A Collaborative Response for Children and Families in Crisis

Community SPIRR Protocol:

Suicide Prevention, Intervention, And Risk Review Protocol

AUGUST 2021

Community Suicide Prevention, Intervention and Risk Review Protocol

A Collaborative Response to Assessing

Young People in Crisis

Acknowledgements

The development of this protocol is the result of the hard work and partnership of the School Boards, Community Mental Health Agencies, Hospitals, Crisis Teams and Police Services, and was coordinated by the Catholic District School Board of Eastern Ontario. The protocol reflects the language and the Applied Suicide Intervention Skills Training (ASIST) provided by LivingWorks Canada. In addition, this protocol also incorporates the language of the protocols by J. Kevin Cameron, Director of the Canadian Centre for Threat Assessment and Trauma Response, and the Human Services Centre for Mental Health for Maine and Colorado.

Community Suicide Prevention, Intervention and Risk Review Protocol

A Collaborative Response to Supporting Young people Experiencing a Suicidal Crisis

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I. RATIONALE FOR DEVELOPING A SUICIDE PROTOCOL

The goal of this Suicide Prevention, Intervention and Risk Review (SPIRR) Protocol is to increase education and awareness on the topic of suicide, to assist district school boards and community partners to take active steps to support a young person who poses a risk of suicide and to ensure the safety and well-being of all children and youth in our communities. All partners agree to develop and support the protocol to prevent suicide and to create suicide-safer communities.

The principal goal of the protocol is to respond as a caring community to reduce the risk of suicide and implement risk-reduction measures. We will do so by proactively sharing information, advice, and support.

Reasons why schools and communities should address suicide

Suicide Facts:

- In Canada, suicide is the second leading cause of non-accidental death among children and youth.
- Suicide is the second leading cause of death young people between the ages of 10-24.
- Ten young peoples' lives are lost each day in Canada through suicide.
- In Ontario, 14% of youth report that they have seriously considered suicide in the past year. 4% of young people (grades 7-12) report that they have attempted suicide in the past year.
- Suicide in children and youth is a complex phenomenon that is associated with risk factors that include social, environmental, and bio-chemical - often interacting together.
- Mental health problems in children and youth, when left untreated, generally get worse. Suicide is frequently related to an underlying mental health problem that may have gone untreated or undiagnosed.
- Rates of suicide increase markedly in late adolescents and early twenties.
- Suicide attempts peak in 16-18 years old youth, particularly in young women.
- Effects of youth suicide go beyond the victim affecting parents, family, friends, schools and the community.

*Statistics Canada, 2019 and the Ontario Young person Drug Use and Health Survey, 2017

Importance of Caring Community Culture

The importance of a caring community is acknowledged **as being a key to creating**:

- Children and youth who are healthy, resilient and feel accepted by peers, and respected for differences, including race, religion, gender, and sexual identity. This is important for a sense of belonging and acceptance.
- Communities that place strong emphasis on safety, respecting differences, inclusivity, communication and programming designed to facilitate social responsibility and healthy relationships.
- Systems that allow for early identification of potential problems that children/youth and families may be experiencing.

II. VISION AND STATEMENT OF PRINCIPLES

All partners will take active steps to follow the SPIRR protocol to assist in the reduction of child and youth suicide in our schools and communities. The partners will work together to establish relationships of mutual respect and trust in a coordinated effort to identify, intervene and support children and youth at risk of suicide.

As partners, we will work together for the benefit of children, youth, and their parents/guardians by:

- Involving children, youth and their families in identifying and planning for outreach referral services and supports.
- Recognizing that each child and youth has unique strengths and needs that should be considered when developing an appropriate Safety Plan.
- Helping children and youth become happy, healthy, active, involved and caring members of the community.
- Building working relationships based on mutual respect and trust between youth, families, schools and communities.
- Working together in ways that promote safe, caring and restorative school environments and practices.

The partners agree to work together for the common goals of:

- Supporting schools and community partners in using the Suicide Prevention, Intervention and Risk Review Protocol.
- Building understanding of the nature of youth suicide: the myths and facts; risk and protective factors; warning signs; and appropriate interventions steps.
- Building collaborative connections within a community and among regional school boards and community support services.
- Educating schools, community services, parents and youth about suicide prevention and intervention.

The protocol is designed to support children, youth and families and to facilitate communication. When the protocol is activated, families, mental health agencies, hospitals, schools/boards and other community partners will communicate relevant information to support the child/youth.

As part of the protocol design, District School Boards and Community Partners will commit to:

- Participate in Steering committee meetings as required.
- Designate a lead contact who has been trained in suicide intervention and assessment.
- Provide staff development in suicide awareness, and/intervention training.
- Conduct a protocol review every three years from the date of signing.

III. COMMUNITY PARTNERS

	LEEDS AND GRENVILLE COUNTY	LANARK COUNTY	PRESCOTT-RUSSELL COUNTY	STORMONT, DUNDAS AND GLENGARRY COUNTY
MENTAL HEALTH SERVICES (AGENCIES AND HOSPITALS)	**Children's Mental Health of Leeds and Grenville** **Brockville General Hospital** **Lanark, Leeds and Grenville Addictions and Mental Health**	**Open Doors for Lanark Children and Youth** **Lanark County Mental Health (18+ yrs.)** **Lanark, Leeds and Grenville Addictions and Mental Health**	**Valoris for Children and Adults of Prescott – Russell** **Hawkesbury and District Community Hospital** • Community Mental Health Clinic **Montfort Hospital** • Community Mental Health Outreach (16+ yrs.)	**Cornwall Community Mental Health and Addiction Centre** • Children Mental Health Programs • Adult Mental Health Services (16+ yrs.) • Mental Health Crisis Team **Children's Treatment Centre**
	***Kingston Health Sciences Centre (KHSC)**		**Canadian Mental Health Association Champlain-East Branch (16+)**	
	***The Children's Hospital of Eastern Ontario CHEO (0-18 yrs.)** **Royal Ottawa Mental Health Centre (16+ yrs.)**			
POLICE & EMERGENCY SERVICES	**Brockville Police Service** **Gananoque Police Service**	**Smiths Falls Police Service**		**Cornwall Police Service**
	Ontario Provincial Police (OPP)			
HOSPITAL EMERGENCY SERVICES	**Brockville General Hospital** **Kemptville District Hospital**	**Carleton Place & District Memorial Hospital** **Almonte General Hospital** **Perth & Smiths Falls District Hospital**	**Hawkesbury & District General Hospital**	**Cornwall Community Hospital** **Glengarry Memorial Hospital** **Winchester Memorial District Hospital**
	***Kingston Health Sciences Centre (KHSC)**			
	***The Children's Hospital of Eastern Ontario CHEO (0-18 yrs.)**			
OTHER SERVICES	**Developmental Services of Leeds & Grenville** **Athens & District Family Health Team** **CPHC – Community Family Health Team** • Prescott Family Health Team • Upper Canada Family Health Team	**Ottawa Valley Family Health Team**	**Valoris for Children and Adults of Prescott - Russell** **ESF Du Bas-Outaouais-Lower Outaouais Family Health Team** **Plantagenet Family Health Team**	**Children's Aid Society of the United Counties of SDG** **Stormont, Dundas and Glengarry Developmental Services Centre** **Seaway Valley Community Health Clinic**
	Child and Family Services Lanark, Leeds and Grenville		**Centre de Sante Communautaire de L'Estrie**	
	School-Based Mental Health and Addiction Nurses (MHAN)			

***CHEO and Kingston Health Sciences Centre (KHSC) have a Child and Youth Mental Health Urgent Consult Clinic (See page 10)**

IV. INFORMATION SHARING

It is best practice that, as early in the process as possible, helpers discuss releasing information with the child, such as the Safety Plan or other documents. It is highly recommended that consent to release this information to others be documented with the child's signature, and preferably their guardian.

- In school boards, personal information (outside of the OSR) is governed by the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*. In this case, a child OR their guardian (when the child is under 16 years of age) may consent to the collection or release of their information.

- In children's mental health agencies, hospitals, physicians, private practitioners or other health institutions, personal information is governed by the *Personal Health Information Protection Act (PHIPA).* In this case, the child is presumed competent to consent to the collection or release of their information (unless a health professional has assessed the child otherwise for that particular decision). In practice, parents are often involved in the decision particularly when the child is under the age of 12.

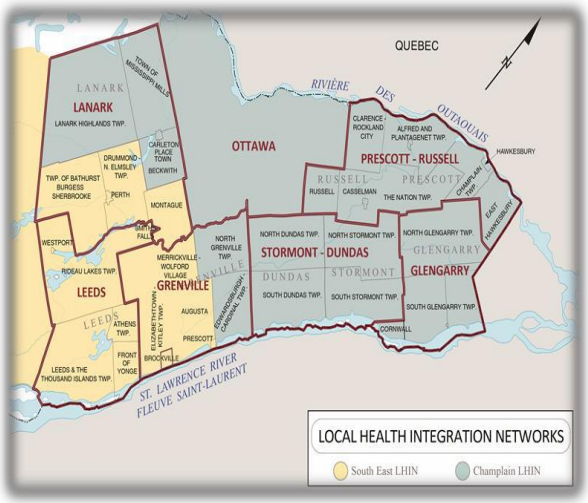
- In Children's Aid Societies or Developmental Services agencies, children aged 12 or older may consent to the release of their information.

When the child/youth is at significant risk to themselves or others, the law provides that information is shared regardless of consent until the appropriate care that reduces the risk is coordinated. The District School Boards and Community Partners are committed to the sharing of relevant information to the extent authorized by law. Children and youth may resist the disclosure of their suicidal intentions and may significantly overestimate their ability to control their actions despite a history of unsafe behaviour. Proceed with the sharing of information unless the child/youth appeals the decision through the Consent and Capacity Board of Ontario.

Generally, parents/guardians will be informed about the health and wellness of their child/youth by practitioners. Practitioners will support parents to understand what information would be helpful to share and with whom as a part of good intervention and aftercare.

Ottawa regional services including CHEO and The Royal are available to Prescott, Russell, Stormont, Dundas and Glengarry counties and parts of Lanark and Grenville

Kingston regional services, including the Kingston Health Sciences Centre, are available to Leeds county and parts of Lanark and Grenville counties



Green Light	Yellow Light	Red Light
Generally speaking, pursuant to freedom of information and privacy acts, relevant personal information CAN be shared under one or more of the following circumstances:	In any of the following circumstances obtain more information and/or get advice from supervisor or the board lawyer:	Information can NEVER be shared under the following circumstances:
• Imminent threat to health/safety can be shared with appropriate partners (police, medical). • With written, informed consent • To avert or minimize imminent danger to the health/safety of any person. • To report a child who might be in need of protection under the Child and Family Services Act (*See Child Protection School Handbook). • By order of the Court.	• Consent is not provided or is refused, but where there may be a health or safety issue for any individual or group(s). • When a professional code of ethics may limit disclosure. • To cooperate with a police and/or a child protection investigation.	• There is a legislative requirement barring disclosure. • No consent is given and there is no need to know or no overriding health/safety concerns, or • Consent is given but there is no need to know or overriding health/safety concern.

***Child Protection School Handbook has been provided to each school and partnering agency**

V. ACTIVATION OF PROTOCOL

The SPIRR protocol is activated when the risk of suicide is raised; when any peer, teacher, or other employee identifies someone as potentially suicidal because s/he has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs. High risk exists when a staff person observes or is told that a young person is making explicit statements indicating the wish or threat to die or has access to or is in possession of lethal means. The child/youth may appear significantly depressed, moody, irritable, unable to concentrate or withdrawn.

ALL STAFF MEMBERS MUST TAKE THREATS TO SELF-HARM AND SUICIDAL BEHAVIOUR SERIOUSLY EVERY TIME.

The following guidelines are intended to help staff make the determination of when to activate the SPIRR protocol within the school environment. It is important to carefully consider each individual's presenting behaviours to ensure the most appropriate response. When the risk of suicide is raised, community partners will follow the protocols and guidelines of their respective agencies.

If a young person is in the process of actively attempting suicide, or is in immediate danger, call 911.

