School Psychologists as Crisis Mental Health Practitioners

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TODAY'S HIGHLIGHTS
- Quick Glance at California Law AB2246
- Adopting a Trauma Informed Approach
- Toolkit for Mental Health Promotion and Suicide Prevention
- Interventions
  - Recognizing the signs of suicides
  - Conducting a risk assessment
  - Student Safety Planning
  - Hospitalization Process
  - Re-entry meetings with family and students
  - Communicating student needs to teachers
- Importance of Self-Care for School-Based Mental Health Providers

Palo Alto Unified School District

CDC reports: Youth suicide rates in Santa Clara County highest in Palo Alto, Morgan Hill

U.S. Health Officials Are Finally Paying Attention To Palo Alto School Suicides

CDC investigates why so many students in wealthy Palo Alto, Calif., commit suicide
California AB2246:

- This bill would require the governing board or body of a local educational agency, as defined, that serves pupils in grades 7 to 12, inclusive, to, before the beginning of the 2017-18 school year, adopt a policy on pupil suicide prevention, as specified, that specifically addresses the needs of high-risk groups. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. The bill would require the department to develop and maintain a model policy to serve as a guide for local educational agencies.

Specifically addressing the needs of high-risk groups (AB2246):

- The policy shall specifically address the needs of high-risk groups, including, but not limited to, all of the following:
  - (A) Youth bereaved by suicide.
  - (B) Youth with disabilities, mental illness, or substance use disorders.
  - (C) Youth experiencing homelessness or in out-of-home settings, such as foster care.
  - (D) Lesbian, gay, bisexual, transgender, or questioning youth.
Youth Suicide Statistics

- Suicide is the **SECOND** leading cause of death for ages 10-24 (2017 CDC WISQARS).
- Suicide is the **SECOND** leading cause of death for college-age youth and ages 12-18 (2017 CDC WISQARS).
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease, **COMBINED.**
- Each day in our nation, there are an average of over 3,069 attempts by young people grades 9-12. If these percentages are additionally applied to grades 7 & 8, the numbers would be higher.
- Four out of five teens who attempt suicide have given clear warning signs.

(Information provided by The Parent Resource Program: Jason Foundation, n.d.)

Who’s here?

What is Prevention/Promotion, Intervention, & Postvention?

- **Prevention/Promotion:** In an RtI or MTSS Model, this is a Tier 1 intervention providing school-wide supports that all students can benefit from. Everyone has access.
- **Intervention:** Students who require more support than what the Tier 1 level can provide, are typically in small groups for Social Emotional Learning (SEL) or other supports. Check-ins with School Counselor or School Psychologist. Some require this level of access.
- **Postvention:** Students who require intensive support and care after a personal or school-wide crisis.
Focusing on the Intervention

Where do you fall in the pyramid?

Wellness Promotion

“*There is a growing body of research proving that social and emotional learning (SEL) is fundamental to academic success, and must be woven into the work of every teacher in every classroom and every after school and summer learning program if we truly want to prepare all our students for college and careers*” (California Department of Education, CDE, 2019).

“**Wellness promotion/SEL is imbedded in CDE**"
Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. “How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as trauma” (Substance Abuse and Mental Health Services Administration, 2014).

“Public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing” (Substance Abuse and Mental Health Services Administration, 2014). Coercive practices: seclusion, restraints, abrupt removal of child from an abusive family, invasive procedures in the medical system, harsh disciplinary practices in school systems, or intimidation practices in criminal justice. These practices can re-traumatize individuals and interfere with achieving the desired outcomes.

“Gaining a better understanding of how to address the trauma experienced by individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems” (Substance Abuse and Mental Health Services Administration, 2014).
Four Assumptions and Six Key Principles:

1. A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery.
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

(SAMHSA, 2014).

The Toolkit from HEARD Alliance

http://www.heardalliance.org/

Go to this link, scroll halfway, click on Promotion & Prevention Toolkit.
Reviewing the Risk Assessment Process

Speaking the same language with other mental health professionals & specialists

QPR Guidelines

- The Mission of the QPR Institute is: To save lives and reduce suicidal behaviors by providing innovative, practical, and proven suicide prevention training. We believe that quality education empowers all people, regardless of their background, to make a positive difference in the life of someone they know.
- QPR stands for Question, Persuade, and Refer — the 3 simple steps anyone can learn to help save a life from suicide.
- Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR can learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone in need.
- As QPR-trained you will learn to:
  - Recognize the warning signs of suicide
  - Know how to offer hope
  - Know how to get help and save a life

