LOUDOUN COUNTY PUBLIC SCHOOLS
Department of Pupil Services

Suicide Prevention Guidelines

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PREFACE

As part of a comprehensive approach to suicide prevention, Loudoun County Public Schools (LCPS) developed suicide prevention guidelines. These guidelines are derived from multiple sources including *Child and Adolescent Suicidal Behavior: School-Based Prevention, Assessment, and Intervention*; the *Columbia-Suicide Severity Rating Scale (C-SSRS)*; *Suicide Assessment Five-Step Evaluation and Triage; Preventing Suicide: a Toolkit for High Schools* and §22.1-272.1 of the *Code of Virginia*.

This document is intended as guidance for LCPS staff and is not intended to create a standard of care or in any way create legal liability for LCPS or its staff to third parties.
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BACKGROUND INFORMATION

Hayes (2006) has outlined several principles for suicide prevention, several of which are highlighted here.

- Suicide prevention should not be viewed as a single event, but as an on-going process. Youth who have made suicidal statements or who have a history of suicidal ideation are at risk for recurrence of suicidal thoughts and behavior. For this reason, children and adolescents who have a history of suicidal ideation or attempts should not “fall off the radar” because they are not currently suicidal.
- Prior risk of suicide is strongly related to future risk.
- We should not rely exclusively on the statements of youth who deny they are suicidal but who also have a prior history of suicidal behavior and their current actions and behaviors suggest otherwise.
- We must provide meaningful suicide prevention training to our licensed school professionals who by training and job-related duties are responsible for screening imminent risk of danger related to suicidal ideation.
- Many preventable suicides result from poor communication between the parties involved.
- One size does not fit all. Basic decisions regarding how to manage a youth who has made suicidal statements or who is suspected of suicidal ideation should be based on his/her individual needs, not simply the resources said to be available.

In addition, Berman and colleagues (2006) identified seven components of comprehensive school-based suicide prevention programs: 1) early detection and referral-making skills, 2) resource identification, 3) help-seeking behavior, 4) professional education, 5) parent education, 6) primary prevention, and 7) postvention. Each of these seven components will be addressed individually in the following sections. However, before discussing these seven components, a review of common myths associated with suicide, risk factors for suicide, and protective factors against suicide will be presented.

Common Myths

**Myth:** Asking questions or talking about suicide will increase the probability that it will occur.  
**Fact:** There is no evidence for this belief (Gould et al., 2005). Children and teens who have a trusted adult to talk with about suicidal ideation typically have better outcomes (Mazza, 2006) and direct questioning of children or teens who are suspected of suicidal ideation is a necessary component of all effective risk assessments (Miller & McConaughy, 2005).

**Myth:** Parents are aware of their children’s suicidal behavior.  
**Fact:** At least one study has found that up to 86% of parents were unaware that their child had engaged in suicidal behavior (Kashani, Goddard, & Reid, 1989) which emphasizes the importance of direct questioning of the child about suicidal ideation and behavior.

**Myth:** Those who attempt suicide usually receive treatment for it.  
**Fact:** At least one study found that 88% of teen suicide attempters received no treatment (Smith & Crawford, 1986), emphasizing the need for awareness and appropriate intervention.
Myth: Those who talk about suicide won’t do it and are just looking for attention.
Fact: Individuals who talk about and are questioned regarding suicide are more likely to receive treatment and therefore less likely to succumb to suicide.

Myth: Those who commit suicide do so impulsively and therefore it is difficult to prevent.
Fact: In most cases, individuals who commit suicide have given careful and lengthy consideration to it and have made specific plans (Joiner, 2010).

Risk Factors & Warning Signs

Risk factors and warning signs are not synonymous. There is a difference between suicide risk factors and warning signs, with warning signs being more indicative of a potential imminent attempt. Thomas E. Ellis, PsyD, ABPP, a nationally renowned clinician and author, uses an analogy involving heart attacks to highlight the differences between risk factors and warning signs. Risk factors for heart attack include age and cholesterol level, but neither is considered signs of an imminent heart attack. On the other hand, chest pain and shortness of breath are warning signs of an impending heart attack. Similarly, gender, age, and psychiatric diagnoses are risk factors for suicide. On the other hand, extreme psychological pain, desperate need for relief from pain, and detailed plans for suicide are warning signs. Multiple organizations have provided guidance as it relates to risk factors and warning signs. Examples are included below.

According to the American Academy of Child and Adolescent Psychiatry, common suicide risk factors for adolescents include:

- Males are at a much higher risk than females
- Among males, these factors create a high risk for suicide: previous attempts, age 16 or older, presence of a mood disorder, and substance abuse
- Among females, these factors create a high risk for suicide: previous attempts and presence of a mood disorder

According to the Centers for Disease Control and Prevention:

- Females are more likely to attempt suicide whereas males are more likely to complete suicide
- The strongest risk factors include depression, substance abuse, and aggressive/disruptive behaviors

The University of Virginia Health System reports the following risk factors:

- One or more psychiatric disorders including substance abuse disorders
- Impulsive behaviors
- Undesirable life events or recent losses
- Family history of psychiatric or substance abuse disorders
- Family history of suicide
- Family violence
- Prior suicide attempt(s)
- Firearm(s) in the home
- Incarceration
- Exposure to the suicidal behavior of others

The National Center for Suicide Prevention Training notes the following risk factors:

**Personal Risk Factors**
- Substance abuse
- Isolation
- Psychiatric disorders
- Poor impulse control
- Confusion or conflict about sexual orientation
- Loss of significant relationship(s)
- Compulsive, extreme perfectionism
- Deficits in social skills
- Loss (perceived or real) of identity or status
- Feelings of powerlessness, hopelessness, or helplessness
- Pregnancy or fear of pregnancy
- Exaggerated humiliation or fear of humiliation
- Certain religious beliefs e.g. that suicide is noble
- Major illness

