

**LOUDOUN COUNTY PUBLIC SCHOOLS**  
**Department of Pupil Services**



**Suicide Prevention Procedures**

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## PREFACE

As part of a comprehensive approach to suicide prevention, Loudoun County Public Schools (LCPS) developed suicide prevention procedures. These procedures are derived from multiple sources including *Child and Adolescent Suicidal Behavior: School-Based Prevention, Assessment, and Intervention*; *Managing Suicidal Risk: A Collaborative Approach*; *Suicide Assessment Five-Step Evaluation and Triage*; *Preventing Suicide: a Toolkit for High Schools* and §22.1-272.1 of the Code of Virginia. The LCPS procedures represent a standard of care for school personnel to follow when identifying, screening, and responding to students who make suicidal statements.

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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.

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?

A mnemonic of the only evidence-based list of warning signs for adults, ages 24 and older is:

IS PATH WARM?

- I Ideation – threatened or communicated
- S Substance Abuse – excessive or increased
  
- P Purposeless – no reasons for living
- A Anxiety – with agitation and insomnia
- T Trapped – feeling no way out
- H Hopelessness
  
- W Withdrawal – disconnection from family, friends, and society
- A Anger – uncontrolled, raging, or revenge seeking
- R Recklessness – risky, unthinking acts
- M Mood changes – very dramatic

In September 2015, a nationwide panel of experts on youth suicide established an empirical list of warning signs 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 changing 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

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
- 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*. One way to classify a student's risk of suicide is to categorize the student's risk into one of several categories. The National Suicide Prevention Lifeline categorizes suicide risk into one of three levels:

*High Risk* – Individuals at high risk of suicide have persistent ideation with strong intent or suicide rehearsal or have a history of potentially lethal suicide attempt; risk factors include

psychiatric disorders with severe symptoms and acute, precipitating stressors; protective factors are irrelevant. Rudd (2006) describes these individuals as exhibiting frequent, intense, and enduring suicidal ideation, specific plans, and both subjective and objective markers of intent (e.g., choice of lethal method).

*Moderate Risk* – Individuals at moderate risk of suicide have suicidal ideation with a plan, but no intent or behavior; they have multiple risk factors and few protective factors. Rudd (2006) describes these individuals as exhibiting frequent suicidal ideation with limited intensity and duration, some specificity in terms of plan but with no associated intent.

*Low Risk* – Individuals at low risk of suicide have thoughts of death, but no plan, intent or behavior; they have modifiable risk factors and strong protective factors. Rudd (2006) describes these individuals as exhibiting suicidal ideation of limited frequency, intensity, duration and specificity.

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.

## **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).

## **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. A quick reference guide highlighting procedures associated with this manual is provided in the *Suicide Prevention Action Plan* (p. 17).

1. It is important for all licensed school professionals, including itinerant staff, to identify and report students at risk for suicide. 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 are expected to immediately report any direct 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 without delay. If the school counselor is unavailable for any reason, the school should contact the school psychologist, school social worker, or the substance abuse prevention specialist in order to request a suicide risk screening.

The school counselor (or school psychologist, school social worker, or substance abuse prevention specialist) shall notify the building principal.

2. School personnel have a responsibility to 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 substance abuse prevention 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 substance abuse prevention specialist) initiates the suicide risk screening and documents the findings using the form entitled *Suicide Risk Screening Documentation Form* (p. 18). The section of this document titled **Screening for Suicide Risk: a Protocol for School Counselors, Social Workers, Psychologists, and Student Assistance Specialists** (p. 13) should also be referenced for additional suggestions. In the course of the suicide risk screening, if issues related to threats against other students or bullying emerge, the school counselor is to notify the principal following the screening.
4. The school counselor (or school psychologist, school social worker, or substance abuse prevention 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 call is to the parent, then whoever conducted the suicide risk screening should initiate the call and provide the following information:
    - provide your name and position in the school
    - state that in your professional judgment, the student is at low, moderate, or high risk of suicide, depending on the results of the suicide risk screening
    - assure the parent or guardian that the student is currently safe
    - provide names of community counseling resources if appropriate (The parent should be provided three referral resources including Loudoun County Mental Health)
    - If appropriate, 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
      - ❖ if during the course of the phone call child abuse or neglect is suspected (e.g., the parent acknowledges the child's suicidal intent but indicates no intent to act for the well-being of the child), immediately follow LCPS protocol for contacting CPS at 703-771-KIDS (5437)
      - ❖ parents who opt for supportive interventions outside the professional mental health arena, such as religious-based interventions, should provide