Suicide Warning Signs

- Warning signs are observable behaviors that may signal the presence of suicidal thinking. They might be considered “cries for help” or “invitations to intervene.” These warning signs signal the need to inquire directly about whether the individual has thoughts of suicide. If such thinking is acknowledged, then suicide interventions will be required. Warning signs include the following:
  - Suicide threats. It has been estimated that up to 80% of all suicide victims have given some clues regarding their intentions. Both direct (“I want to kill myself”) and indirect (“I wish I could fall asleep and never wake up”) threats need to be taken seriously.
  - Suicide notes and plans. The presence of a suicide note is a very significant sign of danger. The greater the planning revealed by the youth, the greater the risk of suicidal behavior.
Suicide Warning Signs

- Making final arrangements. Making funeral arrangements, writing a will, and/or giving away prized possessions may be warning signs of impending suicidal behavior.
- Preoccupation with death. Excessive talking, drawing, reading, and/or writing about death may suggest suicidal thinking.
- Changes in behavior, appearance, thoughts, and/or feelings. Depression (especially when combined with hopelessness), sudden happiness (especially when preceded by significant depressions), a move toward social isolation, giving away personal possessions, and reduced interest in previously important activities are among the changes considered to be suicide warning signs. See Attachment 1.8 in Toolkit.

Warning Signs are not the same as Risk Factors

PROTECTIVE FACTORS
- Frequent, vigorous physical activity or participation in sports
- Spiritual faith or regular church attendance
- Cultural and religious beliefs that affirm life and discourage suicide
- Close friends or family members
- Positive school experiences
- Access to effective care
- Restricted access to alcohol, firearms, and medication

RISK FACTORS
- Dramatic changes from their usual self
- Feelings of sadness, hopelessness, and helplessness
- Loss of interest
- Thoughts, trouble concentrating, difficulty making decisions, trouble remembering, and/or hallucinations
- Delusions and/or hallucinations
- Behavior: Withdrawing from people, substance abuse, risky behaviors, missing school, work, or other commitments, attempts to harm oneself (e.g., cutting), and/or unexplained aches and pains

Risk Assessment Considerations

- Speaking the same language in consult with another mental health professional
- Pertinent questions to ask during a risk assessment
- Moderate risk is always tricky
Activity: Attachment 2.3a (pg. 123)

Find some friends...

When called in a crisis situation...

- Scaling Emotional Pain
  - 1 - 10 (Secondary)
  - 1 - 5 (Elementary)

Risk Assessment...continued...
Case Study #1

Rebecca is a middle school student who identifies as a white female of Jewish heritage. She lives with her parents and reports having a positive relationship with her parents. Rebecca visited the school counselor regarding her classes, but suggested ending her life. The school counselor asked if she was thinking about suicide, and she said, yes, and wanted to create a plan in ending her life that afternoon. The school counselor texted the school psychologist and she conducted a risk assessment. Rebecca shared she was planning her death after lunch, but came to the guidance office instead. On a scale from 1-10 she was an 8 on the “pain threshold”. She loves her parents, but suffering in silence for a long period of time. She has never attempted suicide, but has decided ending her life was her only option. What would you consider her level of suicidality?

Case Study #2

Johnny is a sophomore in high school who identifies as a white male. Parents share custody in the same city; 50% of his week with mom and 50% with dad. He also has a twin brother who is very popular and outgoing while Johnny has a few friends and is quiet. A concerned teacher sent the school psychologist an email reporting that Johnny seems “off” and if I could check in on him. The school psychologist sent a call-slip to come after class. On a scale from 1-10 he reported a 7 on “pain threshold”. He reports thinking about suicide and starts crying uncontrollably. Johnny shared that he does not want to die, but doesn’t want his parents to know. He does not have a plan, therefore no means at this time. He reported his reasons for living are his parents and brother. He can’t imagine doing this to them. He has never attempted suicide and does not know what to do. What would you consider his level of suicidal risk?
Case Study #3

Sarah lives in 2 households with shared custody in two different cities. Sarah is a 2nd grade student of African American heritage and has a younger brother. Her parents are going through a contentious divorce. The teacher reported some behavior concerns and completed a counseling referral for the school psychologist and school counselor to review. The school psychologist notes the sudden change in behavior documented by the teacher and meets with Sarah. During an activity of Play Doh, Sarah shared with the school psychologist she wants to die. On a scale from 1-5, her “pain threshold” is a 5. A risk assessment is conducted and her plan was to be eaten by a pack of wolves charging at her. She loves her parents and feels that “dying can help them not fight”. She has a history of suicidal ideation and Sarah shared with the psychologist that her mom has taken her to the emergency room because of it. What is her risk of suicidality?

