, I like it because it kind of standardized the procedure, the questions that we should ask.

>>Now, SAFE-T is not a standardized screener but it's more of a protocol. So it's an interview format that we use to gather information related to safety risk. The nice thing about SAFE-T is we look at ideation within the last 48 hours, past month, and worst ever. We're looking, we're assessing the plan of action including access to the means and preparatory acts. Are they rehearsing? We're looking at behaviors. So we're considering past and aborted attempts, rehearsals versus non-suicidal self-injurious behaviors, and intent. Is there eminency? Do they intend to follow through? So once again, it's hitting all those variables that we talked about that are important to hit when we're looking at a suicide screening. Another good thing about this is there's a mobile app available. So for those of you, so for example a school site, I think the most schools I've been assigned at one time are maybe six or seven schools. So you can imagine how difficult it is to move from one school to the next. And, having an app available makes things a lot easier in terms of, you know, assessing these types of things. So that's another protocol that you can research if you're looking for something a little bit more, more of a protocol to help your school and or district.

>> So let's say you have a positive screening. Ah oh, what now? Right? What now? We talked about this before. Keep them safe and don't leave them alone even for a minute. And, like I said, I've literally had people just walk outside the door kind of holding onto that door where the student's right behind them, not making eye contact with their student while they're talking, consulting with a clinical psych or whomever it might be

and the student has engaged in some very concerning problematic stuff. So we want to keep them safe. We want to make sure we restrict access to lethal means. So suicides typically occur with little planning, when experiencing a short term crisis. So if they have a backpack, we want to make sure that there's nothing, you know, concerning in that backpack for example. Do you, you know, you thought about using pills, do you have any pills with your right now? Are there pills at home? You want to assess your need to contact the crisis team available at your school district and call 911 if necessary. Like I said I've only had to call 911 one time and that was because a student ran away from me when she found out I had to call the crisis team. And, so we had to call 911 for safety. And, it was scary. But, it was necessary. The other thing we want to do is we want to make sure, you know, let's be honest, administrators, they want to know what's going on with their school. They want to know what's going on at their school. For safety sake they want to make sure their student's safe. They want make sure they know who's going be coming on campus. Is the Crisis Mobile Outreach Team coming on campus? Hey I called 911, they're on their way, FYI, that sort of thing. Let's, make sure your administrators know what's going on. Guardians need to know too. Right? We have a, we have a due diligence to let guardians know if their child is planning on hurting themselves. Not only that, but we want to include them, we're going to talk about this later, we want to include them in safety planning so that we all can be on the same page. We want to make sure that our students and their families are provided resources. So we want to provide them emergency resources such as access to the National Suicide Prevention line and local crisis resources. We also want to provide them with resource for local behavioral health resources and peer support contacts. We want to make sure they're walking away from our office with resources. You can't just let them leave and not have anything for them to access in the event that they experience a crisis once again, they experience ideation once again. And, we want to determine our follow up monitoring plan and behavioral health supports.

>> So if our kiddo is high risk, we want to make sure, definitely don't leave them alone, remove dangerous objects, notify admin and guardians. Ask guardians to come to the school. Contact the crisis team you want to come them and do the assessment to determine the eminency. Or call 911 if necessary. Release only to the parent or crisis responder. So that bell rings at 2:00, you're not letting them leave your office. They have to be monitored with somebody at all times. A team written consent to consult with outside providers. Alert appropriate school officials. Meaning, do you need to report this to your school psychologist, your school clinical psychologist, your department head? We would advise conducting a reentry meeting when they return if they've been away from school to create a safety plan then. It's not advisable to create a safety plan at that moment because kids are going to be out of sorts. You're not going to be able to think clearly to develop a safety plan. So usually this, they're going to create a home safety plan with a crisis team or emergency response. We want to make sure we create a school safety plan upon their return relying on current recs, concerns, and supervisory monitoring needs. So you know, are they allowed to go to the bathroom? If they go to the bathroom, of course they're allowed to go to the bathroom. But, do we need to check on them in five minutes? Are we, you know, sending them, sending them with supports? Do we need to have eyes on supervision at all times? That sort of thing. And,

once again, document everything. Right? The assessment results, who you contacted, the plan of action. In terms of moderate risk, once again, notifying admin and guardians and providing those resources. Refer to community provider. Get the schools, you know, as a school psychologist, I can screen. My job isn't to provide intense treatment. Right? I don't have that type of background. So we want to make sure we're referring to community provider so that they can learn these coping skills and things of that nature. And, make sure we can get written consent to consult if the parents agree to that. Sometimes I have parents who are like no way. And, I can comfort them by saying look, I don't need to know details related to this that or the other. But, if we could have consent specific to safety planning, that would be helpful. And, usually I have parents who are okay with that, if I'm able to specify that in the written consent. Contact crisis team if necessary. Release only to parent or crisis responder. Create that safety plan. If they left school, make sure we have reentry procedures put into place and document. For low risk, once again, we're contacting parents and guardians, we're creating that safety plan if appropriate, providing access to resources, and documenting.

