Oregon Toolkit for Suicide Intervention in Schools

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Background & Scope

In fall of 2024, Oregon Health Authority (OHA) released a Suicide Screening Brief for School Counselors. In support of that Screening Brief, a workgroup was convened of School Counselors, School Mental Health Professionals, School Suicide Prevention experts, and School District and Administrative staff. This workgroup chose four topic areas with needed to support the work of suicide screening in schools and developed this Toolkit.

This is an iterative Toolkit; new additions and edits can and will be made. It is the hope of this workgroup that this Toolkit will grow. There will likely be additional pieces added to this toolkit over time and as capacity allows. It is also intentionally without a logo. Please use it widely and adapt it for your school or district needs.

This Toolkit is very specifically and intentionally focused on suicide intervention in school settings in Oregon. If you are looking for resources for school suicide prevention more broadly, visit the Lines for Life Oregon School Suicide Prevention Resource Library. If you are looking for suicide prevention training for school roles, visit the "Which Training Should I Take" document.

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We'd love to hear from you.

Send any and all feedback to us at: shanda.hochstetler@oha.oregon.gov

Or complete this feedback survey.

Calling Home Resource

Family Communication After Individual Suicide Screening

Considerations Prior to Family Contact and Tools for the Conversation

Background

Calling home and informing a parent/guardian that their child is experiencing or expressing statements of suicidality is a challenging task for even an experienced school based mental health professional. The goal of this resource is to increase confidence in engaging parent/guardians following a suicide risk screening with their child. It is always important to be relational, authentic, and trauma-informed during these conversations. These scripts are meant to be examples. They should be adapted to fit your voice and any cultural considerations that apply and are not necessarily meant to be read verbatim. Consider this communication an opportunity to engage and collaborate with a family rather than simply informing them of the facts of the screening.

This resource first outlines guidance for any outreach or calls to parent/guardian after a screening: “Cultural considerations”, “Preparing yourself for the call”, “During the call”, and “After the call”. Lastly, there are “Example scripts” specific to the results from the screening that can be used to practice and also adapt to fit your own voice and context.

Cultural considerations

- Ensure the conversation is in the parent/guardians' preferred language, if possible.
- For many families, stigma around suicide is strong. Be ready to allow time and space for the parent/guardian to hear your concern. It may be helpful to spend a few moments connecting with the family member prior to speaking about their student's suicide thoughts.
- Stigma may show up differently in a family's culture. More collectivist cultures may have a different view of mental health than more individualistic cultures. For some families, spirituality is a significant component in mental health and wellness.

  Here are two examples of how stigma might show up as spiritual stigma or within collectivism:

  > Spiritual stigma around mental health might sound like this, "God decides what happens—this is in God's hands." You can say something like: "It sounds like your faith is really important in your family. Faith and professional support can work together well, and pulling in professional support is one way to honor the life that God has given to your child and family."
  >
  > Collectivism and shame about mental health issues might sound like this, "I can't believe my child talked about this with you. We don't talk about these things outside our family." You can say something like, "I completely understand wanting to keep this private within your family. There are many resources that can help to work with you as partners to help your child get back to their usual self--and unless there's an emergency, you can keep this information private within the professional services and only focused on what is needed. People in your community don't have to know what's going on at home; that's your choice."

- It is essential to understand and incorporate relevant cultural factors while avoiding stereotypes. Be open-minded and engaging. Lead the conversation with curiosity and wonder; don't assume that you know what the family needs in this moment.
- Suicide Prevention Strategies for Underserved Youth: This document shares both risk and protective factors for underserved youth groups (starting on page 5), which may be helpful in conversations with families.
- Offer multiple ways of receiving the screening information and resources after the phone call to ensure the information and resources are accessible. For example, some families may want an email while others might want to schedule an in-person meeting.
- Before reaching out, prepare culturally specific resource options, so you have them should the family want them.
- Consider that families and students may have real and reasonable concern and mistrust of systems, including law enforcement, child protective services, and healthcare systems. Families and students that are undocumented, that have had painful interaction with child welfare, that are military-connected or have plans for military involvement may hold fears about the implications for their student's safety and future. Acknowledging these real fears and being clear about privacy of information and who will know what information can be impactful. That might sound like, "We want to partner with you to support your child, and this conversation stays private unless immediate safety requires more help. If you or your child's immediate safety is in danger, we will need to reach out to law enforcement."

Preparing yourself for the phone call

- Confirm preferred language of the parent/guardian.
- Acknowledge that this can be difficult. Check in with your own wellbeing and utilize self-regulation strategies prior to calling.
- Think about how your own cultural lens and assumptions may shape how you interpret this family's reaction. Lead the conversation with curiosity and wonder. Don't assume you know what their family needs in this moment.
- Consult with colleagues or supervisors when facing complex situations that require additional guidance.
- Consider which parent/guardian are you reaching out to. Is there more than one guardian that needs to be contacted? Remember that for some students, their guardian might be someone other than a parent. If possible, ask the student to identify who their trusted adults are and, if those are not also the parent/guardian, ask if the student would like you to reach out to that person as well.
- Center the needs, experience, and wellness of the student. Make sure you know what name and pronouns the student wants you to use with their parent/guardian. Ask the student about ways they would or would not like you to talk about their suicide thoughts. Consider role-playing the interaction before calling. Ask curious questions, such as, "What are you most concerned about?" or "How are you expecting your parent/guardian to respond?" Exploring this ahead of the call can help a student feel more at ease. Allow the student to be present with you when you call.
- Know that sometimes a call may be met with caution or hesitation due to distrust of systems, fear of agency involvement, or concern about being judged. Be prepared to slow down the conversation.
- Draw from and lean on your suicide intervention training to support the steps you take.
- Practice what you might want to say. It'll be better for everyone if the words you are using sound like you.
    - Specifically practice or consider how you might respond to these concerns:
        - ☐ Mental health stigma (Such as suicide thoughts are just "attention seeking")
        - ☐ Help-seeking barriers (Such as no transportation to get student to follow up care)
        - ☐ Fear of Immigration and Customs Enforcement (ICE)
        - ☐ Concern about law enforcement and/or child welfare involvement
        - ☐ Fear of hospitalization (by student or family)
        - ☐ Fear of discipline at the school level (by student or family)
        - ☐ Fear of impact of screening in medical and school records

