Durham Catholic District School Board

Suicide Prevention and Intervention Protocol

Celebrating Inclusion
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Introduction:

The Durham Catholic District School Board believes that “Every member of a school community is sacred and made in the image of God. Everyone has a right to be safe.” (Student Well-Being and Achievement Board Improvement Plan, 2013).

As part of DCDSB’s Mental Health and Addition Strategy (Together for Mental Health), this protocol is based on current research and best practice, and has been developed to provide staff with appropriate procedures when supporting students who disclose suicidal thoughts, feelings and/or behaviours.

Guiding Principles Related to Prevention and Intervention:

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

Key Terms:

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

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

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

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

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

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

There are many programs that fall under the banner of “suicide prevention;” however, recent review of the literature points to the relative lack of evidence supporting many of these programs. A large part of suicide prevention involves promoting positive mental health and well-being for all children and youth, reducing vulnerabilities, and building protective factors. Schools offer a natural forum for delivering this type of programming.

Schools are encouraged to carefully consider the evidence when choosing programs. The document Guidelines for Selection of School-Based Mental Health Presentations and Activities should be consulted when making these decisions. Schools are encouraged to consult with a member of the board Mental Health Leadership Team (Mental Health Leader, Chief Psychologist, Manager of Clinical Services or Superintendent of Education, Student Services) if uncertain.

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

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

~School Mental Health ASSIST

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

If the topic of suicide is related to course material, this material must be handled with sensitivity. For some, the material may connect to personal experience, and therefore be risky to their well-being.

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

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

*Throughout this document, “Principal” refers to Principal, VP or designate; “Parent” refers to parent(s)/guardian(s).

**ASIST is a suicide first-aid intervention that provides people with knowledge on how to respond to a person at-risk of suicide. It is intended to prevent the immediate risk of suicide and to support the development of a Safe Plan.

In the vast majority of cases, it will be necessary to inform parent. For students who are 18 and over, it may still be necessary to inform parent; however, for an emancipated student, i.e., one who has withdrawn from parental control, it may be appropriate to explore other options with them (e.g., call Mobile Crisis unit, trusted friend, other relative).
Suicide Intervention Guidelines:

**Staff Person is Alerted to Risk of Suicide:**

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

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

All reports related to suicidal thoughts and/or behaviours must be taken seriously and responded to immediately.

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

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

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

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

**Are there concerns for the student’s immediate safety?**

*If YES:*

During situations in which there is a concern for the student’s immediate safety, and intervention cannot be delayed, the student must be transported to the hospital for medical and/or psychiatric intervention.
There are two different scenarios to consider when there is concern for the student’s immediate safety:

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

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

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

In both cases, the principal, in conjunction with the staff person who receives the information, will document actions taken using the **Suicide Intervention Response Form (Appendix B)**. A copy of the form will be sent by FAX, or with the parent, to the hospital (see **Appendix C: Hospital PHONE and FAX numbers in Durham Region and Vicinity**). When sending a student to the hospital, it is important to share the information we have, related to risk, with hospital staff. When safety risk is imminent, this can be done without the written consent of the student or parent. It is best practice to advise the student and parent that this information is being shared for safety reasons.

The original of this form will be sent to the Manager of Clinical Services to be retained in a confidential file at Student Services. The Manager of Clinical Services will ensure that clinical Student Services staff members currently involved with the student are informed. **This form is not to be retained in a student’s Ontario Student Record (OSR).**

**Are there concerns for the student’s immediate safety?**

**If NO:**

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

As soon as possible, the staff member will notify the Principal. The Principal will call the parent to advise them of the situation, and actions taken or intended, including the intent to involve DCDSB staff trained in LivingWorks’ **ASIST** (see **Appendix E: Guidelines for Supporting and Engaging**).
Parents). Note that when safety is a concern, written consent of the parent is not required to initiate an ASIST intervention.

The school Social Worker has the primary function of crisis response. The principal will initiate a suicide first-aid intervention by contacting the school Social Worker. If the school Social Worker is not immediately available, the principal will contact the Manager of Clinical Services.

The Manager of Clinical Services will make the determination as to whether a member of the Social Worker team will be immediately dispatched, or whether an alternate ASIST trained staff member will complete a suicide first-aid intervention, (Appendix F: List of ASIST Trained Staff Members).

In circumstances where the alternate ASIST trained staff member is able to provide the appropriate intervention and Safe Plan, it may not be necessary for a Social Worker to attend the school; however, in all cases a Social Worker will be consulted to review the intervention and Safe Plan and to determine if further action is required.

