2021

Suicide Prevention Policy

CROOK COUNTY SCHOOL DISTRICT

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Crook County School District

Suicide Prevention Flowchart

Suicide Concern

Interview by School Counselor or Trained Professional

Interview Student using the Suicide Risk Monitoring Tool

If no ideation or

No plan

Document

Inform staff of outcome

Low Risk

Wish to die or suicidal ideation without method, intent, plan, or behavior

Student Support Plan

Parent contact

F/U with student

F/U with Staff

Moderate Risk

Suicidal ideation with method, without plan, intent, or behavior in past month

Student Support Plan

Parent contact – ROI

Decision to take student home

Mental health resources

Check in support

Close gap with teacher

High Risk

Suicidal ideation with intent or intent with plan in past month

Contact Crisis Team Best Care

541-323-5330

Parent contact

ROI from parent

Administration contact

Re-Entry

Parent F/U

Obtain Safety Plan from comm. resource

Create Student Support Plan with Safety Plan

Collaborate with all care involved

Weekly check-in

Crook County Suicide Risk Monitoring Tool

Student Name:______________________ Date:______________________

Completed by:______________________ Title: ______________________

I. IDEATION	
Have you had any thoughts of killing yourself?	☐ Yes ☐ No
Have you wished you were dead?	☐ Yes ☐ No
Past 24 hours?	☐ Yes ☐ No
Past Week?	☐ Yes ☐ No
Past Month?	☐ Yes ☐ No
Have you had these thoughts and had some intention of acting on them? (Frequency)	☐ Daily ☐ Hourly ☐ Every minute
How long do these thoughts last? (Duration)	☐ A few seconds ☐ Minutes ☐ Hours ☐ Days ☐ A week or more
How disruptive are these thoughts to your life? (Intensity)	☐ Daily ☐ Hourly ☐ Every minute

II. INTENT	
How much do you want to live?	☐ Not at all ☐ Somewhat ☐ A great deal

III. PLAN	
Do you have a plan?	☐ Yes ☐ No
Have you written a suicide note in the past month?	☐ Yes ☐ No
Have you been thinking how you may do this?	☐ Yes ☐ No
Do you have access to the method?	☐ Yes ☐ No
Have you identified when and where you would carry Out this plan in the past?	☐ Yes ☐ No

III. PLAN - continued	
Have you made a recent attempt?	☐ Yes ☐ No
If so, when/how/where?	☐ Yes ☐ No

When?____

How?____

Where? ____

IV. WARNING SIGNS			
How hopeless do you feel that things will get better?	☐ Not at all	☐ Somewhat	☐ A great deal
How much do you feel like a burden to others?	☐ Not at all	☐ Somewhat	☐ A great deal
How depressed, sad, or down do you currently feel?	☐ Not at all	☐ Somewhat	☐ A great deal
How disconnected do you feel from others?	☐ Not at all	☐ Somewhat	☐ A great deal
Is there a particular trigger/stressor for this student?	☐ Yes	☐ No	
If so what?	____________________		
	____________________		
	____________________		
Has it improved?	☐ Not at all	☐ Somewhat	☐ A great deal

V. PROTECTIVE FACTORS	
Reasons for living (things good at / like to do / enjoy / other) Supportive People (family / adults / friends / peers)	What could change about your life that would make you no longer want to die?

VI. RISK LEVEL	
Low Risk	☐
Moderate Risk	☐
High Risk	☐

VII. ACTIONS TAKEN / RECOMMENDATIONS	
Parent/guardian contacted?	☐ Yes ☐ No
Released to parent/guardian?	☐ Yes ☐ No
Referrals provided to parent?	☐ Yes ☐ No
Support Plan developed?	☐ Yes ☐ No
Recommending removal of method/means?	☐ Yes ☐ No
If currently in treatment, contact made with therapist/psychiatrist?	☐ Yes ☐ No
Outpatient therapy recommended?	☐ Yes ☐ No
Recommending 24-hour supervision?	☐ Yes ☐ No
Other (please describe):	________________________ ________________________ ________________________ ________________________

________________________ ________________________

Counselor Name (Print) Counselor Signature

____

School Administrator Name (Print) Admin Signature

________________________ ________________________

Notified Pertinent School Staff

________________________ ________________________

________________________ ________________________

Guidelines to Determine Risk Level and Develop Interventions to LOWER Risk Level

The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential *clinical judgment*, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From the American Psychiatric Association,
Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors.