      It's hard to imagine what other families are like when they are different from your own, so taking time to think through these concerns that you may not have experienced in your own family will increase your ability to have a collaborative conversation with the parent/guardian. While you don't know or control the impacts outside the school setting and should not overpromise for other entities, you can be empathetic and attentive to these concerns.
- Gather resources that you might want to offer to the parent/guardian. Include resources for food, housing, and transportation, as well as mental health resources.

During the call

- When transitioning into the conversation about suicide risk, consider adding a statement that might serve as a content warning for the parent/guardian, such as, “I have a potentially difficult topic for us to talk about, and just want to make sure you’re in a place that you can have a confidential conversation. If not, I’m happy to hold while you find a more private space.” Or “I have a potentially difficult conversation to have with you; is this an ok moment to talk?”
- Avoid assessing or quantifying the level of risk (eg: using the terms “low”, “medium”, or “high”) with parents/guardians. *(**Note about risk stratification terms:** C-SSRS questions help us screen for whether a youth might currently be reporting risk factors that have been categorized as at low, moderate, or high risk for suicide. This stratification of self-reported risk factors then guides, but does not dictate, how we intervene. While risk stratification is helpful to inform your next steps for intervention, it's not helpful to "label" the youth low, moderate, or high risk or to share this label with them or their caregiver. This is a screening tool, meant to gather information, not meant to predict the future or to replace a formal suicide assessment. Avoid the inclination to make assurances to parents/guardians about whether the student is “safe” from suicide.*)
    - Focus on the facts and behavior unique to the situation; avoid assumptions.
    - Use precise language. Do not state a student's self report as fact or editorialize. For example, say, “Your student reports not having a plan,” and do not say “Your student does not have a plan.”
- Validate and listen to fears and concerns. Listen with empathy. Look for ways to build rapport so that the family knows who and how to reach out for support from the school and from the community, including support that is culturally specific.
- Advise parents to safely secure or remove lethal means from the home while the child is possibly suicidal, just as you would advise taking car keys from a driver who had been drinking. Always ask about firearms in the home (at minimum, firearms should be secured, locked, and unloaded). If a student identifies a specific means, identify this to the parent/guardian.
    - Resource: Harvard University Means Matter Lethal Means Counseling Recommendations for Clinicians.
    - Resource: Consider the course Counseling on Lethal Means (from Zero Suicide) or Oregon CALM to help you feel prepared to talk with people about means safety.
    - Resource: Oregon Suicide Prevention Firearms Safety
- Consider the needs of youth and incorporate their voice in the process.
    - Resource: Youth thoughts on Mental Health & Crisis Supports in Schools
- Listen for myths of suicide that may be blocking the parent from taking action.
- Explore reluctance to accept mental health resources, address concerns or barriers to accessing resources, and explain what accessing specific resources may look like.
- Ensure that the adult knows how to access immediate help (such as the emergency department, a stabilization center, 911, 988, local crisis lines) as well as resources for ongoing help (such as a mental health referral for ongoing treatment).
    - Resource: Crisis Line Resources for Youth from the Oregon Alliance to Prevent Suicide
    - Key Resource: Mobile Crisis Response Teams can be accessed 24/7 through 988 or through local crisis response lines.

After the call

- Following the call, give yourself a moment to breathe. This work is difficult.
- Reach out to a colleague or supervisor to debrief the call including how culture showed up in the conversation, lessons you learned, unexpected or surprising moments, and any lingering concerns you hold.
- Make sure you provide the resources you said you would, including following up with warm handoffs where possible. If appropriate, create a reminder for yourself for any follow-up care needed.
- Complete paperwork and tracking requirements according to your school's plan and protocol.

Example Scripts for Various Situations

All sample scripts below include:

- How the information was obtained
- What was learned from the student and others
- Recommendations for next steps (these may be different based on the situation, but will always include: resources, warning signs, encouraging help seeking, and lethal means reduction).

Phone Call Introduction Script

Student is referred to a trained suicide intervention staff member regarding concern about possible suicide ideation.

Suggestion of what to say to parent/guardian to begin the conversation once you have confirmed the language preference and have ensured the parent/guardian understands:

> *"I have a potentially difficult conversation to have with you; is this an ok time to talk? Are you in a place with some privacy? We became concerned that your student might be experiencing thoughts of suicide because [reason for concern, e.g., class writing, verbal statement, google search, drawing, social media post, etc]. After speaking with your child, they shared [details of what student shared] as contributing factors for the suicidal ideation [or denial of ideation]. We are contacting you to notify you of the concern reported and talk about next steps."*

Potential Outcomes & Example Scripts

In conversation with student, screening identifies:

- Student denies ideation or indicates no ideation
- Past ideation, not current
- Current but passive ideation with no intent nor plan
- Current and active ideation OR vague plan/distant future plan
- Current and active ideation and student is willing to receive help
- Current and active ideation and student is unwilling to receive help (with parent/guardian support)
- Current and active ideation and student is unwilling to receive help (without parent/guardian support)

Student denies ideation or indicates no ideation

- Offer resources if student expresses warning signs (including 988).
- Share warning signs to look for in the future.
- Address safe storage of firearms and other lethal means.