at a minimum a plan that will include a safety plan and an issues-based intervention procedure that will keep the child safe and will address the precipitant issues

Upon completion of the call, the caller shall document the following using the *Parent Contact by School Personnel/Notification of Suicidal Thoughts or Feelings* (p. 20) 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 the student is suicidal 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 at “moderate” or “high” risk of suicide must remain under adult supervision until a parent or authorized individual accepts responsibility for the student’s safety. In situations in which the student is picked up from school by a parent or guardian, the building administrator and the school counselor should ensure that the *Parent Acknowledgement of Notification of Suicidal Thoughts or Feelings* (p. 21) and *Release of Confidential Information* (p. 25) are signed before the student leaves the building.

For the student who is at “low” risk of suicide, some parents may choose to pick up the student immediately or after school, which is also acceptable.

For students who are at “low” risk of suicide, the school counselor (or school psychologist, school social worker, or substance abuse prevention specialist) should check-in, as necessary, with the student, parents, and/or teachers.

6. Follow up planning is critical for students who are at “moderate” or “high” risk. The form entitled *Follow-Up Meeting* (p. 22) should be completed during the 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 (if a prearranged contact was not determined during the reporting of the suicide risk screening) 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
- 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:

- ascertaining 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?
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: A PROTOCOL FOR SCHOOL COUNSELORS, SOCIAL WORKERS, PSYCHOLOGISTS, AND STUDENT ASSISTANT SPECIALISTS**

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 (unless the student will be leaving the building before you can make contact). 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

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.

Interview the child/adolescent with a focus on the student's suicidal ideation and potential need for a suicide risk assessment/mental health evaluation by a licensed mental health professional. Be straightforward but gentle about the purpose of the screening. Gather information in the following areas to assist in identifying the student's level of risk:

- suicidal ideation (including frequency, intensity and duration of suicidal thoughts)
- specificity of suicide plan
- risk factors
- protective factors

- self-assessment (optional)

The *Suicide Risk Screening Documentation Form* (p. 18), which should be completed either during the screening or immediately after the screening, provides specific suggestions for information to be gathered in each of the four areas. The fifth area, self-assessment, is optional and may be used by school counselors if it is determined that a self-report instrument may be useful in the screening process. In some situations the student may be more forthcoming if provided an opportunity to respond to certain questions via pencil and paper. In these situations, offer the student the opportunity to complete a self-rating form (*Suicide Status Form*; p. 23) regarding his or her current emotional state and suicidality. Note that this form may be used to assist the counselor in identifying the student's risk versus protective factors; however, a suicide inquiry (i.e., inquiry into the student's suicidal ideation and specificity of a suicide plan) is still necessary.

Complete the *Suicide Risk Screening Documentation Form* (p. 18), including making a recommendation regarding the student's probable risk level. In order to make a recommendation about the student's probable risk level, it is helpful to have an understanding of several common terms used related to suicide inquiries. Common terms and their definitions include:

*Frequency* – the rate or number of times the student thinks about suicide or death. How frequently is the student thinking about suicide or death? Monthly, weekly, daily, hourly?

*Intensity* – magnitude; the degree to which the student's thoughts of suicide or death are intense. Is there a high degree of emotion associated with the thoughts of suicide or death? How powerful or overwhelming are the thoughts of suicide or death?

