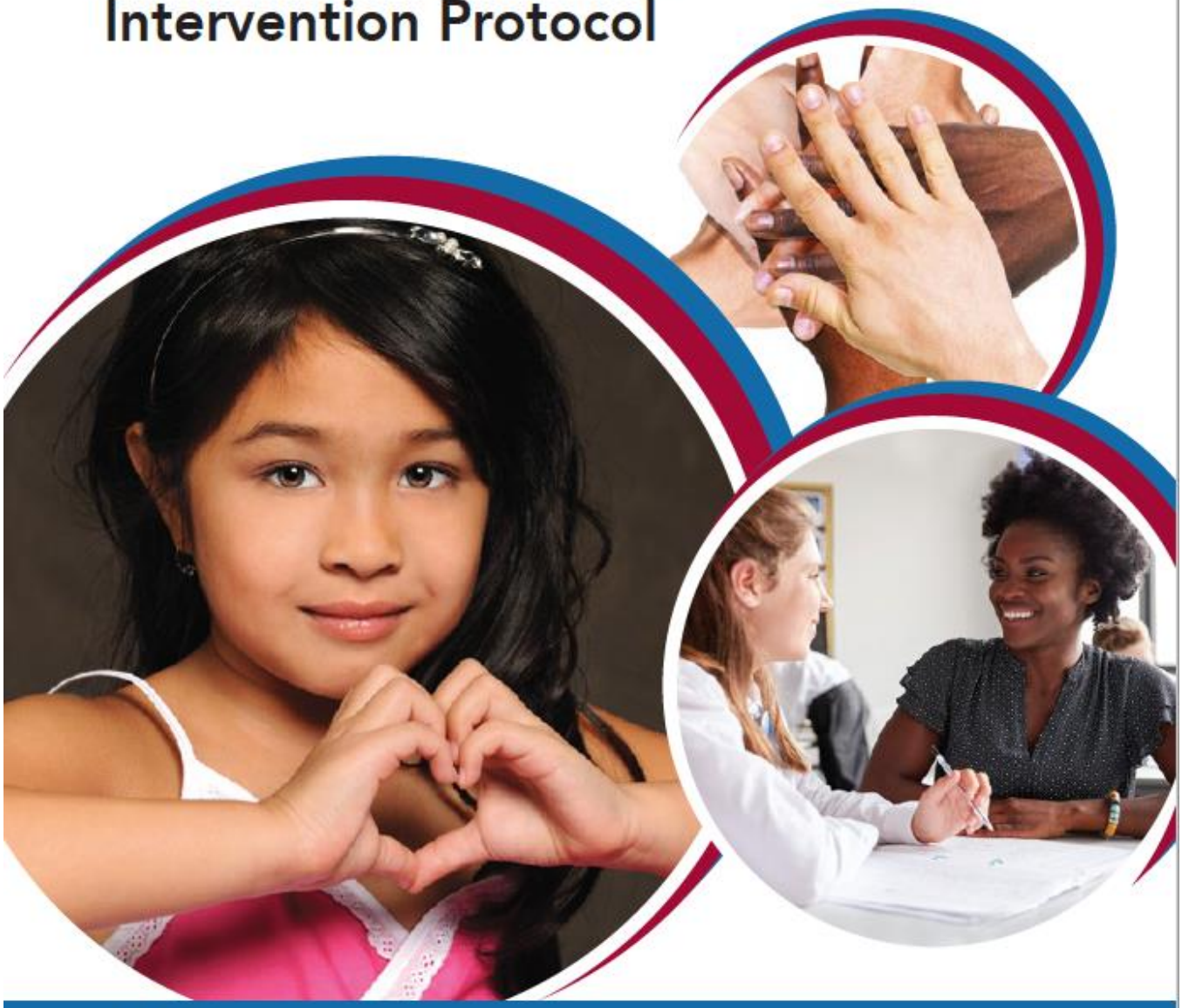
DURHAM CATHOLIC
DISTRICT SCHOOL BOARD
Learning and Living in Faith

Suicide Prevention and Intervention Protocol



2020

Table of Contents

Introduction

The Durham Catholic District School Board believes that all staff members are an essential part of promoting well-being in a safe, welcoming and inclusive learning environment (Discovery 2023: Renewing the Vision). Suicide is a sensitive and difficult issue that requires a collaborative response.

As part of DCDSB's Mental Health and Addition Strategy (**Together for Mental Health**), this protocol is based on current research and best practice, and has been developed to assist staff in knowing how to respond to students who present with suicidal thoughts, feelings and/or behavior in order to help keep them safe and guide them to the appropriate help.

Guiding Principles Related to Prevention and Intervention

- The safety and well-being of all students is a priority, and response to suicide risk should be considered of utmost priority.
- Suicide behaviours and comments must be taken seriously and responded to immediately.
- Students who disclose suicidal thoughts will be treated with dignity and respect. Although information received regarding suicidal thoughts and/or behaviours will be treated with the utmost discretion, it is not appropriate or acceptable to promise confidentiality. **Suicidal thoughts or behaviours cannot be kept secret and must be disclosed to the appropriate people, according to this protocol.**
- When required and appropriate, a suicide first-aid intervention should be conducted by a staff member trained in LivingWorks Applied Suicide Intervention Skills Training (ASIST).
- Where a concern related to suicidal risk is present, the student must remain, at all times, in the presence of a caring adult with whom the student is comfortable.

Key Terms

Suicide Thoughts/Ideation: thoughts of suicide that include both contemplating death by suicide and planning actions that could result in death.

Suicide Behaviour: any deliberate action that has potentially life-threatening consequences.

Non-suicidal Self-injury: a deliberate attempt to cause injury to one's body without the conscious intent to die.

