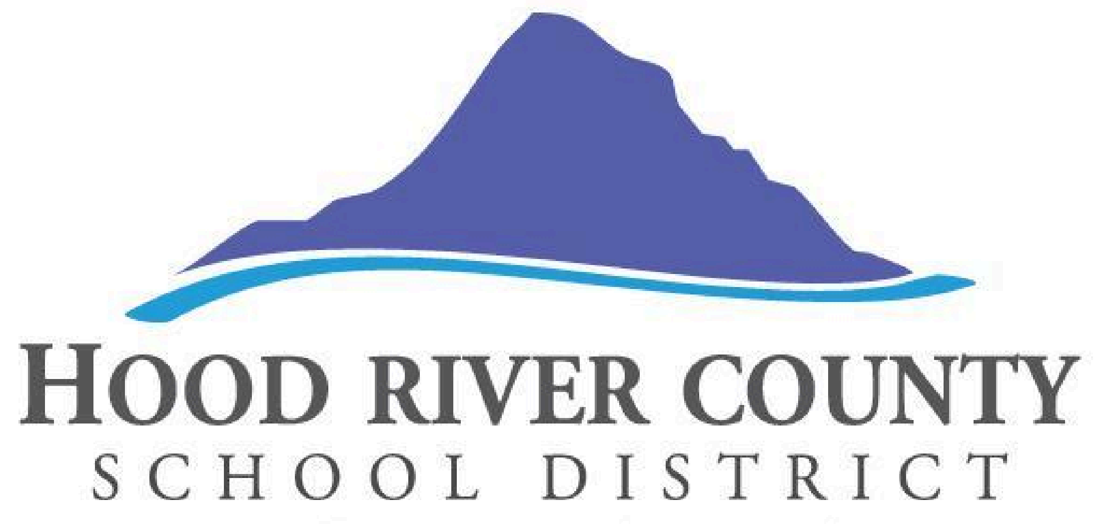

Suicide Prevention Plan and Procedures 2024-25

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Introduction

The U.S. Surgeon General promotes the adoption of suicide prevention protocols by local school districts to protect school personnel, and to increase the safety of at-risk youth and entire school community. In 2019, the Oregon legislature passed Senate Bill 52, also known as "Adi's Act", which requires school districts to develop and implement a comprehensive student suicide prevention plan.

Purpose

This document recognizes and builds on the skills and resources inherent in school systems. Schools are exceptionally resilient and resourceful organizations, whose staff members may be called upon to deal with a crisis on any given day. Schools can be a source of support and stability for students and community members when a crisis occurs in their community. Accordingly, this guide is intended to help school staff understand their role and to provide accessible and effective tools.

Hood River County School District:

Recognizes that physical and mental health underpin all learning. Physical and mental health and wellness are integral components of student outcomes, both educationally and beyond graduation.

- ❏ Further recognizes that suicide is a leading cause of death among young people aged 10 - 24 in Oregon.
- ❏ Has an ethical responsibility to take a proactive approach in preventing deaths by suicide.
- ❏ Acknowledges the school's role in providing a culture and environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience.
- ❏ Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components.
- ❏ Will publish its policy and plan on the district website and will revisit and refine the plan as needed.

Definitions

At-Risk

Risk for suicide exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention. A high-risk student may have thoughts about suicide, including potential means of death, and may have a plan. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset of potential mental health conditions or a deterioration of mental health.

Crisis Response Team

The HRCSD Crisis Response Team is a group of people (school psychologists, school counselors, and the director of student services) who work in collaboration with school administrators to address crisis preparedness, intervention, response and recovery.

Mental Health

A state of mental health, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders. Mental health can be impacted by the home, school, social environment, early childhood adversity or trauma, physical health, and genes.

Parent/Guardian

As used in this plan, the term parent means a parent of a student and includes a natural parent, a legal guardian, or an individual authorized in writing to act as a parent in the absence of a parent or a guardian.

Risk Assessment

An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated staff (e.g., school psychologist, school counselor, or in some cases, trained school administrator). The Columbia-Suicide Severity Rating Scale (C-SSRS) is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

Risk Factors for Suicide

Characteristics or conditions that increase the chance that a person may attempt to die by suicide. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological, and/or social factors in the individual, family, and environment. The likelihood of an attempt is highest when factors are present or escalating, when protective

factors and healthy coping techniques have diminished, and when the individual has access to lethal means.