Safety Planning

Reviewing the safety plan document and how to adopt it into your practice

See Attachments 2.11 & 2.12

Johnny – Case #1

- A safety plan was developed. He had enough protective factors to not hospitalize, but did have to communicate to a parent. Johnny preferred to talk to mom since he was going to her house that evening. He contracted for safety within the safety planning discussion. Johnny was sent back to class and he was aware that his mom will bring up the safety plan after school.
- At home, Johnny had a hard time talking about it so he decided to write notes and pushed them across the dining room table.
- The school psychologist and mom were in communication about supports outside of school-based mental health.
- Mom made an appointment with the pediatrician and was given the HEAR Alliance website to compare Mental Health providers with her insurance providers.
- Johnny walked away with his safety plan on the link http://my3app.org/.
Safety Planning

Step 1: Helping the student identify warning signs.
Step 2: Discussing coping strategies that can be done in the classroom or at home.
Step 3: People and places that the student can go on campus.
Step 4: Help the student identify people that can help such as counselor or psychologist.
Step 5: Private therapist; local ER; and additional numbers.
Step 6: Reducing access to trauma.
Hospitalizations

Who should be involved? Who is notified? What happens?

Hospitalization Hand-off

Rebecca was hospitalized due to at-risk behavior. The school psychologist further assessed intent, plan, and means and was within the high risk. The School Psychologist excused herself from the counselor’s office while she notified the SRO (School Resource Officer). Rebecca remained with the counselor. Since the SRO was not available, 911 was contacted. Patrol came and were briefed on the situation before meeting Rebecca. They were given her profile sheet with name and other identifying information. Once they conducted their interview, she was placed on a 5150 hold.

Rebecca was taken to Stanford in a marked car. The school psychologist called her parents and notified them she was on the way to the ER. At the hospital, she was kept on a 72 hour hold.

Looping Back: Trauma-Informed Approach

- The hospitalization process has the potential for re-traumatizing for students. Some examples are:
  - Abruptly pulled out of class
  - Not knowing what will happen next
  - Police officers (e.g. gun, vest, handcuffs, and patrol car)
  - Items being taken away from them
Re-Entry Meetings

What are they? Who is typically invited?

Communicating Student Needs to Staff

- Who are the pertinent members that should know about what occurred?
- Do parents need to give permission to communicate to teachers?
- Making up assignments and or tests?
- How should it be communicated to the student’s teachers?
- Is the student sharing what happened with friends? What is the reason for their absence? Script?
- What did the doctors say?
- Does she have a follow-up appointment?
- See Attachment 2.14

Return to School or Re-entry

A meeting is scheduled (by school counselor) before the student returns to school

- Family is strongly encouraged to bring all paperwork to the meeting

- Attendees include:
  - Parent
  - Student
  - School Counselor
  - Psychologist
  - ERMHS (if applicable)
  - Administrator
Re-entry Meeting Agenda

- Review any release papers and recommendations
- Discuss a script for student to talk with others
- Discuss what the counselor can/will share with teachers
- Create a transition plan for reentry/ make adjustments to schedule if needed
- Create a plan for student to check in (when and with who – ex: Student to meet with Psychologist/Counselor at brunch) for the first few days/week
- Discuss safety plan process – individually created with psych and student
- Once safety plan is developed, those identified as safe people will be contacted

Applying Trauma-Informed Approach

Connecting Resources

Goals of 1:1 Crisis Counseling:

- Safety: Ensures the individual is safe. If lethality existed before 1:1 crisis counseling, this risk has been reduced and resources, if available, have been provided.
- Stability: Ensures the individual is stable and has a short-term plan which includes mastery of self and the emergency or disaster situation.
- Connection: Help connect the individual to formal and informal resources and support. If resources or supports are not readily available, 1:1 crisis counseling helps the individual pursue potential natural supports/resources.

“It is during our darkest moments that we must focus to see the light.”

- Aristotle Onassis
Importance of Self-Care

Other factors that can escalate psychologists’ occupational stress levels include the time pressures of managed care, having young children, working in isolation, juggling many high-level roles, and being part of a professionally competitive field, says ACCA Chair Michael O’Connor, PhD, a clinical assistant professor in Stanford University’s School of Medicine and a private practitioner in Palo Alto, Calif. “There’s quite a bit of pressure on psychologists to walk the walk, to be a competent person who doesn’t have problems and who has the answers,” he says.

Self Care

Thank you!

If I didn’t get to your question, email me at:

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