Suicide Prevention: efforts to reduce the risk of suicidal thoughts and behaviour in a systematic way.

Suicide Intervention: practices involved in recognizing and responding to students with suicidal ideation or behaviour, and in supporting vulnerable students transitioning to and from professional mental health care.

Safe Plan: a concrete plan developed with an individual at risk of suicide that outlines a clear description of how support and contingency planning will be established.

Suicide Prevention Guidelines

A large part of suicide prevention involves promoting positive mental health and well-being for all children and youth, reducing vulnerabilities, and building protective factors. Schools offer a natural forum for delivering this type of programming.

There are many programs that fall under the banner of "suicide prevention;" however, recent review of the literature points to the relative lack of evidence supporting many of these programs. Schools are encouraged to carefully consider the evidence when choosing programs and to consult with a member of the board Mental Health Leadership Team (Mental Health Leader, Chief Psychologist, Manager of Social Work and Child and Youth Counsellors, Superintendent of Education, Student Services) if uncertain. When making these decisions, schools are also encouraged to access resources from School Mental Health Ontario, specifically the **Decision Support Tool: Student Mental Health Awareness Activities**: https://smho-smso.ca/blog/online-resources/school-mental-health-decision-support-tool-student-mental-health-awareness-activities/

Early identification of children and youth at risk for suicidal behavior is also a critical factor in prevention. School staff are in an optimal position to notice changes in behavior and other "warning signs," and to promote or assist students in accessing supports and intervention.

"It is never advisable to share high impact videos or stories about suicide with students. Messages, stories, videos and images that show or describe methods for suicidal behavior or that glamourize suicide are particularly dangerous. Large-scale assemblies are not an appropriate format for suicide prevention initiatives" **~ School Mental Health Ontario**

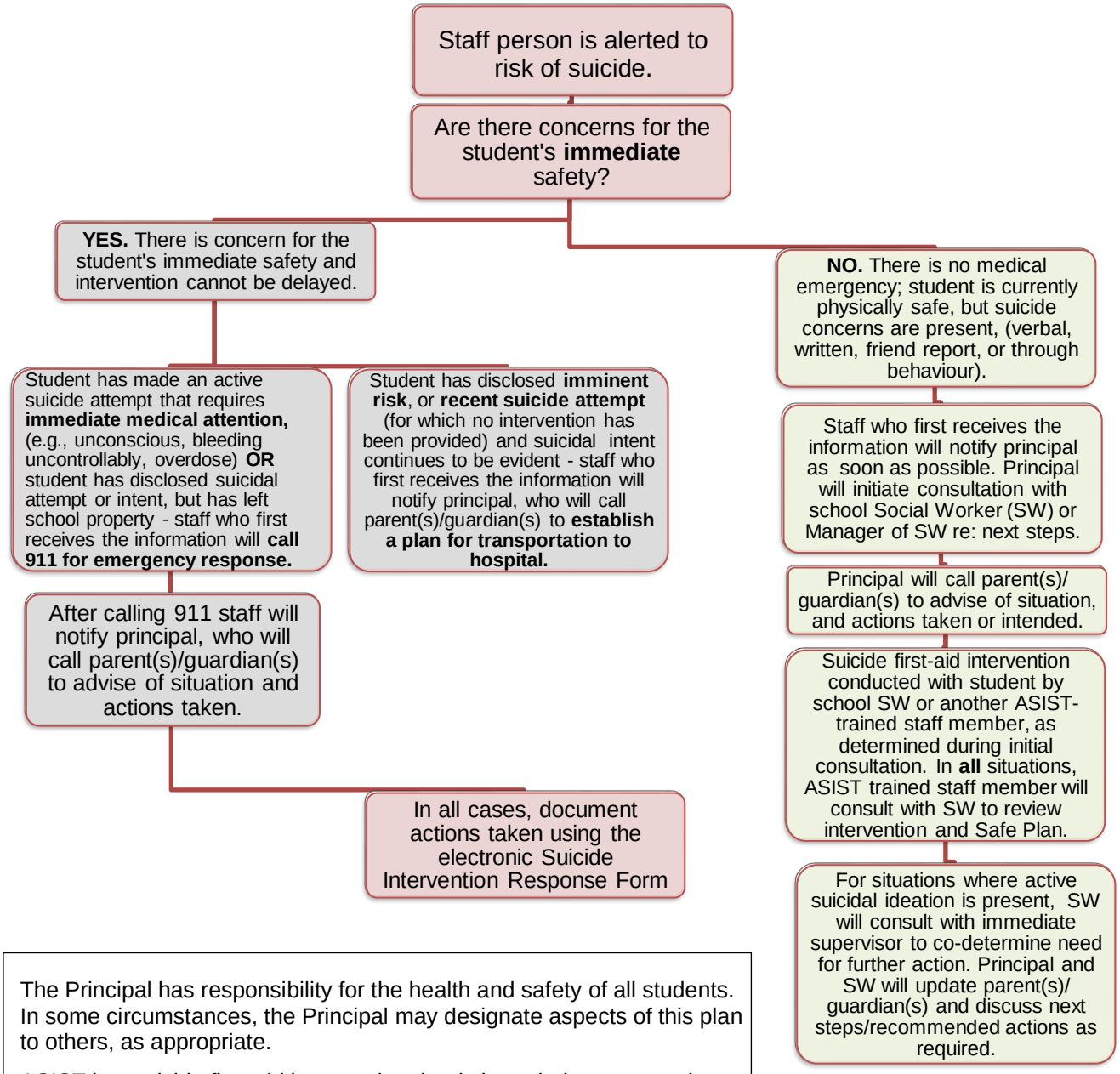
When it is necessary for schools to connect with groups of students about youth suicide, (e.g., following a high profile death by suicide covered in the media) school staff can provide factual information, drawing links to mental illness and the social determinants of health, and describing the complex nature of this act. They can talk about ways of healthy coping and where to get help when students, or their peers, are struggling (see **Appendix F: Talking with Students About Suicide**).