*Duration* – the length of time the suicidal ideation lasts. When the student thinks of suicide or death, for how long does it last? Are the thoughts fleeting or does the student engage in thoughts of suicide or death for minutes or hours?

*Specificity* (of the plan) – the degree to which the plan is clear-cut or precise. How detailed or specific is the student's suicide plan or thoughts of death? Are the thoughts vague (e.g., "It'd be better if I wasn't here."), passive (e.g., "I wish I were dead"), or active (e.g., "I could overdose on my mother's pills")?

*Intent* – how decided or determined is the student to carry out suicide? Intent can be broken down into two types: 1) expressed or subjective intent and 2) observed or objective intent. Expressed or subjective intent refers to what the student *says* during the suicide screening. Observed intent refers to information provided by the student that would indicate *objective markers of intent* (e.g., choosing a lethal means of suicide). Markers of objective intent include behaviors that demonstrate 1) a desire to die; 2) preparation for death (e.g., writing letters); and 3) efforts to prevent discovery. Occasionally expressed/subjective intent does not match observed/objective intent and this must be considered when screening for intent.

Ultimately, the screening of risk is based on clinical judgment after completing the suicide inquiry and determining the student's risk and protective factors. The chart below may help

guide the school counselor in determining the student’s probable level of risk. If unsure, err on the side of caution (i.e., recommend a suicide risk assessment/mental health evaluation by a licensed mental health professional) in order to protect the student.

<b>Risk Level</b>	<b>Risk/Protective Factors</b>	<b>Suicidality</b>	<b>Possible Interventions</b>
<b>High</b>	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent, frequent, and intense ideation with strong subjective and objective markers of intent or suicide rehearsal	Mental health evaluation is critical. Admission is generally indicated unless a significant change reduces risk. Suicide precautions.
<b>Moderate</b>	Multiple risk factors, few protective factors	Frequent suicidal ideation with limited intensity and duration; some specificity of plan, but no intent or behavior	Mental health evaluation may be warranted. Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers.
<b>Low</b>	Modifiable risk factors, strong protective factors	Thoughts of death of limited frequency, intensity and duration; no plan, intent or behavior	Outpatient referral or contact therapist to give update. Work towards symptom reduction. Give emergency/crisis numbers.

Adapted from the National Suicide Prevention Lifeline’s *Suicide Assessment Five-Step Evaluation and Triage* and Rudd (2006)

## REFERENCES

- American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors can be downloaded at:  
[http://www.psych.org/psych\\_pract/treatg/pg/suicidalbehavior\\_05-15-06.pdf](http://www.psych.org/psych_pract/treatg/pg/suicidalbehavior_05-15-06.pdf)
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# APPENDICES OF FORMS



**LOUDOUN COUNTY PUBLIC SCHOOLS**  
**Department of Pupil Services**

**SUICIDE PREVENTION ACTION PLAN**

In accordance with VA Code 221.272.1 and Loudoun County Public Schools *Suicide Prevention Guidelines*, complete all of the following items and/or documents indicating specific actions taken.

❖ **Suicidal Screening**

- a. Interview student to gather information regarding student's suicidality, risk factors and protective factors. Refer to the *Suicide Risk Screening Documentation Form* and the *Screening for Suicide Risk: A Protocol for School Counselors, Social Workers, Psychologists, and Student Assistance Specialists* for additional guidance.

❖ **Issues of Abuse and Neglect**

If a student indicates that parental abuse or neglect is the reason for contemplating suicide, parental contact should NOT be made. Instead, immediately inform the building principal and follow LCPS protocol for contacting Child Protective Services. When notifying CPS, it must be emphasized that immediate action is necessary to protect the child from harm.