**Behavioral Risk Factors**
- Prior suicide attempts
- Aggression/rage/defiance
- Running away from home
- School failure, truancy
- Fascination with death, violence

**Family Risk Factors**
- Family history of suicide
- Changes in family structure e.g. death, divorce, remarriage, etc.
- Family involvement in alcoholism/other drug abuse
- Lack of strong bonding/attachment within the family
- Withdrawal of support
- Unrealistic parental expectations
- Violent, destructive parent-child interactions
- Inconsistent, unpredictable parental behavior
- Depressed, suicidal parents
- Abuse e.g. physical, emotional, or sexual

**Environmental Risk Factors**
- Stigma associated with help-seeking
- Lack of access to helping services
- Frequent moves and changes in living situation
- Social isolation or alienation from peers
- Access to lethal means e.g. firearms
• Exposure to suicide of a peer
• Anniversary of someone else’s suicide or unexpected death
• Incarceration or loss of freedom; trouble with the law
• High levels of stress, including the pressure to succeed
• High levels of exposure to violence in mass media

**Warning Signs for Suicide**

- Difficulties in school (especially dramatic decreases in academic performance)
- Pervasive, exaggerated or inappropriate feelings of sadness and/or anger
- Drug or alcohol abuse, especially if the young person has not been involved in this previously or if the experimentation turns into habitual use
- Sleeping too much or too little
- Sudden changes in weight (either gains or losses)
- Lack of interest in usual activities/friends
- Loss of religious or spiritual beliefs
- Persistent physical complaints
- Restlessness, agitation, anxiety, aggression
- Feeling like a failure/worthless
- Overwhelming guilt or shame
- Hopelessness or helplessness
- Pessimism
- “Roller coaster” moodiness; more often and for longer periods than usual
- Overly self-critical, self-hatred
- Difficulty concentrating
- Preoccupation with death (often expressed through music or poetry)

**Imminent (Late) Warning Signs**

- Talking of suicide, death
- Isolating self from friends and family
- Feeling life is meaningless
- Putting life in order
- Picking fights, arguing
- Refusing help, feeling beyond help
- Sudden improvement in mood after being down or withdrawn
- Neglect of appearance, hygiene
- Dropping out of activities
- Increasing hopelessness and helplessness
- Giving away favorite possessions
- Verbal cues (see below)
- A detailed plan for how, when, and where
- Obtaining a weapon
- Suicide gestures (e.g. overdose, cutting)

**Direct Verbal Cues**
• I wish I were dead
• I’m going to end it all
• I’ve decided to kill myself
• I believe in suicide
• If such and such doesn’t happen, I’ll kill myself

Less Direct Verbal Cues
• You will be better off without me
• I’m so tired of it all
• What’s the point of living?
• Here, take this. I won’t be needing it anymore
• Pretty soon you won’t have to worry about me
• Goodbye. We all have to say goodbye
• How do you become an organ donor?
• Who cares if I’m dead, anyway?

Much of the information provided regarding warning signs is relevant for individuals aged 24 or older. Until recently, there was no agreed upon warning signs established for young people.

However, in September 2015, a nationwide panel of experts on youth suicide established an empirical and consensus-based list of warning sides in youth. These include:

1. Talking about or making plans for suicide.
2. Expressing hopelessness about the future.
3. Displaying severe/overwhelming emotional pain or distress.
4. Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:
   • Withdrawal from or changes in social connections/situations
   • Changes in sleep (increased or decreased)
   • Anger or hostility that seems out of character or out of context
   • Recent increased agitation or irritability

The more of these warning signs a youth has, the greater the imminent risk.

Protective Factors

The National Center for Suicide Prevention Training identifies the following protective factors:

Personal Protective Factors
• Attitudes, values, and norms prohibiting suicide e.g. strong beliefs about the meaning and value of life
• Good social skills e.g. decision-making, problem-solving, and anger management
• Good health and access to health care
• Friends, supportive significant others
- Cultural, religious or spiritual beliefs (this can also be a risk factor depending on the beliefs)
- A healthy fear of risky behaviors and pain
- Hope for the future
- Sobriety
- Medical compliance and a sense of the importance of health and wellness
- Good impulse control
- Strong sense of self-worth
- Sense of personal control

External/Environmental Protective Factors

- Strong interpersonal bonds, particularly with family members and other caring adults
- Opportunities to participate in and contribute to school and/or community projects/activities
- A reasonably safe, stable environment
- Restricted access to lethal means
- Responsibilities/duties to others
- Pets

Of note, the fact that an individual will agree to sign a suicide contract is not a protective factor. There is an emerging consensus that suicide contracts can provide a false sense of security. Of equal importance, the use of suicide contracts was never evidence-based. There is no scientific evidence of its effectiveness in preventing suicidal behavior, it may be potentially destructive to therapeutic relationships, may lead to concealment of suicidal ideation, and is useless as a defense in liability litigation.

Early Detection and Referral-Making Skills

School-based suicide risk screenings have two primary purposes (Miller, 2011). The first is to determine if a student is potentially suicidal and, if so, to what extent. From the Berman, et al. (2006) perspective, suicide risk screenings partially reflect early detection.

The second important objective of school-based suicide risk screening is linking the screening results with interventions that will best meet the student’s needs. From the Berman, et al. (2006) perspective, this second objective represents referral-making skills. In other words, students who have a lower risk of suicide may not require the same level of intervention that students of higher risk require, but they may still require some degree of attention, intervention or monitoring.