If the topic of suicide is related to course material, this material must be handled with sensitivity. For some, the material may connect to personal experience, and therefore be risky to their well-being. Students should be able to opt out if they choose.

It is not advisable to give permission for suicide to be the **sole** topic of an essay, debate, play, etc. Whenever possible, try to redirect students who are interested in this topic to focus on positive mental health, coping strategies, reducing stigma, seeking help and accessing support

Suicide Intervention Flow Chart

- Suicide behaviours and comments must be taken seriously and responded to immediately.
- **Do not promise confidentiality**. Suicidal thoughts or behaviour cannot be kept secret.
- Where a concern related to suicide risk is present, the student **must remain, at all times, in the presence of a caring adult**. Do not release the student from school to go home alone.
- If student is not currently at school, staff will **attempt to determine location** of student.



The Principal has responsibility for the health and safety of all students. In some circumstances, the Principal may designate aspects of this plan to others, as appropriate.

ASIST is a suicide first-aid intervention that is intended to prevent the immediate risk of suicide and to support the development of a Safe Plan.

Suicide Intervention Guidelines

Staff Person is Alerted to Risk of Suicide:

Disclosures of suicidal thoughts may be explicit or implicit invitations for help. Staff may be alerted to a student's potential for suicide in a variety of manners including, but not limited to:

- A verbal disclosure of suicidal ideation from the student;
- A report from a friend or family member that a student has expressed suicidal thoughts;
- A student's writing, artwork or social media communications;
- Repeated expressions of hopelessness, worthlessness, loneliness, helplessness or desperation, (e.g. "I can't go on like this anymore," "I should have never been born," "My problems won't end until I die.");
- Signs of depression such as sleeplessness, social withdrawal, loss of appetite, loss of interest in usual activities, change in routine behaviours;
- Actions such as giving away possessions, withdrawal from family or friends, or risky behavior;
- Any significant **changes** in behavior.

All reports related to suicidal thoughts and/or behaviours **must be taken seriously and responded to immediately,** i.e., not at the end of the day after the student has left the building.

The term "baseline" does not apply in situations where suicide concerns are present, i.e., each instance or report must be followed up on, even for students who express concern on a regular basis.

Where a concern related to suicide risk is present, **the student will remain, at all times, in the presence of a caring adult.** At no time should the student be left unsupervised at school, or released from school to go home alone.

If the student is not currently at school, staff should attempt to determine the location of the student.

Although information received regarding suicidal thoughts and/or behaviours is to be treated with the utmost discretion, **it is not appropriate or acceptable to promise confidentiality.** This information **must** be shared with the appropriate personnel, as outlined in this protocol.

Provisions to support the staff person in caring for the student and relaying information may need to be put in place (e.g., classroom coverage).

During the course of an intervention, it is important to recognize that the actions may not always occur in a step-by-step manner and that ideally, more than one staff member will be involved, i.e., different staff members may be performing various tasks (supporting student, calling parent(s)/guardian(s), contacting Social Worker) simultaneously

Are there concerns for the student's immediate safety?
If Yes

During situations in which there is a concern for the student's immediate safety, **and intervention cannot be delayed**, the student must be transported to the hospital for medical and/or psychiatric intervention.

There are different scenarios to consider when there is concern for the student's immediate safety:

- the student has made an active suicide attempt that requires immediate medical attention, (e.g., unconscious, bleeding uncontrollably, overdose); OR the student has disclosed recent suicide attempt or imminent intent, but has subsequently left school property. In these cases, the staff person first alerted to the information shall call 911 for emergency response. As soon as possible, the Principal (or designate) shall be notified. The Principal shall contact the parent(s)/guardian(s) as soon as possible to notify them of the situation and actions taken.

Note: when a student must be transported by ambulance, the system standard is that a staff member, (if possible, one with whom the student is familiar) should follow the ambulance to the hospital and remain with the student until a family member is present.

- the student has disclosed imminent risk of suicide or a recent suicide attempt, for which no intervention has been provided, and suicidal intent continues to be evident. In these cases, the staff person first alerted to the information will notify the Principal, who will call the parent(s)/guardian(s) to notify them of the situation, and to establish a plan for transportation to the hospital.

In both cases, the Principal or 'gatekeeper' who has been involved will document actions taken using the electronic Suicide Intervention Response Form.

When sending a student to the hospital, it is important to share the information we have, related to risk, with hospital staff. The school Social Worker will share this information by phone. When safety risk is imminent, this can be done without the written consent of the student or parent(s)/guardian(s). It is best practice to advise the student and parent(s)/guardian(s) that this information is being shared for safety reasons.

Students 18 and over: In the vast majority of cases it will be necessary to inform parent(s)/guardians(s); however, for students 18 and over, parental involvement should be carefully considered and will require permission from the student. If consent is **not** given, or for an emancipated student (i.e. one who has withdrawn from parental control) it will be necessary to explore other options with them (i.e. Durham Region Crisis Response, trusted friend or relative)

Are there concerns for the student's immediate safety?
If No

If there is **no medical emergency**, i.e., the student is currently physically safe, but suicide concerns have been reported (verbal, written, report from friend or family member, or through behavior) the staff member who initially receives the information will talk privately with the student (see **Appendix A: Tips for Meeting with a Student**).