3 Step Process Overview

Suicide Prevention, Intervention and Risk Review Protocol

1 Awareness and Connections with Student at Risk

* **If suicide attempt has already been made, call 911**
* Explore risk alerts and invitations
* If the young person is indeed suicidal, do not leave him/her alone
* Contact Principal and ASIST-trained staff member
* Principal to contact Parent/Guardian
* Move to Stage 2

2 Suicide First Aid Intervention and Safety Review

* ASIST-trained staff complete the Safety Plan with the student (Appendix A)
* Principal to contact board designate (i.e., BCC at CDSBEO and SSC/Mental Health Lead at UCDSB)
* Safety Plan is shared with Board Designate, the principal, parents and the young person
* Team initiates referrals to Community Mental Health supports as per the Safety Plan
* Move to Stage 3, Board Designate to initiate Urgent Care Protocol if criteria are met, or student is sent to hospital if in imminent risk

3 Postvention Commitments and Follow Up

* If the young person has been hospitalized, or emergency services were involved, it is anticipated the hospital staff will endeavour to link the student with the Mental Health and Addiction Nurse (MHAN) or other appropriate community support agency prior to discharge from hospital
* Follow-up meeting is scheduled with family, community partner(s) and school team for intervention planning, safety plan review and to support the student's return to school
* Child/Youth Feedback Form is completed (Appendix F) at CDSBEO
* If, unfortunately, the young person dies by suicide, refer to the Postvention section of this protocol for next steps

A 3-STAGE MODEL FOR ALL YOUNG PEOPLE WITH SUICIDAL BEHAVIOURS AND IDEATION

Risk Alerts and Invitations
Stressful Events with Feelings of Loss

Change in Actions	Change in Thoughts	Change in Feelings	Changes in Physical
• Giving away possessions • Withdrawal • Loss of interest in hobbies/activities • Abuse of alcohol, drugs • Extreme behaviour changes • Self-injury	• *"No one can do anything to help me now"* • *"I can't do anything right"* • *"I wish I were dead"*	• Hopeless • Desperate • Angry • Worthless • Lonely • Sad • Helplessness	• Lack of interest in appearance • Disturbed sleep • Change or loss of appetite, weight • Physical health complaints

In consultation, it may <u>not</u> be necessary to move to Stage 2

- If the child/youth is not having thoughts of suicide but requires supports, refer to appropriate service internally, or to appropriate community partners. Alert the child/youth's "circle of care" and supports
- Document and arrange follow up with the young person
- Follow up with case conference(s), when required, with parents/guardians and the multidisciplinary team
- Referrals to community supports as necessary

Activation of the School and Community Suicide Protocol and Intervention

STAGE 1: AWARENESS & CONNECTIONS WITH STUDENT AT RISK **KEEP YOUNG PERSON SAFE AND UNDER IMMEDIATE SUPERVISION – THE YOUNG PERSON SHOULD NOT BE LEFT ALONE** **Automatic Activation**: - Suicide attempt - Verbal/written threats to suicide - Internet, social media, IM, or blog messages to suicide - Plan and/or means to carry out a suicide attempt **WITHIN HOURS / SAME DAY**	**KEY TASKS** • If a suicide attempt has already been made, call 911 • Explore risk alerts and invitations • Contact Principal and ASIST-trained staff member • Principal to contact parent/guardian • Move to Stage 2	**SUPPORT NETWORK** • Child/Youth with thoughts of suicide • ASIST-trained personnel • School Administrator • Parents/Guardian **As needed:** - Community Mental Health Services - Mental Health Crisis Team - Police - Hospital - Hospital Therapists with consent
STAGE 2: SUICIDE FIRST AID INTERVENTION & SAFETY REVIEW **Young person is identifying as suicidal with or without a plan** **THE <u>SAFETY PLAN</u> MUST BE COMPLETED WITHIN HOURS/SAME DAY**	**KEY TASKS** • ASIST-trained staff complete the <u>Safety Plan</u> (Appendix A) in collaboration with the child/youth • Principal to contact Board Designate (BCC at CDSBEO or Mental Health Lead at UCDSB) • <u>Safety Plan</u> is shared with Board Designate, Principal, parents and the young person • Team initiates referrals to Community Mental Health supports as per the <u>Safety Plan</u> • Move to Stage 3, or Board Designate to initiate Urgent Consult Clinic protocol if criteria are met	**SUPPORT NETWORK** • Child/Youth with thoughts of suicide • ASIST-trained personnel • School Administrator • Parents/Guardian • Board Designate • Community Mental Health Services **As needed:** - Mental Health Crisis Team - Hospital - School Based Mental Health Addiction Nurse (MHAN) - CHEO/KHSC Mental Health Urgent Consult Clinic - Hospital Therapists with consent
STAGE 3: POSTVENTION COMMITMENTS & FOLLOW UP **Youth has been hospitalized or emergency services were involved due to suicide ideation and/or attempt to suicide** **If, unfortunately, a young person dies by suicide, please refer to the school board's traumatic events protocol for direction (**(i.e., *Hope in Time of Loss* at CDSBEO and *Caring Together* at UCDSB) **AS SOON AS POSSIBLE PRIOR TO A CHILD/YOUTH'S RETURN TO SCHOOL, OR IMMEDIATELY FOLLOWING A YOUNG PERSON'S RETURN TO SCHOOL**	**KEY TASKS** • Following a young person's hospitalization or visit to emergency services, it is anticipated that the hospital staff will endeavour to link the student with the Mental Health and Addiction Nurse (MHAN), or other appropriate community support agency, prior to discharge • Follow-up meeting scheduled with family, community partner(s) and school team for intervention planning, <u>Safety Plan</u> review and to support the student's return to school • <u>Child/Youth Feedback Form</u> (Appendix F) is completed at CDSBEO	**SUPPORT NETWORK** • Child/Youth with thoughts of suicide • ASIST-trained personnel • School Administrator • Parents/Guardian • Board Designate • Hospital • Community Mental Health Services **As needed:** - Mental Health Crisis Team - School-Based Mental Health Addiction Nurse (MHAN)

When there is a threat of violence or risk to others, activation of the Community Violence Threat Risk Assessment (VTRA) Protocol is initiated

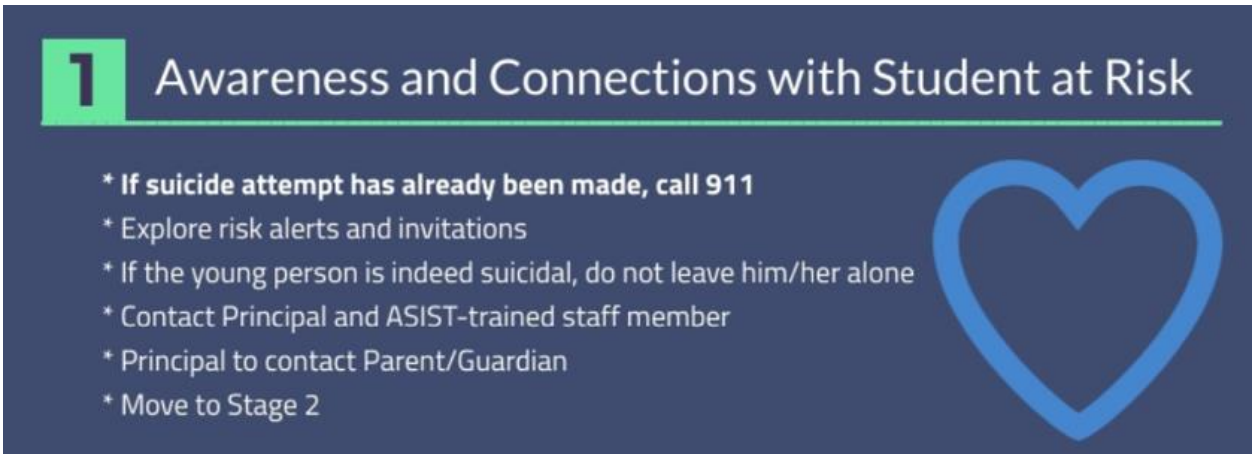
Hospital Child and Youth Mental Health Urgent Consult Clinic Protocol

CHEO/KHSC are able to provide prompt mental health assessments on an outpatient/voluntary basis for children and youth who are in crisis but not at immediate risk of suicide and meet specific triage criteria including:

- **current suicidal/homicidal ideation,**
- **current or recent suicide attempt/gesture, who are medically stable,**
- **recent history of suicide attempts,**
- **acute change in mental status, particularly as a result of psychosis**
- **able to engage in safety planning until scheduled appointment.**

The Board Designate, upon their assessment of the situation and in consultation with the school, may refer the young person to CHEO/KHSC Child and Youth Mental Health Urgent Consult Clinic for further assessment and follow-up by completing the "Referral to CHEO/KHSC Child and Youth Mental Health Urgent Consult Clinic" form. The referral package may also include additional information such as the young person's IEP, psychological assessments and Safety Plan. The Board Designate will then contact the Urgent Consult Clinic at CHEO/KHSC to determine eligibility to their program and complete the "School Board Consent Forms". A young person requiring urgent care will be provided with an appointment with a psychologist or psychiatrist at CHEO within 7-10 days as per CHEO's Urgent Care Protocol, which protocol may be updated and amended by CHEO from time to time, and follow-up with a psychologist or psychiatrist as determined by the practitioner. For young people accessing the KHSC Child and Youth Mental Health Urgent Consult Clinic, the young person will be provided with an appointment with a psychiatrist, registered nurse, social worker, psychometrist and/or social service worker within 24-48 hrs (72-96 hours when a referral is received on a Friday or there is a holiday). Follow-up sessions will be determined by the care provider. All completed documentation including the referral form, HEADS-ED and consent form, should be faxed to the appropriate hospital intake service once the referral is accepted and booked. The young person should bring any additional relevant documentation to their first appointment. Following CHEO/KHSC's involvement, a referral to community-based mental health care will also be facilitated by the Urgent Consult Clinic and Board Designate. With consent, CHEO/KHSC will strive to provide feedback to the referral source (e.g., Board Designate), who may then share this information with the school as appropriate.

THE SPIRR PROTOCOL FOLLOWS A THREE-STAGE PROCESS



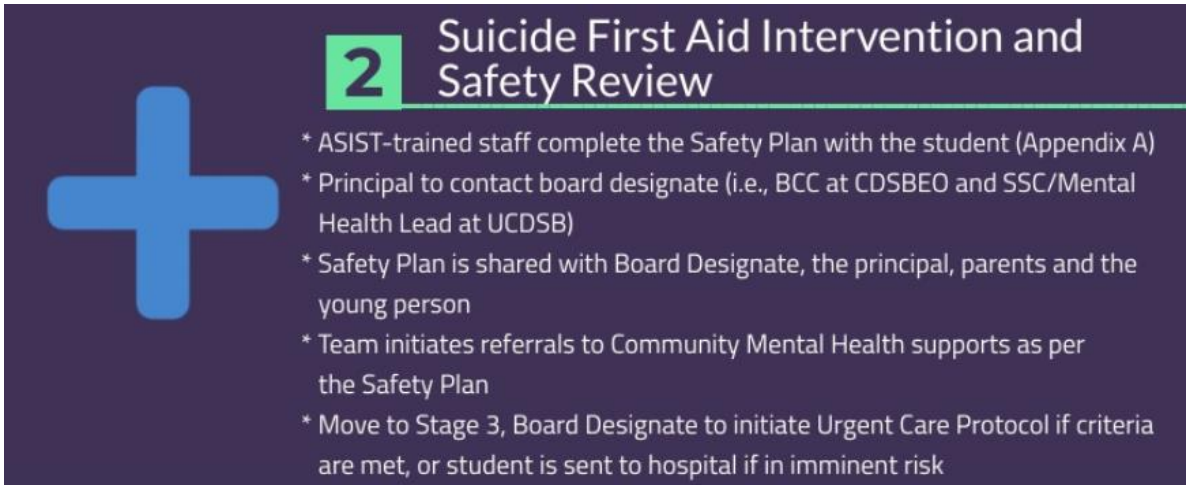
Stage 1 – Awareness and Connections with Student at Risk

- A person with thoughts of suicide almost always signals to others that they are having troubles, unhappy or in pain. These signals are commonly referred to as invitations or risk alerts.
- Risk alerts and invitations may be as direct as statements to kill themselves or as subtle as behaviour changes or the giving away of items of significance.
- All risk alerts and invitations are to be taken seriously and explored with the young person. The young person should be asked directly if they are having thoughts of suicide.
- The young person should not be left alone, and the ASIST-trained school staff and Administrator are to be contacted immediately.
- If a school staff member receives a disclosure and is not ASIST-trained, they will continue to support the young person, remaining with them while they contact the ASIST-trained staff member in the school or at the Board.
- If imminent suicidal plan and/or in possession of the means, or suicide attempt has been made, call the Mental Health Crisis Team, Emergency and/or 911. The referral form, HEADS-ED and "School Board Consent Forms" should accompany the young person to CHEO/KHSC.
- Parent/Guardian notified by the Administrator.
- If there is no risk of suicide, planning regarding other issues presented is to be completed with the young person, parent/guardian, school-based team and community services (as appropriate). This is in cases where a young person identifies that they are not suicidal but may be struggling with other issues and require support and intervention. (At CDSBEO, refer to the Guide for Working Together to Respond to Children and Youth Struggling with Substance Use, Addictions and Mental Health Concerns)

The Stage 1 SPIRR Teams **MAY** include the following professionals and other members as the team deems appropriate:

- Young person with thoughts of suicide
- ASIST-trained staff (school/community)
- Parent(s)/Guardian(s)
- School lead/designate
- School based Mental Health and Addiction Nurses (MHAN)
- Community Mental Health Services
- Hospital Crisis Response Teams
- Hospital Therapists with consent
- Police

If the young person is in possession of lethal means (e.g., weapon), call 911, secure the area and prevent other young people from accessing this area. Activation of the **COMMUNITY VIOLENCE THREAT/RISK ASSESSMENT (VTRA) PROTOCOL** is now necessary.