❖ **Parent Notification**

- a. **Contact parent: Complete form titled *Parent Contact by School Personnel/Notification of Suicidal Thoughts or Feelings***
  - i. In the course of contact with the parent, if abuse or neglect is suspected (e.g., a parent acknowledges the child's suicidal intent but indicates no intent to act for the well-being of the child), immediately follow LCPS protocol for contacting CPS.
  - ii. If unable to contact the parent or guardian by the end of the school day, then follow your school's crisis management plan for seeking emergency treatment for a student without the parent's authorization.
- b. **Meet with parent: Complete form titled *Parent Acknowledgement of Notification of Suicidal Thoughts or Feelings* (Keep original and give copy to the parents)**
  - i. A student who is at moderate or high risk of suicide must remain under adult supervision until a parent or authorized individual accepts responsibility for the student's safety.

❖ **Following-Up an Intervention**

- a. **Conduct follow-up meeting with student, parent and school personnel: Complete form titled *Follow-Up Meeting***
  - i. A follow-up meeting should be held even if the parents/guardians are not cooperative or refuse to be involved.

❖ **Maintenance of Documentation**

- a. **Maintain all documentation as part of the student's 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.**



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**SUICIDE RISK SCREENING DOCUMENTATION FORM**

**This form is intended for use by school counselors, social workers, psychologists or student assistance specialists to document the screening conducted with the student. Please refer to the *Screening for Suicide Risk: A Protocol for School Counselors, Social Workers, Psychologists, and Student Assistance Specialists* for additional details on how to use this form. The determination of imminent risk of suicide ultimately depends on clinical judgment. In uncertain situations, err on the side of caution in order to protect the student.**

**Student's Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**School:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

**Screening Date:** \_\_\_\_\_

Interview the student to gather information regarding the student's suicidality (via suicide inquiry), risk factors, and protective factors.

**Suicide Inquiry** (*Specific items that tap the student's thoughts, behaviors, plans and intent*)

**Who reported the suicidal statements? (Circle) Student      Staff      Peer**

**If the reporter was someone other than the student, provide details about his/her statement and concerns.**

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**Frequency:** How **frequently** is the student thinking about suicide? Daily? Hourly?

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**Intensity:** How **intense** are the student's emotions when thinking about suicide? How powerful or overwhelming are the thoughts of suicide?

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**Duration:** What is the **duration** of the suicidal thoughts? For how long does the student think about or fantasize about suicide? Fleeting? Almost constantly?

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**Plan:** Does the student have a plan? How specific is the plan? Does the student have the timing, location, and method identified? How lethal is the means chosen? What is the likelihood of rescue? Have preparatory acts been made?

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**Intent:** How serious is the student about carrying out the plan? Does the student believe the plan will result in death as opposed to injury? Are there objective markers of intent?

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

Is there a personal or 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 key warning signs such as agitation, self-hate, psychological pain or hopelessness? Are there present precipitants or stressors? Does the student have access to firearm(s), express reasons to die, or engage in substance abuse? IS PATH WARM?

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**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?

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**Risk Level** (Refer to the *Screening for Suicide Risk: A Protocol for School Counselors , Social Workers, Psychologists, and Student Assistance Specialists* section of this document for additional guidance in determining current risk)

- No risk or probable low risk level (referral for suicide risk assessment/mental health evaluation not indicated; counseling or therapy may be recommended)
- Probable moderate risk level (referral for suicide risk assessment/mental health evaluation warranted; counseling or therapy recommended)
- Imminent risk or probable high risk level (referral for suicide risk assessment/mental health evaluation critical; immediate intervention necessary)



**LOUDOUN COUNTY PUBLIC SCHOOLS**  
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**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, Substance Abuse Prevention Specialist)

**When contacting the student's parent or guardian:**

- provide your name and position in the school
- state that in your professional judgment, the student is at low, moderate, or high risk of suicide, depending on the results of the suicide risk screening
- assure the parent or guardian that the student is currently safe
- provide names of community counseling resources if appropriate (The parent should be provided three referral resources including Loudoun County Mental Health)
- If appropriate, 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

**Parent's or Guardian's Response:** \_\_\_\_\_

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**Any Required Follow Up:** \_\_\_\_\_

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**LOUDOUN COUNTY PUBLIC SCHOOLS**  
**Department of Pupil Services**

**PARENT ACKNOWLEDGMENT OF NOTIFICATION OF**  
**SUICIDAL THOUGHTS OR FEELINGS**

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 we should immediately seek consultation from a community-based mental health professional, mental health center, or hospital emergency room at parental expense. Mental health resources have been provided by LCPS staff.