As soon as possible, the staff member will notify the Principal, who will initiate consultation with the **school Social Worker, who has the primary function of crisis response.** If the school Social Worker is not immediately available, the principal will contact the Manager of Social Work and Child and Youth Counsellors regarding next steps. Consultation will include decisions around what additional information is required, how the information will be shared with the parent(s)/guardian(s), who will share the information with parent(s)/guardian(s) and who will conduct the ASIST intervention, if required and with parental permission.

*ASIST is a **first-aid intervention**, intended to prevent the immediate risk of suicide and to support the development of a Safe Plan. It is not intended to replace a mental health assessment or a formal **suicide risk assessment**. The school Social Worker, through their clinical training, adds this critical layer which will inform next steps and outcomes.

Following the Social Worker consultation, the Principal will call the parent(s)/guardian(s) to advise them of the situation, and actions taken or intended, including the intent to involve DCDSB staff trained in LivingWorks ASIST (see **Appendix B: Guidelines for Supporting and Engaging Parents/Guardians**).

Note that when safety is a concern, written consent of the parent(s)/guardian(s) is not required to initiate an ASIST intervention; however, if parent(s)/guardian(s) explicitly indicate that they would prefer to have an external suicide assessment completed, it is their right to do so. In this case, a school staff member will wait with the student until the parent(s)/guardian(s) arrives.

In many cases, a member of the Social Worker team will attend the school as soon as possible to conduct the ASIST intervention. When it has been determined that an alternate ASIST trained staff member will complete the intervention, it may not be necessary for a Social Worker to attend the school; however, **in all cases a Social Worker will be consulted to review the intervention and Safe Plan, and to determine if further action is required.**

As much as possible, it is important for the student to feel empowered in the development of the Safe Plan. A student is more likely to commit to and follow a plan that they have co-created. Whenever possible, the Safe Plan should be written. A written Safe Plan will ensure that those identified in the plan are familiar with and in agreement with the expectations (see page 10 for "My Safe Plan" that can be used with students). A Safe Plan may be revised as new information becomes available.

The Safe Plan:

The Safe Plan is intended to support a student's immediate safety until further and on-going supports are in place.

Components of a Safe Plan may include, but are not limited to:

- Assessment by a psychiatrist, pediatrician or primary health care physician
- Meeting with a community-based mental health worker
- Involvement with a crisis support service such as a mobile crisis team or local hospital emergency department
- Linking the student to key support people and crisis resources **(Appendix D: Crisis and Local Agency Numbers** can be used to select **relevant resources** for the individual student)
- Parent(s)/guardian(s) to keep watchful eye and invite conversation whenever appropriate
- Identifying a caring adult (and an alternate) at the school who the student is comfortable contacting if feeling suicidal. (Include the method of contacting this "go to" person and a back-up support, when necessary)
- Suggestions for making the environment safer, including removing or securing items that can potentially be used for suicide (i.e., disabling any suicide plans)
- Identifying and remediating clear sources of stress, (e.g., difficult course load)

The Safe Plan should ease the pain felt by the student and provide a sense of hope.

At times, the Safe Plan may include further assessment by a qualified mental health professional. Even in such conditions, it is important to include follow-up steps to support the student's well-being at school.

For situations where active suicidal ideation is present, the Social Worker will consult with their immediate supervisor and review the plan to co-determine need for further action. The Principal and Social Worker will update the parent(s)/guardian(s) and discuss the Safe Plan and recommended actions. **Although the Safe Plan is initially developed by the student and a staff member, parent(s)/guardian(s) are the most vital link to keeping their children safe.**

The Principal or 'gatekeeper' who has been involved will document actions taken using the electronic **Suicide Intervention Response Form**.

My Safe Plan

If needed, I can phone these crisis numbers:

- Kids Help Phone: 1-800-668-6868 or **text** 'Connect' to 686868 (24/7)
- Durham Mobile Crisis: 1-800-742-1890 (24/7)
- Distress Centre Durham: 1-800-452-0688 (24/7) or **text** 258258 (2:00 p.m.-2:00 a.m.)
- Crisis Services Canada: 1-833-456-4566 (24/7) or **text** 45645 (4:00 p.m.-12:00 a.m.)

If I can't keep myself safe:

Call 911 or go to the nearest hospital Emergency room

I can call my family doctor, counsellor or other mental health professional to make an appointment:

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

I can talk to someone for support (who, when and how?):

- Parent(s)/guardian(s):_____
- Teacher: _____
- Caring Adult: _____
- Caring Adult: _____

I can use my healthy coping strategies, such as:

• Exercise • Deep Breathing • Meditation	• Journaling • Connect with Friends • Other _____

What works for me?_____ When will I do this?_____

I will take these steps to make sure I am safe:

At home: • Alcohol and drugs (safe/no use) • Remove other risks: _____	**At school/in community:** Tell someone when I feel unsafe (who?): _____
Other Steps:	

DURHAM CATHOLIC DISTRICT SCHOOL BOARD
Learning and Living in Faith

BeSafe
You deserve help.

Be Safe app:
www.mindyourmind.ca

When to Report to a Child Protection Agency

In most situations, a child protection agency **will not** need to be called.

Suicidal thoughts/actions do not constitute a mandatory report to a child protection agency.

Parent(s)/guardian(s) of students considered to be at immediate risk of suicide, **under the age of 18,** should always be given the opportunity to respond appropriately to their child's needs before a report is made to a child protection agency, unless there is a perceived risk to the student by contacting the parent(s)/guardian(s), (e.g., abuse situation).

A report must be made to the appropriate child protection agency (Durham Children's Aid Society OR Dnaagdawenmag Binnoojiiyag Child and Family Services), in respect to a child under 18 years old when:

- The parent(s)/guardian(s) refuses or fails to cooperate with the school in accessing assistance for the student that is necessary to mitigate immediate risk;
- The Principal has reason to believe that the student's risk status is the result of abuse or neglect;
- The student has indicated that they fear parent(s)/guardian(s) physical reprisal if their suicidal ideation is shared with their parent(s)/guardian(s).