The Safe Plan:
The Safe Plan is intended to support a student’s immediate safety until further and on-going supports are in place. Components of a Safe Plan may include, but are not limited to:

• Assessment by a psychiatrist, pediatrician or primary health care physician
• Meeting with a community-based mental health worker
• Involving a crisis support service such as a mobile crisis team or local hospital emergency department
• Parent(s)/guardian(s) to keep watchful eye and invite conversation whenever appropriate
• Identifying a caring adult at the school who the student is comfortable contacting if feeling suicidal. (Include the method of contacting this “go to” person and a back-up support, when necessary)
• Suggestions for making the environment safer, including removing or securing items that can potentially be used for suicide
• Identifying and remediating clear sources of stress, (e.g., difficult course load)

A Safe Plan should include: disabling any suicide plans; easing the pain felt by the student; providing a sense of hope; linking the student to supports and resources (see Appendix G: Contact Numbers for Local Agencies/Services).

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

As much as possible, it is important for the student to feel empowered in the development of the Safe Plan. A student is more likely to commit to and follow a plan that he/she has co-created. A written Safe Plan will ensure that those identified in the plan are familiar with and in agreement with the expectations. A Safe Plan may be revised as new information becomes available.
For situations where active suicidal ideation is present, the Social Worker will consult with their immediate supervisor and review the plan to co-determine need for further action. The Principal and Social Worker will update the parent and discuss the Safe Plan and recommended actions. Although the Safe Plan is initially developed by the student and a staff person, parents are the most vital link to keeping their children safe.

The Principal will document actions taken using the Suicide Intervention Response Form (Appendix B). This form will be sent to the Manager of Clinical Services to be retained in a confidential file at Student Services. The Manager of Clinical Services will ensure that clinical Student Services staff members currently involved with the student are informed. This form is not to be retained in a student’s Ontario Student Record (OSR).

**When to Call Children’s Aid Society:**

In most situations, Children’s Aid Society will NOT need to be called.

Parents of students considered to be at immediate risk of suicide, **under the age of 16**, should always be given the opportunity to respond appropriately to their child’s needs before a report is made to CAS, unless there is a perceived risk to the student by contacting the parents, (e.g., abuse situation).

A report must be made to CAS when:

- The parents refuse or are reluctant to cooperate with the school in accessing assistance for the student;
- The principal has background information which leads him/her to believe that parents will not follow-through on seeking immediate assistance for the student;
- The principal has reason to believe that the student’s risk status is the result of abuse or neglect.

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

Parents of students considered at immediate risk of suicide who are **16 years of age or older** should also always be given the opportunity to respond to their child’s needs.

**Emergency services should be notified when:**

- The parents refuse or are reluctant to cooperate with the school in accessing assistance for the student;
- The principal has background information which leads him/her to believe that parents will not follow-through on seeking immediate assistance for the student.

*When in doubt, consult with a member of the Student Services team and/or a CAS intake worker about reporting requirements.*
**Follow-up:**

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

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

Following the initial intervention, the student may return to thoughts of suicide. In such circumstances, further intervention/risk review may be required and it may be necessary to adjust the Safe Plan. In each situation, it is important to again take the warning signs seriously.

**Recovery Following Suicide Attempt (Transition Back From Care):**

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

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

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*When supported by a caring community versed in student mental health and well-being, children and youth are more likely to feel safe and secure.*

*When followed, these guidelines provide a process to help ensure the safety and well-being of students.*
Appendix A

Talking with Students About Suicide
Adapted from HWDSB “Talking With Students About Suicide”

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

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

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

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

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

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

Promote resiliency in students:
Help students to identify their areas of strength (skills and abilities); the people in their lives who provide support and understanding; and healthy living skills, such as hobbies, sports, exercise, nutrition, proper sleep, and having a positive attitude.
Encourage help-seeking behavior:
Let students know that help is available and where they, or someone they know, can get help. Sometimes students might be unsure of where to turn for help, but there is help available. Some helpful websites include: www.ementalhealth.ca / www.mindyourmind.ca / www.kidshelpphone.ca

See Appendix G for a list of contact numbers for local agencies, including crisis support and help phones.

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

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

WAYS NOT TO TALK ABOUT SUICIDE BECAUSE OF POTENTIAL HARM

• Watching or showing a video of someone discussing their suicidal thoughts or discussing images or media coverage about a specific instance of death by suicide when the coverage is glamorized, sensationalized or graphic in nature is known to heighten the risk for vulnerable students.