Example Script with Parent/Guardian: *After having a conversation with [Student], they are currently reporting no suicidal thoughts or ideation. They explained the initial concern by [student's response to the initial concern, e.g., they were researching something for class, they were joking and didn't realize their friend took it seriously]. However, we want to make sure that you and [Student] have the support you need. We have a list of warning signs to look out for as well as local and national resources for support if needed. How would you like us to share these resources?*

Past ideation, not current

- Specify timeline of when ideation occurred.
- Offer resources (including 988 and mobile crisis).
- Share warning signs to look for in the future.
- Address safe storage of firearms and other lethal means.

Example Script with Parent/Guardian: *After having a conversation with [Student], [Student] reports having suicidal thoughts in the past, but not at the present time. [Student] says that the last time they had these thoughts was [share timeframe]. It's important to remember that suicidal ideation can come and go with stressors and changes in mood, so we want to ensure you have the resources and support you need for your student. We are going to share with you a list of warning signs to look out for; the most important thing to keep in mind is to notice if there is a change in mood, behavior, or activity level. This also includes a list of local and national hotlines for support if needed. Would you prefer that I email this to you or send it home with your student? I also want to check in with you about whether your firearms are safely stored with locks. Your local law enforcement agency or county mental health agency can get you a gun lock if you'd like one--I'll include that in the list of resources I'm sending you.*

Current, but passive ideation. Student reports no intent, no plan

Recommendation for referral to outside mental health supports (potentially including additional assessment)

- Offer resources (including 988 and Mobile Crisis Response Teams)
- Share signs that might come with increased risk (if passive ideation becomes active)
- Lethal means counseling
- Safety planning

Example Script with Parent/Guardian: *After having a conversation with [Student], they are reporting current suicidal thoughts. At this time, they are not reporting having a plan to end their life. [Student] describes [e.g., fleeting thoughts, wanting to go to sleep and not wake up, wanting the pain to end, feeling stuck and not seeing a way out – USE students' words]. [Student] is open to receiving help and collaborating on a plan to keep them safe. Can we talk through some options and see which one feels like the right next step?*

Current and active ideation and student willing to receive help

Recommend referral to outside mental health supports (including additional assessment).

- Offer resources (include at least: where to get a same-day suicide risk assessment and safety planning, Mobile Crisis Response Teams and 988)
- Lethal means counseling, including specific discussion of means relevant to plan and safe storage of firearms
- Safety planning

Example Script with Parent/Guardian: *After having a conversation with [Student], they are reporting current suicidal thoughts. [Student] has thought about a plan, and that plan includes [share student's plan] OR [student] has not thought about a specific plan, but does express actively wanting to die. We want to support you in helping to keep your student safe, and at this time, your student says they are open to receiving help and collaborating on a plan to keep them safe.*

Current and active ideation, student unwilling to receive help (with parent involvement)

Current and active ideation, high or fluctuating intent, specific plan, unwillingness to receive help or collaborate on a plan for safety.

- Lethal means counseling including specific discussion of means relevant to plan and safe storage of firearms
- Offer resources (include at least: where to get a same-day suicide risk assessment and safety planning, Mobile Crisis Response Teams and 988)
- Safety plan at return to school (ask the family to consider a release of information with the provider or facility where the student receives a suicide risk assessment)

Example Script with Parent/Guardian: *After having a conversation with [Student], they are reporting current suicidal thoughts. [Student] has thought about a plan, and that plan includes [share student's plan] and expresses actively wanting to die. We want to support you in helping to keep your student safe, and at this time, your student does not indicate an openness to receiving help or collaborating on a plan to keep them safe. For those reasons, we are asking that you come to the school as soon as possible in order to take your student for an outside assessment. We cannot safely keep your student here at school until this assessment has occurred and we are able to develop a plan for safety at school.*

Current and active ideation, student unwilling to receive help (if unable to speak directly with parent)

Active Ideation, High Intent, Specific plan (imminent risk)

- When parent is reached:
    - Lethal means counseling including specific discussion of means relevant to plan and safe storage of firearms
    - Offer resources (include, at least, Mobile Crisis Response Teams and 988)
    - Safety plan at return to school (ask the family to consider a release of information with the provider or facility where the student received the suicide risk assessment)

Example Script with Parent/Guardian: *I am sorry to have to leave a message, please know that I have some potentially concerning information to share with you. After having a conversation with [Student], they are reporting current suicidal thoughts. [Student] has thought about a plan, and that plan includes [share student's plan] and expresses actively wanting to die. We want to support you in helping to keep your student safe, and at this time, your student does not indicate an openness to receiving help or collaborating on a plan to keep them safe. We cannot safely keep your student here at school, and we have been unable to reach you or [other guardian if applicable], so we are [insert action being taken; e.g., calling in crisis response, calling 911, transport to hospital].*

Related resources

- Lines for Life's Oregon School Suicide Prevention Resource Library
- Resource from Kansas with example language (pgs 36, 42-46)
- Penn State School Resources, Parent Notification following a Suicide Risk Assessment (includes parent reaction scenarios)
- Lethal Means Handout (from the Counseling on Lethal Means course from Zero Suicide)
- Oregon Suicide Screening Brief for School Counselors
- ASCA Information Gathering Tool (IGT)
- ASQ screening form (pg 3) and ASQ toolkit
- Culture and Suicide Prevention Institute

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Liability Resource

Considerations and recommendations for legal liability in school-based individual suicide screening

Fear of liability should not be the driving force behind suicide screening, risk assessment, and safety planning procedures; although it is a real concern for many school staff. Centering student wellness must be the foundation from which school counselors, school social workers, school psychologists, and other school mental health staff act to intervene in suicidal thoughts and mental health crisis. **The best way to avoid liability is to stay student-centered in your screening approach.**

Suicide screening and providing indicated follow up support is unquestionably a part of the role of school counselors, school social workers, and school mental health staff. How this suicide intervention work is done may raise concern around liability. The greatest liability is when school staff are NOT asking directly about suicide and do not connect students care.