Risk Stratification	Triage
High Suicide Risk □ Suicidal ideation with intent or intent with plan **in the past month** Or □ Suicidal behavior **within the past month**	□ Contact Crisis Team - Best Care 541-323-5330 □ Notify the parents of their child's crisis status and request that they come to school □ Request that parent sign a Release of Information (ROI) form so that personnel can collaborate and communicate with community mental health providers □ Update administration and appropriate staff of student's status
Moderate Suicide Risk □ Suicidal ideation with method, **without plan, intent, or behavior in the past month** Or □ Suicidal behavior more than 1 months ago Or □ Multiple risk factors and few protective factors	□ Notify the parents of their child's status □ Develop Support Plan with student □ Release the student to the parents □ Obtain an ROI form from parent □ Provide mental health resources □ Follow-up with staff to close the gap
Low Suicide Risk □ Wish to die or suicidal ideation **without method, intent, plan, or behavior** Or □ No reported history of suicidal ideation or behavior	□ Develop a Support Plan with the student □ Notify parents of their child's suicidal ideation □ Provide community mental health resources list □ Close gap with appropriate staff

Suicide Risk Levels and Required Action Steps

<table>
<tr><th colspan="2">Low Risk (Ideation Only)</th></tr>
<tr><td>
☐ Fill out the CCSD Suicide Risk Monitoring Tool
☐ Develop a support plan with the student
☐ Notify parents of their child's suicidal ideation
☐ Provide community mental health resources list
☐ Close gap with appropriate staff
</td><td>
☐ Check-in with the student weekly until ideation is no longer present
☐ Check-in with staff to obtain student behavior feedback
☐ Add interactions to Student Support Plan
</td></tr>
<tr><th colspan="2">Moderate Risk (Current Ideation without Plan, Intent, or Behavior)</th></tr>
<tr><td>
☐ Supervise student until they are in a safe location with staff
☐ Develop Support Plan with the student
☐ Notify the parents of their child's suicidal ideation
☐ Release student only if: parent or guardian agrees to increase supervision and provide mental health resources and encourage services
☐ Obtain a ROI form from parent Check-in with student (weekly basis or as needed) Follow-up with staff to close the gap
</td><td>
☐ Check-in with the student weekly to provide healthy coping skills
☐ Follow-up with parents about status of mental health therapist (where and who is student seeing)
☐ Reach out to mental health therapist or other community member to collaborate and best support student at school
☐ Add information to student's Support Plan
☐ Provide appropriate staff an update of student's ongoing services and treatment
</td></tr>
<tr><th colspan="2">High Risk (Current Plan and Access to Method)</th></tr>
<tr><td>
☐ Supervise student at all times (including restroom)
☐ Contact Crisis Team (Best Care: 541-323-5330)
☐ Notify the parents of their child's crisis status and explain what has been done to assist student. Request that student comes to school.
☐ Request that parent sign a ROI so that school staff can collaborate and communicate with community mental health providers
☐ Update administration and appropriate staff of student's status and plan
</td><td>
☐ Document all actions, including:
☐ Interventions taken (contacted Best Care, parents are informed, staff are aware, etc.)
☐ Forms filled by parents (ROI)
☐ Plan for student
☐ School must develop a re-entry plan if the student is hospitalized, or was seen by any outside agency because of suicide risk
☐ A re-entry meeting with parents, school, and community mental health personnel should take place before student returns to school to support the student
</td></tr>
</table>

CROOK COUNTY SCHOOL DISTRICT
CHILD ABUSE / NEGLECT REFERRAL

Person initiating this referral must: Report incident immediately by telephone to law enforcement agency (LEA) or Department of Human Services (DHS) at 855-503-7233; (FAX) 541-693-8999

ALLEGED VICTIM: Interpreter Needed __ Yes __ No **Disability: ______________________**

______________________________ ____ ____________ __ Male __Female
LAST NAME FIRST M.I. AGE DATE OF BIRTH

SCHOOL ______________________________ **GRADE ____________**

PARENT/GUARDIAN: ______________________________ **PHONE ____________**
LAST NAME FIRST M.I.