If we opt for supportive interventions outside the professional mental health arena, such as religious-based interventions, we will provide at a minimum a safety plan and an issues-based intervention procedure that will keep the child safe and address the precipitant issues. If we choose interventions other than a mental health professional (such as religious-based interventions) we will inform school personnel of the outcome, including any safety plan.

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>)

A follow-up conference with school personnel has been scheduled for: \_\_\_\_\_.

\_\_\_\_\_  
(Parent or Legal Guardian)

\_\_\_\_\_  
(School Personnel Name and Title)

\_\_\_\_\_  
(Parent or Legal Guardian)

\_\_\_\_\_  
(School Personnel Name and Title)

*Note: This form will be maintained for 5 years after the student graduates, completes a Board of Education program, or withdraws.*



**LOUDOUN COUNTY PUBLIC SCHOOLS**  
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**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assistance for parents/guardians: \_\_\_\_\_  
\_\_\_\_\_

Referrals to community based teams or service providers: \_\_\_\_\_  
\_\_\_\_\_

Future meeting dates (if needed): \_\_\_\_\_

Action plans: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**LOUDOUN COUNTY PUBLIC SCHOOLS**  
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**SUICIDE STATUS FORM**

**Student Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Rate and fill out each item according to how you feel right now.

_____	<p>1) <b>RATE PSYCHOLOGICAL PAIN</b> (hurt, anguish, or misery in your mind; <b>not</b> stress; <b>not</b> physical pain):  <b>Low Pain</b> 1 2 3 4 5 <b>High Pain</b></p> <p>What I find most painful is: _____            _____</p>
_____	<p>2) <b>RATE STRESS</b> (your general feeling of being pressured or overwhelmed):  <b>Low Stress</b> 1 2 3 4 5 <b>High Stress</b></p> <p>What I find most stressful is: _____            _____</p>
_____	<p>3) <b>RATE AGITATION</b> (emotional urgency; feeling that you need to take action; <b>not</b> irritation; <b>not</b> annoyance):  <b>Low Agitation</b> 1 2 3 4 5 <b>High Agitation</b></p> <p>I most need to take action when: _____            _____</p>
_____	<p>4) <b>RATE HOPELESSNESS</b> (your expectation that things will not get better no matter what you do):  <b>Low Hopelessness</b> 1 2 3 4 5 <b>High Hopelessness</b></p> <p>I am most hopeless about: _____            _____</p>
_____	<p>5) <b>RATE SELF-HATE</b> (your general feeling of disliking yourself; having no self-esteem; having no self-respect):  <b>Low Self-Hate</b> 1 2 3 4 5 <b>High Self-Hate</b></p> <p>What I hate most about myself: _____            _____</p>
_____	<p>6) <b>RATE OVERALL RISK OF SUICIDE</b></p> <p align="center"><b>Extremely Low Risk:</b> 1 2 3 4 5 <b>Extremely High Risk</b>            (will not kill self) (will kill self)</p>

**Rank** Then rank items (in the blanks provided in the left hand column) in order of importance from 1 to 5 (1 = most important to 5 = least important)

*From Managing Suicidal Risk: A Collaborative Approach (Jobes, 2006)*



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**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:**

_____	_____
Agency Name	Telephone Number
_____	_____
Agency Address	Contact Person and Position
_____	_____
City, State, Zip Code	Additional Information

Child's Name	_____
Date of Birth	_____
School of Attendance	_____

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

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**