Resource Identification

Schools should have trained professionals available to conduct some form of suicide risk assessment and be able to identify when a referral into the community should be made on behalf of a student. Local mental health agencies, private practitioners, and psychiatric hospitals should be identified and contact information should be readily available. Resources to help students within each school should be identified and communicated to them (Berman, et al., 2006).
**Help-Seeking Behavior**

Schools can increase student’s help-seeking behavior through programs or procedures that encourage reporting of suicidal ideation and creating readily identifiable strategies for addressing student’s suicidal ideation or statements. It has been suggested that schools who have a carefully thought out plan for addressing suicidality decrease the stigmatization associated with suicide and mental illness, which increases students’ willingness to seek help.

**Professional Education**

Berman, et al. (2006) emphasize the importance of continuing education of school personnel as it relates to suicidal ideation and behavior. Professional education should focus on warning signs of suicide, risk factors, protective factors and resources for assistance. Of particular note is the fact that increasing school personnel’s knowledge of suicide has been shown to increase the school’s resource identification.

**Parent Education**

Parents should also receive education regarding suicidal behavior, similar to the information shared with school personnel (i.e., warning signs, risk/protective factors, and resources for help). Because the most frequent method of youth suicide is by firearm in the home, parents can be provided with community resources as it relates to gun management and safety (Simon, 2007), particularly for children who have been identified as at risk for suicide. Parents should take all suicidal statements seriously and to seek professional help for their child. In situations in which the parent reports that the suicidal statements are manipulative or attention-seeking, parents should understand that professional assistance is still required and that these children remain at risk for future suicide attempts. Children who will make suicidal statements manipulatively or for attention are also in need of professional mental health services.

**Primary Prevention**

One major component of suicide prevention is universal prevention through programs that educate youth about suicide and that teach “health-enhancing” behaviors (Berman, et al., 2006). Other programs such as the SOS Signs of Suicide® High School Prevention Program focus on depression awareness, education, and promotion of referral seeking for at risk adolescents.

**Postvention**

Although Berman et al. (2006) identifies postvention to include crisis support to affected students and adults after a student has committed suicide, postvention is more broadly defined as follow up of any screening or assessment that has resulted in an intervention of some type, particularly for students who have been identified as at risk for suicide or who have a history of suicide attempt. Schools must remember that suicide risk screenings/assessments are not a single event, but an ongoing process in which students at risk for suicide are monitored and interventions offered/changed as circumstances warrant.
SUICIDE PREVENTION PROCEDURES

Listed below are the procedures for LCPS school personnel to follow when it is suspected that a student may be at risk of attempting suicide.

1. Some school personnel, such as building administrators and teachers, do not by training and job responsibility possess the skills necessary to professionally screen for suicide risk. These school personnel should immediately report any direct or indirect communication of suicidal ideation from a student or on behalf of a student to the school counselor so that a suicide risk screening can be conducted promptly. If the school counselor is unavailable for any reason, the school should contact the school psychologist, school social worker, or the student assistance specialist in order to request a suicide risk screening.

The school counselor (or school psychologist, school social worker, or student assistance specialist) will notify the building principal as soon as feasible but no later than the end of the day.

2. School personnel should ensure the student is safe and supervised by an adult. If the report is made near the end of the school day, do not allow the child to board the school bus or leave the building until a suicide risk screening has been conducted by a school counselor (or a school psychologist, school social worker or student assistance specialist) and an appropriate plan has been established.

Note: Although parents or Child Protective Services (CPS) are usually contacted after the suicide risk screening, in situations in which the child is held from the bus and is expected home, it may be appropriate for a building administrator to contact the parent (or CPS, if that has already been determined to be the appropriate route) while the school counselor conducts the suicide risk screening.

3. The school counselor (or school psychologist, school social worker, or student assistance specialist) initiates the suicide risk screening and documents the findings using the form entitled Suicide Risk Screening Protocol and Documentation (see Appendices for all forms). The section of this document titled Screening for Suicide Risk Protocol should also be referenced for additional suggestions. In the course of the suicide risk screening, if issues related to threats against the students or bullying emerge, the school counselor is to notify the principal following the screening so that the issue of threats or bullying can also be addressed for the safety of the student.

4. The school counselor (or school psychologist, school social worker, or student assistance specialist) makes contact with the parents following the suicide risk screening. If the reason for the child contemplating suicide is related to parental abuse or neglect, the school counselor notifies the principal but parental contact should NOT be made.

   a. If the parent is to be notified, then whoever conducted the suicide risk screening should initiate the call and provide the following information:
• provide your name and position in the school,
• assure the parent or guardian that the student is currently safe,
• state that you have conducted a suicide screening on the student, the reason for doing so, and explain thoroughly the results of the Columbia Suicide Severity Rating Scale (C-SSRS),
• recommend in your judgment as a school counselor one of the following based on the screening results:
  1) emergency suicide assessment by a licensed mental health professional, or
  2) consultation and/or counseling with a licensed mental health professional
• provide names of community counseling resources if appropriate (the parent should be provided at least two referral resources including Loudoun County Mental Health [703-777-0320]and George Mason University’s Center for Psychological Services [703-993-1370]),
• offer to facilitate the referral and/or contact the child’s therapist (mention the Release of Confidential Information form),
• if the parent requests an additional justification for the call, cite the legal requirement (22.1 – 272.1 of the Code of Virginia),
• determine the parent’s intent to seek appropriate services for the student depending on the screening results
  ▪ parents who opt for supportive interventions outside the licensed mental health arena should be cautioned that such interventions may not be evidence-based and can unintentionally increase a child’s suicidality; if the parent insists on interventions outside of the professional mental health arena, provide at a minimum a recommendation that supportive interventions will include a safety plan and an issues-based intervention procedure that will keep the child safe and will address the precipitant issues
  ▪ in situations in which you recommend a referral to a licensed mental health professional for an emergency suicide assessment (based on the results of the suicide screening) and the parent indicates that they have no intention of seeking services, inform the parent of your legal obligation to contact CPS for medical neglect (703-771-KIDS),