ADDRESS / CITY / ZIP: ______________________________

INFORMATION GATHERED: **Be as detailed and factual as possible without soliciting further information. Include what was said regarding where, when, people involved, people reporting and relationship to victim. Note type of abuse (physical, sexual, emotional neglect) and indicators (use reverse side if necessary).**

____
____
____
____
____
____
____

(Notification of parent is responsibility of DHS or LEA)

REPORTED TO: (Indicate which agency)

Local Office for Services to Department of Human Services (DHS) Involvement:

Date ____________ **Time ____________**

Name of Contact at DHS ______________________________

Law Enforcement Agency (LEA) Involvement (if known): ______________________________

Date ____________ **Time ____________**

Agency Response (if known) ______________________________

Signature of LEA/DHS Agent, if child taken into Protective Custody ______________________________

INFORMATION GATHERED BY AND MADE CALL

Person who gathered information and made call (signature): ____________ Date: ________ Time: ________

Administrator / Supervisor (Signature) ____________ Date: ________ Time: ________

DO NOT FILE IN CHILD'S SCHOOL RECORD

Copy of Report to Superintendent's Office: Updated 1/10/2020

Authorization to Use and/or Disclose Educational and Protected Health Information

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

________________________________ ________________________________

(Student/Child's Name) (Date of Birth)

________________________________ ________________________________

(Other Names Used by Student/Child) (School or Program Name)

Name and address of health care provider authorized to:

- ❑ Send/disclose protected health information
- ❑ Receive/use educational information

Name and address of school/EI/ECSE program authorized to:

- ❑ Send/disclose educational information
- ❑ Receive/use protected health information

____

____

2. I understand that this information will be used for the following purposes (check all that apply):

❑ Determining eligibility for Special Education, EI/ECSE, or other services ❑ Determining student/child's current levels of performance ❑ Developing an individualized health plan	❑ Developing an appropriate Individualized Education Program or Individualized Family Service Plan ❑ Other (specify): ______________________

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

❑ Physician's Eligibility Statement	❑ Educational Information	❑ Psychological evaluations
❑ Health Assessment Statement	❑ IFSP/IEP document	❑ Social work reports
❑ History and physical exam	❑ Clinic records	❑ Other: ________________
❑ Entire medical record	❑ Communicable disease(s)	________________________
❑ Prenatal information	❑ Progress notes	

4. By *initialing* the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.

____Drug/alcohol diagnosis, treatment or referral information requested: ______________________________

_____HIV/AIDS related records requested:____

____Mental health related information requested: ______________________________________

_____ Genetic testing information requested: ____

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

c. I may revoke this authorization at any time by notifying _____________________in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

____

(Signature of Parent, Legal Guardian, Student/Child) (Date)

____

(Relationship)

This authorization expires on ____________________ (Month/Day/Year) (not to exceed one year from date of signature above).

Authorization to Use and/or Disclose Educational and Protected Health Information

Purpose of form:

- This form was created so that educational agencies could request information from health entities that require HIPAA-compliant release forms. (HIPAA: Health Insurance Portability and Accountability Act)

- This form is used when there is a need to obtain consent from a parent, legal guardian or student/child to authorize the named agency to:
- Send/disclose protected health information and/or educational information; and/or
- Receive/use protected health information and/or educational information

Directions for completing form:

Box 1. Required.

- Enter the student/child's full legal name including middle name;
- Enter other names used by the child including nicknames;
- Enter child's date of birth;
- Enter the name and address of the health care provider who will send or receive requested protected health and/or educational information;
- Enter the name and address of the school district or EI/ECSE program sending or receiving the requested protected health and/or educational information; and
- Check all appropriate boxes that apply indicating which provider is authorized to send and which provider is authorized to receive protected health and/or educational information.

Box 2. Required.

- Mark all the boxes that apply regarding how the requested protected health and/or educational information will be used. For a record that is not represented in the list, check the "other" box and specify a different type of purpose.

Box 3. Required.

- Mark all the boxes that apply regarding which specific medical and/or educational records are being requested. For a record that is not represented in the list, check the "other" box and specify a different type of record.

Box 4. Required only if any of the four types of records indicated are requested. This box should be left blank if none of these four types of records are requested.

- The four types of records indicated require an additional level of protection. To request any record in Box #4, the specific type of record must be listed in the spaces provided and the parent, legal guardian or student/child must initial the space before each type of record requested. For example, for mental health information, a program might indicate "psychologist's assessment" and then the parent, guardian or student/ child would initial the space at the beginning of the mental health information line.

Box 5. Required.

- This box contains information relating to the parent's, guardian's, or child's rights in giving authorization including the right to refuse to sign, the right to request a copy after signing, the right to inspect the information to be used and/or disclosed, and the right to revoke the authorization. Information is given that clarifies that when requested information is sent, the laws that protect that information may no longer apply since the receiving agency may not be bound by the same laws as the sending agency.
- In item c., identify who will receive the potential revocation. The statement clarifies that if an action has already been taken, for example, protected health information has already been sent, then the revocation for that specific information is not valid. However, the agency may voluntarily return the information received after the revocation has been signed and submitted.