• Discussing the means of how someone died by suicide increases risk for vulnerable students.

• Allowing suicide to be the sole topic of an essay, debate, play, etc. is strongly discouraged. Whenever possible, try to redirect students who are interested in this topic to focus on positive mental health, coping strategies, reducing stigma, seeking help and accessing support.

• Talking with students about suicide in large assemblies has been found to have harmful effects for students and is not recommended. In particular, this kind of format “does not provide enough exposure to the messages of suicide prevention, nor do they allow for monitoring of student reactions.” Additionally, “media depictions of suicidal behaviours or speeches by teens who have made suicide attempts should not be used, as they could have modeling effects for at-risk teens.” As well, there is risk of students being exposed to unsupportive and/or stigmatizing and judgmental comments made by peers.
Appendix B

Suicide Intervention Response Form
Confidential
(To be completed for each student)

Student Name: ______________________ Date of Birth: ______________________
School: ___________________________ Grade: ___________________________
Name of Parent(s)/Guardian(s): ___________________________
Contact Number(s): ___________________________

School Level Assessment of Concerns

Date of Incident: ___________________________
Summary of Concerns (include what was reported and observed):
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Action Taken (Check those that apply)

☐ Parent / Guardian contacted?

☐ School Board Social Worker contacted? Yes ____ No ____

If yes, please specify name: ___________________________

☐ Did ASIST Trained staff member(s) conduct suicide first-aid intervention? Yes ____ No ____

If yes, please specify name(s)/position(s): ___________________________

Intervention Plan

☐ Monitoring only. Parent notified.

☐ Need for additional assessment or intervention. Recommendation made to parent for further assessment/intervention by ___________________________

☐ Immediate action required:

Call police/ambulance
Parent to take to hospital
Contact local Children’s Mental Health mobile crisis (Durham Region Crisis Response: 905-666-0483 or 1-800-742-1890)

Completed by Principal (or Designate): ___________________________ Name/ Position

In all cases of suicide intervention, whether or not the student has visited the hospital, this form is to be forwarded to the Manager of Clinical Services to be retained in a confidential file at Student Services. This form is NOT to be retained in student’s O.S.R.
Appendix C Hospital PHONE and FAX Numbers in Durham Region and Vicinity

Local Hospitals with youth crisis services and/or psychiatric consultation available:

Lakeridge Health Oshawa

Phone: 905-576-8711
FAX#: 905-721-4743

Families with a child or adolescent experiencing a psychiatric emergency should seek assistance from the Crisis Intervention Team by visiting the Emergency Room. The Lakeridge Health Child, Youth and Family Program (CYFP) at Lakeridge Health Oshawa provides services for children and adolescents, aged 5 to 18, who are struggling with serious mental health issues. In addition to crisis intervention, an inpatient unit and outpatient services, are available.

Rouge Valley Health System Centenary Hospital

Phone: 416-284-8131
FAX#: 416-284-3155

Rouge Valley Health System Ajax & Pickering Hospital

Phone: 905-683-2320
FAX#: 905-428-5292

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

Markham-Stouffville Hospital

Phone: 905-472-7000
FAX#: 905-472-7026

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

Other local hospitals (no on-site youth crisis services):

Lakeridge Health Port Perry

Phone: 905-985-7321

Markham-Stouffville Hospital-Uxbridge Site
(Uxbridge Cottage Hospital)

Phone: 905-852-9771

Ross Memorial Hospital (Lindsay)

Phone: 705-324-6111

Ross Memorial offers mental health services for individuals who are 16 years of age or older. Young patients can be connected with Child & Adolescent Psychiatrists in other hospitals using videoconferencing technology.
Appendix D

Tips for Meeting with a Student

The following are some “dos and don’ts” to consider when talking with a student:

**DO:**
- Find a quiet and private place to talk
- Take time to hear the student. This may mean making alternate arrangements to cover your other responsibilities
- Remain calm and demonstrate a caring manner
- Establish rapport with your words and your body language
- **Promise privacy but not confidentiality.** You must inform someone if there is potential risk to the student or others. You cannot keep suicidal thoughts or behaviour a secret
- Listen carefully and avoid interrupting the student. Listen for the feelings behind the words
- Paraphrase what the student is saying in order to clarify and to indicate your understanding
- Allow for periods of silence
- Keep the student’s perspective in mind (no matter how unrealistic). It is the student’s perception that reveals his/her thoughts and feelings
- Take charge with respect to asking pointed questions or making arrangements for student safety