Upon completion of the call, the school counselor shall document the following using the Parent Contact by School Personnel/Notification of Suicidal Thoughts or Feelings documentation form:

• the time and date of the call
• the name of the individual contacted
• the parent’s response
• any required follow up

If the caller is unable to contact either parent or guardian by the end of the school day, then he or she shall contact the building principal to discuss the school’s crisis management plan for seeking treatment for a student without the parent’s authorization.
b. If the reason for the suicide screen of the student is related to parental abuse or neglect, the school counselor informs the principal who, consistent with procedures established by LCPS, calls CPS to report the suicidal statements related to suspected child abuse or neglect. Parental contact should NOT be made. The principal provides the following information:

- emphasize the fact that immediate action is required in order to prevent harm to the child
- his or her name and position in the school
- the name and identifying information of the child
- the legal requirements for the call, citing §22.1-272.1 of the Code of Virginia

**Note:** The investigation of alleged abuse or neglect is often an involved process. CPS workers will be called upon to begin the process of investigation with a child who is very likely to be difficult to interview. It is expected that emergency treatment will be sought *jointly* by school and social services personnel prior to the completion of such an investigation.

Upon completion of the call, the principal shall document the phone call to CPS. The documentation shall include:

- the time and date of the call
- the name of the individual contacted
- the response plan agreed upon
- any required follow up

When CPS needs to be contacted before or after business hours, Monday through Friday, 8:30 am. - 5:00 pm. or CPS is not answering the phone during regular business hours, the principal should call the Virginia State Child Protective Services (CPS) Hotline, 800-552-7096, or call the Sheriff's Office, 703-777-0445, and ask to have the on-call CPS worker paged.

5. The student who is in need of an *emergency suicide assessment* by a licensed mental health professional must remain under adult supervision until a parent, guardian, or authorized individual (in the case of abuse) accepts responsibility for the student’s safety. Ensure that the *Parent Acknowledgement of Notification of Suicidal Thoughts or Feelings* (see Appendices of Forms for explanation) is signed and encourage the parent to sign a *Release of Confidential Information* before the student leaves the building in order to facilitate student safety.

It is possible that some parents may choose to pick up their child immediately in situations in which you have recommended a *consultation and/or counseling* with a licensed mental health professional; of course, this is also acceptable.
6. Follow up planning is critical for students who have been determined to need an emergency suicide assessment with a licensed mental health professional. The form entitled Follow-Up Meeting should be completed during the follow-up planning meeting in order to document the student’s recommended follow-up care. A failure to communicate with all relevant parties and to arrange for follow-up care is the most common reason for failure to prevent suicide. The school counselor initiates follow-up contact with the parents and invites the parent to attend a follow up meeting, emphasizing the following:

- the meeting is intended to be a constructive, collaborative effort to ensure the best interests of the child are met
- the importance of the parent’s involvement in the meeting and specific information regarding the meeting time and place
- the follow-up is a team effort that includes the school, the parent, the child, and the child’s mental health provider, if applicable, and
- the follow up will focus on identifying actions to be taken to create a “safety net” around the child

The follow up meeting should be held even if the parents/guardians are not cooperative or refuse to be involved, or in cases of suspected abuse/neglect, and should address the following issues:

- Ascertainng the child’s status (e.g., How is the child now? Is the child receiving mental health treatment? Did the parents follow through with all recommendations? If not, what was the reason or rationale for not following through?)
- Facilitating an exchange of information. (e.g., What recommendations were made by the mental health provider? Were there any specific recommendations to assist the child in school? How will the school handle the issue of make-up work and/or academic accommodations?
- Do the parents need assistance? Can the school assist in identifying community resources? What actions need to happen?
- Specific recommendations as to how the child will make a smooth transition back to school (e.g., what work has been missed and timelines/strategies for making up work)
- Specific recommendations as to how the child’s absence will be addressed (e.g., include the child in the meeting to discuss how questions about the child’s absence should be answered in a way that is comfortable to the child)

7. All documentation completed during this process should be maintained by the professional(s) providing these services as part of the Student Cumulative File for five (5) years after the student graduates, completes Board of Education program, transfers, or withdraws in accordance with the Library of Virginia, General Schedule 21, Series 200315. Alternatively, this documentation may be maintained in the Cumulative Health Record; however, the school professional must note on the M-2 label of the Student Cumulative File that these records are separately maintained in the Cumulative Health Record to ensure proper access to this information.
SCREENING FOR SUICIDE RISK PROTOCOL

School counselors (social workers, psychologists or student assistance specialists) may find the following information helpful prior to conducting a suicide risk screening with a student.

In situations in which a third party (e.g., another student; a teacher) has shared information with the school counselor about a suicidal statement, be sure to gather relevant facts before interviewing the student (be sure that the student in question is properly supervised in the interim). Relevant facts may include but are not limited to:

- verbatim statements made by the student
- names of individuals who overheard the statement
- location the statement was made
- the context in which the statement was made
- perceptions of the comments by the third party (e.g., how worried is the third party that the student may commit suicide)

It is important to gather as many details as possible prior to interviewing the student so that a clear picture of the circumstances surrounding the statement(s) can be made and any discrepancies can be readily addressed.

Complete the LCPS Suicide Risk Screening Protocol and Documentation Form which includes the Columbia-Suicide Severity Rating Scale (C-SSRS) using an interview format with the child. Be direct but compassionate while asking questions. If needed, gather additional information in the following areas to assist you in accurately completing the C-SSRS.