School Screener

A staff member at every school who is trained to screen youth who have indicated suicide ideation or self-harm impulses. Typically the school counselor, the student support specialist, or the school administrator.

Self-Harm

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm increase the long-term risk of a future suicide attempt or accidental suicide.

Suicide

Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide Attempt

A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of unresolved mindset, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, unresolved mindset is not reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.

Suicidal Ideation

Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one's life is still considered suicidal ideation and will be taken seriously.

Suicide Contagion

The process by which suicidal behavior or a death by suicide influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.

Postvention

Suicide postvention is a crisis intervention strategy designed to assist with the grief process following a death by suicide. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school's healthy postvention effort can act as prevention and save lives.

Quick Facts - What Schools Need to Know

Take suicidal behavior SERIOUSLY EVERY time. Take IMMEDIATE action!
Contact the school counselor (grade 6-12), student support specialist (grade k-5) or a building administrator to inform them of the situation. NO student expressing suicidal thoughts should be sent home alone or left alone during the screening process. You must provide supervision!
If there is a reason to believe a student has thoughts of suicide, do not send the student home to an empty house.

- School staff are frequently considered the first line of contact with potentially suicidal students. Most school personnel are neither qualified, nor expected, to provide the in-depth assessment or counseling necessary for treating a suicidal student. They are responsible for communicating with the school counselor/student support specialist, who will take reasonable and prudent actions to help at-risk students, such as notifying parents, making appropriate referrals, and securing outside assistance when needed.
- All school personnel need to know that they are required to refer at-risk students to school counselors/student support specialists; the burden of responsibility does not rest solely with the individual "on the scene."

  Research has shown talking about suicide, or asking someone if they are feeling suicidal, will not put the idea in their head or cause them to kill themselves.

  School personnel, parents/legal guardians and students need to be confident that help is available when they raise concerns regarding suicidal behavior. Students often know, but do not tell adults, about suicidal peers. Having support in place may lessen this reluctance to speak up when students are concerned about a peer.
- Advanced planning is critical to providing an effective crisis response. Internal and external resources must be in place to address student issues and to normalize the learning environment for everyone.

Confidentiality

School employees are bound by laws of The Family Education Rights and Privacy Act of 1974; commonly known as FERPA. FERPA generally precludes schools from disclosing student information without first obtaining consent, but there are exceptions, including health and safety emergencies and communication with district staff who have a legitimate educational interest. Further, there are situations when confidentiality must NOT BE MAINTAINED, meaning that staff have a legal obligation to share information.

If at any time, a student has shared information that indicates the student is in imminent risk of harm/danger to self or others, that information MUST BE shared immediately. The details regarding the student can be discussed with those who need to intervene to keep the student safe. This is in compliance with FERPA.

Groups at Increased Risk for Suicidal Behavior

Youth Living with Mental and/or Substance Use Disorders

Mental health conditions, in particular depression/dysthymia, attention-deficit hyperactivity disorder, eating disorders, intermittent explosive disorder, and conduct disorder are important risk factors for suicidal behavior among young people. An estimated one in four to five children have a diagnosable mental condition that will cause severe impairment, with the average onset of depression and dysthymia occurring between ages 11 and 14 years; therefore, school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk and enhance overall performance and improve long-term outcomes.

Youth Who Engage in Self-Harm or Have Attempted Suicide

Risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Whether or not they report suicidal intent, one study found that 70 percent of adolescents admitted into inpatient psychiatric treatment who engage in self-harm report attempting suicide at least once in their life. Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. One study found that as many as 88 percent of people who attempt suicide for the first time and are seen in the Emergency Department go on to attempt suicide again within two years. Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources, transportation, insurance, copays, parental consent, etc.

Youth in Out-of-Home Settings

Youth involved in the juvenile justice or child welfare systems have a high prevalence of risk factors for suicide. As much as 60 to 70 percent of young people involved in the juvenile justice system meet criteria for at least one psychiatric disorder, and youth in juvenile justice residential programs are three times more likely to die by suicide than the general youth population. According to a study released in 2018, nearly a quarter of youth in foster care had a diagnosis of major depression in the last year. Additionally, a quarter of foster care youth reported attempting suicide by the time they were 17.5 years old.