>> Safety planning, what is safety plan? We're developing a plan collaboratively with students and families. And, it serves as a, like a reference point if suicidal thoughts happen again. We're not using this as a moral discussion. We're not using this as a permanent removal of means. But, we want to make sure we're developing this after the crisis.

>> Some of the things we want to talk about are what are their warning signs and cues and triggers of potential crisis? We want to identify what those are. What are the triggering stressors? We want to identify the child's coping strategies. What can we use on their own and with others? We want to distract from the crisis. What can we do, what can be done to distract them? We want to identify their supports considering family, peers, supportive adults. Who can they talk to in order to help with resolving a crisis? We want to identify resources, emergency and crisis numbers as well as local resources. And, we want to talk about, with parents in particularly as well as just how do we reduce access to lethal means? Sometimes they're going to have to lock things up for a while and be very mindful of what's in their environment. And, we want to make sure we're reviewing this plan periodically so that it can grow and change with the child.

>> In terms of school safety planning, we talked about a reentry meeting. I highly recommend this. I've done this with my schools. It's very helpful. We do want to make sure, it is helpful to have one staff member be the primary point of contact. Make sure communications streamline. We want to make sure we do daily check ins for the first couple of weeks. Daily check ins could be on the scale of one to ten, how are you feeling? Are you having any suicidal thoughts today? We do want to temporarily increase counseling supports or phone check ins if they're not in school. You want to do that, increase that for the first couple of weeks as well. We want to insure relevant staff, understand the child's warning signs, triggers, side effects of medications, and referral steps if they need it. We want to arrange for make up work so that they're not penalized for missing school or inability to concentrate and produce work at the same level as they're going through this. And, arrange for safety preventions. Can they leave class without an escort for safety? Things like that.

>> In terms of parent notification, you do want to notify parents as soon as the students identified at risk for suicide and request to come to school immediately for high risk, and review potential lethal means at home and the need to temporarily remove them. For those that are low to moderate risk that don't require hospitalization, we want to provide resources. If you believe a student is in danger of self-harm and a parent refuses to seek services, it may result in a mandated report to Child Protective Services for negligence. If there's an eminent risk of suicide that's related to parental abuse, you do want to notify Protective Services, it's about the safety of the child. So you want to contact them first. If you're, you do want to follow up with parents in a few days. Hey, how's it going? Did you see an outside provider? If they have not, find out why. Is there anything you can do to help? Document every contact with parents, okay, every contact you have. And, some schools do have parents sign an acknowledgment form saying that they've been informed of their child's risk and has received referral. So it really is up to your school and your district as to whether they want to proceed with that or not.

>> In terms of confidentiality, do not share clinical information on details related to suicidal behavior. Only share information with staff necessary to research student safety such as that related to the treatment and support needs. We're not having general classroom discussions because that's violating confidentiality. In terms of FERPA, we can disclose student information without consent to appropriate parties if that information is necessary to protect the health and safety of the student. So if you have a student who is suicidal or expressing suicidal thoughts, there are some officials that have interpreted this to mean that this is a significant threat to health and safety. So that's how FERPA has interpreted that.

>> Some schools have been found negligent for failure to notify parents if students have appeared suicidal. If they fail to get assistance for students at risk for suicide and failure to adequately supervise a student at risk for suicide. Now, part of my typo, I just noticed some of those now. You never want to negate a child's suicidal thoughts. So if they say I've had thoughts, you don't say oh they're just looking for attention. You always, always take it seriously 100% of the time. Always heir on the side, on the side of caution. If you truly have evidence to show this is attention seeking, you want to get together with your team of professionals and maybe develop a behavioral support plan. But you never, ever, ever, you know, take this as a joke. It's always serious.

>> I'll let you guys go through the resources on your own. But, we've got some crisis lines, reviews of some advance training and risk assessment, if you want to get advanced training. I've done one or more of these myself and service training for your teachers. One thing they recommend is for teachers to be aware of warning signs and risk factors so that they can be better able to refer. And, they're doing this for peers as well in middle schools and high schools so that they can refer their peers at risk. Access examples as safety plans as well as other general resource as well as references.

>> So thank you for coming today. I appreciate your time. I'm going to go ahead and hand this back to David.

>> Thanks so much Erin.