- risk factors
- warning signs specific to youth
- protective factors

Note: The C-SSRS requires a 35 minute web-based training in order to administer it correctly. A certificate of completion can be printed out after completing the training. Retraining must occur every 2 years in order for the training to remain valid. Please refer to [http://www.cssrs.columbia.edu/](http://www.cssrs.columbia.edu/) for additional information and to complete the training and print the certificate.

Use the results of the C-SSRS to determine if the child needs either:

1. parental notification that a suicide screening occurred, explanation of results, and an emergency suicide assessment by a licensed mental health professional, or
2. parental notification that a suicide screening occurred, explanation of results, and recommendation of a consultation and/or counseling by a licensed mental health professional.
REFERENCES

American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors can be downloaded at:


APPENDICES OF FORMS
SUICIDE RISK SCREENING PROTOCOL AND DOCUMENTATION FORM

This protocol and form is intended for use by school counselors, social workers, psychologists or student assistance specialists trained in the administration of the Columbia-Suicide Severity Rating Scale (C-SRSS)© and to document the suicide screening conducted with the student and the subsequent actions taken to promote student safety. Please refer to LCPS’s Suicide Prevention Procedures and Screening for Suicidal Risk Protocol as a companion to this form.

Place a check in the box after each step is completed to assist you in remembering to complete all steps.

□ Step 1: After receiving a report of suicidal ideation and ensuring the student is under adult supervision, complete the following information about the student:

Student’s Name: _______________________________  DOB: ________________
School: ______________________________________  Age: ________________
Grade: ________________________________  Screening Date: _________
Name of school personnel completing the form: ____________________________

Who provided information that triggered the suicide screening? (Circle) Student  Staff  Peer
Provide details about the suicidal statements and concerns.
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

□ Step 2: Complete the Columbia-Suicide Severity Rating Scale (C-SSRS) with the student. If needed, use multiple sources of information to complete the ratings. For instance, if a friend of the student reported to you that the student has been talking about wishing to be dead, but during the interview the student denies this, you should include the information provided by the friend in the ratings. In many cases, completion of this form will provide sufficient information to guide decision making. The C-SSRS is intended to be used by individuals who have received training in its administration. The questions contained in the C-SSRS are suggested probes.

□ Step 3: If needed, use the additional interview questions about Risk Factors, Youth Warning Signs, and Protective Factors to assist you in completing the C-SSRS and to provide a broader context to the situation.
□ **Step 4:** Using the C-SSRS Decision Guidelines, determine whether the results of the C-SSRS suggest the need for either (check one):

- **Parental notification** that a suicide screening was conducted, *explanation of results*, and recommendation for an *emergency suicide assessment* by a licensed mental health professional, [Recommended Action 1] or

- **Parental notification** that a suicide screening occurred, *explanation of results*, and recommendation for *consultation and/or counseling* by a licensed mental health professional [Recommended Action 2a, 2b, or 2c]

□ **Step 5:** Unless the student reported that the reason for suicidal ideation is because of abuse (see Suicide Prevention Procedures) contact the parents and explain that a suicide screening was conducted and the results and recommendations from Step 4 of the screening. Use the Recommended Actions column of the C-SSRS Decision Guidelines to guide your conversation with the parent.

- In situations in which the screenings suggests the student requires an *emergency suicide assessment*, inform the parent that the student must remain under adult supervision until the parent or authorized individual accepts responsibility for the student’s safety. Make arrangements to meet with the parent and request that the parent sign a *Release of Confidential Information* so that you can speak directly with the mental health provider about the screening results. Once the parent arrives to collect the student, have him or her complete the *Parent Acknowledgement of Notification of Suicidal Thoughts or Feelings*. Provide the parent with a copy of the student’s C-SRSS and encourage them to share it with the licensed mental health professional. If needed, share with the parent your legal obligation to contact CPS in situations of medical neglect.

- In situations in which the screening suggests a recommendation for a *consultation or counseling*, document the contact with the parent using the *Parent Contact by School Personnel/Notification of Suicidal Thoughts or Feelings*. Offer the parent a copy of the student’s C-SRSS and encourage them to share it with the licensed mental health professional. It may also be appropriate to request the parent sign a *Release of Confidential Information* in order to coordinate and facilitate care for the child. If the parent decides to pick up the student at school, have him or her complete the *Parent Acknowledgement of Notification of Suicidal Thoughts or Feelings*.

□ **Step 6:** For students in which you are recommending an *emergency suicide assessment* by a licensed mental health professional, make arrangements for a follow-up meeting with the parents and child in order to ease the transition back to school. Complete the form titled *Follow-Up Meeting* during this meeting. Refer to the Suicide Prevention Procedures for additional details regarding recommended actions for the follow-up meeting.

□ **Step 7:** Maintain completed documentation. Refer to the Suicide Prevention Procedures for details
### SEVERITY OF SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to “Suicidal Behavior” section. If the answer to question 2 is “yes”, ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is “yes”, complete “Intensity of Ideation” section below.

<table>
<thead>
<tr>
<th>Lifetime: Time He/She Felt Most Suicidal</th>
<th>Past 1 month</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wish to Be Dead</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If yes, describe:</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

| 2. Non-Specific Active Suicidal Thoughts | Yes | No | Yes | No |
| General non-specific thoughts of wanting to end one’s life/commit suicide (e.g., “I’ve thought about killing myself”) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. Have you actually had any thoughts of killing yourself? | ☐ | ☐ | ☐ | ☐ |
| If yes, describe:                       | ☑ | ☑ | ☑ | ☑ |

| 3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act | Yes | No | Yes | No |
| Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, “I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it… and I would never go through with it.” Have you been thinking about how you might do this? | ☐ | ☐ | ☐ | ☐ |
| If yes, describe:                       | ☑ | ☑ | ☑ | ☑ |

| 4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan | Yes | No | Yes | No |
| Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them.” Have you had these thoughts and had some intention of acting on them? | ☐ | ☐ | ☐ | ☐ |
| If yes, describe:                       | ☑ | ☑ | ☑ | ☑ |

| 5. Active Suicidal Ideation with Specific Plan and Intent | Yes | No | Yes | No |
| Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? | ☐ | ☐ | ☐ | ☐ |
| If yes, describe:                       | ☑ | ☑ | ☑ | ☑ |

### INTENSITY OF IDEATION

The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.