Stage 2 – Suicide First Aid Intervention and Safety Review

- If the young person is identifying as suicidal with or without a plan, an ASIST-trained staff completes the Safety Plan (Appendix A) with him/her and the Administrator contacts the board designate (BCC at CDSBEO and SSC/Mental Health Lead at UCDSB).
- This Safety Plan is completed reviewing the young person's level of physical and/or emotional pain, and the current formal and informal resources. The Safety Plan will also review the risk of background factors such as prior suicidal behaviour and current or past mental health supports.
- All Safety Plans will include the following: a plan to enable the young person to keep themselves safe for right now, safety contacts which will include a crisis line, safe or no use of alcohol and drugs and the disabling of the suicide plan if one is present.
- ASIST-trained staff will support the young person in linking to appropriate community mental health supports, both immediate and longer term.
- Board Designate may refer young person to CHEO/KHSC Child and Youth Mental Health Urgent Consult Clinic if required and criteria are met (Appendix D). Referral documents to be faxed to the hospital intake team after the referral is accepted and booked, so that communication back to the referral source may be facilitated.
- With the young person, the ASIST-trained staff and/or Administrator will contact the parent/guardian and complete the Parent/Guardian Contact Acknowledgement Form.
- Administrator will connect with Board Designate (Superintendent, Mental Health Lead, Behaviour Crisis Consultant and/or Special Services Counsellor) for follow up, supports and community referrals.
- Team makes referral(s) to Community Mental Health supports, as per the Safety Plan.
- The Safety Plan is shared with the Board Designate, Principal, parents and the young person at risk.
- If the young person is refusing to engage in the creation of a Safety Plan, emergency services and or mental health crisis team to be called.

Parents/Guardians

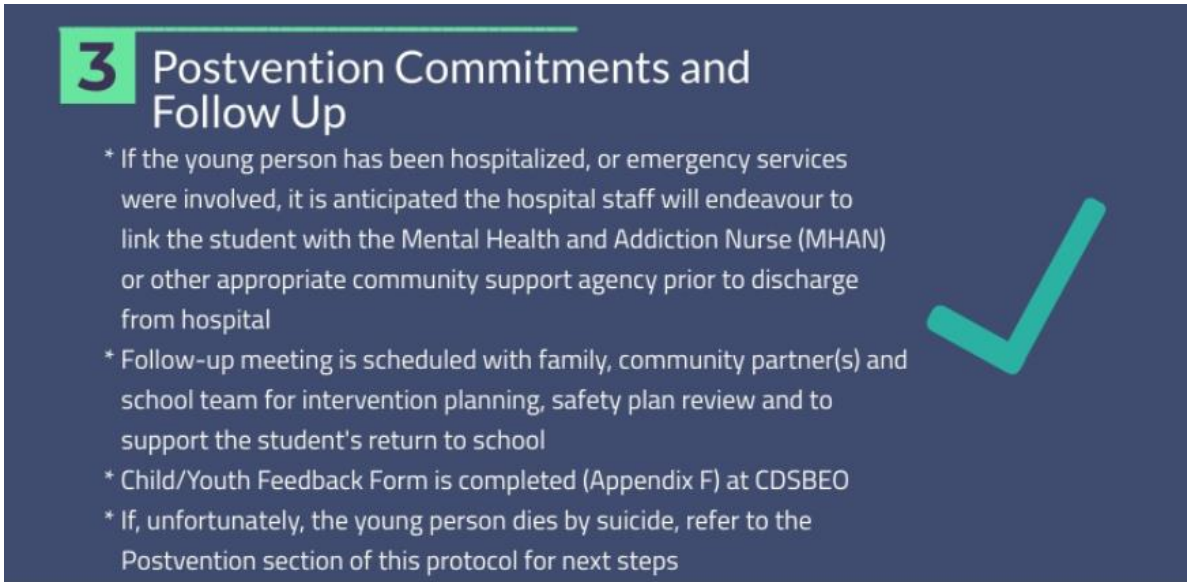
- Parents/Guardians are notified and requested to come to the school. Parent/Guardian Acknowledgement Form completed (Appendix B) at CDSBEO.
- Parent/guardian is updated and informed of Safety Plan.
- Discuss and collaborate on next steps to be taken.
- Young person is released to the care of the parents/guardians with clear, agreed upon next steps, Safety Plan, safety contacts and other referrals, and a list of culturally appropriate community resources. These community resources should include Kids Help Phone.
- A follow-up meeting date to review the situation and identify ways to best support the young person's return to school (Stage 3) is determined.
- If the parent/guardian refuses to obtain services for a child up to age 16, and the child is believed to be in danger of self-harm, staff involved should explore the underlying reasons for not seeking services and aid the caregivers in making referrals. If after parent engagement is unsuccessful, a report should be made to Police and/or the local child welfare agency (Family and Children's Services/Children's Aid Society). The Ontario Eligibility Spectrum identifies **Neglect – failure to seek necessary mental health treatment which may place the child/youth at risk of serious harm** as a potential child welfare entry point. The child welfare agency will, based on the facts, establish eligibility, and may conduct an assessment to determine if maltreatment (e.g., abuse/neglect) is a factor and whether any community links or ongoing child welfare services are required. NOTE: The same referral process ***may*** be followed for 16- and 17-year-olds as per amendments to the Child, Youth, and Family Services Act in 2017.)
- Ensure parents are aware of the support available to them through PLEO.

The Stage 2 SPIRR Teams may include the following professionals and other members as the team deems appropriate:

- Young person with thoughts of suicide
- Parent(s)/Guardian(s)
- ASIST-trained staff member
- School Administrator
- School Board Crisis Response Team Member

As needed:

- Mental Health Addiction Nurses (MHAN)
- Community Mental Health Partner
- Children's Aid Society
- Community Mental Health Agency Therapist
- Hospital Therapist with consent
- Child and Youth Mental Health Urgent Consult Clinic



Stage 3 – Postvention Commitments and Follow Up

- When a young person has been hospitalized or emergency services were involved due to suicide ideation and/or an attempt, the link back to the home school will be supported by the School Based Mental Health Addiction Nurse (MHAN) and/or the Board Designate.
- Prior to the young person's return to school, a meeting with parents/guardian, young person, school-based team, Board Designate, MHAN and community services will take place for ongoing intervention and safe planning to support a positive return to school.
- If young person is absent for an extended period time, connection with family, hospital and school/board liaison (MHAN or Board Designate) will work to collaboratively support the young person's return to school where appropriate.
- At CDSBEO, in consultation with a trusted adult who has been involved in supporting them, the youth person will be invited to complete the "Child/Youth Feedback Form" (Appendix F)
- If a young person has, unfortunately, died by suicide, please refer to the school board's traumatic events protocol (*Caring Together* at UCDSB and *Hope in Time of Loss* at CDSBEO).

STEPS FOR RESPONDING TO A DEATH BY SUICIDE

- Activate the School Board's procedure for responding to the media and notify the Superintendent of Education for the school.
- Utilize and follow the School Board's guidelines for dealing with a traumatic event.
- Respond to a death by suicide within 24 hours or as soon as possible.
- Act in a caring and concerned manner.
- At school, the Administrator will inform staff about the suicide and provide a debriefing session where staff may voice their concerns, apprehensions and questions. Armed with the correct information, they can help dispel rumors and false information that may be circulating regarding the suicide.
- Utilize the support offered by members of the School Board (i.e., crisis team) and community support agencies.
- Use a common language when discussing the suicide. Use the statement "has died by suicide", rather than "committed suicide".
- Provide the opportunity for debriefing or counselling throughout the school for staff and young people.
- Avoid glorification of the young person or the means of the young person's death; instead, emphasize coping and community resources.
- Continue to monitor the community and school's emotional climate, paying particular attention to young people that may have been close to the person who died by suicide, as well as young people who may have previously attempted suicide or had suicidal/homicidal ideations. Ensure youth are aware of Kids Help Phone services and parents are aware of the supports offered by PLEO.
- Utilize the community network to make referrals to appropriate services. Additionally, exchange information concerning next steps for treating those affected by the suicide.

The Stage 3 SPIRR Teams may include the following professionals and other members as the team deems appropriate:

- Young person with thoughts of suicide
- Parent(s)/Guardian(s)
- School Administrator
- School Board Crisis Response

As needed:

- Mental Health Addiction Nurses (MHAN)
- Community Mental Health Partner
- Hospital Therapist with consent
- Children's Aid Society
- Community Mental Health Agency Therapist

VI. COMPONENTS OF SUICIDE PREVENTION

EDUCATION, AWARENESS AND CAPACITY BUILDING

SCHOOL, SCHOOL BOARD AND COMMUNITY PARTNER EDUCATION AND TRAINING

Key Steps:

- Develop a plan to educate and train staff
- All staff will know key information regarding suicide, such as risk factors and invitations
- Key persons trained as ASIST and safeTALK trainers to provide training to designated staff and senior young people in schools and community agencies
- Review this protocol annually at a staff meeting and ensure that any new staff hired throughout the year are aware of the protocol

Although there are a variety of advanced training programs that may be used to teach how to conduct a suicide risk review, the District School Boards and Community Partners involved in this protocol are committed to provide training for staff in Applied Suicide Intervention Skills Training (ASIST) developed by LivingWorks Canada.

Public health, the mental health sector, and the school system share a responsibility for education to the community at large. Raising staff awareness about suicide, and training staff to take steps that prevent suicide, are important components of any board-wide suicide prevention program.

- All staff should be made aware that suicide can pose a risk to both young people and staff
- District school boards and community agencies continue to partner to create suicide-safer communities for all
- All staff should be trained to recognize the risk alerts and invitations of suicide in children and youth and to take appropriate action

All staff will be provided with information and awareness about suicide and the school's role in suicide prevention.

The mental health of young people affects their academic performance. It is part of the district school boards' mission to provide a safe learning environment in which education can take place and the mental health needs can be addressed through an ongoing partnership with our community agencies.

Suicide awareness education will be ongoing and combined with other Board and community initiatives around suicide awareness and mental health. **Resilience and Protective Factors**, describes resilience and identifies factors associated with resiliency such as psychological, social, cultural and physical resources that sustain young people' well-being and promote positive mental health, thereby reducing the risk of suicide.