Liability is a real concern for school staff who are tasked with suicide screening of students. There are actions that can decrease or increase liability.

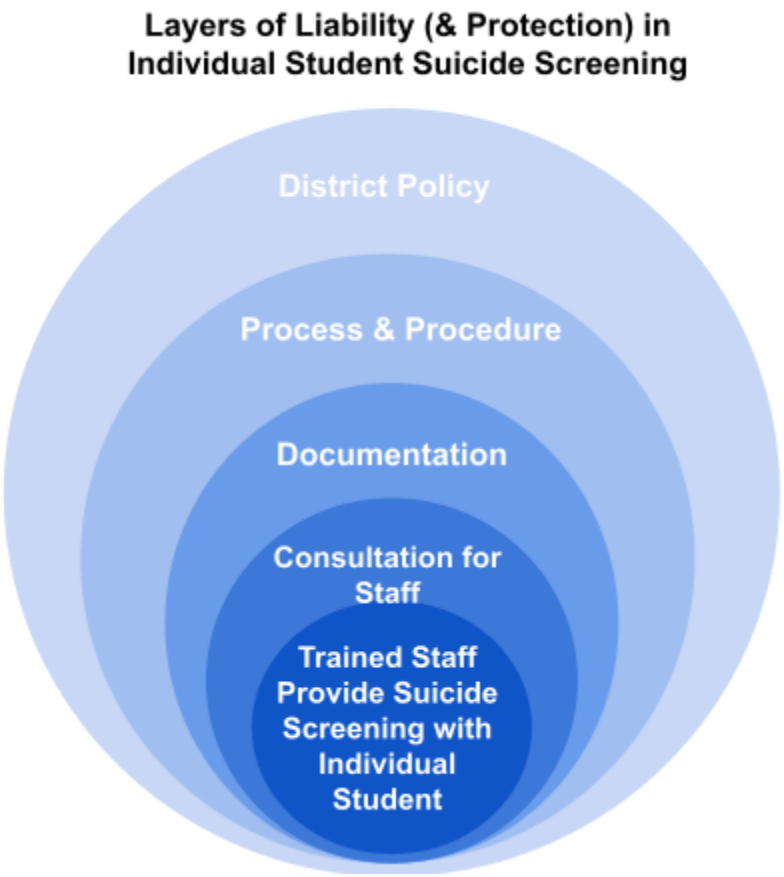
***Disclaimer: the information and recommendations in this document are intended for educational purposes only and should not be construed as legal advice. While every effort has been made to ensure accuracy and relevance, the creators of this document are not only professionals. Users are encouraged to consult with qualified legal professionals. Users are encouraged to consult with qualified legal experts regarding specific legal matters and considerations. This is not a substitute for personalized legal advice, and many actions taken based on the information provided herein are at the user's discretion and risk. The creators of this toolkit disclaim any liability for errors, omissions, or any consequences arising from the use of the information presented.*

Actions that decrease liability	Actions that increase liability
Taking all suicide warning signs seriously every time	When calling home or documenting the screening, using language that minimizes or dismisses risk.
Having a clear protocol in place, including documentation	Having inaccurate or unclear documentation
Ensuring staff receive ongoing training appropriate to their role	Approaching screening as a checklist rather than a tool for a process
Utilizing an evidence-based screening and assessment tool as approved by the school district	Using predictive language about future risk in documentation or in communicating home
Documenting screening and assessment, including using descriptive language about observable behaviors, disclosures, and context	One single adult making decisions without consultation
Ensuring staff and students know the protocol	Not asking students directly about suicide
Informing, engaging, and equipping families/adults/caregivers to provide the support indicated through the screening process and acknowledging the limits of a screening/assessment as a single point in time	Communicating ineffectively with families/adults/caregivers
Having a plan in place for staff consultation and support	Expecting one staff member to do this work alone
Providing warm hand-off referrals	Referrals that are not accessible, realistic, or relevant to the student
Strong, collaborative, culturally-infused safety planning	Acting in the interest of liability instead of centering the needs and wellbeing of the student
Providing student-centered care	Ignoring concerns of suicide because staff are uncomfortable or ill-equipped
Reviewing suicide prevention, intervention, and postvention plan and protocol with school district legal counsel	Using informal, undocumented, or subjective methods of screening and assessment

School staff are protected under Oregon's Tort Claims Act under which the public entity will defend and indemnify their public employees for lawsuits filed against them while they were acting within the course and scope of their employment.

Further Support

The Oregon School Boards Association provides legal advice to member districts, including guidance on liability concerns. Districts should consult with their legal counsel to address specific questions and seek further clarification on liability and related issues.



A school district suicide prevention **policy** is required by Adi's Act (SB 52, 2019). It requires a plan that is equity-centered and includes a screening process, protocol, and staff training to ensure staff are equipped for their roles. A district's plan should include documentation, consultation, and screening tools.

Process and procedure should be written out, be reviewed and updated regularly, and be made known to all staff. The process and protocol should include the who, what, and how of documentation, consultation, and individual screening. Staff need to be both aware of and equipped for their specific role in the process and protocol.

Strong **documentation** of suicide screening is rooted in capturing the facts - what information was gathered and how it was gathered. Documentation includes the screening and consultation and must be shared and stored appropriately. Memorandums of Understanding are a key piece of suicide intervention plan. MOUs create a relationship and system for being connected. MOUs, however, do not permission sharing identifiable student data. A release of Information (ROI) is needed for sharing specific student data and needs to also be built into the intervention plan.