<table>
<thead>
<tr>
<th>Type # (1-5)</th>
<th>Description of Ideation</th>
<th>Most Severe</th>
<th>Most Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime - Most Severe Ideation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent - Most Severe Ideation:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
<th>How many times have you had these thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Less than once a week</td>
<td>(2) Once a week</td>
</tr>
<tr>
<td>(1) Fleeting - few seconds or minutes</td>
<td>(2) Less than 1 hour/some of the time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
<th>When you have the thoughts how long do they last?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Fleeting - few seconds or minutes</td>
<td>(4) 4-8 hours/most of day</td>
</tr>
<tr>
<td>(2) Less than 1 hour/some of the time</td>
<td>(5) More than 8 hours/persistent or continuous</td>
</tr>
<tr>
<td>(3) 1-4 hours/a lot of time</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controllability</th>
<th>Could/can you stop thinking about killing yourself or wanting to die if you want to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Easily able to control thoughts</td>
<td>(4) Can control thoughts with a lot of difficulty</td>
</tr>
<tr>
<td>(2) Can control thoughts with little difficulty</td>
<td>(5) Unable to control thoughts</td>
</tr>
<tr>
<td>(3) Can control thoughts with some difficulty</td>
<td>(0) Does not attempt to control thoughts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deterrents</th>
<th>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Deterrents definitely stopped you from attempting suicide</td>
<td>(4) Deterrents most likely did not stop you</td>
</tr>
<tr>
<td>(2) Deterrents probably stopped you</td>
<td>(5) Deterrents definitely did not stop you</td>
</tr>
<tr>
<td>(3) Uncertain that deterrents stopped you</td>
<td>(0) Does not apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Ideation</th>
<th>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn’t go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Completely to get attention, revenge or a reaction from others</td>
<td>(4) Mostly to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
</tr>
<tr>
<td>(2) Mostly to get attention, revenge or a reaction from others</td>
<td>(5) Completely to end or stop the pain (you couldn’t go on living with the pain or how you were feeling)</td>
</tr>
<tr>
<td>(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain</td>
<td>(0) Does not apply</td>
</tr>
</tbody>
</table>
### SEVERITY OF SUICIDAL BEHAVIOR

*Check all that apply, so long as these are separate events; must ask about all types*

<table>
<thead>
<tr>
<th>1. Actual Attempt:</th>
<th>Lifetime</th>
<th>Past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt.</td>
<td>[ ] Yes [ ] No</td>
<td>[ ] Yes [ ] No</td>
</tr>
</tbody>
</table>

*There does not have to be any injury or harm,* just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Infering Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

**Have you made a suicide attempt?**

**Have you done anything to harm yourself?**

**Have you done anything dangerous where you could have died?**

*What did you do?*

- Did you _____ as a way to end your life?
- Did you want to die (even a little) when you _____?
- Were you trying to end your life when you _____?
- Or Did you think it was possible you could have died from _____?

**Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?**  (Self-Injurious Behavior without suicidal intent)

If yes, describe:

**Has subject engaged in Non-Suicidal Self-Injurious Behavior?**

<table>
<thead>
<tr>
<th>2. Interrupted Attempt:</th>
<th>Lifetime</th>
<th>Past 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred).</td>
<td>[ ] Yes [ ] No</td>
<td>[ ] Yes [ ] No</td>
</tr>
</tbody>
</table>

**Overdose:** Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

**Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?**

If yes, describe:

**3. Aborted or Self-Interrupted Attempt:**

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

**Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?**

If yes, describe:

**4. Preparatory Acts or Behavior:**

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

**Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?**

If yes, describe:

### Actual Lethality/Medical Damage:

| 0. No physical damage or very minor physical damage (e.g., surface scratches). | Enter Code | Enter Code | Enter Code |
| 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). | Enter Code | Enter Code | Enter Code |
| 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). | | | |
| 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). | | | |
| 4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). | | | |
| 5. Death | | | |

### Potential Lethality: Only Answer if Actual Lethality>0

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

| 0 = Behavior not likely to result in injury | Enter Code | Enter Code | Enter Code |
| 1 = Behavior likely to result in injury but not likely to cause death | Enter Code | Enter Code | Enter Code |
| 2 = Behavior likely to result in death despite available medical care | Enter Code | Enter Code | Enter Code |
If needed to effectively complete the C-SSRS and put a greater context to the situation, interview the student about risk factors, warning signs specific to youth, and protective factors.

**Risk Factors** *(Specific factors that, if present, increase the risk of suicide)*

Is there a family history of suicide, suicide attempts or aborted attempts? Is there a personal or family history of psychiatric hospitalization or current/past psychiatric diagnoses? Are there present precipitants or stressors? Does the student have access to firearm(s), express reasons to die, or engage in substance abuse?