**DO NOT:**
- **Do not leave the student unattended**
- Do not judge what the student says in terms of moral or adult standards; don’t debate whether suicide is right or wrong or whether life is valuable
- Do not argue about suicidal behaviour
- Do not panic if the student admits to suicidal thoughts
- Do not try to stop the suicidal thinking or behaviour without adding other supports
- **Do not allow yourself to be sworn to secrecy; this becomes a safety issue for the student**
- Do not ignore the student’s need to talk
- Do not make promises or remarks that might be unrealistic
- Do not assume that the person isn’t the suicidal type; anyone can be suicidal
- Do not discount the student’s problems or distress as minor or suggest she/he will get over it or that everything will be all right
- Do not discuss the interview with staff or persons outside of the school team (unless the team and student agree to involve others)
- Do not give up if the student just shrugs or is uncommunicative. She/he may say more given additional time. You may want to offer a drink and/or small snack
Appendix E

Guidelines for Supporting and Engaging Parents

The following guidelines can help support and engage parents:

- Document all contacts with parent
- Align yourself with the parent if possible
- Acknowledge the parents’ emotional state, including anger, if present
- Acknowledge that no one can do this alone - appreciate their presence
- Invite the parents’ perspective. State what you have noticed in their child’s behavior and ask how that fits with what they have observed
- Remind parents that they are the most vital link in keeping their child safe
- Emphasize safety, e.g., advise parents to remove lethal means from the home
- Explore reluctance to accept a mental health referral, address those issues, explain what to expect

APPENDIX F

List of ASIST Trained Staff Members

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

DCDSB Board staff:

Social Worker: ________________________________________________________________

Psychological Services: _______________________________________________________

Child and Youth Counsellor: ____________________________________________________

In-school staff:

Administrator(s): _______________________________________________________________

Student Success: _______________________________________________________________

Guidance Counsellor(s): _______________________________________________________

Chaplain: ________________________________________________________________

Program Support Teacher(s): __________________________________________________

Other: _______________________________________________________________

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

LivingWorks ASIST (Applied Suicide Intervention Skills Training) is a suicide first-aid intervention that provides people with knowledge on how to respond to a person at-risk of suicide. It is intended to prevent the immediate risk of suicide and to support the development of a Safe Plan. The ASIST suicide intervention is not intended to replace a mental health assessment or a formal suicide risk assessment, nor is it intended to replace on-going therapeutic involvement, as continued supports and resources are an essential component of the Safe Plan.
APPENDIX G  

Contact Numbers for Local Agencies/Services

**Durham Region Crisis Response**  
905-666-0483 or 1-800-742-1890  
Telephone support is available toll free, 24 hours per day, to support the individual in crisis and/or their supports. A community visit by our mobile crisis team can be arranged to support the individual in their preferred environment. Follow-up support and short-term case management, including linkage and referral to other community supports, are also available. This service is provided by the following partnering agencies: Frontenac Youth Services, Chimo Youth Services, Durham Mental Health Services and Kinark Child and Family Services.

**Kids Help Phone**  
(www.kidshelpphone.ca)  
1-800-668-6868  
Kids Help Phone is a free, anonymous and confidential phone and on-line professional counselling service for children and youth. To reach a Kids Help Phone professional counsellor, kids, teens and young adults (age 5-20) from any community in Canada, can call or go online 24 hours a day, 365 days a year.

**Distress Centre Durham**  
905-430-2522 or 1-800-452-0688  
Our specially trained volunteer team is made up of men and women 18 and older who are non-judgmental, empathetic, caring individuals who share the desire to make a significant and meaningful contribution to the Durham Region Community. The Helpline is a good community resource to provide referral information pertaining to appropriate inquiries from the callers. The Helpline is available to the callers 24 hours a day, 7 days a week and 365 days a year.

**Ontario Shores Centre for Mental Health Sciences, Prompt Care Clinic**  
905-430-4055  
The Prompt Care Clinic provides care for individuals, 16 years of age or older, who require timely access to psychiatric services, but do not require an emergency department visit. A psychiatrist and nurse or social worker provide clinical assessments and a care plan for follow-up or shared care in the community. Individuals who are symptomatic to the point where a significant amount of personal distress is evident and where distress may increase if there is a delay in treatment can be referred to this clinic.