Box 6. Required.

- Parent, legal guardian, or student/child must sign for the authorization to be valid. If parent or guardian, the relationship to the child must be indicated. The date of the signature must be entered.
- The authorization is only valid for the purposes checked or stated in the form.

Box 7. Required.

- The month, day, and year that this authorization will expire must be included in the space provided. The date must not go beyond one year past the date of the signature.

Additional directions

- Place a copy of this form into the student/child's file.
- HIPAA requires that the school district/EI/ECSE program give a copy of the authorization form to individuals who sign it and request a copy. However, it is recommended practice that the school district/program automatically give the parent, guardian, or student/child a copy of the form after they have signed it, whether or not they request it, so they will have a record of the authorization.

Checklist for School Re-entry of Suicidal Student

Designee

- ✓ Meet with student's parent(s)/guardian(s) to discuss re-entry and steps needed to ensure the student has a successful return to school.
- ✓ If ROI form was signed, review student's progress with community mental health provider. If ROI was not signed, discuss with parents/guardians and the benefits of this form.
- ✓ Review all information from the mental health provider, especially with regards to safety planning and needed support services at school.
- ✓ Plan the follow-up services within the school in order to further assist the parents/guardians and the student.
- ✓ Discuss any foreseeable social and/or academic challenges their child will experience and make a plan for easing those challenges.

Counselor or Designated Staff Member (i.e., Suicide Prevention/Risk Specialist)

- ✓ Meet with the student on first day of return before he/she attends any classes. Regularly (at least once a week) check in with the student to assess his/her adjustment to academic and social environment.
- ✓ Discuss with student the progress he/she feels they made while under mental health care.
  - Do they feel hopeful for the future?
  - Are they looking forward to getting back to classes?
  - Are they looking forward to meeting up with friends?
  - Who are their friends?
- ✓ Help them identify and know how to find you (or another adult they express trust in) if they are distressed or have a question.
- ✓ Review the plan for staying in touch with him/her to make sure they are adjusting to the academic and social requirements.
- ✓ If the student has been out for an extended time, missed assignments may have to be prioritized by importance. Counselor coordination with teachers is advised in order to set up a manageable schedule for the student. Also, consider postponing interim or final course grades until the student has had time to catch up
.
- ✓ Provide appropriate information to the student's teachers and any other staff on a need-to-know basis, so they can be alert to any further warning signs.

Re-Entry Support Plan

Student Name:______________________________________ Date:_______________________________

Completed by:_______________________________________ Title: ______________________________

Recommendations from Safety Plan

Provided by________________________________

School Support

Triggers (things that make me feel upset):

Signs I am having a hard time (what do I look like when I am starting to have a hard time):

Challenging behaviors (things I do when I am upset):

Coping skills (things that make me less upset and do well):

What doesn’t work (things that make me feel worse):

Other:

Coping Strategies

(Have student identify at least three strategies)

- ☐ Practice deep breathing
- ☐ Do a puzzle
- ☐ Squeeze an ice cube or stress ball
- ☐ Make your bed
- ☐ Play a computer or video game
- ☐ Turn on all the lights
- ☐ Throw rocks into the woods
- ☐ Suck on a peppermint or chew gum
- ☐ Drink tea, hot chocolate, or warm milk
- ☐ Rearrange your bedroom
- ☐ Go for a walk
- ☐ Read a book/go to the library
- ☐ Write something
- ☐ Bake something
- ☐ Take a warm bath
- ☐ Take a hot or cool shower
- ☐ Give yourself a manicure or pedicure
- ☐ Play cards
- ☐ Wash your face
- ☐ Do something nice for someone else
- ☐ Clean/organize/do laundry
- ☐ Make a gift for a loved one
- ☐ Visit someone in your support system
- ☐ Play with a pet or visit an animal shelter
- ☐ Look at photos
- ☐ Look at recipes to try
- ☐ Memorize something
- ☐ Go for a drive
- ☐ Arrange not to be alone
- ☐ Eat healthy
- ☐ Pray
- ☐ Keep up with a 12-step program
- ☐ Ask how someone's day was
- ☐ Write down things you are thankful for
- ☐ Say one affirmation each day
- ☐ Garden
- ☐ Write a letter Journal
- ☐ Cook your favorite meal
- ☐ Call a friend/family member
- ☐ Go window shopping
- ☐ Do a craft or art project
- ☐ Paint a picture
- ☐ Draw
- ☐ Light candles
- ☐ Listen to music
- ☐ Volunteer somewhere
- ☐ Sing/play a musical instrument
- ☐ Dance
- ☐ Watch tv or a funny movie
- ☐ Smile at or compliment someone
- ☐ Sew, knit, or crochet
- ☐ Spend time outside/in the sun with eyes closed
- ☐ Meditate/do yoga
- ☐ Count backwards from 500
- ☐ Stretch
- ☐ Exercise Take a nap
- ☐ Do something you enjoy
- ☐ Buy something you've been wanting
- ☐ Go to a support group
- ☐ Take a day trip