---

**Youth Warning Signs** *(Are any of these warning signs that are specific to youth present?)*

- □ Talking about or making plans for suicide
- □ Expressing hopelessness about the future
- □ Displaying severe/overwhelming emotional pain or distress
- □ Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:
  - ○ Withdrawal from or changes in social connections/situations
  - ○ Changes in sleep (increased or decreased)
  - ○ Anger or hostility that seems out of character or out of context
  - ○ Recent increased agitation or irritability

**Protective Factors** *(Specific factors that, if present, reduce but do not eliminate the risk of suicide)*

Is there a strong family support system? Does the student have a perception of belongingness within the family, community, and/or among friends? Does the student have strong religious beliefs proscribing against suicide? Does the student exhibit the ability to cope with stress? Does the student feel a sense of responsibility to others and identify reasons to live?
## C-SSRS Decision Guidelines

C-SSRS decision-making is guided primarily by two sections of the C-SSRS: 1) the severity of suicidal ideation, and 2) the severity of suicidal behavior. The rubric below should be used to assist you in the recommendations you make on behalf of a student. Interpretation of the C-SSRS results must progress in a top-to-bottom manner (i.e., 1, 2a, 2b, 2c) based on the presence of affirmative (“Yes”) responses to specific questions in order to ensure a correct recommended action is determined. When uncertain, err on the side of caution to protect the student and recommend a higher level of action.

<table>
<thead>
<tr>
<th>C-SSRS Results</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Severity of Suicidal Ideation:</strong></td>
<td>1) <strong>Parent notification</strong> that a suicide screening was conducted;</td>
</tr>
<tr>
<td>“Yes” to either #4 or #5 in the past month, and/or</td>
<td><strong>Explanation of results</strong>; and recommendation for an emergency</td>
</tr>
<tr>
<td><strong>Severity of Suicidal Behavior:</strong></td>
<td><strong>suicide assessment</strong> by a licensed mental health professional.</td>
</tr>
<tr>
<td>“Yes” to any of the 4 behaviors in the past 3 months</td>
<td>When explaining the results to the parents share with them that their child has</td>
</tr>
<tr>
<td></td>
<td>indicated *active suicidal thoughts with at least some intent to act on these</td>
</tr>
<tr>
<td></td>
<td>thoughts within the past month and/or that their child has *actively engaged in</td>
</tr>
<tr>
<td></td>
<td>suicidal behavior* within the past 3 months.</td>
</tr>
<tr>
<td></td>
<td>Explain that in all cases this requires an emergency suicide assessment by a</td>
</tr>
<tr>
<td></td>
<td>licensed mental health professional in order to protect the child.</td>
</tr>
<tr>
<td><strong>2a) Severity of Suicidal Ideation:</strong></td>
<td>2a) <strong>Parent notification</strong> that a suicide screening was conducted;</td>
</tr>
<tr>
<td>“Yes” to either #1, #2, or #3 in the past month, and/or</td>
<td><strong>Explanation of results</strong>; and recommendation for <strong>consultation or</strong></td>
</tr>
<tr>
<td></td>
<td><strong>counseling</strong> by a licensed mental health professional.</td>
</tr>
<tr>
<td><strong>Non-Suicidal Self-Injury:</strong></td>
<td>When explaining the screening results to the parents share that their child has</td>
</tr>
<tr>
<td>“Yes” in the past 3 months</td>
<td>indicated *a wish to die within the past month and/or active suicidal thoughts</td>
</tr>
<tr>
<td></td>
<td>*within the past month (but without any intent to act on these thoughts) but</td>
</tr>
<tr>
<td></td>
<td>denies any suicidal behavior within the past 3 months or explain that their child</td>
</tr>
<tr>
<td></td>
<td>has reported engaging in non-suicidal self-injury within the past 3 months.</td>
</tr>
<tr>
<td></td>
<td>Explain to the parent that a wish to die or active suicidal thoughts within the</td>
</tr>
<tr>
<td></td>
<td>past month, even without intent to act on these thoughts, indicates a level of</td>
</tr>
<tr>
<td></td>
<td>emotional distress that warrants contact with a licensed mental health professional</td>
</tr>
<tr>
<td></td>
<td>in order to identify the reason for the feelings and what level of treatment is</td>
</tr>
<tr>
<td></td>
<td>indicated. In situations in which only non-suicidal self-injury is reported,</td>
</tr>
<tr>
<td></td>
<td>explain to the parents that this is a risk factor for future suicidal ideation and</td>
</tr>
<tr>
<td></td>
<td>attempts and that their child is engaging in this behavior to relieve psychological</td>
</tr>
<tr>
<td></td>
<td>pain and for this reason needs to see a licensed mental health professional.</td>
</tr>
</tbody>
</table>
### C-SSRS Results:

<table>
<thead>
<tr>
<th>2b) Severity of Suicidal Ideation:</th>
<th>2c) Severity of Suicidal Ideation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes” to at least one lifetime suicidal ideation, and/or</td>
<td>“No” to all 5 items in the past month and during lifetime, and</td>
</tr>
<tr>
<td><strong>Severity of Suicidal Behavior:</strong></td>
<td><strong>Severity of Suicidal Behavior:</strong></td>
</tr>
<tr>
<td>“Yes” to at least one lifetime suicidal behavior, and/or</td>
<td>“No” to all 4 behaviors in the past 3 months and during lifetime, and</td>
</tr>
<tr>
<td><strong>Non-Suicidal Self-Injury:</strong></td>
<td><strong>Non-Suicidal Self-Injury:</strong></td>
</tr>
<tr>
<td>“Yes” to lifetime</td>
<td>“No” in the past 3 months and lifetime</td>
</tr>
</tbody>
</table>

### Recommended Action:

<table>
<thead>
<tr>
<th>2b) Parent notification</th>
<th>2c) Parent notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>that a suicide screening was conducted; explanation of results; and recommendation for consultation or counseling by a licensed mental health professional.</td>
<td>that a suicide screening was conducted; explanation of results; and recommendation for consultation by a licensed mental health professional.</td>
</tr>
</tbody>
</table>

When explaining the results of the screening to the parent share that their child has **denied any wish to die/suicidal ideation within the past month or any suicidal behaviors within the past 3 months, but has acknowledged either a wish to die, suicidal thoughts, or suicidal behaviors at some point in his/her life.**

Explain to the parent that because of a reported history of either suicidal ideation or suicidal behavior that, at minimum, a consultation with a licensed mental health professional is warranted to determine the degree of service, if any, is needed.