STAFF DEVELOPMENT AND TRAINING

Select staff to be trained in an evidence-based suicide awareness program, such as safeTALK, to identify suicide risk factors and warning signs among young people and to take appropriate action. Suicide awareness training will be offered to all staff. ASIST training will be offered to selected community, school-based and central staff members to provide leadership and support in the development of a Safety Plan for a young person who is at risk of suicide.

Training select school staff to recognize and respond appropriately to young people who may be at risk of suicide can save lives.

- Staff interact with young people on a daily basis and are therefore in a position to recognize changes in personality, appearance, and performance that may indicate a young person is at risk for suicide.
- Young people may be more likely to turn to a trusted staff member for help.
- Young people may also confide in a trusted adult at school if they are worried about a friend or classmate.

Specialized training programs, such as LivingWorks' safeTALK and/or ASIST (Applied Suicide Intervention Skills Training), will be made available to selected staff to:

- Develop suicide awareness
- Identify individuals who may be at risk for suicide
- Verify this risk by talking with the individual
- Refer the individual to mental health services that will help reduce their risk

Many of these programs describe themselves as *"gatekeeper training".* Some gatekeeper trainings teach people additional skills, including how to do the following:

- Reduce a person's suicide risk by talking with them, listening to them and developing a Safety Plan with them
- Keep a person at imminent risk of suicide safe until additional help can be found
- Facilitate referrals and increase the likelihood a person at risk will receive timely professional help

As a result of increased training and awareness, staff may identify young people at risk of suicide more so than they would have in the past. This is to be expected. Components included in this protocol are to support and respond to young people at risk and in crisis.

Warning signs and risk factors for children/youth who may be contemplating suicide can differ by culture. A young person's attitudes, sharing of personal information, speaking with adults, or seeking help can all be culturally influenced. Staff attitudes about suicide and their role in prevention can also be affected by culture.

Selected central board administration and school staff will continue to be trained to assess suicide risk in individual young people. Young people can exhibit a range of suicide-related behaviours, including ambiguous statements that may indicate risk. Most suicide awareness programs teach people to recognize the warning signs indicating that a young person may be at risk for suicide. They usually do not train staff to assess the level of risk beyond recognizing when a young person may be at immediate risk of suicide and should

not be left alone. The availability of **community mental health partners** who have been trained to assess suicide risk in individual young people is an important component of a comprehensive suicide prevention program.

PARENT/GUARDIAN AND YOUNG PERSON EDUCATION AND AWARENESS

It is important to note that when schools and communities implement programs to educate parents and young people about suicide, they may experience an increase in the number of young people who seek help for behavioural health and suicide-related problems. Prior to implementing parent/guardian programs, schools should put in place:

- Protocols to respond to young people at risk and in crisis
- Suicide prevention education and training for school staff

Providing parents with specific suicide prevention education is important for the following reasons:

- The information may help parents identify and get help for children who may be at risk sooner.
- Suicide prevention education for young people is more effective when it is reinforced by the same information and messages at home.
- Involving parents is an important way to ensure that efforts appropriately target the needs of one's community.

What Parents Need to Know

Although parents may be aware that children and youth die by suicide, they often do not think it could happen to their child or in their community (Schwartz, Pyle, Downs, & Sheehan, 2010).

Parents need information about:

- Ways to prevent children/youth from becoming suicidal (i.e., the importance of relationships and fostering resiliency)
- The prevalence of suicide and suicide attempts among youth
- The warning signs, invitations and risk factors that may indicate a person is thinking about suicide
- How to respond and where to go for help if they suspect a child/youth may be thinking about suicide
- The available resources in their community (including PLEO)

COMMUNITY PARTNERS—including parent groups and representatives of the faiths, cultures, and tribal communities, are important to the success of outreach activities. When designing and implementing parent outreach and education activities the following should be considered:

- **Engage parents in a variety of ways -** at school orientations (e.g. GR 7 and GR 9), health and safety events at the school, senior transition activities (e.g. GR 12), and other regularly scheduled events for parents. Efforts should not be limited to a one-time event.
- **Select appropriate formats for outreach -** written materials (e.g. newsletters, cards, emails, posters) or presentations (by school staff, a professional from the

community, or a national expert).

Partner with other community organizations to share fact sheets and information regarding suicide. Such partners include Community Mental Health providers, The Royal, Canadian Mental Health Association, CHEO, etc.

The School Board leads (or designate) under the direction of the Superintendent involved in the Suicide Prevention, Intervention and Risk Review Steering Committee shall participate and review suicide awareness implementation at district schools. Discussions of suicide and self-harm, whether part of curriculum or mental health awareness, should focus on warning signs, coping with 'risks factors', and seeking help rather than discussions on means/methods or portrayals in the media.

Teaching Adaptive Skills to Young people: Like physical health, all young people benefit from learning about caring for their mental health. Programs such as *Kids Have Stress Too! and Stress Lessons* (Strong Minds, Strong Kids, 2020) can help facilitate this learning. It is also important for young people to be aware of the supports available to them through Kids Help Phone when schools and community partners are not available and a child or youth requires support. The counsellors at Kids Help Phone aid young people with a variety of concerns (not only crises) and always support those who reach out to their service to connect with their local mental health agencies when needed. For identified higher-risk young people (children/youth diagnosed with mood problems, substance problems, young people who have previously attempted suicide or otherwise disengaged), the use of evidence-based mental health interventions within a school or clinical setting will be supported by partnerships between community-based agencies and schools, and through connecting with mental health professionals in the community. These interventions are aimed at reducing known risks of suicide and may include interventions that are evidence-based specifically for the presenting concern which may include mood, anxiety, substance use or other difficulties.

Screening: This committee does not endorse school wide screenings with psychometric instruments. The low base rates of suicides create significant issues with "false positives". Identification of cases happens through education programs to young people and staff in recognizing warning signs and having specific conversations about suicide risk with identified individuals. Protocols then guide action to reduce the risk of suicides.

There is no list of indicators or risk criteria that fully encompasses young people who may engage in suicidal behaviour. Warning signs and risk factors are neither a checklist nor a predictive scale. While there are common signs and risk factors that **may** contribute to the likelihood of suicidal behaviour, no list is designed as a way to profile behaviour. Rather warning signs and risk factors are intended to be reminders of possible areas to investigate further.

School Climate: Reducing risk factors in a school and community is related to creating safe and inclusive spaces that encourage help-seeking and connectedness with a young person's peers and community. Schools and community partners are encouraged to review bullying campaigns, mental health anti-stigma campaigns, and issues related to gender identity and sexuality as appropriate.

VII. COMPONENTS OF SUICIDE INTERVENTION

IDENTIFYING YOUNG PEOPLE AT RISK OF SUICIDE

While there is no list of behaviours that describes a young person at risk, there are factors that are described by LivingWorks Suicide Intervention Training as **Invitations**.

SUICIDE RISK ALERTS AND INVITATIONS

Identifying young people who are at risk of suicide and implementing procedures to follow when a young person is identified as being at risk, will help prevent suicide and connect the young person with the appropriate community services.

The following is a list of risk alerts and invitations that young people may present with which will help staff in identifying young people who may be at risk of suicide:

Risk Alerts and Invitations *Stressful Events with Feelings of Loss*			
Change in Actions	**Change in Thoughts**	**Change in Feelings**	**Changes in Physical**
Giving away possessions Withdrawal Loss of interest in hobbies/activities Abuse of alcohol, drugs Reckless behaviours Extreme behaviour changes Self-Injury/Self Harm	"No one can do anything to help me now" "I can't do anything right" "I wish I were dead"	Hopeless Desperate Angry Worthless Lonely Sad Helplessness	Lack of interest in appearance Disturbed sleep Change or loss of appetite, weight Physical health complaints

GUIDELINES FOR SUPPORTING YOUNG PEOPLE ENGAGED IN SELF-INJURY BUT WHO ARE NOT AT RISK OF SUICIDE

Non-Suicidal Self-Injury (NSSI) - also known as self-injury, self-mutilation or deliberate self-harm - is defined as intentionally and often repetitively inflicting bodily harm to oneself without the intent to die. Self-injury includes a wide variety of behaviours, such as cutting, burning, head banging, picking or interfering with healing of wounds, and hair pulling.

The relationship between self-injury and suicide is complicated. Researchers believe self-injury is behaviour separate and distinct from suicide and the result of a very complex interaction among cognitive, affective, behavioural, environmental, biological, and psychological factors. In some people, the self-destructive nature of self-injury may accidently lead to suicide.

Young people who injure themselves intentionally are to be taken seriously and treated with compassion. Teachers or other staff who become aware of a young person who is intentionally injuring themselves are to refer the young person to an ASIST-trained staff member in the school. The Administrator/designate will link with appropriate community services and parents to collectively support the young person.

GUIDELINES FOR RESPONDING TO A SUICIDAL THREAT OR ATTEMPT ON SCHOOL PREMISES

When a young person exhibits life-threatening behaviour, an immediate response is necessary. Actions and interventions must be carefully planned and follow the 3-step process as outlined on page 8 of this resource.

- Keep the young person safe and under close supervision – do not leave the young person alone.
- Notify the school Administrator/designate who will contact appropriate emergency services and notify the designated regional board staff and the Superintendent of Safe Schools.
- Parents/guardians will be notified, and arrangements will be made to meet.
- Consult with the community mental health crisis team (see chart below) for assistance in assessing the young person's mental state and obtain recommendation for treatment and follow-up.
- If the young person does not require immediate emergency treatment or hospitalization and the crisis has subsided, the young person will be released to the parent/guardian with arrangements for ongoing counselling and treatment as required. A follow-up meeting with the school and community team is also arranged at this time.
- If the young person does require immediate emergency treatment and transportation to hospital or crisis services, arrangements will be made with designated regional board staff to follow up with the parent/guardian and maintain contact while the young person is away from school.
- Arrangements for schoolwork and assignments will be made through the designated regional board staff.
- When returning to school, a postvention meeting with family, school and involved community partners will take place to facilitate a supported return to school as per the Postvention section of this protocol.

Mental Health Crisis Teams			
Stormont, Dundas and Glengarry	Prescott-Russell	Lanark	Leeds and Grenville
Mobile Crisis Team through the Cornwall Community Mental Health and Addiction Centre: **1-866-996-0991**	Mental Health Support offered by Valoris: **1-800-675-6168**	Quick Response Service through Open Doors for Lanark Children and Youth: **1-877-232-8260**	Mental Health Crisis Response Service offered by Children's Mental Health of Leeds and Grenville: **1-800-809-2494**

NOTIFYING PARENTS

Parents or guardians should be contacted as soon as possible after a young person has been identified as being at risk of suicide. The person who contacts the family is typically the Administrator, designated regional board staff, or a staff member with a special relationship with the young person or family. Staff needs to be sensitive toward the family's culture, including attitudes towards suicide, mental health, privacy, and help-seeking.

1. Parents/Guardians are notified and requested to come to the school. Parent/Guardian Acknowledgement Form completed (Appendix B) at CDSBEO.
2. Parent/guardian is updated and informed of the Safety Plan.
3. Acknowledge the parents/guardians' emotions, including anger. Recognize that no one can intervene and support the child/youth alone – appreciate their presence. Discuss and collaborate on next steps to be taken.
4. The young person is released to the care of the parents/guardians with clear, agreed upon next steps, Safety Plan, safety contacts and other referrals, and a list of culturally appropriate community resources. These community resources should include Kids Help Phone. Provide the parents with the contact information of mental health service providers in the community. If possible, call and make an appointment while the parents are with you. Ensure parents/guardians are also aware of the support that they can receive for themselves through PLEO.
5. A follow-up meeting date to review the situation and identify ways to best support the young person's return to school (Stage 3) is determined.
6. Explain the importance of removing from the home (or locking up) firearms and other dangerous items, including sharps, ropes, car keys, over-the-counter and prescription medications, alcohol etc.
7. If the parent/guardian refuses to obtain services for a child up to age 16, and the child is believed to be in danger of self-harm, staff involved should explore the underlying reasons for not seeking services and offer assistance to the caregivers in making referrals. If after parent engagement is unsuccessful, a report should be made to Police and/or the local child welfare agency (Family and Children's Services/Children's Aid Society). The Ontario Eligibility Spectrum identifies **Neglect – failure to seek necessary mental health treatment which may place the child/youth at risk of serious harm** as a potential child welfare entry point. The child welfare agency will, based on the facts, establish eligibility, and may conduct an assessment to determine if maltreatment (e.g., abuse/neglect) is a factor and whether any community links or ongoing child welfare services are required. NOTE: The same referral process ***may*** be followed for 16- and 17-year-olds as per amendments to the Child, Youth, and Family Services Act in 2017.
8. Document all contact with the parent/guardian.