Following a screening, the process should include **consultation** as an opportunity to decrease liability by ensuring staff review their screening and assessment with a qualified, trained colleague.

With the individual student, the sucicide **screening** itself should be done using an evidence-based and clear tool. Trained school staff should center the needs of the unique student using their professional skills along with the screening tool. A collaborative and student-centered screening can then guide the safety planning process.

Tools, Templates, and Protocols

Oregon Suicide Intervention in Schools
Sample Tools, Training, and Protocols

Purpose
To provide Oregon schools examples of suicide intervention training, tools, and protocols from school districts in Oregon

Background/context
School districts in Oregon use a variety of suicide intervention tools, protocols, and training programs to support students and staff. School staff are often the first point of contact for students experiencing suicidal ideation. Each district has its own approach, with different individuals leading the process and adapting intervention models to suit their specific needs. These models can be modified to fit the unique context of each school or district. Below are several examples of intervention models from a variety of educational service districts and school districts. There is not a specific required tool or protocol in Oregon, but Oregon law requires districts to have a policy to have a process and protocol for suicide intervention.

Regardless of the tool or protocol that a district uses, **these components** should be included in a district's suicide prevention plan:

1. **Student Conversation(s)** - Discussions need to be person-centered, trauma-informed, and culturally and linguistically responsive.
    a. Impact factors/risk factors (Suggested formatting: checkboxes with narrative)
        i. Prior attempt/history of suicide
        ii. Substance use
        iii. Access to lethal means
    b. Protective factors (Suggested formatting: checkboxes with narrative)
    c. Asking directly about suicide
        i. Frequency of suicide thoughts--ask about active or passive thoughts
        ii. Intent or suicide attempt plans
        iii. Means & Access to lethal means
        iv. History--Prior attempts (as defined by student)
        v. Thoughts of harm towards self or towards others

2. **Parent/Guardian Conversation(s)** - Discussions are person-centered, trauma-informed, and culturally and linguistically responsive.
    a. Discussion about impact factor/risk factors for student, including, but not limited to:
        i. Prior attempt/student/family history of suicide or mental health
        ii. Substance use
        iii. Access/Means
        iv. Supervision needs/Safety planning--any immediate needs? Safe plan for now
        v. Parent perspective of suicide concern
        vi. Resources available
        vii. Additional concerns that weren't asked about?

Sample Intervention Forms

- Columbia Suicide Severity Rating Scale (C-SSRS) in English and in Spanish
- Columbia Suicide Severity Rating Scale Very Young Child
- Corvallis School District Suicide Ideation Protocol and Screener
- Gresham-Barlow SD Suicide Screening Tool
- Junction City SD SIP
  - Intervention (p. 7-10)
  - Flowchart (p. 23)
  - Student Safety Plan (p. 24)
- Kansas School Suicide Intervention Guidance - Screening Protocol on p41
- McMinnville SD Intervention Protocol (w/links embedded)
- North Clackamas SD Protocols
- Portland PS Suicide Prevention & Intervention (Short Version)
- Portland PS Suicide Prevention & Intervention (Long Version)
- Oregon City SD SIP
  - Intervention (p. 15-17)
  - Flowchart (p. 18)
- Reynolds SD Screener
- Salem-Keizer SD SPP Level 1 Form
- Sherwood SD Intervention Forms
- Willamette ESD Level Risk Assessment 1
- Willamette ESD Non-Suicidal Self-Injury (NSSI) Protocol
- ASCA Information Gathering Tool

Sample Safety Plans

Elementary

- Dallas SD Elementary Safety Plan (p.18)
- Springfield PS Elementary Safety Plan
- Lane County Public Health Elementary Safety Plan
- Safety Plan for Young Kids

Secondary

- Gresham-Barlow SD Safety Plan Staff
- Gresham-Barlow SD Safety Planning for Student
- SKPS SPP Student Safety and Support Plan
- Willamette ESD Level 1 Safety Plan (English)
- Willamette ESD Level 1 Safety Plan (Spanish)
- Youth SAVE Safety Plan
- Stanley-Brown Safety Plan in English, in Spanish, and in many other languages
- 988 Safety Plan in Spanish (Modified from Stanley-Brown)
- Youth Wellbeing Tools & Resources

Sample Reentry Plans (Returning to school from inpatient healthcare)

- WESD Reentry Plan
- SPP Re-Entry Student Safety Form
- Springfield Public Schools Reentry Plan

Sample Intervention Protocol Flowcharts

- Beaverton SD Flowchart
- Eugene 4J SD Intervention Forms
  - Flowchart (p. 30)
- Dayton SD Flowchart (p.11)
- Gresham HS Flowchart
- Gresham-Barlow SD Flowchart for Suicide Screening
- Portland Public Schools Flowchart
- Salem-Keizer SD Systems Flowchart
- Salem-Keizer SD Documentation Flowchart
- Springfield Public Schools Flowchart
- Willamette ESD Intervention Flowchart
- Baker SD Flowchart in English
- Baker SD Flowchart in Spanish
- Adrian SD Flowchart

Resources Outside of Oregon

- A Guide for Suicide Prevention in New York Schools
- A Guide Suicide Prevention for School Personnel - New York