When explaining the results of the screening to the parent share that their child **denied both current and past suicidal ideation, suicidal behaviors, and non-suicidal self-injury.**

Explain to the parent that a recommendation for a consultation with a licensed mental health professional is warranted because the child underwent a suicide screening based on either: 1) something the child said or did (e.g., the child told you he was depressed), 2) concerns about the child expressed by others (e.g., the child’s friend shared with you how worried he/she is about the child), or 3) concerns about the validity of the C-SSRS results because the child may not be willing to share his/her feelings with you out of embarrassment or some other factor.
LOUDOUN COUNTY PUBLIC SCHOOLS
Department of Pupil Services

PARENT CONTACT BY SCHOOL PERSONNEL/
NOTIFICATION OF SUICIDAL THOUGHTS OR FEELINGS

Student’s Name: ___________________________ Date of Contact: __________

Parent’s/Guardian’s Name: ___________________________ Time of Contact: __________

School Team Member: ___________________________ School: ___________________________

(School Psychologist, Social Worker, School Counselor, Student assistance Specialist)

When contacting the student’s parent or guardian:

- provide your name and position in the school
- assure the parent or guardian that the student is currently safe
- state that you have conducted a suicide screening on the student, the reason for doing so, and explain thoroughly the results of the C-SRSS
- recommend in your judgment as a school counselor one of the following based on the screening results:
  - emergency suicide assessment by a licensed mental health professional (Recommended Action 1 from the C-SSRS Decision Guidelines)
  - consultation and/or counseling with a licensed mental health professional (Recommended Action 2a, 2b, or 2c from the C-SSRS Decision Guidelines)
- provide names of community counseling resources if appropriate (provide at least two referral resources including Loudoun County Mental Health [703-777-0320] and George Mason University’s Center for Psychological Services [703-993-1370]),
- offer to facilitate the referral or contact child’s therapist (mention the Release of Confidential Information form)
- if the parent requests an additional justification for the call, cite the legal requirement (22.1 – 272.1 of the Code of Virginia)
- determine the parent’s intent to seek appropriate services for the student depending on the screening results (see Suicide Prevention Procedures if concerns arise during the conversation that the parent may not seek appropriate services)

Parent’s or Guardian’s Response: ________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Any Required Follow Up: ________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
PARENT ACKNOWLEDGMENT OF NOTIFICATION OF SUICIDAL THOUGHTS OR FEELINGS

This form is to be completed if the parent picks the student up from school.

I/We ____________________________, the parents of ____________________________, have had a conference with school personnel (name) ____________________________ on ____________________________.

I/We have been notified that our child is experiencing suicidal thoughts and may be in danger of harming himself/herself. We have been advised that, at minimum, we should seek an emergency suicide assessment by a licensed mental health professional because the results of the suicide screening indicate that my/our child is having active suicidal thoughts with at least some intent to act on these thoughts within the last month, and/or has engaged in suicidal behavior within the last 3 months.

In signing this form, we acknowledge that we have been informed in writing that evidence-based mental health services for children with suicidal ideation involve the following: 1) active parental involvement in the child’s treatment at every session, 2) the development of a detailed safety plan (not a no-suicide contract) in collaboration with the child and the parent(s), 3) review of the safety plan at every session, 4) check-in with the parent by the mental health professional at every session about the child’s mood, stressors, and substance use, and 5) review with the parent(s) at every session the skills that are being developed in the child and ways that the parents can foster these skills.

I/We have been informed of an electronic brochure titled What Every Parent Should Know About Preventing Youth Suicide created by the Virginia Department of Health. (http://www.vahealth.org/Injury/preventsuicideva/documents/2010/pdf/Every%20Parent.pdf)

(Parent or Legal Guardian) ____________________________ (School Personnel Name and Title) ____________________________

(Parent or Legal Guardian) ____________________________ (School Personnel Name and Title) ____________________________
FOLLOW-UP MEETING

Student’s Name: __________________________ Date of Meeting: ________________
Parent(s) in Attendance: __________________________
School Personnel in Attendance: __________________________

Student’s status including any current mental health treatment or counseling: ________________

Offer the parent(s) the Release of Confidential Information form, if not already done (document parent’s response): ________________

Recommendations by therapist: ________________

Strategies for handling make-up work or academic accommodations: ________________

Strategies for handling questions about the student’s absence: ________________

Assistance for parents/guardians: ________________

Referrals to community based teams or service providers: ________________

Future meeting dates (if needed): ________________
Action plans: ________________

______________________________________________________________________________
LOUDOUN COUNTY PUBLIC SCHOOLS  
Department of Pupil Services  

RELEASE OF CONFIDENTIAL INFORMATION  

I, ________________________________, hereby give my consent for

Printed Name of Parent/Guardian

Loudoun County Public Schools

_______to consult with and/or release records regarding my child to:

_______to request and/or receive information regarding my child from:

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Address</td>
<td>Contact Person and Position</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>Additional Information</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child’s Name ________________________________

Date of Birth ________________________________

School of Attendance ________________________________

This information may be released/exchanged for the following purpose: ________________________________

____________________________________________            _______________________
PARENT/GUARDIAN SIGNATURE                                                      DATE