Supporting Parents Through Their Child's Suicidal Crisis

Family Support is Critical

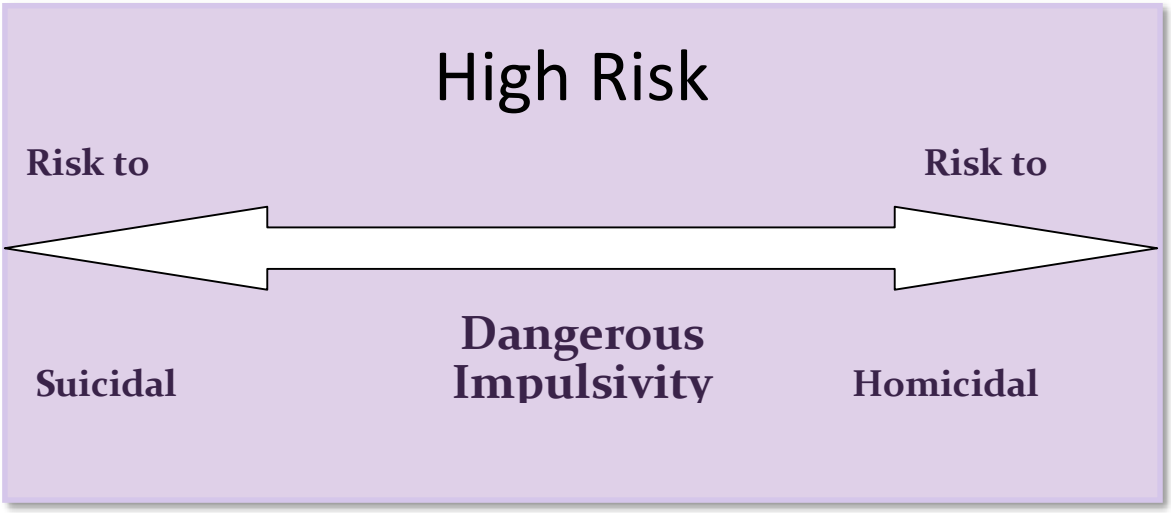
When a child or adolescent experiences a suicidal crisis, the whole family is in crisis. It is important to reach out to the family for two very important reasons:

- **First**, the family may be without professional support or guidance in what is often a state of acute personal shock or distress. Many people do not seek help because they may not know where to turn.
- **Second**, informed parents are probably the most valuable prevention resource available to the suicidal child or youth.

A prior suicide attempt is the strongest predictor of suicide. The goal of extending support to the parents is to help them to determine where they can intervene appropriately to prevent the child/youth from attempting suicide again. Education and information are vitally important to family members who find themselves in a position to observe, intervene and support the at-risk individual

FLUIDITY: MOVING FROM A SUICIDE RISK TO A VIOLENCE RISK THREAT ASSESSMENT (VTRA)

Fluidity refers to the way a person can move from having ***suicidal*** thoughts and intent to having ***homicidal*** thoughts and intent. A person may move from thinking about harming themselves to harming others.



When conducting a risk review with a child/youth who is expressing thoughts or the intent of suicide, information gathered during the development of the Safety Plan may suggest that the child/youth may also be struggling with having thoughts or the intent to harm others, particularly if they have recently been traumatized or been part of a traumatic aftermath. The child/youth may project their pain not only onto themselves but also onto others. A traumatized person may also act out impulsively and inadvertently be a threat to others, for example a distraught friend of a suicide victim gets in their car and dangerously races out of the school parking lot putting others' lives at risk. The possibility of fluidity must be examined. If fluidity exists, a Stage 1 VTRA may also need to be conducted, and immediate risk reducing actions and interventions put in place.

VIII. COMPONENTS OF SUICIDE POSTVENTION PLANNING

GUIDELINES FOR POSTVENTION

Postvention guidelines are intended to provide a timely and proper response to suicidal crises (suicidal threats, attempt, or death by suicide). Appropriate postvention programs can be viewed as a form of prevention since, if carried out correctly and successfully, they can reduce potential cluster suicides.

By not having an adequate postvention program in place, schools may unknowingly contribute to further suicidal behaviours or copycat suicides. One such method necessary for any adequate response is utilizing an established response team made up of school staff members, board level crisis response team members, and various members of the community. By having postvention guidelines in place, schools can provide a timely, effective and appropriate response to a suicidal crisis.

Suicide contagion is a process by which the suicide or suicidal behaviour of one or more persons influences others to suicide or attempt suicide. How a school/community responds to a suicide can help to prevent suicide contagion.

FACILITATING A YOUNG PERSON'S RETURN TO SCHOOL FOLLOWING AN ABSENCE FOR SUICIDAL BEHAVIOUR

A designated central board or school staff, with the support of the Mental Health Addiction Nurse/mental health worker, will facilitate a young person's re-entry to school after an absence due to suicidal behaviour. The school and community-based team will assist the young person to engage in the planning for the re-entry to school.

Confidentiality is critical to protecting the young person and facilitating a positive re-entry to school. It is recommended that, prior to planning for re-entry, consent be obtained from the young person and/or parent/guardian to communicate with the young person's therapist, counsellor, and team at the hospital or treatment facility regarding the needs of the child/youth. Meeting with the parents, school, community, and young person prior to the return to school is integral to making decisions concerning needed supports and any modifications to the routine. An individualized re-entry plan will be developed in partnership with the young person, parent(s) and involved community partners.

As the student returns to school, some areas to consider are as follows:

- Establish who a safe person is for the young person at school, and determine how the young person can access him/her when the need arises
- The school and community team will meet to facilitate young person's return to school
- School Administrators will address rumours and false information through a staff de-briefing. A possible student de-briefing may also be necessary.
- The school principal will designate a person who will be responsible to:
    - Follow up on recommendations from therapist, counsellor and SPIRR team
    - Be familiar with the risks and warning signs for the young person, and communicate intervention strategies to the appropriate school-based team members

- Support the young person during readmission to school/class/academic expectations
- Be a link between school, home and community
- Coordinate a follow-up meeting once the young person has returned to school

GUIDELINES FOR RESPONDING TO A DEATH BY SUICIDE

Deaths by suicide are tragic and affect many people beyond the person who died. It is crucial to monitor and assist others who are considered at-risk for suicide. Follow up with young people who were close to the person who died is critical. School teams need to be aware of young people at-risk and/or young people who may display a change in their baseline behaviours.

Suggesting that the death was caused by a single problem (e.g., break up of a relationship), or detailed description of the suicide can also raise the risk among other vulnerable young people.

It is important to develop a coordinated and timely response to a death by suicide. An unexpected death of a peer or someone they know can increase a young person's sense of vulnerability; they may experience conflicting emotions such as feelings of loss, guilt, anger and betrayal, making it difficult to focus on their regular activities and academics. As a result, young people may feel lost and present as withdrawn, increasing their risk of suicidal and self- harm behaviours.

The Substance Abuse and Mental Health Service Administration (2012) developed a resource entitled "Prevention Suicide: A Toolkit for High Schools". This document offers valuable guidance on supporting schools following a suicide. For example, it is recommended that:

- The school Administrator verifies the young person's death; ensures staff are aware and able to respond to inquiries from young people, other parents, concerned community members and fellow staff members who may have questions or concerns.
- The school Administrator communicates to the Superintendent and other schools that may be directly affected (e.g., if the victim had siblings attending another school). The Administrator will coordinate with external mental health professionals for immediate crisis support and will aid with the identification and monitoring of young people who may be at an increased risk for suicide.

The "Preventing Suicide: A Toolkit for Schools" has also made samples of the following resources available:

- Sample script for office staff (regarding inquiries from concerned parents, young people, and media)
- Guidelines for working with the family
- Guidelines for notifying staff
- Sample announcements
- Sample letter to families
- Talking points for young people and staff after a suicide

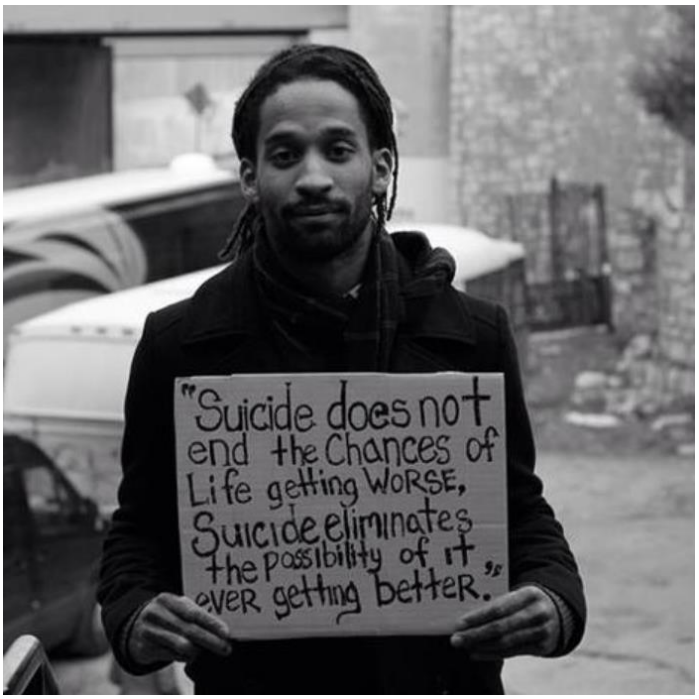
- Guidelines for working with the memory of the young person
- Appropriate commemoration in yearbook, graduation, and guidelines regarding anniversaries of the death or other high-risk times

If a peer does die by suicide, this may be the first experience with death for many young people. Children/youth, families and staff will need opportunities to express their grief in a safe and supported environment. Grieving is an important part of healing and provides an opportunity to learn how to cope with loss. When the death is by suicide, it is a delicate balance between providing opportunities for the expression of feelings and giving death so much attention that it makes the idea of suicide attractive to vulnerable young people. It requires a thoughtful and balanced approach.

At school, for complete guidelines to respond to this tragic event, please refer to each school board's tragic events protocol (i.e., *Hope in Time of Loss* at CDSBEO and *Caring Together* at UCDSB).

GRIEF PROCESS AFTER SUICIDE

It is common to struggle with the search for the reasons "why", however this can lead to blaming, "scapegoating", and may put the person being blamed at risk for suicide. Feelings of personal guilt and rejection are also common in the aftermath of a death by suicide. It is important to connect individuals experiencing significant distress or impairment with evidence-based interventions for the concerns they are experiencing.



APPENDIX A SUICIDE SAFETY PLAN FOR COMMUNITY PARTNERS/CDSBEO (see below for UCDSB)

SAFETY PLAN		
YOUTH'S NAME:		**AGE:**
SCHOOL:		**GRADE:**
DATE:	**ASIST-TRAINED STAFF:**	
Other staff/people involved who should receive a copy of this Safety Plan: • • • • •		
SETTING THE STAGE 1. Be clear about your role and state limits of confidentiality 2. Be calm and non-judgmental 3. *If the person with thoughts of suicide is NOT able to participate in the intervention, activate emergency response and 24-hr monitoring services*		
CURRENT FACTORS – what will keep you safe RIGHT NOW?		
CURRENT PLAN:		
Do you have a current plan to kill yourself? Or harm someone else?	◯ **YES**	◯ **NO**
If YES, what is your plan?		
What things have you done to get ready?		
How soon?		
What life/situational factors are contributing to these feelings now?		
Are you experiencing physical and emotional pain?		

If the young person has a plan, it needs to be disabled. List interventions to disable plan here: (who, what, when and how)

PRECIPITANT AND MOTIVATION – Safety Guards

Are you currently using alcohol or drugs, or prescription medication?
Plan for safe or no use of alcohol or drugs.
Confirm safe use of any medication
List interventions here: (who, what, when and how)

-
-

PAST SUICIDAL BEHAVIOUR

Have you thought or attempted killing yourself in the past? :

When?