Intervention Trainings for Staff

- Recommended & available at low or no cost through OHA: Big River programming
  - Applied Suicide Intervention Skills Trainings (ASIST)
  - Youth SAVE
  - Question, Persuade, Refer (QPR)
  - Youth Mental Health First Aid (YMHFA)
  - Be Sensitive, Be Brave (Get a free code by emailing roger.brubaker@oha.oregon.gov)
- Suicide Intervention Training Guidance for Oregon Schools
- Which Training Should I Take? Specifically for Oregon Schools
- Signs of Suicide (Included in the purchase of their suicide prevention curriculum)
- Columbia-SSRS Training (No cost)
- Ask Suicide-Screening Questions (asQ) (No cost)
- Suicide Screening and Play Therapy
- Motivational Interviewing Techniques

If you want a resource removed or added to this list, please let us know through this survey or emailing shanda.hochstetler@oha.oregon.gov

If you find any broken or out-of-date links, please let us know through this survey or by emailing shanda.hochstetler@oha.oregon.gov

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Terms Defined Resource

Suicide Intervention in Schools Definition of Terms

Note about differing definitions in the field of suicide prevention: The purpose of these definitions is to bring clarity to how these terms are used **throughout this toolkit**. The authors are aware that there are differing definitions of many of these terms in the field of suicide prevention, particularly when comparing medical or behavioral health settings with school settings.

Note about training and scope of work: The authors of this section of the toolkit are aware that school districts in Oregon have flexibility to make policy and procedures that fit their unique needs, and that includes which school staff/roles are responsible for screening for suicide risk. Regardless, it is essential that those who are responsible for screening for suicide risk and supporting students and their families with additional safety planning and services are (1) trained appropriately and (2) acting within the scope of their role.

Note about risk stratification terms: C-SSRS questions help us screen for whether a youth might currently be reporting risk factors that have been categorized as low, moderate, or high risk for suicide. This stratification of self-reported risk factors then guides, but does not dictate, how to intervene. While risk stratification is helpful to inform next steps for intervention, it's not helpful to label the youth “low,” “moderate,” or “high risk” nor to share these labels with the youth or their caregiver. This is a screening tool, meant to gather information, not meant to predict the future nor to replace a formal suicide assessment. See more about suggested ways to language this in the “Calling Home Resource” of this Toolkit.

Term and Definition	Notes and Sources of Definition
Those in **green** have full workgroup consensus	**yellow** means there are slight differences and not full consensus, and **orange** means the full workgroup group couldn't achieve consensus due to philosophical differences.
Assessment (generally) is the process of gathering and discussing information from multiple and diverse sources in order to develop a deep understanding. Assessment starts with engagement and occurs throughout the helping process. This can include gathering information, making observations, identifying strengths and challenges, looking for perception changes, listening to understand, synthesizing information, identifying our own reactivity and dysregulation, and consulting with others to create the full picture. For example, during lunchtime, any school staff may walk through the school cafeteria or hallways and assess. "**Conducting an assessment**" includes general information gathering and usually means using a more formalized tool or process such as a Mental Health Assessment, Behavioral Health Assessment, Risk Assessment, Threat Assessment, Biopsychosocial Assessment.	Youth SAVE Version 4 Curriculum
Behavioral Health Assessment means a process which determines a person's need for individual services or supports for mental health or substance use services through evaluation of the patient's strengths, goals, needs, and current level of functioning. This is conducted by a Qualified Mental Health Professional (QMHP) and usually includes a mental health assessment and substance use assessment.	OHA Oregon Administrative Rule (OAR) 309-019-0105 aligned "Best Practice Risk Assessment" is defined in OAR 309-023-0110.
Conducting an assessment includes general information gathering and may include using a more formalized tool or process such as a Mental Health Assessment, Functional Behavior Assessment, Behavioral Health Assessment, Behavioral Safety Assessment, Risk Assessment, Threat Assessment, Biopsychosocial Assessment, or include a more thorough interviewing process to gather specific data and history.	Workgroup defined in consultation with faculty at PSU School of Social Work

Term and Definition	Notes and Sources of Definition
High Risk (per the C-SSRS) The Columbia Suicide Severity Rating Scale (C-SSRS) considers a young person **"high risk"** (also known as imminent risk) when they have current thoughts of suicide with a plan (method, time, and place) and intent to carry out their plan, OR they had a recent suicide attempt, OR they have taken actions in preparation to kill themselves, sometimes called rehearsal behaviors. Note that C-SSRS questions help us screen for whether a youth might be at low, moderate, or high risk for suicide, which then guides, but does not dictate, how we intervene. While risk stratification is helpful to inform your next steps for intervention, it's not helpful to "label" the youth low, moderate, or high risk or to share this label with them or their caregiver. This is a screening tool, meant to gather information, not meant to predict the future or to replace a formal suicide assessment.	The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS) Youth SAVE Version 4 Curriculum Risk stratification remains an area without complete consensus in the field of school suicide prevention. Please reference the "Note about risk stratification terms" at the top of this section of the toolkit.
Individual Screening for Suicide Risk Using a standardized instrument, protocol, or process to ask an individual student about their thoughts of suicide when one or more factors indicate they could be at current risk for suicide. This is done to determine what level of support and resources the student and their parent/caregiver might need.	Workgroup defined This term is included in order to differentiate between universal screening and individual screening.
Information Gathering Tool Term used by the American School Counselor Association (ASCA) for their suicide prevention tool that does not quantify risk, designed to 1) ask clearly and directly about suicide, 2) identify suicide ideation clues, risk factors, and protective factors, 3) consult with another qualified professional, and 4) communicate with parent/guardian about concerns and potential resources, including prevention of access to lethal means.	Workgroup defined, influenced by work with ASCA
Level 1 screen is used in this toolkit with the same meaning as a suicide screen.	See definition of "suicide screen." Because of how they have been conflated with behavioral threat assessment terminology, some school districts have tried to avoid using the terms Level 1 and Level 2 in suicide intervention.