Youth Experiencing Homelessness

For unhoused youth, the rate of self-injury, suicidal ideation, and suicide attempts is over two times greater than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorder, and post-traumatic stress disorder. One study found that more than half of runaway and unhoused youth experience suicidal ideation.

Racial and Ethnic Minority Youth

American Indian/Alaska Native (AI/AN) Youth

In 2017, the rate of suicide among AI/AN youth ages 15-19 was over 1.6 times that of the general youth population. Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see ihs.gov/suicideprevention.

Black Youth

Among Black populations, suicide rates peak during adolescence and young adulthood, then decline. This is a different pattern than is seen in the overall U.S. population, where suicide rates peak in midlife. A particularly important risk factor associated with suicide behavior among Black youth is exposure to racism and trauma. Black youth who experience racism often feel alienated, rejected by society, ignored, marginalized, depressed, and anxious.

Latinx Youth

Suicide and suicide attempts are especially concerning among Latinx adolescent girls, who have the highest suicide rates among all adolescent groups nationwide. Statistics reveal that in the United States, 15.6% of Latinx adolescent girls have attempted suicide one or more times and 25% have thought about it. Risk factors include alienation - including disconnection from family or family origin, acculturative stress and family conflict, hopelessness and fatalism, discrimination, and racism.

Asian Youth

For Asian Americans and Pacific Islanders between the ages of 15 and 19, suicide was the leading cause of death in 2016, according to CDC data, accounting for 31.8 percent of all deaths. Asian youth may be susceptible to different risks than other racial/ethnic groups, such as ethnic and cultural socialization or orientation, poverty, education related stress, familialism, discrimination, and acculturation that can take root at a young age, affecting mental health outcomes.

LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) Youth

The CDC finds that LGBTQ+ youth are 4.5 times more likely, and questioning youth are over twice as likely to consider attempting suicide as their heterosexual peers. One study found that 40 percent of transgender people attempted suicide sometime in their lifetime — of those who attempted, 73 percent made their first attempt before the age of 18. Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental health condition), these experiences can place them at increased risk. It is not their sexual orientation or gender identity that place LGBTQ+ youth at greater risk of suicidal behavior, but rather these societal and external factors: the way they can be treated, shunned, abused, or neglected, in connection with other individual factors such as mental health history.

Youth Bereaved by Suicide

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are nearly four times as likely to attempt suicide themselves.

Youth Living with Medical Conditions or Disabilities

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive delays that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.

Comprehensive Suicide Prevention Plan Components

Prevention Procedures

Hood River County School District takes intentional steps to create a school culture that encourages positive coping skills by building protective factors while communicating about suicide in a safe and healthy way. Suicide prevention includes mental and physical wellness education, accessible resources, staff training, mental health awareness campaigns, restorative practices, and building a culture of belonging. The district has adopted the staff and student training programs set forth below

Staff:

All staff receive training (or a refresher) once a year on the policies, procedures and best practices for intervening with students and/or staff at risk for suicide.

- Building School Counselors/Student Support Specialists will provide training at the beginning of each school year. To review the HRCSD Suicide Prevention, intervention, and postvention, protocols.
- School Counselors and Student Support Specialists receive specialized training to intervene, assess, and refer students at risk for suicide.
- Ensure that all staff know that the School Counselors, Student Support Specialists, and Administrators are the "go-to" people within the school and are familiar with the intervention protocol.
- All staff will be trained in the Question, Persuade, and Refer (QPR) training annually.

Only trained school staff members may act as School Screeners who perform Level 1 suicide response protocols and safety planning. Trained screeners in your school can be:
❏ School Counselor/Student Support Specialist
❏ School Administrator

Students:
Students receive information about suicide prevention in Health (grades 6th- 9th) and Advanced Health (grade 11) class. The purpose of this curriculum is to teach students how to access help at their schools for themselves, their peers, or others in the community.

- (1) Use curriculum in line with Oregon State Standards for health such as RESPONSE. Students should be made aware each year of the staff that have received specialized training to help students at risk for suicide. (2) Consider engaging students to help increase awareness of resources.
- QPR for High School Students

Parents/Community:
Provide parents with informational materials to help them identify whether their child or another person is at risk for suicide. Information should include how to access school and community resources to support students or others in their community that may be at risk for suicide.