The above information must be outlined to the child protection agency, as well as the reasonable grounds to suspect that the student is at risk for suicidal behavior.

In situations of imminent risk, emergency services should be notified when the parent(s)/ guardian(s) refuses to cooperate with the school in accessing assistance for the student.

When in doubt, consult with a member of the Student Services team and/or a child protection agency intake worker about reporting requirements.

Contact Information:

Durham Children's Aid Society: 905-433-1551
Dnaagdawenmag Binnoojiiyag Child and Family Services: 1-844-523-2237

Follow-up

The caring staff person identified in the Safe Plan has an important role in follow-up. Ideally, this "go to" person is someone whom the student trusts. This staff member should be consulted and have an identified and reasonable means of checking in with the student, as well as back-up in the event they are unavailable.

At this point, it may be helpful to introduce the student to the **Be Safe** app if deemed appropriate (https://besafeapp.ca/). The **Be Safe** app is meant to help youth make decisions in a crisis. It allows the user to make a safety plan, it provides information about local resources and it gives options for getting help.

Following the initial intervention, the student may return to thoughts of suicide. In such circumstances, further intervention/risk review may be required and it may be necessary to adjust the Safe Plan. In each situation, it is important to again take the warning signs seriously. **Again, the term "baseline" does not apply in situations where suicide concerns are present,** i.e., each instance or report must be followed up on, even for students who express concern on a regular basis.

Recovery Following Suicide Attempt (Transition Back from Care)

Students who have been seen in the Emergency Department or have had a stay in hospital related to suicidal behavior should be welcomed and feel supported when they return to school. With this in mind, consider the following:

- If appropriate, arrange for a School Team Meeting, including parent(s)/guardian(s), school Social Worker, community agency staff (if appropriate), and student (if appropriate), to discuss the discharge and Safe Plan (may be referred to as "safety plan" at hospital).
- In order to facilitate further collaboration and communication, a signed release of information form is required to share and receive information with hospital staff. Consult with hospital staff about implementation of the Safe Plan at school, and follow accordingly.
- If appropriate, the Social Worker may request Mental Health and Addictions Nurse (MHAN) involvement to provide support and bridge transition.
- Obtain parent(s)/guardian(s) permission and student assent to share relevant information with selected school staff, (e.g., student's subject teachers) about their needs at school.
- If other students are aware of the situation, monitor those who may be vulnerable.
- If a student returns to thoughts of suicide, further first-aid intervention/risk review may be required and it may be necessary to adjust the Safe Plan. In each case, it is important to again take the warning signs seriously and consult with the Social Worker.

When followed, these guidelines provide a process to help ensure the safety and well-being of students. When supported by a caring community versed in student mental health and well-being, children and youth are more likely to feel safe and secure.

Appendices

Appendix A: Tips for Meeting with a Student

As the staff member who first receives the information, your role is to support the student and connect them with an ASIST-trained caregiver, someone who can help keep them safe. It is not your job to specifically ask about a plan, or to probe for further details.

The following are some "**dos** and **don'ts**" to consider when talking with a student:

Do:

- Find a quiet and private place to talk
- Take time to hear the student. This may mean making alternate arrangements to cover your other responsibilities
- Remain calm and demonstrate a caring manner
- Establish rapport with your words and your body language
- Listen carefully and avoid interrupting the student; Allow for periods of silence
- Validate the student's concerns and emotional pain
- Paraphrase what the student is saying in order to clarify and to indicate understanding
- **Promise privacy but not confidentiality**. You must inform someone if there is potential risk to the student or others. You cannot keep suicidal thoughts or behaviour a secret
- Respect the privacy of the student and the sensitivity of the information they have chosen to share with you by only sharing with those, as outlined in the protocol (i.e., Principal)
- Keep the student's perspective in mind (no matter how unrealistic)
- If the student is vague, **ask them directly** if they're thinking about suicide
- Let the student know that your first priority is to keep them safe
- Make arrangements for student safety, "We need extra help. I will connect you with someone who can help you keep safe"
- Practice self-care

Do Not:

- Do not leave the student unattended
- Do not judge what the student says in terms of moral or adult standards; don't debate whether suicide is right or wrong or whether life is valuable
- Do not argue about suicidal thoughts/behaviours
- Do not panic if the student admits to suicidal thoughts
- Do not allow yourself to be sworn to secrecy; this is a safety issue for the student
- Do not make promises or remarks that might be unrealistic
- Do not assume that the person "isn't the suicidal type" - anyone can be suicidal
- Do not discount the student's problems as minor or suggest they will get over it
- Do not give up if the student just shrugs or is uncommunicative. They may say more given additional time
- Do not act alone. Always reach out for support - 'widen the net.'

Note: staff members are encouraged to take safeTALK training to build confidence with these initial steps and become a "suicide-alert helper."

Appendix B: Guidelines for Supporting and Engaging Parent(s)/ Guardian(s)

The following guidelines can help support and engage parent(s)/guardian(s):

- Ensure that you've consulted with the school Social Worker and that a plan is in place for intended actions/next steps, including the intent to involve DCDSB staff trained in LivingWorks ASIST and/or school Social Worker
- Document all contacts with parent(s)/guardian(s)
- Align yourself with the parent(s)/guardian(s) if possible
- Acknowledge the emotional state of the parent(s)/guardian(s), including anger, if present
- Acknowledge that no one can do this alone - appreciate their presence
- Invite the perspective of the parent(s)/guardian(s). State what you have noticed in their child's behavior and ask how that fits with what they have observed
- Remind parent(s)/guardian(s) that they are the most vital link in keeping their child safe
- Emphasize safety, e.g., advise parent(s)/guardian(s) to remove lethal means from the home
- If the parent expresses reluctance to accept a mental health referral, address those issues, explain what to expect and if necessary, offer a phone call with the school Social Worker to explore reluctance further.