Term and Definition	Notes and Sources of Definition
Level 2 is used in this toolkit with the same definition as "suicide risk assessment" or "suicide assessment". *Note: Some districts have called this a “Level 2 Screen” which further conflates the screening vs assessment processes. We have chosen to leave the word “screen” off this term in an effort to differentiate the two.	See definitions of "suicide risk assessment" and "suicide assessment." Because of how they have been conflated with behavioral threat assessment terminology, some school districts have tried to avoid using the terms Level 1 and Level 2 in suicide intervention.
Low risk (per the C-SSRS) A person is described as low risk on the C-SSRS when they have thoughts of suicide but they do NOT share a detailed plan, access to means, or intent to attempt suicide. Note that C-SSRS questions help us screen for whether a youth might be at low, moderate, or high risk for suicide, which then guides, but does not dictate, how we intervene. While risk stratification is helpful to inform your next steps for intervention, it's not helpful to "label" the youth low, moderate, or high risk or to share this label with them or their caregiver. This is a screening tool, meant to gather information, not meant to predict the future or to replace a formal suicide assessment.	The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS) Youth SAVE Version 4 Curriculum Risk stratification remains an area without complete consensus in the field of school suicide prevention. Please reference the "Note about risk stratification terms" at the top of this section of the toolkit.
Mental health assessment A comprehensive mental health assessment is conducted by a Qualified Mental Health Professional (QMHP). It is an important tool in assessing and evaluating a client and determining criteria for a mental health diagnosis. Core features include conversation and observation, understanding signs and symptoms, and establishing therapeutic alliance. Supports the formulation of clear treatment goals and plans. Usually a requirement of insurance companies for reimbursement.	Workgroup defined Consulted with faculty at PSU School of Social Work

Term and Definition	Notes and Sources of Definition
Mobile Crisis Services means mental health services for individuals in crisis provided by mental health practitioners who respond to behavioral health crises onsite at the location in the community where the crisis arises and who provide a face-to-face therapeutic response. The team can respond to a home, school, business, or any other preferred location of the caller. The goal of mobile crisis services is to help an individual resolve a psychiatric crisis in the most integrated setting possible and to avoid unnecessary hospitalization, inpatient psychiatric treatment, involuntary commitment, and arrest or incarceration. These teams can be requested through local crisis numbers (see link below) or by calling 988.	Oregon Health Authority (including Oregon Administrative Rule) Oregon local mobile crisis teams
Moderate Risk (per the C-SSRS) A person is described as moderate risk on the C-SSRS when they have thoughts of suicide with a plan that includes an identifiable method but does not include a specific time or place and they deny intent to carry out the plan. Using the C-SSRS, this level of risk could also include a young person who previously engaged in suicide behaviors over 3 months ago. Note that C-SSRS questions help us screen for whether a youth might be at low, moderate, or high risk for suicide, which then guides, but does not dictate, how we intervene. While risk stratification is helpful to inform your next steps for intervention, it's not helpful to "label" the youth low, moderate, or high risk or to share this label with them or their caregiver. This is a screening tool, meant to gather information, not meant to predict the future or to replace a formal suicide assessment.	The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS) Youth SAVE Version 4 Curriculum

Term and Definition	Notes and Sources of Definition
Protective factors for suicide are characteristics or conditions that can help reduce the likelihood of someone attempting or dying by suicide. Trainings like Youth SAVE use the term “resiliency factor” rather than the more common term “protective factor.” The term resiliency factor can encompass the protection that comes from outside the individual and their community, but also the strengths and qualities within the individual. This term can encompass both the extrinsic and intrinsic factors that may support a youth from experiencing suicide thoughts or behaviors. Examples include: healthy coping skills, pets, connection with family and friends, social connections (activities, sports, clubs, church, etc), access to mental health care, access to health care, engagement with school. The Sources of Strength program highlights research-based protective factors.	Harmer B, Lee S, Rizvi A, et al. Suicidal Ideation. Youth SAVE Version 4 Curriculum
Risk factors are characteristics or conditions that statistically increase the chance that a person may have thoughts of suicide. While warning signs are applicable to individuals, risk factors are found in individuals, families and communities. Talking about risk factors helps people understand what might need to change within an individual or a community in order to decrease suicide risk over time. Risk factors may be fixed (those things that cannot be changed, such as a family history of suicide) or modifiable (those things that can be changed, such as depression). Youth SAVE uses the term “**impact factor**” instead of “risk factor.” Many identities are associated with an increased risk of suicide, though we mustn’t imply that the risk is intrinsic to the person. It’s more accurate to convey that the risk is imposed by their environment, not their inherent traits. Rejection, oppression, and other negative experiences from living in cisnormative, heteronormative, and colonized environments are what impact the likelihood of suicide.	Influenced by ASIST training and American School Counselor Association (ASCA) Source: Risk factors, protective factors, and warning signs Youth SAVE Version 4 Curriculum