- (1) List resources in the school handbook or newsletter. (2) Ensure cross-communication between community agencies and schools within bounds of confidentiality.
- Question, Persuade, and Refer offered to parents and community members.

PROGRAM	WHO	TIME
QPR Question, Persuade, Refer Gatekeeper Training for all student-facing staff members.	All student-facing staff.	1.5 hours
Columbia Suicide Severity Rating Scale **(C-SSRS)** Evidence-based first responder to gauge risk and response level needed during a potential suicidal engagement. Includes protocols for both initial and follow-up screening and documentation.	School Counselor Student Support Specialist School Psychologist	30 minutes for initial gatekeeper training online to 3.5 hours in person (2 hours online) for clinical training
Sources of Strength Secondary level peer-based suicide prevention program Research supported	Peer-based with adult facilitators	Varies: 4-6 hours initial adult training 4-6 hours peer leaders Meeting times throughout the year

Suicide prevention activities are best conducted in the context of other prevention efforts such as health and wellness curriculum, sexual violence prevention, drug awareness, unhoused youth, wraparound services, social-emotional learning, trauma-informed education, disability identification and services, and supports for underrepresented populations such as positive identity development and affinity groups. Prevention efforts are best characterized as being part of a multi-tiered system of support (MTSS) where universal practices across domains are employed, increasingly intensive training and support are engaged as screening, and intervention outcomes are evaluated.

All students K - 12 receive direct instruction on social emotional learning/mental health and wellness promotion using restorative practices.

School Program	
Social/Emotional Learning curriculum (SEL) including regulating emotions.	K - 5
Mental health as a part of physical health; Purposeful People	K - 5
Wellness, community and strength-building (protective factors) embedded throughout classes. Character Strong Curriculum	6 - 8
Wellness, community and strength-building (protective factors) embedded throughout classes such as Advisory, i.e., Character Strong.	9 - 12
Sources of Strength-HRVHS	9 - 12
Digital Device Program	
All school issued student devices will have an app with easily accessible crisis resources .	K - 12
A student safety device screening software program is placed on all devices to detect high risk searches.	K - 12

Screening Process

If imminent danger to the student is present (such as where a suicide attempt is in progress or the student is having an acute mental health crisis), the trained school screener or other staff member is to call 911.

If the student is not in immediate danger but a concern about suicide risk exists, the trained school screener initiates the screening process.

1. Suicide screening is conducted by the school counselor, student support specialist or a school administrator.
2. The trained school screener conducts a Level 1 interview of the student using the Columbia - Suicide Severity Rating Scale (C-SSRS) screening tool.
3. After the assessment, the trained school screener will consult with another trained school screener (another school counselor, SSS, administrator) to determine if a Level 2 Suicide Assessment is appropriate. Sharing decision-making with another professional is best practice. The outcome of the consultation will be one of the following:

    a. When a Level 2 suicide assessment **is NOT** warranted:
    1. Inform the parent or legal guardian the same day that a screening was conducted and why. Parents are a critical part of the student's care team and possess information that the school may not have access to.
    2. If low risk, schedule a follow up meeting and determine next steps. Follow up with parent/legal guardian as appropriate. If necessary, create a plan for support.

3. If moderate risk, schedule follow up meetings and complete the Stanley - Brown Safety Plan with the student (and parent or legal guardian, if possible) by the end of the next school day. Schedule a minimum of two follow ups 14 days and 30 days after the screening.

b. When a Level 2 external assessment **IS** warranted.

1. After consultation, if concern about suicidal ideation is sufficiently high, the trained school screener will contact and assist the student's parent or legal guardian in referring the student to an in-depth suicide assessment by an external licensed and qualified Mental Health Professional. A Level 2 Assessment of students aged 13 or under will require parental consent.
2. A School Safety Plan should be developed and updated upon the student's return to school prior to or the morning of re-entry. Schedule a minimum of two follow ups 14 days and 30 days after the screening.

***Follow up dates of 14 and 30 days after assessed risk are minimum scheduled contacts. It should be understood that Student Support and Student Safety Plans may include daily, bi-weekly, or weekly follow ups with the student.**

Documentation

- ❏ Document when the parents or legal guardians were notified. (If applicable, document contacts with DHS).

