

Self-Harm Assessment

The objective of this screening is to determine if a student poses a threat to his or her own safety and to assist school staff in developing a safety and supervision plan.

Student Name: _____

School: _____ ID: _____

DOB: _____ Grade: _____ Age: _____

Gender: _____ Date of Incident: _____

Location of Incident: _____

Description of Incident: _____

Staff Involved: _____

Special Education Y/N: _____ Disability: _____

504 Plan Y/N: _____ Disability: _____

Check those staff members involved in this screening:

Administrator (Name/Title: _____)

SRO (Name/Title: _____)

Nurse (Name/Title: _____)

Teacher (Name/Title: _____)

School Psychologist (Name/Title: _____)

School Social Worker (Name/Title: _____)

School Social Worker (Name/Title: _____)

Special Education representative (if applicable) (Name/Title: _____)

Parent/Guardian (Name: _____)

Other (Name/Title: _____)

Response Guidelines for Self-Harm Assessment

1. Take threat seriously.

- _____ Do not leave the student alone without an adult. Do not allow the student access to coats, backpacks, or lockers. Conduct search of student's person and belongings as deemed necessary.
- _____ Tell a building administrator or immediate supervisor.
- _____ For best practice, one of the following people must respond to assess the level of risk: School Psychologist, School Nurse, and/or School Social Worker (if available).
- _____ Involve your school social worker or school psychologist for additional support. If unable to reach them, you may contact another building to request assistance from additional support staff.
- _____ Utilize the *Self-Harm Assessment Worksheet* to assess level of risk.
- _____ If the student has special education services, the following need to be contacted: Laurin McWhorter/Tracie Bauer at District Office, 632-3666, Special Education Coordinators, School Psychologist and/or Social Worker providing services.

2. You MUST notify parent/guardian (for every incident).

- _____ If the parent is willing, they **may** take the student to a counselor of choice or they **may** transport the student to a Behavioral Health Center. Agency: _____
- _____ If the parent or significant person is unavailable or unwilling to help, the student **may** be taken to where an evaluation will be performed. Utilize ambulance or police as determined by administration of SRO.
- _____ If the risk is deemed to be moderate to high based on the *Self-Harm Assessment Worksheet* **and** if the student is eligible for Medicaid services or has no insurance, the CARES line (1-800-345-9049) **must** be called in order to initiate a risk assessment by the SASS team.
- _____ If the risk is deemed to be moderate to high based on the *Self-Harm Assessment Worksheet* and if the parent is unwilling to help, the Department of Children and Family Services (DCFS) **must** be notified at 1-800-252-2873. (DCFS will make the determination to take a report or not.)
- _____ If the parent or significant person is unavailable, administration may call emergency medical assistance for transport by calling 911 or utilizing O'Fallon Police.

3. Document in writing using the *Self-Harm Assessment Worksheet* form.

- _____ Following the assessment, a meeting **must** be held with building administrator, school psychologist, social worker, and other involved parties to discuss recommendations regarding school programming and intervention plan. Parent/guardian **must** be invited and is encouraged to attend.
- _____ Involved school personnel and administration **must** debrief following any incident to review the incident and procedures followed. Assigned point person: _____

Self-Harm Assessment Worksheet

	2 points	1 point	0 points
Are there any previous suicide attempts?	Yes	No	
Contract for safety	Unwilling to contract -or- unable to contract because of impaired reality testing (hallucinations, delusions, dementia, delirium, disassociation)	Contracts but is ambivalent or guarded	Reliably contracts for safety
Suicide plan	Has plan with actual or potential access to planned method	Has plan without access to planned method	No plan
Plan lethality	Highly lethal plan (gun, hanging, jumping, carbon monoxide)	Low lethality of plan (mild cutting, over the counter medication overdose)	Low lethality of plan (superficial scratching, head banging, pillow over face, biting, holding breath)
Elopement risk	High elopement risk	Low elopement risk	No elopement risk
Suicidal ideation	Constant suicidal thoughts	Intermittent or fleeting suicidal thoughts	No current suicidal thoughts
Attempt history	Past attempts of high lethality	Past attempts of low lethality	No previous attempts
Symptoms (check all that apply) <ul style="list-style-type: none"> • Hopelessness • Helplessness • Sadness/Sorrow • Guilt/shame • Anger/rage • Impulsivity 	5-6 symptoms present	3-4 symptoms present	0-2 symptoms present
Current morbid thoughts (Reunion fantasies, preoccupation with death, etc.)	Constantly	Frequently	Rarely
Subjective appraisal of patient's reliability	Replies not trustworthy – several nonverbal cues	Replies questionable – at least one nonverbal cue	Replies trustworthy
Scoring Key	10 or more = High risk	4-9 = Moderate risk	0-3 = Low risk

Signature of Person completing form/Date

Signature of Building Principal/Date

Signature of Person completing form/Date

Adapted from: ASSAULT and VIOLENCE ASSESSMENT TOOL (Courtesy of Psychiatric Nursing, Institute of Psychiatry, Medical University of South Carolina)

The results of this screening do not predict specific episodes of violence, nor are they a foolproof method of assessing an individual's potential to harm others. The purpose of this screening is to identify circumstances that may increase the risk for potential violence and assist school staff in developing a safety and supervision plan.

Parent Acknowledgement

This is to verify that I have spoken with school staff member _____ on _____ (date), concerning my child's suicidal/self-harm risk. I have been advised to seek the services of a mental health agency or therapist.

I will sign a release of information with the assessing therapist/agency/hospital to allow for an exchange of information with school staff.

I understand that _____ (name of staff) will follow up with me, my child, and the agency to whom my child has been referred for services within two weeks.

Parent Signature: _____ Date: _____

Faculty Member Signature: _____ Date: _____

[From DiCara, C., O'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines (p.45). Augusta, ME: Maine Youth Suicide Prevention Program]