Term and Definition	Notes and Sources of Definition
The Safety Plan is personal, unique, and includes the individual's identification of the thoughts, feelings and experiences just prior to a decline in mental health that may signal an impending suicidal crisis; and helpful and effective actions they have found helpful at earlier times of distress in their life. The Safety Plan steps can be written down or contained in one of many apps. It is most effective when an individual creates their plan with someone who is knowledgeable about the goals and components of a Safety Plan. The plan is feasible and accessible with the goal of providing options when the suicidal person may feel like there are none. A Safety Plan is personal and lists things the person will actually do when in distress. In this way, the person is actually trusting their own knowledge, being an expert on their own experiences and what helps them best. People are in fact using Safety Plans and research has shown that when they are used, suicidal behavior can be averted. (AFSP)	American Foundation for Suicide Prevention Oregon College and University Suicide Prevention Project (OCUSPP) Biannual Meeting - influenced by "Why People Die by Suicide" by Thomas Joiner (6/27/19) Youth SAVE Version 4 Curriculum
School Safety and Prevention Specialist (SSPS) Located in the Education Service Districts across the state, SSPSs work collaboratively with districts and schools, and may provide assistance to private alternative schools and nonprofits that support youth-centered activities for public school students. They ensure access to trainings, resources, and consultation are available in the areas of Behavior Safety Assessments, suicide prevention, intervention, and postvention, and the prevention of bullying, harassment, intimidation, and sexual violence.	Oregon Department of Education
Self-harm refers to when a person hurts their own body on purpose. A person who self-harms usually does not mean to kill themselves, but they are at higher risk of attempting suicide and dying by suicide if they do not get help. Self-harm tends to begin in teen or early adult years. Some people may engage in self-harm a few times and then stop. Others do it more often and have trouble stopping. For many people, self-harm gives them a sense of relief and is used as a means to cope with a problem. Some teens say that when they hurt themselves, they are trying to stop feeling lonely, angry, or hopeless. Examples of self-harm include: Cutting one's skin with a sharp object, Piercing the skin with sharp objects, Hitting or punching oneself or	Substance Abuse and Mental Health Services Administration (SAMHSA)

Term and Definition	Notes and Sources of Definition
punching things (like a wall), Burning oneself with cigarettes, matches, or candles, Breaking bones or bruising oneself **Self-injury behavior** Self-injurious behavior (SIB) involves the occurrence of behavior that could result in physical injury to one's own body. SIB is displayed by 10 to 15 percent of individuals with intellectual disabilities. Common forms of SIB include, but are not limited to, head-hitting, head-banging, and self-biting. SIB can result in minor injuries such as scratches and bruises or more severe injuries such as blindness, broken bones, or even death.	
Suicide assessment usually refers to a more comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the youth, and decide on a course of treatment. The National Action Alliance Clinical Care & Intervention Task Force concluded that suicide assessment "should be completed by a professional with appropriate and specific training in assessing for and evaluating suicide risk. This professional must have the skills to engage [people] in crisis and to elicit candid disclosures of suicide risk in a non-threatening environment." Common instruments used: Columbia SSRS (Risk Assessment Version), ASQ (Brief Suicide Safety Assessment), Scale for Suicide Ideation-Worst (SSI-W), Beck Scale for Suicide Ideation, CAMS (Collaborative Assessment and Management of Suicidality), SAFE-T (Suicide Assessment Five-step Evaluation and Triage). This is the same definition as a "Level 2".	Suicide Screening & Assessment Youth SAVE Version 4 Curriculum
Suicide intervention occurs when suicide risk factors and/or warning signs (also known as suicide clues [QPR] or invitations [ASIST]) have been identified and action is taken to collaboratively create more safety with that person and their social supports. It may include: calling 988, mobile crisis or emergency services; engaging in treatment for mental health; improving coping strategies; reducing risk factors (i.e. substance misuse, social determinants of health, or social vulnerability).	Informed by trainings: Question, Persuade, Refer; and ASIST. Workgroup defined
Suicide screen Using a standardized instrument or protocol to identify individuals who may be at risk for suicide. Provides a preliminary indication that there are concerns that need follow-up. Most effective when followed up by engagement in a thorough assessment which yields treatment recommendations. Same as a "Level 1" in this toolkit.	"Suicide Screening and Assessment" "Screening/Assessing Students: Indicators and Tools"

Term and Definition	Notes and Sources of Definition
	"Suicide Screening and Prevention" Youth SAVE Version 4 Curriculum
Suicide screening tool Standardized instrument or protocol to identify individuals who may be at risk for suicide. Common examples: Columbia SSRS (Suicide Severity Rating Scale), ASQ (Ask Suicide-Screening Questions), PSS-3 (Patient Safety Screener), PHQ-9 (Patient Health Questionnaire).	Youth SAVE Version 4 Curriculum
Behavioral Safety Assessment (also known as a "**Threat Assessment**") helps identify situations that may pose a risk of violence or harm, determine the seriousness of that risk, and develop both safety and supervision strategies.The initial assessment of concerning statements or behaviors is addressed at the school level. Most safety threats fall within the Level 1 protocol conducted by a school-based team comprised of an Administrator, School Counselor/School Psychologist/School Social Worker, and an SRO/YSO or representative from law enforcement.The Level II protocol, which is followed if there is a perceived high risk, is a collaborative, multidisciplinary effort involving representatives from schools, public mental health, law enforcement, juvenile justice, child welfare, and other community-based services. Schools may partner with other resources (ESDs, outside organizations) to complete/evaluate a Level II assessment.	Northwest Regional ESD Note: This is not the same as Level 1 or Level 2 as indicated in this Toolkit and the two processes should not be conflated.

Term and Definition	Notes and Sources of Definition
Universal Screening for Suicide (School Based) processes are intended to survey a large group of students with the purpose to identify individual students who might be at risk for suicide and includes follow up on individual needs. Students universally (eg: whole grade level, school/district) take a suicide screening tool at and during school that is administered by school staff and includes questions designed to discover students who may have active higher risk or need individual follow up due to suicidal ideation/thoughts, multiple risk factors, etc. The purpose of this type of screening process is to identify individual students who could benefit from a follow up with trained school-based staff (eg: school counselor, administrator, school nurse, school psych, school based social worker, etc) to initiate more in-depth suicide screening protocols (including potentially referring them to resources outside of the educational setting) and to inform guardians with the goal of identifying and developing wrap-around supports for the student. This could be part of a broader screening questionnaire (eg: bullying concerns, broader mental health concerns, etc) or could only ask about suicide concerns.	Workgroup defined

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