Appendix C: Hospitals with Youth Crisis Services and/or Psychiatric Consultation (Durham Region and Vicinity)

Lakeridge Health Oshawa **905-576-8711**
Families with a child or adolescent experiencing a psychiatric emergency should seek assistance from the Crisis Intervention Team by visiting the Emergency Room. The Child, Youth and Family Program (CYFP) at Lakeridge Health Oshawa provides services for children and adolescents, aged 5 to 18, who are struggling with serious mental health issues.

Lakeridge Health Ajax Pickering Hospital **905-683-2320**
Families with a child or adolescent experiencing a psychiatric emergency should seek assistance from the Crisis Intervention Team by visiting the Emergency Room (8:00 a.m. to 11:30 p.m.).

Rouge Valley Health System Centenary Hospital (Scarborough) **416-284-8131**
Rouge Valley Health System has a comprehensive mental health program for children and adolescents, including a Crisis Team, an inpatient unit and outpatient services available at the Shoniker Clinic. The program is designed to provide integrated and seamless services to children and adolescents with significant mental health problems.

Markham-Stouffville Hospital **905-472-7000**
The Child and Adolescent Services team offers assessment and treatment for a wide range of concerns affecting children and adolescents under the age of 19. If, as a result of a crisis, your child/youth has been seen in the Emergency Department, a referral may be made at that time through Emergency Department staff to the Child and Adolescent Services team.

Ross Memorial Hospital (Lindsay) **705-324-6111**
Ross Memorial offers mental health services for individuals who are 16 years of age or older. Young patients can be connected with Child & Adolescent Psychiatrists in other hospitals using videoconferencing technology.

Appendix D: Crisis and Local Agency Numbers

Durham Region Crisis Response **1-800-742-1890**
Telephone support is available 24 hours per day. A community visit by the mobile crisis team can be arranged to support the individual in their preferred environment. Follow-up support and short-term case management are also available.

Kids Help Phone **1- 800-668-6868** or **text CONNECT to 686868**
A free, anonymous and confidential counselling service for children and youth (age 5-20). To reach a Kids Help Phone professional counsellor 24 hours a day, 365 days a year: call, text, or chat online www.kidshelpphone.ca.

Distress Centre Durham **1-800-452-0688** or **text 258258**
The 24-hour helpline is staffed by volunteers who are specially trained to provide emotional support, crisis management, suicide risk assessment, community resource/referral information and emergency intervention. Text and online chat options are available from 2:00pm to 2:00am. https://distresscentredurham.com/ontario-online-text-crisis-services/

LGBTQ Prideline Durham **1-855-877-7433**
The helpline is aimed at providing emotional support, crisis intervention and community referral information specific to the concerns and issues of the LBGTQ community in Durham Region. (Hours: 6:00 p.m. to 10:00 p.m.)

Black Youth Helpline **1-833-294-8650**
Serves all youth and specifically responds to the need for a Black youth specific service, positioned and resourced to promote access to professional, culturally appropriate support. Service in French and other languages available upon request. (9:00 a.m. to 10:00 p.m.)

Hope for Wellness Helpline **1-855-242-3310**
The helpline offers immediate mental health counselling and crisis intervention to all Indigenous people across Canada. Phone and chat counselling options are available in English and French, 24 hours a day, 7 days a week. On request, phone counselling is also available in Cree, Ojibway and Inuktitut. https://www.hopeforwellness.ca/

Ontario Shores Centre for Mental Health Sciences, Prompt Care Clinic **905-430-4055**
Provides care for individuals 16 years+ who require timely access to psychiatric services, but do not require an ED visit. Individuals who are experiencing significant personal distress and where distress may increase if there is a delay in treatment can be referred to this clinic. (physician referral required)

Durham Region Central Intake **1-888-454-6275**
Centralized Intake is the front door to services for several agencies, including: Kinark Child and Family Services, Frontenac Youth Services, Chimo Youth and Family Services, Ontario Shores Centre for Mental Health Sciences, Lakeridge Health Child Youth and Family Program and John Howard Society of Durham Region. When parent(s)/guardian(s) call the Central Intake line, a clinician will guide them through the process.

Appendix E: List of ASIST Trained Staff Members

List of staff members in our school who have been trained in LivingWorks ASIST and are able to lead suicide first-aid intervention:

School Social Worker: _____

In-school staff:

- Administrator(s): _____
- Student Success:_____
- Guidance Counsellor(s): _____
- Chaplain: _____
- Program Support Teacher(s): _____
- Other:_____

Other Board staff:

- Psychological Services: _____
- Child and Youth Counsellor: _____

It is recommended that schools photocopy this form, update annually and post or communicate this information to all staff.

Note: LivingWorks Applied Suicide Intervention Skills Training (ASIST) is a suicide first-aid intervention that provides people with knowledge on how to respond to a person at-risk of suicide. It is intended to prevent the immediate risk of suicide and to support the development of a Safe Plan.

The ASIST suicide intervention is **not intended to replace a mental health assessment or a formal suicide risk assessment, nor is it intended to replace on-going therapeutic involvement,** as continued supports and resources are an essential component of the Safe Plan.

Appendix F: Talking with Students About Suicide

In a small group or class setting, students may ask about suicide and/or want to discuss recent events or media coverage.

