East Porter County School Corporation

RISK ASSESSMENT AGREEMENT

I, ______________________________, the Parent/Guardian of ______________________________ student (DOB:______________) enrolled in East Porter County School Corporation have been informed by ____________________ (Social Worker/Counselor) at ____________________(school) that ____________________ (student) has made statements or displayed actions that warrant a concern for the safety of the above listed student, a fellow student(s), and/or school personnel.

East Porter County School Corporation is requesting the parent/guardian have a risk assessment completed by a licensed Mental Health professional.

The parent/guardian understands and agrees that the parent/guardian will be responsible for all costs related to this evaluation and that East Porter County School Corporation will not be financially responsible for any costs related to assessment and/or treatment.

The above listed parent/guardian further gives permission for the referring social worker and the mental health provider chosen by the parent/guardian to exchange information concerning the student listed above. This release will be in effect for one school year or until the parent/guardian revokes this agreement in writing to East Porter County School Corporation.

______________________________ ______________

Parent/Guardian Date

______________________________ ______________

Social Worker/Counselor Date

Social Worker/Counselor to keep original agreement;

One copy given to Parent/Guardian for Mental Health Professional and one copy for their records;

Parent/Guardian to provide name and phone number for Mental Health Professional to Social Worker/Counselor within 48 hours.

Mental Health Professional: ______________________________

Phone Number: ____________________

SUICIDE IDEATION FORM

Student Name: ______________________ Date: __________ Time: ______

What does the student say?

Has the student considered this for some time? _____no _____ yes, how long? __________

What problems does the student mention?

What emotions are in evidence? ____ anger ______ frustration _____ hopelessness* ______ rejection _____ self-hate* ______ revenge _____ indifference* _____depression*

Other not listed: ____

Who does the student live with?

Does the student mention alcohol or drug use? _____no _____ yes, frequency __________

Is there evidence of rational thinking?

Is suicide plan thought out? ______ or vague? ________

Method?

Possibility of rescue?

Availability of materials?

Can student name friends, family, or other social supports he/she would like to speak to about this?

Are there any school problems?

Has a precipitating event occurred such as a death of a loved one, major change in home situation, etc?

Can the student think of any other solutions to the underlying problem?

ASSESSMENT OF SUICIDE RISK

Student Name: ____________________ Date: __________ Social Worker: ______________

PROBABLITY OF ATTEMPT ______ **LOW** ______ **MEDIUM** ______ **HIGH**

	RISK		
	Low	**Medium**	**High**
Suicide Plan			
A. Details	____vague	____ some specifics	____ knows when, where, how
B. Availability of Means	____ not available	____available, has close by	____ has on hand
C. Time	____ no specific time	____ within in a few hours	____ immediately
D. Lethality of Method	____ pills/slash wrists	____ substances, car wreck	____ violent action, carbon monoxide
E. Chances of Intervention	____others present	____ others available if called	____ no one nearby, isolated
Previous Attempts	____ none or 1 low lethality	____ several low or 1 med.	____ 1 high or several med.
Stress	____ no significant	____med. reaction to loss, pressure, or change	____severe reaction
Symptoms			
A. Coping Behavior	____daily activities, as usual	____ some disturbances	____ gross disturbances
B. Depression	____ mild, slightly down	____moderate	____ overwhelmed with hopelessness
Resources	____ help available/willing	____ family and friends inconsistent	____ family and friends unwilling/annoyed
Type of Communication	____ direct	____ interpersonalized goal	____ very indirect or non-verbal
Life Styles	____ stable	____ recent acting out/substance abuse	____ unstable
Medical Status	____ no problems	____ acute or psychosomatic	____ chronically debilitated or ill

TOTAL ____LOW ____ MEDIUM ____ HIGH

SUICIDE REPORT FORM

Student Name: ______________________________ **Date:** __________

Name of Person Making Initial Report: ______________________________

Name and Position of Person Handling Case: ______________________________

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Student Interviewed By: ______________________________

Student Statements:

Parent or Guardian Contacted: ______________________________

Parent Contact Made By: ______________________________

Follow-Up Taken:

Follow-Up Done By: ______________________________

Comments:

Other People/Organizations Contacted:

This form is to be filed in confidential file separate from the student's curriculum file.