What have you learned from your past experience that might help with keeping safe now?

-
-

MENTAL HEALTH

Are you currently engaged in any mental health treatment or other counselling support?	**YES** ◯	**NO** ◯
Have you had any previous mental health concerns where you sought counselling?	**YES** ◯	**NO** ◯

What have you learned from current or past counselling or mental health supports that might help with keeping safe now? *If the young person agrees, connect/contact current or past counsellor for additional ongoing supports*

-
-

IMMEDIATE SAFETY PLAN

Agreement to keep safe for now	**YES** ◯	**NO** ◯

What is doable now?
Situational changes that provide some relief:

-
-
-

What personal strengths are available to the youth at risk now?

-
-
-

Establish safety contacts		
Who is able, available and acceptable? (List name and contact info) • • • • Family doctor • Kids Help Phone – Text "CONNECT" to 686868, or call 1-800-668-6868		
CHECKING THE PLAN		
Is the suicide plan disabled and was the person with thoughts of suicide able to participate in the development of this Safety Plan (remove the means and opportunity)?	**YES** ◯	**NO** ◯
Has the person with thoughts of suicide been provided with appropriate and available safety contacts, including their doctor or mental health counsellor and the Kids Help Phone contact information?	**YES** ◯	**NO** ◯
SIGNATURES		
Parent / Guardian - signed Parent/Guardian Acknowledgment Form (Appendix B)	**YES** ◯	**NO** ◯

Position	**Signature**	**Date**
Child/Youth		
Parent		
Principal/Vice Principal		
ASIST-trained Staff Member		
Designated Board Staff		
Other		

NOTE: This form is to be completed by *ASIST-trained staff*. A copy needs to be provided to the school Administrator and kept in a secure location within the Administrator's office (and not placed in the OSR). This form also needs to be scanned to the Board Designate (i.e., BCC within CDSBEO and Mental Health Leader at UCDSB).

UPPER CANADA District School Board

SUICIDE SAFETY PLAN AND FOLLOW-UP FOR UCDSB

STUDENT SUICIDE REVIEW & SAFE FOR NOW PLAN

STUDENT NAME:	**GENDER:**	**DATE:**
SCHOOL:	**GRADE:**	**AGE:**
STAFF CONDUCTING REVIEW:		

SETTING THE STAGE

1. Be clear about your role and state limits of confidentiality (e.g., *I work for the school board, and I need to talk to our support team at the school. If there's a big risks, I need to tell others as well to keep you safe*).
2. Be calm and non-judgmental. Don't shy away from asking hard questions.
3. You may start with 'easier topics' (such as school) and acknowledge feelings to establish rapport
4. Understand the student perspective while exploring reasons for living and dying. Use the "Pathway for Assisting Life"

"I understand you're feeling (use the student's own words). **Tell me about that."** *(also question physical or emotional pain)*

"What has lead up to feeling this way, right now?"

PART A: CURRENT FACTORS

If the student is NOT able to participate in the intervention, strongly consider crisis-line / hospital

Safety Guard #1: Suicide Planned?

"Do you have a plan to kill yourself?"	**YES**	**NO**
"…or hurt someone else?"	**YES**	**NO**

If yes to either, **"Can you tell me about that?" "What is your plan?"** *(who, if hurt someone else)***".**
If no plan for either, consider skipping to 'Additional Safety Guards". If harm to others – also see VTRA protocol.

"What things have you done to get ready?"

"How soon?"

Listen closely for reasons for living (for now) and talk about them.
Reasons for living

-
-
-

*When a turning point….***"Let's start talking about how we can keep you safe for now."**
List interventions to *disable plan* here: (what & who; when & how)

-
-
-
-

Additional Safety Guards…		
Ask if they take medication and how often they drink/smoke/use other drugs.	**YES**	**NO**
If yes, talk about whether this is a safety risk and plan to minimize risk (what & who, when & how) List interventions here: (what & who; when & how) • •		
Ask if they've tried to kill themselves before…	**YES**	**NO**
"When?" "How?" **"What have you learned that might help with safety now?"**		
Ask if they receive counselling for mental health concerns (current or in past).	**YES**	**NO**
"What have you learned from current or past counselling or mental health supports that might help with keeping safe now? *Consider adding previous counsellor to 'Supports needed' below.*		

PART B: SAFETY AIDS		
"Do you agree you will keep safe for now?"	**YES**	**NO**
Situational Changes*:* **"What is doable now to help your (pain, problem, etc.)?"** • • Strengths: **"What are you good at? What do other people say? How can that help you keep safe?"** • • •		

Supports needed: "**Who can help?"** (able, available, and acceptable) *Consider caregiver, school staff, crisis line, other family. Also list contact info.*	**"Can we speak with them, if needed"** (Y/N)? *Complete consent.*

CHECKING THE PLAN		
Is the suicide plan disabled (with help from the student)? *If no, consider urgent care supports such as crisis team / hospital.*	**YES**	**NO**
Has the student been provided with appropriate and available SAFETY CONTACTS, including their doctor or mental health counsellor and the local CRISIS LINE numbers? *If no, provide these to student and/or caregiver as appropriate.*	**YES**	**NO**

SIGNATURES		
Your signature below indicates you've had a conversation about the current situation (above) with the individuals involved, and can help the student disabling the plan and seeking further supports.		
Student[1]:		Date:
Parent / Caregiver[1]:		Date:
Participating Staff Member:		Date:
Principal / Vice Principal:		Date:
Other:		Date:

CC: Student and/or guardian; Principal; Chief Psychologist to maintain copy. Do not place in OSR.

1. Staff: If limited opportunity, simply document conversation about the plan with your initials and date/time

PROTECTIVE FACTORS
also see Supporting Minds document

- Secure attachment to internal and external resources
- Positive school experience/connection with school
- Not acting on previous suicidal thoughts
- Religious affiliation (cultural belief)
- Willingness to seek help
- Positive peer relationships
- Existing formal and informal resources

RISK FACTORS

Psychosocial Factors

- Past suicidal behaviour
- Availability of lethal agents
- Social support
- Disrupted relationships
- Economic problems
- Bullying
- Family history of suicide
- Exposure to suicide
- Parent mental illness
- Chronic stressors
- Abuse/Maltreatment
- Questioning Identity (e.g. Sexuality, cultural new immigrant)

Cognitive, Emotional and Behavioural Factors

- Impulsive
- Hopeless
- Poor distress tolerance
- Poor emotional regulation
- Rigid/Inflexible thinking
- Poor problem solving
- Social skills deficit
- Lack of positive emotion
- Aggressive
- Antisocial behaviour
- Sleep problems

Mental Health Disorders

- History of diagnosed mental health disorder (in particular…)
  - Depression
  - Schizophrenia
  - Substance Abuse
  - Post-Traumatic Stress Disorder
  - Eating Disorder
  - Borderline Personality Disorder
- Poorly managed pain disorder (or pain from previous medical intervention)

LEVEL 1: AWARENESS

- Some / infrequent suicidal thoughts
- No plan or intent, does not have access to a potential lethal weapon
- The presence of adequate social supports

Potential supports required:
Refer back to family doctor or mental health supports. May be limited need for Mental Health Supports follow-up form (Appendix B).

LEVEL 2: EXTRA CARE

- Persistent and ruminative thoughts of suicide but generally able to cope and function
- The presence of some social support/clinical resources

Potential supports required:
Arrange for a mental health supports / agree to inform clinical resources on enhanced need
School staff may initiate periodic follow-up and check-in.

LEVEL 3: URGENT CARE

- Specific plan with intent & persistent suicidal thoughts
- Previous attempt
- Difficulties with mental illness (e.g., depression, schizophrenia) and/or substance use
- Inadequate social supports
- Availability of lethal agent(s)/ means

Potential supports required:
Engage *emergency* mental health resources, e.g., Crisis Line Worker, Direct to emergency department
Consider use of Safety Support Plan when completing Mental Health Supports Follow-Up (Following 2 pages).

MENTAL HEALTH SUPPORTS FOLLOW-UP

Completed less than 2 weeks after concerns arise or at school re-entry

Date:	**Name of School:**		
Name of Student:	**Gender:**	**Date of Birth:**	**Grade**:
Parent/Guardian (Name):			
Staff Members Involved (School and Board Level): • • • •			
REASON(S) FOR PRIOR/CURRENT CRISIS:			
REASON(S) FOR LIVING:			
STUDENT'S IDENTIFIED RESOURCES (AREAS OF STRENGTH)			
INTERNAL **(e.g., spirituality, motivated, athletic, caring, future plans, artistic, funny):**	• • •		
EXTERNAL **(e.g., friends, church, guidance counsellor, parents)**	• • •		
FOLLOW-UP SAFE PLANNING AND RECOMMENDATIONS:			
• • • • •			
ADDITIONAL EDUCATIONAL OR COMMUNITY SERVICES ACCESSED/TO BE ACCESSED: (e.g., Family Physician, Inter-School Board Referrals; Community Referrals to:)			
INTERNAL SCHOOL BOARD REFERRALS:			
COMMUNITY MENTAL HEALTH REFERRALS:			
COMMUNITY PROGRAMS: **(Youth center, church, athletic programs)**			

Interventions (e.g., Children's mental health, physician / psychiatry, SSP, SSC, Teacher, Administrator, Guidance, Justice, Addictions Services, Protection Services, other)	**Name:**	**Intervention:**	**Date:**

Other Recommendations:

MONITOR THIS INTERVENTION PLAN REGULARLY AND MODIFY AS APPROPRIATE		
TEAM MEMBERS	**DATE**	**SIGNATURE (as appropriate)**
Student		
Principal/ Vice-Principal		
Special Services Counsellor		
Community Mental Health Partner		
Community Mental Health Partner		
Parents/Guardian(s)		
Other		

CC: Student and/or guardian; Principal (do not place in OSR).

APPENDIX B PARENT/GUARDIAN ACKNOWLEDGEMENT FORM

This form is an example that can be used to verify that the parents/guardians have been advised of a young person's suicide risk.

PARENT/GUARDIAN CONTACT ACKNOWLEDGEMENT FORM

SCHOOL NAME: _____

STUDENT NAME: _____

This is to verify that I _____ (parent/guardian)

have spoken with _____ (staff member)

on _____ (date), concerning my child/youth's suicidal risk. I have been advised to seek services of a mental health agency or mental health professional immediately.

I understand that_____(staff member) will follow up with me, my child/youth and the agency to whom my child/youth has been referred to for services within two weeks, with consent.

PARENT/GUARDIAN SIGNATURE:_____

DATE:_____

STAFF MEMBER SIGNATURE: _____

ADMINISTRATOR SIGNATURE: _____

DATE: _____

CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

PARENTAL CONSENT FOR RELEASE OF INFORMATION

Date: _____

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

I hereby authorize _____

Name/Agency: _____

Address: _____

☐ To release information to

Name: _____

Address: _____

Information to be release and/or obtained: _____

_____

_____

_____

Signature of Parent or Guardian

_____

Signature of Witness

I DO NOT GIVE MY CONSENT for release of information at this time.

Parent/Guardian Signature: _____ Date: _____

UPPER CANADA
District School Board

CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____ give permission for those initialed below

Please initial:

___ A. School(s): _____
(Name of school and contact)

___ B. Mental Health: _____ Contact info: _____
(Specify)

___ C. Hospital: _____Contact info: _____
(Specify)

___ D. Family Doctor: _____
(Name and address)

___ E. Other Community Agency: _____
(Name and address)

___ F. Specialised Services: _____
(Name and address)

to share written and/or verbal information regarding *(specify name of client/family and type of information sought):*

_____ _____
Student Date of Birth

for the purposes of:

_____

_____

I understand that:
(a) I may revoke my consent at any time.
(b) Information gathered will be treated confidentially.
(c) Information will be used for purposes for and providing services for my child and family.

Information will not be released to any other third party without my permission unless:
(a) I have or my child has indicated that there is risk of harm occurring to me or my family or another person, or there is a disclosure of harm done to me, my family or another person.
(b) My file is subpoenaed or subject to review by legislation.