It is important to talk about suicide, but how we talk about suicide is of critical importance: Talking about suicide in helpful ways can raise awareness of mental health and mental health problems, reduce stigma about mental health concerns, assist us to identify (or self-identify) concerns, encourage/promote coping skills, promote caring and connectedness in our relationships and get help for students in need. If the topic of suicide is featured in curriculum or associated readings, question any portrayal of suicide as romantic, heroic or tragic. The following recommendations regarding discussions with students in groups about suicide are intended as a supportive guide for educators. Educators can also speak with school-based mental health providers to review these recommendations.

Talking About Suicide: When we talk about suicide, we need to stress the link between suicidal thoughts and behaviours and mental health; for example, “Most people who are experiencing suicidal thoughts and behaviours have a mental health problem, but having a mental health problem like depression doesn’t mean that the person **will** become suicidal. It’s important to know that there is help available for mental health problems, and that people can and do get better.”

We need to stress that suicide, and the reasons for it, are not simple: Explain that: “Suicide is a complicated reaction to a number of overwhelming factors. There is no one single cause for suicide.” “Suicide is not caused by a single event such as bullying, fighting with parent(s)/guardian(s), a bad grade, or the break-up of a relationship.”

Provide clear information about bullying and suicide: Bullying may be linked to someone having thoughts of suicide. Bullying behavior may increase vulnerability for suicide, but the link is not simple. Our message about bullying and suicide needs to acknowledge this; for example: “Victims of bullying behaviour frequently experience social isolation from peers, decreased self-worth, loneliness, and withdrawal. Sometimes being bullied can result in new or increased feelings of depression and anxiety. Being the victim of bullying can become a risk factor for suicidal thoughts and actions, particularly when added to other major stressors and/or mental health problems.” **Again, there is no one cause of suicide.**

Provide information about mental health problems: Let students know that some feelings require immediate help such as threats of suicide, talking about wishing to die or having a plan. Talk about, provide information and reinforce helpful problem-solving, coping and stress management skills. Ask students about their coping strategies, and encourage them to use strategies that help them to feel better and solve the problem. Discuss stress management strategies.

Promote resiliency in students: Help students to identify their areas of strength (skills and abilities); the people in their lives who provide support and understanding; and healthy living skills, such as hobbies, sports, exercise, nutrition, proper sleep, and having a positive attitude.

Encourage help-seeking behavior: Let students know that help is available and where they, or someone they know, can get help. Sometimes students might be unsure of where to turn for help. Helpful websites include: www.ementalhealth.ca | www.mindyourmind.ca | www.kidshelpphone.ca.

See Appendix D for a list of contact numbers including crisis support and help phone lines.

Help Students Develop a List of Caring Adults in Their Lives: If suicide is raised in a classroom discussion, remind students of helpful adults that are available. For example, "There are people here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried, depressed or had thoughts of suicide? Parent(s)/guardian(s), extended family members, and religious leaders can be a source of support and help. There are also people here at school who care about you and are here to help. I am willing to support you and/or there are these people here at our school who can help." (List Student Services staff, Guidance staff, Chaplains, Student Success and Administration, as appropriate).

Remind students to **talk to an adult if concerned about a friend**. "If you have a friend that you are worried about tell a trusted adult. Friends don't let friends get hurt.

Do No Harm: What to Avoid When Talking About Suicide

- Watching or showing a video of someone discussing their suicidal thoughts or discussing images or media coverage about a specific instance of death by suicide when the coverage is glamorized, sensationalized or graphic in nature is **known to heighten the risk for vulnerable students**.
- Discussing the means or method of how someone died by suicide **increases risk** for vulnerable students.
- Allowing suicide to be the **sole** topic of an essay, debate, play, etc. is strongly discouraged. Try to redirect students who are interested in this topic to focus on positive mental health, coping strategies, reducing stigma, seeking help and accessing support.
- Talking with students about suicide in large assemblies has been found to have harmful effects for students and is not recommended. In particular, this kind of format "does not provide enough exposure to the messages of suicide prevention, nor do they allow for monitoring of student reactions." Media depictions of suicidal behaviours or speeches by teens who have made suicide attempts should not be used, as they could have modeling effects for at-risk teens. As well, there is risk of students being exposed to unsupportive and/or stigmatizing and judgmental comments made by peers.

Appendix G: Supporting Students who Self-Injure

Self-injury is the intentional destruction of one's body tissue, without suicidal intent and for reasons not socially sanctioned. This definition excludes tattooing or piercing, and indirect injury such as substance abuse or eating disorders. The most common methods of self-injury include cutting, burning, scratching and bruising. Although the most common age of onset for self-injury is early adolescence, individuals at any age can engage in this behaviour.

In most cases, a student who engages in self-injury has a different intent than a student engaging in suicide-related behaviour. While self-injury is a sign of distress, it is **usually not** a suicidal act. However, self-injury is one of the risk factors for suicide. For all youth who engage in self-injury, it is important to conduct a suicide inquiry and to explore factors that are known to exacerbate risk. Consultation with the school Social Worker is important when determining how the suicide inquiry should be done.

For further information, refer to DCDSB's Guide to Supporting Students Who Self-Injure (2020).