Report of Threat or Threatening Behavior

School: ____

Principal: ____

Please answer the following:

1) When the event(s) took place (date, time)?
2) Where it happened (place, location)?
3) Who was involved {names of person(s)}?
4) What happened?
5) What was the result?

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Copies to: Principal; Social Worker

Social Worker Signature: ____________________

Principal Signature: ______________________

Date Submitted: _________________________

GUIDELINES FOR PARENTS IF A CHILD EXPRESSES SUICIDE IDEATION OR THOUGHTS OF HARMING SELF

Having a child express thoughts of suicide or causing harm to himself/herself can be a very shocking experience for a parent. Your own personal reactions may vary from anger, guilt, sense of failure, embarrassment, denial of the situation, and/or feelings of total loss as to how to respond. While these are very common reactions, a priority needs to be given to providing support for your child.

East Porter County School Corporation has taken the position that it is extremely important that we notify the parent whenever it is learned that a student is expressing thoughts of suicide or causing harm to himself/herself. While we are not in the position to provide intensive counseling to your child, the school is willing to continue to work with you to insure the safety and wellbeing of your child. In doing so, you may be asked to help develop an action plan with the school to provide the support that is needed.

The following are presented as general guidelines to follow.

1. **Take every complaint and feeling expressed seriously:** Do not dismiss or under value what your child is expressing. All talk of self-harm should be taken seriously. Often the child may express concerns in a very low-key manner, but may be trying to express profound feelings of distress.
2. **Be concerned and competent:** Talk with your child in a very calm, confident, and reassuring manner. Present yourself as a model of a competent, problem solving, adult who can take in information, remain calm, help choose alternatives, and take action to help your child. Even if you are "falling apart" inside, you need to project the image of calm, concerned, and competent. Let the child know that you will work through this together.
3. **Avoid using the phrase "You shouldn't feel that way":** The feelings that your child is experiencing are very real to him/her at that moment and need to be acknowledged. It often helps to reflect back or repeat what your child has told you. Acceptance of his/her feelings of confusion is very important. The last thing a child needs at this time is the feeling that he/she has disappointed another person or has made another person angry with the child.
4. **Be a listener:** Be empathic while listening to your child...anticipate a wide range of possible reactions from your child...be reassuring and continue to stress the need to develop a plan of action with the child.
5. **Accept all feelings, fears, and concerns of your child:** Acceptance helps to keep feelings out in the open. Even though the concern may seem very small to you, it is very important to your child.
6. **Ask "what" questions instead of "why":** Asking **WHAT** questions as opposed to **WHY** questions helps avoid putting the child on the defensive (i.e. "What are the things that are bothering you? Instead of "Why are you acting like this?")
7. **Do not be misled by your child's comments that he/she is past the emotional crisis:** Often a child will feel initial relief after talking about suicide ideation, but the same thinking may occur later. Continued observation and follow-up is crucial to insure a good intervention.
8. **Be an observer:** Be alert for personality and behavioral changes in your child. Changes may be noticed immediately or even several weeks later. Be aware of changes in academic performance or personal habits. These changes can be subtle or very direct. Be aware of both positive and negative changes.
9. **Know your own feelings and reactions:** Be aware of your own feelings about your child's behavior before you interact with him/her. You will not necessarily be sharing your feelings with your child, but you can be aware of them because they will influence your reactions and responses.
10. **DO NOT HESITATE TO SEEK PROFESSIONAL HELP:** This is a situation where it is better to be safe than sorry. Do not let your personal feelings interfere with you contacting your family physician, a counselor/therapist, or Porter Strake for assistance.
11. **Suicide watch:** In high or moderate risk situations, you may need to organize a family "suicide watch" until the crisis is past or you have gotten help. This may mean that you do not leave your child alone without adult supervision. You may also need to remove obvious methods of suicide from your home.
12. **Do not try to win arguments about suicide with your child:** It is best to offer and supply support and reasons for living to your child.
13. **Keep communication open with the school:** It is important that the home and school work together and communicate openly with each other in order to provide the best support for your child.