Valid from _____ to _____
(dd/mm/yy) *(dd/mm/yy)*
(Maximum of 1 year)

The above has been explained to my satisfaction and is clearly understood by me.

_____ _____
(Legal guardian of client under 12 years of age) *(Client 12 years old or over)*

_____ _____
(Relationship to student) *(Witness)*

cc. To each initialled organization

APPENDIX D REFERRAL TO CHEO/KHSC CHILD AND YOUTH MENTAL HEALTH URGENT CONSULT CLINIC

Date:		**Form completed by:**	
Child/Youth Name:		**Date of birth:**	
Address:		**Legal custodian:**	
		Caregiver aware of consult?	☐
School:		**Grade:**	
IEP:	Yes No Unknown	**Referring agent:**	

Please list any professionals currently involved in the child/youth's care:

Please list any medications taken by the child/youth:

Reason for referral to department (mark with a check):

☐	Sudden/recent onset of psychotic symptoms	☐	Current/recent suicide attempt/gesture
☐	Specific homicide plan (time/date/means)	☐	Previous history of suicide attempts
☐	Specific suicide plan	☐	Current suicidal/homicidal ideation without specific plan
☐	Inability to care for self	☐	Acute change in mental status particular as a result of a psychosis
☐	Inability to plan for safety	☐	Acute mental health services
Details:			

Mark with a check

Urgent Care protocol followed	☐	Parents aware and informed of referral to CHEO	☐

Name of CHEO staff consulted:			
Person accompanying child/youth to hospital:			
Agency contact person:			
Phone number:		Fax number:	

Fax Form to Centralized Mental Health Intake at 613-738-4235 or Emergency 613-737-2328 (as appropriate)

OR

Email form to designated CHEO Mental Health Intake or Emergency Department staff with documentation of consent for use of password protected electronic communication for information and documents

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

CHILD AND YOUTH MENTAL HEALTH PROGRAM
URGENT CLINIC REFERRAL

PHONE: 613-544-3400 ext. 2518 | **FAX:** 613-544-4643

NOTE: Youth must be at imminent risk for suicidal/ homicidal behaviour. All referrals are triaged by the team to determine appropriateness and acuity. If the referral does not meet criteria they may be referred to the closest Children's Mental Health Service; if the youth is in immediate crisis please refer them to the closest emergency department.

Date of Referral: _____ (yyyy/mm/dd) **Person completing Referral** (print): _____

Telephone: _____ **Family Health Team/Agency (if applicable):** _____

Name of child/youth (print): _____ **Date of Birth:** _____ (yyyy/mm/dd)

OHIP: _____-_____ **Telephone (Home/Mobile/Work):** _____

Address: _____

Caregiver/Parent: _____ **Relationship:** _____

Is the parent or youth aware that this referral has been made? ◯ Yes ◯ No **Chart Number:** _____

Presenting Concern/Reason for Referral (provide as much detail as possible)**:**

Relevant Medical or Psychiatric History:

Current Medications (include herbal supplements, prescriptions non-prescription medication or naturopathic remedies)**:**

Previous or current psychiatric/community mental health involvement (provide as much detail as possible)**:**

☐ **I have attached previous psychiatric reports, psychoeducational testing, treatment summaries or other reports.**

We strive to see patients within 48 hours of receipt of their information. Weekends, Holidays or lack of access to a Psychiatrist may delay scheduling your appointment.

APPENDIX E HEADS-ED

If a young person is going to the hospital, this form must go along with him/her

Please complete the following assessment online at:

https://www.heads-ed.com/en/survey

Once complete, please print and send with the student to the hospital

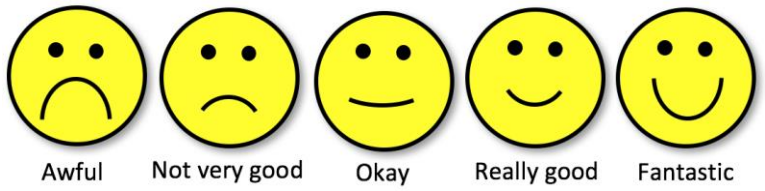
	0 No action needed	1 Needs action but not immediate / moderate functional impairment	2 Needs immediate action / severe functional impairment	
Home sample questions	○ Supportive	○ Conflicts	○ Chaotic / Dysfunctional	Notes
Education, employment sample questions	○ On track	○ Grades dropping / or absenteeism	○ Failing / not attending	Notes
Activities and peers sample questions	○ No change	○ Reduction in activities / increased peer conflicts	○ Increasingly to fully withdrawn / significant peer conflicts	Notes
Drugs and alcohol sample questions	○ No or infrequent	○ Occasional	○ Frequent / daily	Notes
Suicidality sample questions	○ No thoughts	○ Ideation	○ Plan or gesture	Notes
Emotions, behaviours, thought disturbance sample questions	○ Mildly anxious / sad / acting out	○ Moderately anxious / sad / acting out	○ Significantly distressed / unable to function / out of control / bizarre thoughts / significant change in functioning	Notes
Discharge or current resources sample questions	○ Ongoing / well connected	○ Some / not meeting needs	○ None / on wait list / non-compliant	Notes

☐ I have read and agree to the terms and conditions of use.

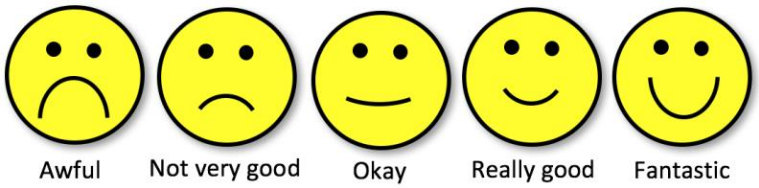
APPENDIX F CHILD/YOUTH FEEDBACK FORM

Child/Youth Feedback Form

1) Before we worked together to develop your Safety Plan, how were you feeling (please circle one)?



2) Now that we've created and worked with your Safety Plan, how are you feeling (please circle one)?



3) Did you feel like you had the right support in place to help make things better (please circle one)?

Yes No

4) If you said "No" to Question #3, what could we have done better to make sure you felt supported?

5) Is there anything else you would like to tell us?

APPENDIX G ROLES AND RESPONSIBILITIES

Young Person

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Participate in Suicide Awareness/Prevention presentations • Advise school team/agency staff of any concerns and available supports	• Provide information for the completion of the Safety Plan • Participate in treatment where appropriate	• Participate in strategies outlined in intervention/management plan • Complete the Child/Youth Feedback Form

Parent/Guardian

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Advise school team/agency staff of any concerns and available supports	• Provide information for the completion of the Safety Plan • Participate in meetings and in developing any recommended intervention/management plans	• Follow up on recommended interventions/management plans

ASIST-Trained Staff

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Promote suicide-safer communities	• Inform Administrator • Create a Safety Plan with the young person at risk • Participate in multidisciplinary team meetings as required	• Participate as required in the intervention/management plans developed by the team • Provide the young person with the Child/Youth Feedback Form

Board Designates (BCC at CDSBEO and SSC or Chief Psychologist at UCDSB)

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Train school/school board staff in prevention, assessment and intervention programs	• As designate, participate in the suicide intervention team • Consult with the Administrator, school team, and superintendents involved • Contact community partners to facilitate consultations, and conduct interviews as required • Assist in the completion of the young person's Safety Plan	• Follow up on recommended interventions/management plans • Attend meetings as required

School Administrator/Designate

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Include community partners in the delivery of suicide prevention presentations to appropriate grades • Identify and maintain a list of staff members trained in ASIST – Applied Suicide Intervention Skills Training • Review this protocol with staff annually at an initial staff meeting	• Designated school team leader • Advise your school and Safe Schools Superintendent • Contact and meet with parent or guardian. Complete the Parent/Guardian Contact Acknowledgement Form • Contact Board Designate (i.e., BCC or Chief Psychologist) • Ensure the student's Safety Plan is completed and signed by all parties • Designate a person to follow-up following a student's hospitalization (see page 26) • Contact appropriate community partners after a young person has been determined to have suicidal thoughts • Ensure the "Child/Youth Feedback Form" has been completed	• Follow up and coordinate intervention/management plans • Forward the required documentation to the Board Designate • Store the intervention/ management plan securely in Administrator's file

Lead School-Based Mental Health Staff (SERT, SSW, IAW)

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Trained staff members in suicide prevention programs to deliver prevention programming	• Assist in data gathering as assigned by the Administrator • Assist the Administrator and ASIST-trained personnel in completing the Safety Plan • Assist in developing plans/interventions, facilitating access to programs or resources, help families obtain needed assistance	• Assist in the implementation of the plan as required

Community Partners

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Follow internal procedures in support of the Suicide Intervention Protocol • Determine the lead or designate staff for each agency • Deliver Suicide Prevention Programs to identified grades (where appropriate)	• Respond, where appropriate, to suicide threats • A trained staff member to consult and participate, where appropriate, on community suicide intervention team • Participate in completion of the Safety Plan • Participate in a review of school suicide assessment team findings • Participate in developing any recommended intervention/ management plans	• Follow up on recommended interventions/management plans

Police Services

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Participate in Suicide Prevention Programs (where possible)	• When it is determined a young person will be transported to a hospital, support may be provided • When required and available, an officer trained in ASIST will be involved in school suicide assessment teams • Activate VTRA protocol if evidence of fluidity and threats of violence are made	• When the hospital recommends involving police services, police will endeavor to implement recommendations. (e.g. removal/disposal of firearms)

Mental Health and Addiction Nurse

PREVENTION	RISK REVIEW/ INTERVENTION	POSTVENTION
• Offer education to school and community regarding suicide risks • Aid with transitioning young person back to school following a hospitalization • Share admission and discharge info with school/board team (consent required)	• Participate in suicide intervention team where consent and procedures allow • Complete assessment as warranted • Consult with school and Board team • Refer to community partners • Assist in the completion of the Safety Plan • Act as a liaison between medical professionals and school board	• Follow-up on recommended interventions/management plans • Make community referrals and follow up as necessary

APPENDIX H REGIONAL COMMUNITY RESOURCES

SUICIDE CRISIS NUMBERS, MENTAL HEALTH COMMUNITY RESOURCES AND HOSPITALS

LANARK COUNTY	
SUICIDE CRISIS NUMBERS	
DISTRESS CENTRE (16 years +) Service available from 5 pm – 12 am	1-800-465-4442
CHILD, YOUTH & FAMILY CRISIS LINE (Telephone counselling support only)	1-877-377-7775
MENTAL HEALTH HELPLINE (Agency information and referrals to mental health agencies in Ontario)	1-866-531-2600
KIDS HELP PHONE	1-800-668-6868
POLICE EMERGENCY	
ONTARIO PROVINCIAL POLICE	1-888-310-1122
SMITHS FALLS POLICE SERVICE	613-283-0357
MENTAL HEALTH COMMUNITY RESOURCES	
OPEN DOORS FOR LANARK CHILDREN AND YOUTH	1-877-232-8260
LANARK COUNTY MENTAL HEALTH (18 years +) – Smiths Falls	613-283-2170
LANARK COUNTY MENTAL HEALTH (18 years +) – Carleton Place	613-257-5919
LANARK, LEEDS AND GRENVILLE ADDICTION AND MENTAL HEALTH	613-283-7723
PLEO	1-855-775-7005
HOSPITALS	
ALMONTE GENERAL HOSPITAL	613-256-2500
CARLETON PLACE & DISTRICT MEMORIAL HOSPITAL	613-257-3533
PERTH & SMITHS FALLS DISTRICT HOSPITAL	613-267-1500
KINGSTON HEALTH SCIENCES CENTRE	613-544-3310
CHEO	613-737-7600
THE ROYAL	613-722-6521