Screening Process for online students only

1. The trained school screener will retrieve the parent or legal guardian's contact information and determine the student's location. The school screener will contact the parent or legal guardian and notify them of the need for screening.
2. Retrieve student's contact information and confirm their exact physical location.
3. Contact the student and obtain consent to conduct the Level 1 risk assessment.
4. Contact the parent or legal guardian if a student could not be contacted or refused consent.
   i. Contact Mid-Columbia Center for Living's crisis team or the Hood River County police/sheriff's department for a wellness check if previous methods to contact the student fail.
   ii. Call 911 if there is a direct and imminent suicide threat.
   iii. Call 911 if the student terminates the remote assessment without reason or warning.
5. Conduct a Level 1 suicide risk assessment interview using the C-SSRS. Determine student risk level.
6. The trained school screener will consult with another trained school screener (another school counselor, SSS, school psychologist, administrator) . Sharing decision-making with another professional is best practice. The outcome of the consultation will be one of the following:

iv. Level 2 Assessment is not warranted. A Student Safety/Support Plan is completed by the end of the next school day.
v. Level 2 Assessment is warranted.

7. Communicate risk assessment results to parents or legal guardians, and conduct a post C-SSRS parent or guardian interview, if possible.
8. Determine updated risk level, if including results from the parent or legal guardian interview.
9. Notify the school administrator of the results of the Level 1 screening. and/or Level 2 referral.
10. Provide parents or legal guardians with school and community crisis intervention resources.
11. Complete district reporting process.

Process Following Suicide Attempt or Acute Mental Health Crisis

1. Collaborate with parents and legal guardians, if possible, to select interventions, and develop a school support or safety plan, as needed.
2. Provide parents and legal guardians with school and community crisis intervention resources.
3. Schedule minimum follow up meetings 14 days after and 30 days after comments, ideation and/or attempt. Designate a trained school screener (counselor, SSS, school psychologist, or nurse) or administrator to serve as the school point person for follow up communication and ongoing support/safety plan organization.

Developing a School Safety/Support Plan

After every suicide screening, the trained school screener consults with another SSS, counselor, mental health professional or administrator to determine if a School Safety/Support Plan is necessary and schedules follow up meetings.

The **School Safety/Support Plan** provides a structure for intentional support, designates the responsibilities of each person, and includes a review date to ensure follow-through and coordinated decision making. A designated staff member will serve as the school point person for follow-up communication with parents and, legal guardians and community providers for students who have been screened for suicide.

The **School Safety Plan** provides a more extensive structure for support, designates responsibilities of each person, supervision, and includes a review date to ensure follow-through and coordinated decision making. A designated staff member will serve as the school point person for follow-up communication with parents and legal guardians, and community providers, for students who are moderate to high risk or who have attempted suicide. If the child is transitioning after a hospital stay a re-entry meeting to develop a plan should take place prior to re-entry.

Developing a Re-Entry Plan

The re-entry process occurs after a student has been hospitalized for an attempt or has been out of school for a mental health crisis. Students who have made a suicide attempt are at a higher risk of re-attempting during the first 90 days after the attempt. It is important for the student to be monitored by parents or guardians, mental health professionals, and designated school professionals in order to establish a support system. It is critical to connect the student, his/her/their parents or legal guardians, the mental health team working with the student, as well as the school counselor/SSS so that pertinent information flows, and a safety net is created.

The Re-Entry Meeting and/ Re-Entry Plan is scheduled by the designated school counselor/SSS with the student, parent or legal guardian, and administrator.

1. A re-entry meeting should occur when students are returning to school following a suicide attempt, even if the school did not complete a suicide screening. This is a best practice approach contributing to student safety.
2. The Re-Entry Plan should be completed upon the student's return to school (prior to attending classes).

Suicide Intervention Flowchart

Suicide attempt, gestures or ideation occurs and is recognized

Staff uses QPR to engage student and reports event to Trained Suicide Screener: school counselor, school psychologist, or administrator

School counselor, school psychologist, or administrator determines if there is immient danger

CALL 911 if imminent danger exists

LEVEL 1
Suicide Risk Screener

Trained Screener begins student interview with explanation about confidentiality and mandated reporting

Trained Screener uses C-SSRS screening tool

Trained Screener contacts parent, legal guardian, or primary caregiver to inform and to obtain further information

Trained Screener determines level of risk with a potential to complete a Level 2 for high risk

Trained Screener consults with another Trained Screener to consult if a Level 2 Suicide Risk Assessment is warranted

Trained Screener informs administrator of student status

LEVEL 2
Suicide Risk Assessment

Trained Screener supports parent, legal guardian, or primary caregiver with a referral to Center for Living.