Student Re-Entry Plan (If Applicable)

Student: ______________________________________ Date: ______________

Primary School Contact: ______________________________________

Secondary School Contact: ______________________________________

What will the student's schedule look like upon returning to school?

Will accommodations need to be made for missed work?

Additional accommodations

Updated 4/16/21

Need Help with paying for counseling services?

You may qualify for a reduced fee through a program that most counseling partners call a *Sliding Scale*. They use your income level as a measure to what you can afford for services. Partners want to work with families to the best of their ability so they typically work to make counseling as affordable as possible. When you call to talk to a scheduler ask about their sliding scale program.

You may qualify for The Oregon Health Plan.

The **Oregon Health Plan** (OHP) is a program that pays for low-income Oregonians' healthcare. The State of **Oregon** and the US Government's Medicaid program pay for it. It covers different groups of services, called benefit packages.

To see if you qualify contact – Crook County Health Department *(541) 447-5165*

Crook County Private Counseling Resource list

Best Care Treatment Services

Location (Prineville)

1103 NE Elm St,

Prineville, OR 97754

541-323-5330

Hours 9:00 am – 7:00 pm

Finances

- Initial Intake cost: Based on income
- Sliding Scale: Yes
- Accepts Insurance/OHP: Yes
- Session length: 30, 45, or 60 min.

Can Assist with OHP enrollment services

Brightways Counseling Group

Location (Redmond, Madras, - coming to Prineville 2021!)

Eagle Crest Resort

7515 Falcon Crest Drive #200
Redmond, OR 97756

Scheduler: 541.904.5216

Hours 8 am – 5 pm

- Initial Intake cost: Varies
- Cost per Session: Varies
- Sliding Scale: Yes – Application Required
- Accepts Insurance/OHP: Yes

Forever Family Therapy

Location (Prineville, Bend)

Prineville

446 NW 3rd St.
Suite 105
Prineville, Or. 97754

Scheduler: 541.846.8173

Hours Available upon request

- Initial Intake cost: Sliding scale; $150 - $200
- Cost per Session: Individual; Sliding scale $50 - $100
  Family; sliding scale $60 - $110
  In home counseling; Sliding scale $70 - $120
- Sliding Scale: Yes
- Accepts Insurance/OHP: Yes

https://www.foreverfamilytherapy.org/

Imagine Freedom Counseling

<u>Location</u> (Prineville)

445 NW Third Street,
Prineville, Oregon 97754

(541) 447-6959

<u>Hours</u>	9:00 AM - 12:00 PM, 1:00 PM - 5:00 PM	Monday – Thursday
	9:00 AM – 12:00 PM	Fridays

<u>Finances</u>

- Initial Intake cost: Free
- Cost per session based off of income
- Sliding Scale: Yes
- Accepts Insurance/OHP: Yes

Prineville Counseling Center

Donna Hamlin LPC Counseling
Licensed Professional Counselor, LPC

<u>Location</u> (Prineville)

190 NW 4th St
Prineville, Oregon 97754
Call Donna Hamlin

(541) 416 - 3697

<u>Hours</u> 9:00 am – 6:00 pm

<u>Finances</u>

- Cost per Session: Varies
- Sliding Scale: Yes
- Accepts Insurance/OHP: Yes

Rimrock Outpatient Services

-Mental Health & Substance Abuse Counseling-

Location (Prineville)

1333 NW 9th St.
Prineville, Oregon 97756

Hours

Scheduler (541) 388-8459

- Intake Assessment required
- Cost per Session: 50 min: Call for quote
- Accepts Insurance/OHP: Yes
- Sliding Scale:

St. Charles Behavioral Health

Location (Prineville, Redmond, Bend)

384 SE Combs Flat Road
Prineville, Oregon 97754

Scheduler (541) 706 – 2768

Hours 8 am – 5 pm

- Initial Intake cost: Yes
- Cost per Session: Varies
- Sliding Scale: No
- Accepts Insurance/OHP: Yes