LEEDS & GRENVILLE COUNTIES	
SUICIDE CRISIS NUMBERS	
MENTAL HEALTH CRISIS LINE (16+)	1-866-281-2911
DISTRESS CENTRE (16 +) Service available from 5 pm – 12 am	1-800-465-4442
MENTAL HEALTH HELPLINE (Agency information and referrals to mental health agencies in Ontario)	1-866-531-2600
KIDS HELP PHONE	1-800-668-6868
POLICE EMERGENCY	
ONTARIO PROVINCIAL POLICE	1-888-310-1122
BROCKVILLE POLICE SERVICE	613-342-0127
GANANOQUE POLICE SERVICE	613-382-4422
MENTAL HEALTH COMMUNITY RESOURCES	
CHILDREN'S MENTAL HEALTH OF LEEDS AND GRENVILLE	1-800-809-2494
LANARK, LEEDS AND GRENVILLE ADDICTION AND MENTAL HEALTH	613-342-2262
	613-345-0950
	1-800-361-6948
DEVELOPMENTAL SERVICES OF LEEDS AND GRENVILLE	1-866-544-5614
PLEO	1-855-775-7005
HOSPITALS	
BROCKVILLE GENERAL HOSPITAL	613-345-5645
KEMPVILLE DISTRICT HOSPITAL	613-258-6133
KINGSTON HEALTH SCIENCES CENTRE	613-544-3310
CHEO	613-737-7600
THE ROYAL	613-722-6521

PRESCOTT-RUSSELL COUNTIES	
SUICIDE CRISIS NUMBERS	
CHILD, YOUTH & FAMILY CRISIS LINE	1-877-377-7775
MENTAL HEALTH CRISIS LINE (16 years +)	1-866-996-0991
MENTAL HEALTH HELPLINE (Agency information and referrals to mental health agencies in Ontario)	1-866-531-2600
KIDS HELP PHONE	1-800-668-6868
POLICE EMERGENCY	
ONTARIO PROVINCIAL POLICE	1-888-310-1122
MENTAL HEALTH COMMUNITY RESOURCES	
VALORIS FOR CHILDREN AND ADULTS OF PRESCOTT-RUSSELL	1-800-675-6168
PRESCOTT-RUSSELL COMMUNITY MENTAL HEALTH CENTRE (16 years +)	1-800-267-1453
CANADIAN MENTAL HEALTH ASSOCIATION (16 years +)	613-686-4379
HAWKESBURY AND DISTRICT HOSPITAL ADDICTION SERVICES	1-855-624-1415
PLEO	1-855-775-7005
HOSPITALS	
HAWKESBURY & DISTRICT GENERAL HOSPITAL	613-632-1111
CHILDREN'S HOSPITAL OF EASTERN ONTARIO	613-737-7600
THE ROYAL	613-722-6521

STORMONT, DUNDAS AND GLENGARRY COUNTIES	
SUICIDE CRISIS NUMBERS	
CHILD, YOUTH & FAMILY CRISIS LINE	1-877-377-7775
MENTAL HEALTH CRISIS LINE (16 years +)	1-866-996-0991
KIDS HELP PHONE	1-800-668-6868
MENTAL HEALTH HELPLINE (Agency information and referrals to mental health agencies in Ontario)	1-866-531-2600
POLICE EMERGENCY	
ONTARIO PROVINCIAL POLICE	1-888-310-1122
CORNWALL POLICE SERVICE	613-933-5000
MENTAL HEALTH COMMUNITY RESOURCES	
MENTAL HEALTH COMMUNITY RESOURCES	613 361-6363 X 8763
CHILD AND YOUTH MENTAL HEALTH SERVICES	613 361-6363
YOUTH TRANSITION IMPROVEMENT PROGRAM (16 -24 yrs)	613 361-6363
ADULT MENTAL HEALTH SERVICES	613-361-6363
ADDICTION SERVICES – CORNWALL COMMUNITY HOSPITAL	613-361-6363
INSPIRE – FORMERLY SDG DEVELOPMENTAL SERVICES	613 937-3072
PLEO	1-855-775-7005
HOSPITALS	
CORNWALL COMMUNITY HOSPITAL	613 938-4240
GLENGARRY MEMORIAL HOSPITAL	613 525-2222
WINCHESTER MEMORIAL DISTRICT HOSPITAL	613 774-2420
CHILDREN'S HOSPITAL OF EASTERN ONTARIO	613-737-7600
THE ROYAL	613-722-6521

APPENDIX I LINKS AND RESOURCES

- **www.ReachOutNow.ca** offers information on suicide prevention and local resources for the Champlain East area
- **Honouring Life** - The National Aboriginal Health Organization offers culturally relevant information and resources on suicide prevention for Aboriginal youth
- **www.eMentalHealth.ca** – developed and maintained by psychiatrists at CHEO
- **Kids Help Phone** offers on-line information and counselling for children and youth 1-800-668-6868
- **Mental Health First Aid** is a two day certified program of the Mental Health Commission of Canada
- **Mind your Mind** is a website for youth created by youth offering information, resources and the tools to help manage stress, crisis and mental health problems
- **River of Life program** provides on-line training about Aboriginal youth suicide
- **Teen Mental Health** provides information about adolescent mental health to advance the understanding of mental illness and to improve the lives of young people with mental disorders
- **MyHealthMagazine** from IWK Health Centre is an interactive health magazine for schools, youth and parents
- **Your Life Counts** is a website for youth to share thoughts and get help with their problems

THE FOLLOWING ORGANIZATIONS PROVIDE INFORMATION ON SUICIDE AND SUICIDE PREVENTION:

- **Canadian Association for Suicide Prevention** works towards reducing suicide and its impact in Canada, through advocacy, support and education **http://www.suicideprevention.ca/**
- **Centre for Suicide Prevention** **http://www.suicideinfo.ca/**
- **Ontario Association for Suicide Prevention** **http://www.ospn.ca/**
- **American Association for Suicidality** works to understand and prevent suicide through research, training, and promotion **www.suicidology.org**
- **Canadian Mental Health Association** **www.cmha.ca**
- **LivingWorks** offers training in Applied Suicide Intervention Skills Training, as well as other suicide awareness and prevention training programs **www.livingworks.net**
- **Mental Health Commission of Canada** **http://www.mentalhealthcommission.ca/English/Pages/default.aspx**
- **Reasons to Go on Living Project** **http://www.thereasons.ca**
- **Suicide Prevention Resource Centre** provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies. **www.sprc.org**

APPENDIX J RESILIENCE AND PROTECTIVE FACTORS

WHAT IS RESILIENCE?

Most commonly, the term resilience has come to mean an individual's ability to overcome adversity and continue his or her normal development. However, the RRC (Resilience Research Centre) uses a more ecological and culturally sensitive definition. Dr Michael Ungar, Principal Investigator with the RRC, has suggested that resilience is better understood as follows:

"In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways."

This definition shifts our understanding of resilience from an individual concept, popular with western-trained researchers and human services providers, to a more culturally embedded understanding of well-being. Understood this way, resilience is a social construct that identifies both processes and outcomes associated with what people themselves term well-being. It makes explicit that resilience is more likely to occur when we provide the services, supports and health resources that make it more likely for every child to do well in ways that are meaningful to his or her family and community.

A MULTIDIMENSIONAL MODEL OF RESILIENCE

There are many factors associated with resilience. Some of the more common aspects of successful navigation and negotiation for well-being under stress include the following:

- assertiveness
- ability to solve problems
- self-efficacy
- ability to live with uncertainty
- self-awareness
- a positive outlook
- empathy for others
- having goals and aspirations
- ability to maintain a balance between independence and dependence on others
- appropriate use of or abstinence from substances like alcohol and drugs
- a sense of humour
- a sense of duty (to others or self, depending on the culture)

Relationships Factors

- parenting that meets the child's needs
- appropriate emotional expression and parental monitoring within the family
- social competence
- the presence of a positive mentor and role models
- meaningful relationships with others at school, home, and perceived social support
- peer group acceptance

Community Factors

- opportunities for age-appropriate work
- avoidance of exposure to violence in one's family, community, and with peers
- government provision for children's safety, recreation, housing, and jobs when they are at the appropriate age to work
- meaningful rites of passage with an appropriate amount of risk
- tolerance of high-risk and problem behavior
- safety and security
- perceived social equity
- access to school and education, information, and learning resources

Cultural Factors

- affiliation with a religious organization
- tolerance for different ideologies and beliefs
- adequate management of cultural dislocation and a change or shift in values
- self-betterment
- having a life philosophy
- cultural and/or spiritual identification
- being culturally grounded by knowing where you come from and being part of a cultural tradition that is expressed through daily activities

Physical Ecology Factors

- access to a healthy environment
- security in one's community
- access to recreational spaces
- sustainable resources
- ecological diversity (http://www.resilliance.org publications)

Source: Resilience Research Centre, School of Social Work, Dalhousie University
www.resilienceproject.org/

GLOSSARY OF TERMS

Community Referral:
To obtain additional services provided by hospitals, mental health agencies, organizations, consultants, and/or mental health professionals in the local area.

Copycat Behaviour or "Contagion":
A process by which exposure to suicidal behaviour of other person(s), influences another to attempt or complete suicide. This behaviour may imitate or mimic another suicide by method, timing (such as on an anniversary of another suicide), or in other ways. Numerous studies have shown an increase in suicides, particularly among youth, following prominent or repetitive media coverage of a suicide that gives specific details of the suicide, such as giving a detailed description of the methods used.

Crisis Team:
A group of individuals trained and assembled for the purpose of responding to the needs of others during and after a crisis event/situation.

Debriefing:
A facilitated session to provide staff intervening in a crisis with an opportunity to discuss and process crisis related events. The purpose of debriefing is to provide support, recognition, and information.

Evidence-Based/Informed:
An intervention that has been based on scientific literature and/or studies.

Gatekeeper:
This is the term used to define the role of individuals who are routinely in direct contact with a specific target audience who are trained to know basic suicide prevention steps. Gatekeepers are trained to recognize and respond appropriately to warning signs of suicidal behaviour and to assist at-risk individuals in getting the help they need.

Invitations:
A person with thoughts of suicide usually gives what are referred to as invitations, or more commonly known as signs/indicators/risk alerts. A person is inviting help either through stating their intent directly or indirectly or through their behaviours and actions that they are having thoughts of suicide.

Mandatory Reporting/Duty to Report:
People who work with children and families are required by law to make reports of suspected child abuse and neglect to the Children Aid Society of that jurisdiction.

Non-Suicidal Self-Injury (NSSI):
The deliberate and direct alteration or self-destruction of healthy body tissue without suicidal intent.

Postvention:
A sequence of planned support and interventions carried out with survivors in the aftermath of a suicide or suicide attempt.

Prevention:
A coordinated and comprehensive set of specific interventions strategically linked to target populations at risk for the development of specific disorders and dysfunction.

Protective Factors:
Personal or environmental characteristics that reduce the probability of suicide. Protective factors can buffer the effects of risk factors. The capacity to resist the effects of risk factors is known as resilience.

Re-entry:
The process of returning to the school environment following an extended period of absence is re-entry.

Risk Alert:
Changes in actions, thoughts, feeling and personal appearance that may lead one to believe that a person may be contemplating suicide.

Risk Factors:
Personal or environmental characteristics about the factors that are associated with suicide risk. People affected by one or more of these risk factors have a greater probability of suicidal behaviour. There are six risk factors outlined in ASIST: suicidal thoughts, current suicide plan, pain, resources, prior suicidal behaviour and mental health.

Safety Plan:
A detailed and specific plan/contract that outlines what the person at risk will do if he/she is having suicidal thoughts (e.g. safety contract, resources, safety contact, what to do to prevent suicide).

Stigma:
Stigma is commonly defined as the use of stereotypes and labels when defining someone. Stigmatization of people with mental disorders is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid people with mental disorders. It reduces access to resources and leads to low self-esteem, isolation, and hopelessness.

Suicide:
Suicide is defined as death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) the injury was self-inflicted and the decedent intended to kill himself/herself. (Note: The term “completed suicide” can be used interchangeably with the term “suicide”.) Never use the term “successful” suicide. Suicide completion is not a success.

Suicide Attempt:
A non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicidal Behaviour:
Threats of self-injury, gestures, attempts, and completions are all suicidal behaviours.

Suicide Clusters:
A series of consecutive suicides in the same geographic area among a demographically similar group of individuals is termed a suicide cluster.

Suicidal Ideation:
Thoughts about completing suicide are clinically referred to as “suicidal ideation.”

Suicide Threat:
A verbal statement indicating that suicide is being considered.

Warning Signs:
Indications that someone may be in danger of suicide, either immediately or in the near future.

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