If a parent, legal guardian, or primary caregiver is unavailable or unwilling to consent and the risk for self harm is high, the school team will call the crisis response team at Center for Living or law enforcement.

SCHOOL PLAN

Support Plan

Structure for intentional support

Designates the responsibility of each person

Includes a review date to ensure follow through and coordinated decision making

Designated staff members serves as point person for follow up communication with family, legal guardian, or primary caregiver and community providers.

Safety Plan

More extensive structure for intentional support for students who are at moderate or high risk or have attempted suicide.

Should be developed in collaboration with school team, parent, legal guardian, primary caregiver and outside providers before student return to school.

The Support/Safety Plan lives in the school counselor's student's working file.

DOCUMENTATION:
The Trained School Screener will complete a confidential Google Form in compliance with district reporting policy and place a mental health alert form in the student's cum file.

Parents/Guardians must always be notified when there appears to be any risk of self-harm.

a. Whenever a student has directly or indirectly expressed suicidal thoughts or demonstrated other warning signs, the student's parent/guardian is to be informed the same day. Such notice shall be made by the school counselor, SSS, or the school administrator. These people are the school site's trained School Screeners.
b. If the student discloses thoughts of suicide or if the trained School Screener has reason to believe there is a current risk for suicide, the trained School Screener will request that a parent/ legal guardian come to school to discuss the screening results, review the school safety plan (if developed) and will help develop the home safety plan, usually in collaboration with the parent or legal guardian and student. This can be completed over the phone, or via zoom, though it is not preferred.
c. If the student denies experiencing thoughts of suicide and the trained School Screener does not have reason to believe there is a current risk of suicide, it is still HRCSD practice that the trained School Screener notify the parent to share that a screening was conducted and why.
d. If a student is in crisis and the trained School Screener has exhausted all methods to reach the parent or legal guardian (including Emergency contacts and sibling's schools), it may be necessary, after consultation, to contact the Department of Human Services (Child Protective Services) or local law enforcement at 911 if the risk of self-harm may be imminent.

EXCEPTION - Abuse or Neglect

Parents and legal guardians need to know about a student's suicidal ideation unless the trained School Screener, after conferring with the school administrator, reasonably believes that child abuse or neglect would result from disclosure and would place the student at an imminent increased risk of harm. In such a case, the trained School Screener or other staff person must make a report to the Child Welfare Hotline through the Oregon Department of Human Services at (855) 503-7233, Hood River Police Department-541-386-2121, or Hood River County Sheriff-541-386-2711.. The trained School Screener will also review with the student that they will be communicating with essential staff members in order to keep them safe.

If a student makes a statement such as "My dad/mom would kill me" as a reason to refuse, the trained School Screener can ask questions to determine if parental abuse or neglect is suspected. If there is no indication that abuse or neglect is suspected, compassionately disclose that the parent needs to be involved.

Privacy is of utmost importance, and every effort will be made to respect the confidentiality of the student while attending to the safety needs of the student and school building. The student and Parent should be informed of the limited information sharing that the district requires:
For safety reasons, the school building administrator will be notified of every suicide ideation or attempt and district documentation protocols will be followed.
Depending on the School Support/Safety Plan, specific school staff may receive certain information about concerns as part of a plan to maintain safety and provide support to the student. The student and parent/guardian are invited to help develop this plan.
A mental health alert sheet will be kept in the cumulative file with contact information for the counselor and student services department.

Recommended Resources

For emergencies:	Other resources:
By phone: • 911 • Mid-Columbia Center for Living crisis line 888-877-9147	• The Trevor Project (LGBTQIA2S+)-oriented crisis hotline) 866-488-7386 or thetrevorproject.org
In person: • Providence Hood River Memorial Hospital emergency department • Mid-Columbia Center for Living (during office hours) 1610 Woods Ct, Hood River (off of Pacific Ave)	To set up a counseling appointment: Mid-Columbia Center for Living 541-386-2620 Providence Behavioral Health Services 541-387-6138 One Community Health Behavioral Health Care 541-386-6380