PORTER STARKE SERVICES: 219-531-3500
SUICIDE PREVENTION 24/7 HOTLNE: 1-800-273-8255
TREVOR PROJECT 24/7 HOTLINE FOR LGBTQ YOUTH: 1-866-488-7386

THE LINKS BETWEEN DEPRESSION AND SUICIDE

- Major depression is the psychiatric diagnosis most commonly associated with suicide.
- About 2/3 of people who complete suicide had a depressive disorder at the time of their deaths.
- People who are diagnosed with depression have a lifetime risk of suicide at 15%; the majority have not received treatment.
- The risk of suicide amongst people with depression is approximately 30 times that of the general population.
- Suicide is particularly likely during early stages of a depressive episode, which is why early intervention is encouraged.
- People who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.
- People who drink alcohol in addition to being depressed are at a greater risk for suicide.
- People who are depressed and exhibit the following symptoms are at particular risk for suicide:
  - Extreme hopelessness
  - A lack of interest in activities that were previously enjoyed
  - Heightened anxiety
  - Insomnia
  - Panic attacks
  - Delusions or hallucinations

THE FACTS ABOUT SUICIDE

5,491 youth age 15-24 died by suicide in 2015.

Suicide was the 2nd leading cause of death for 10-24 year olds in 2015.

Nearly 18% of high school students surveyed in 2015 admitted to seriously considering suicide in the last 12 months.

Girls are more likely to attempt suicide, but boys are 4.34 times more likely to die by suicide than girls.

There were approximately 1,104,825 attempts of suicide made in 2015. This is one attempt made every 29 seconds.

Overall, the most predominant method of suicide in the US was firearms. This holds true for men, but the leading method of suicide for women was poisoning.

Facts and Data from the American Association of Suicidology

WARNING SIGNS OF SUICIDIAL INTENTION

Approximately 75% of adolescents who attempt suicide exhibit warning signs. They typically tell peers or siblings more often than adults. They may use either direct or indirect means of signaling their distress. Some of these signals are:

1) Specific comments about death – "I'd be better off dead" "I might as well kill myself" "They won't have to worry about me much longer."
2) Remarks about a personal sense of worthlessness – "They'll be sorry when I'm gone" "Nobody will really miss me" "I can't do anything right, why try?"
3) Expressions of self-destructive thoughts in either written form (i.e. journals, letters, poetry) or art work, preoccupation with death or the "darker" side of life.
4) A lack of "connectedness" having only a few acquaintances, no close friends, recent break-up with friends or significant other, recent death in the family or among peers, withdrawn behavior, a refusal to communicate with others.
5) Prior history of suicide in the family of previous attempts, threats or gestures by the adolescent.
6) Expressions of depressed behavior such as, enduring sadness, lack of energy, apathy about the pleasures of life.
7) Inadequate problem-solving skills, fatalistic view of the world, seeing oneself as a victim, dichotomous thinking.
8) Dramatic changes in behavior: life threatening risk-taking, changing eating or sleeping habits, drop in grades, behavioral or personality changes, and disinterest about one's appearance.
9) Prolonged involvement in drug or alcohol abuse or recent heavy usage.
10) Family system problems: chaotic family structure, physical and/or sexual abuse, alcoholism fostering co-dependency behaviors, enmeshed interactions which foster dependency.

LATE STAGE WARNING SIGNS

1) A threat of suicide, either to a friend or staff member (threat can be verbal or written).
2) Making final arrangements…putting things in order.
3) Giving away valuable possessions.
4) Saying good-bye to friends and teachers.
5) Abrupt changes in behavior.
6) A recent suicide (or loss) of someone the student valued or identified with.
7) Preoccupation with death.
8) Communication of this preoccupation with death.
9) Increased isolation.
10) Increased feelings of despair and loneliness.
11) Sudden lift in mood/appearance and behavior after demonstrating feelings of despair and depression.

IF ONE OR MORE OF THESE BEHAVIORS ARE NOTICED, INTERVENE AND ACT… WE CANNOT TAKE THE RISK THAT IT IS JUST A PASSING MOOD.