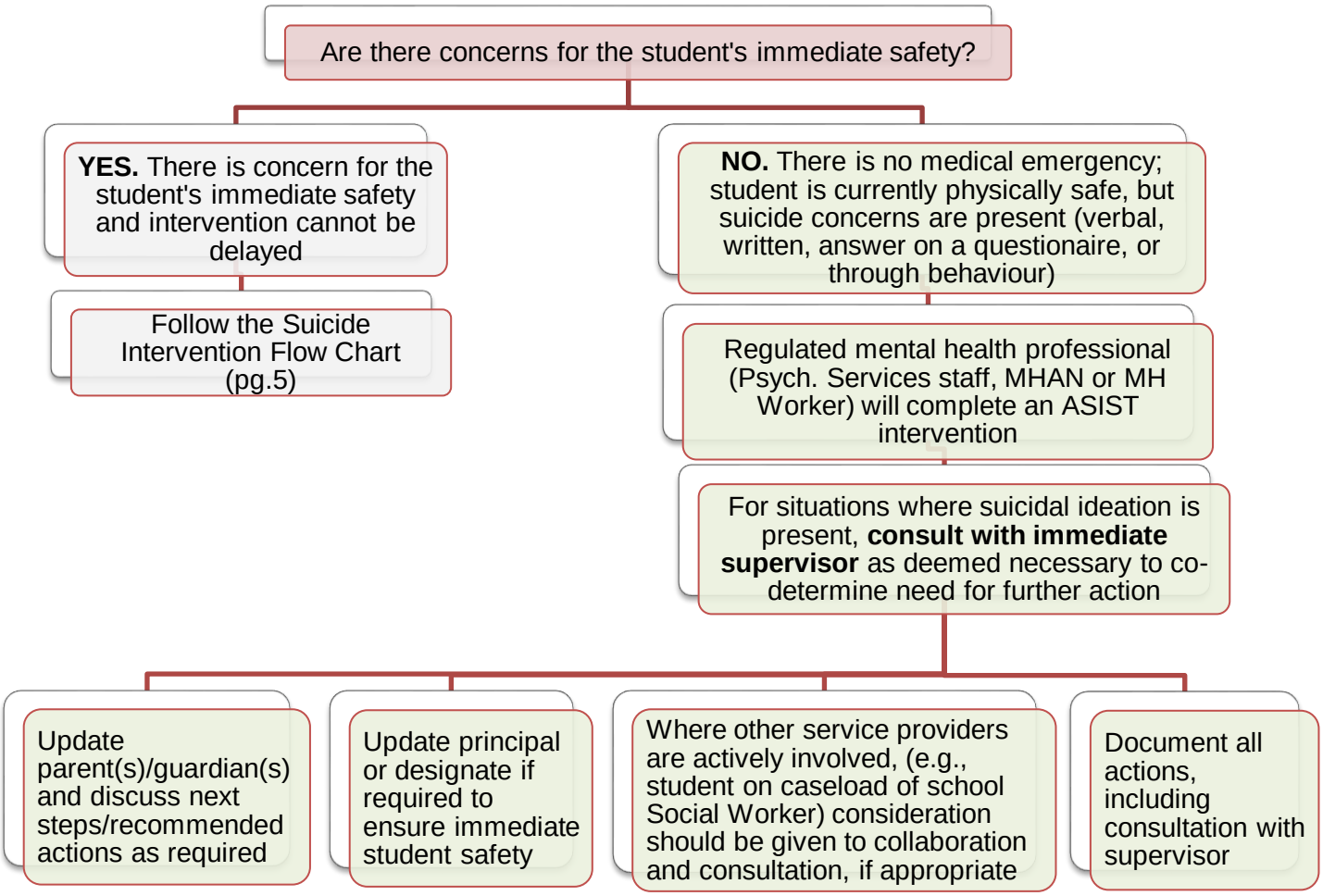
"It is essential for school personnel to monitor themselves to ensure they respond in a calm, respectful and helpful way if a student discloses NSSI. This may be the student's only disclosure about their self-injury, and therefore, an important one."

~Self-Injury Outreach and Support

Appendix H: Suicide Intervention Process for Regulated Mental Health Professional with Students on Their Caseload

This flow chart is to be used when an ASIST-trained **regulated mental health professional** (e.g., Psychological Services staff member, Mental Health and Addiction Nurse, Mental Health Worker from community partner agency, i.e., Kinark Child and Family Services, Frontenac Youth Services, Chimo Youth and Family Services, Pinewood Centre of Lakeridge Health) is meeting with **a student who is on their caseload**, and a concern for suicide is expressed directly to the mental health professional **in the course of their work with that student** (e.g., in the middle of a psychological assessment).

It is **not** intended for schools to follow when a concern for suicide has been presented to a school staff. In this case, the school staff will follow the Suicide Intervention Flow chart (page 5) **even if the student is on the caseload of a regulated mental health professional, as listed above**.



References and Acknowledgements

The DCDSB Suicide Prevention and Intervention Protocol has been informed by the following sources:

Youth Suicide Prevention at School: A Resource for School Mental Health Leadership Teams (School Mental Health ASSIST), Fall 2013

Substance Abuse and Mental Health Services Administration (2012). Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Centre for Mental Health Services, Substance Abuse and Mental Health Services Administration. http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

Maine Youth Suicide Prevention Program (2009). Youth Suicide Prevention, Intervention and Postvention Guidelines: A Resource for School Personnel. Augusta, ME: Maine Youth Suicide Prevention Program. www.maine.gov/suicide/docs/guidelines.pdf

Acknowledgements:

We wish to acknowledge the work compiled by the creators of the original (2015) Suicide Prevention and Intervention Protocol. Acknowledgement is extended to the various school board and community stakeholders who provided input and recommendations for this revision.

Members of the Revision Committee

Dr. Jessica Abrams, Manager, Psychological and Speech-Language Services/Chief Psychologist
Janine Bowyer, Superintendent of Education
Susie Lee-Fernandes, Superintendent of Education
Diane Mullane, Manager, Mental Health Initiatives/Mental Health Leader
Shelley Phoenix, Manager, Social Work and Child Youth Counsellors/Chief Attendance Officer
Gerard Winn, Superintendent of Education