**Durham Region Central Intake**  
1-888-454-6275  
Centralized Intake is the front door to services for several agencies, including: Kinark Child and Family Services, Frontenac Youth Services, Chimo Youth and Family Services, Ontario Shores Centre for Mental Health Sciences, and Lakeridge Health CYFP, Fernie House Child and Youth Services and John Howard Society of Durham Region. When parents call the Central Intake line, they will talk to a clinician who will guide them through the process.

In very rare circumstances, child protection may need to be notified to ensure the student’s safety, (see guideline for **When to Call Children’s Aid Society** on page 9).  
**Durham Children’s Aid Society:**  
905-433-1551
Non-Suicidal Self-Injury (NSSI) is the deliberate and direct destruction of one’s body tissue, without suicidal intent and for reasons not socially sanctioned. This definition excludes tattooing or piercing, and indirect injury such as substance abuse or eating disorders. NSSI should also be distinguished from self-injurious behaviour (SIB) that is commonly seen among individuals with intellectual and developmental disabilities (e.g., repetitive stereotyped head banging).

It is important to distinguish NSSI from suicide. NSSI is NOT a suicidal gesture although those who engage in NSSI can at times have suicidal thoughts, and may need to be assessed for suicide risk.

The most common methods of NSSI include cutting, burning, scratching and bruising. Students who engage in NSSI do so for a variety of reasons, the most common being to cope with difficult feelings (e.g. numbness, anxiety, stress, sadness, distress). A student may feel a sense of relief from these negative emotions if they injure themselves. Students often have more than one reason for engaging in the behaviour and their reasons can change over time.

**What should I do if I discover that a student is engaging in NSSI?**

The most important thing is to remain calm. The first response that a student receives after disclosing that they self-injure can influence the student’s willingness to seek help, so it is important to keep in mind that the student is likely feeling nervous or scared. Students CAN and DO stop self-injuring. However, the longer the student self-injures, the more difficult it can be to stop. It is important to remember that stopping a frequently used maladaptive coping strategy will take time, effort and new healthy coping strategies. Stopping self-injury is not something that occurs overnight, or with threats (e.g., you cannot come to school until you stop). In fact, this approach may increase negative emotions for the student and may increase self-injury.

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

**What about contagion?**

The spread of NSSI can occur through communication between peers about the behaviour. If a group of students is involved, they should be responded to on an individual basis. It is not appropriate to use school-wide communication, assemblies or announcements to communicate or share information about NSSI. It is important to reduce public exhibition of scars and wounds in school, and to make efforts to prevent the sharing of NSSI related images or stories. Emphasize the need for students who are engaging in the behaviour to seek support.
If you discover that a student is self-injuring:

**Do:**
1. In a calm and caring way, let the student know that there are people who care about him/her and that he/she is not alone
2. Understand that this is a way for the student to cope with the pain that he/she is feeling
3. Use the student’s language for self-injury when talking about self-injury
4. Ask students to cover wounds and scars
5. Use individual intervention if more than one student is involved
6. Reduce communication about NSSI among members in a peer group by explaining the potential negative impact
7. **Contact your school Social Worker or Psychological Services staff member to consult on next steps (referral, risk assessment, parental contact, etc.)**

**Don’t:**
1. Be overly reactive, which could lead to alienating the student
2. Try to stop the self-injury behaviour with discipline, threats or ultimatums
3. Show excessive interest in the details of the student’s self-injury (e.g., what exactly was done)
4. Permit the student to relive or describe the experience of self-injury in detail as this may trigger the desire to engage in self-injury again
5. Address the behaviour with a group
6. Talk about the student’s behaviour in front of the class or around peers
7. Engage in unmonitored discussions about self-injury with your class and avoid class presentations of certain books, music videos, movies that glamorize NSSI
8. Tell the student that you won’t tell anyone about their self-injury

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**The information in this handout was adapted from:** [http://www.sioutreach.org/](http://www.sioutreach.org/)

The Self-injury Outreach and Support initiative, as part of a collaboration between McGill University and the University of Guelph, provides current information and helpful resources about self-injury.
Content for the DCDSB Suicide Prevention and Intervention Protocol has been informed by the following resources:

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


Suicide guidelines and protocols from the following School Boards:
- Toronto Catholic District School Board
- Peel District School Board
- Hamilton-Wentworth District School Board
- Trillium-Lakelands District School Board
- Ottawa-Carlton District School Board

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