Life Promotion/Suicide Prevention, Intervention and Postvention Protocol

To: Program and School Services Committee

Date: 27 March, 2019

Report No.: 03-19-3594

Strategic Directions

- Create a Culture for Student and Staff Well-Being
- Allocate Human and Financial Resources Strategically to Support Student Needs
- Build Strong Relationships and Partnerships Within School Communities to Support Student Learning and Well-Being

Recommendation

It is recommended that the Life Promotion/Suicide Prevention, Intervention and Postvention Protocol and implementation plan be received.

Context

Background

The Multi-Year Strategic Plan (MYSP) commits to *Creating a Culture of Student and Staff Well-Being.* Various research reports including the Toronto District School Board's *2017 Student Census* and the *2017 Mental Health and Well-Being of Ontario Students Report* (The Centre for Addiction and Mental Health (CAMH) - Appendix A) provides evidence of the need for a suicide protocol and suicide prevention training for staff. The CAMH report illustrates the prevalence of issues relating to suicide for youth: One-in-seven (14%) Ontario students in Grades 7 to 12 had serious thoughts about suicide in the past year and 4% of Ontario students report a suicide attempt in the past year (CAMH, 2017 [5]).

The *Student Well-Being and Mental Health Action Plan* identifies the specific strategies connected to life promotion and suicide intervention. The actions are as follows:

- Provide training on suicide prevention to various employee groups,
- Support principals in collaborating with staff to ensure every student is connected to at least one caring adult and monitor the impact, and

- Partner with students, families and others (I.e., School Mental Health Ontario, Ministry of Education and Toronto Public Health) in the development and implementation actions to enhance student resilience, coping and help-seeking skills.

This report introduces the new TDSB resource entitled *Life Promotion/Suicide Prevention, Intervention and Postvention Protocol* (Appendix B) and details an implementation plan which includes training about the interventions and resources available to students who may be struggling with their mental health and who could be at risk of self-harm.

Action Plan and Associated Implementation Timeline

With the support of School Mental Health Ontario, a Steering Committee was established to draft the staff protocol during the 2017-18 school year. Current evidence-based and evidence–informed resources/practices and community partner information was included as part of the process. The Implementation Plan is currently underway and all training will be mandatory.

In the fall of 2018 the draft document was reviewed, revised and finalized to ensure alignment with the Vision For Learning, the Board's focus on Anti-Oppression and Equity and the Multi-Year Strategic Plan. This included consultation with Principals, Superintendents of Education, Professional Support Services staff and the Mental Health Leads. Preventative steps have already commenced as part of this implementation plan, including the certification of all Social Workers in Applied Suicide Intervention Skills Training (Suicide ASIST) over the last two years.

The Life Promotion/Suicide Prevention, Intervention and Postvention Protocol is a resource document that will be available to all staff to support students. Included will be a flow chart to guide immediate Principal decision making in three distinct areas: suicidal ideation, third party disclosure and a suicide attempt. Contacting the school Social Worker for support is a mandatory part of the protocol. Below is the Phase 1 implementation plan for the current school year.

Phase 1: 2018-19 and beginning in February 2019

- The final Suicide Protocol resource document will be published and be made available to all staff.
- The Senior Manager of Professional Support Services (PSS) and the Mental Health Leads (MHLs) will facilitate a workshop on the Suicide Protocol for all Social Workers in preparation for staff training.
- Training by the MHLs of the following groups: all secondary and senior public school Principals, one Vice Principal per secondary school, Elementary Itinerant Guidance Counsellors, one Secondary Guidance Counsellor per school, Psychologists and Child Youth Counsellors. Note that elementary Principals/Vice Principals will be the focus in 2020-21.
- Two teachers per secondary school and senior public school will be identified for a half day of training as Teacher Mental Health Leads (TMHLs). This training will

focus on building capacity in the area of preventative Mental Health and Well-Being, cannabis awareness and will include an introduction to the *Life Promotion/Suicide Prevention, Intervention and Postvention Protocol*.

- Training by the MHLs for all newly promoted Principals/Vice Principals (2x/year)
- Voluntary training of Vice Principals through Key 2 Learn (2x/year)
- Identification of 24 volunteer Principals/Vice Principals and Social Workers for Applied Suicide Intervention Skills (ASIST) Trainer certification. This team will build system capacity by providing ongoing training and support.
- In 2019-20 Applied Suicide Intervention Skills Training (ASIST) certification will be offered to two secondary, elementary and senior public school staff per school. This training will be facilitated by the TDSB certified trainers. Note that all current Social Workers completed this training prior to the 2018-19 school year.

Through our commitment to promote positive mental health and well-being for every student we will work to continue to listen to student voices, to engage them in conversation and find ways to support them.

Resource Implications

The cost for Phase 1 implementation in 2018-19 will be approximately $90,000 and is currently being funded through the Well-Being grant from the Ministry of Education. Funding for future years will be pending budget approval.

Communications Considerations

To provide clarity and context around the new protocol, communication will continue with all key internal stakeholder groups over the coming weeks.

Appendices

- Appendix A: The Mental Health and Well-Being of Ontario Students Summary Report (2017) https://www.camh.ca/-/media/files/pdf---osduhs/mental-health-and-well-being-of-ontario-students-1991-2017---summary-osduhs-report-pdf.pdf
- Appendix B: The Life Promotion/Suicide Prevention, Intervention and Postvention Protocol

From

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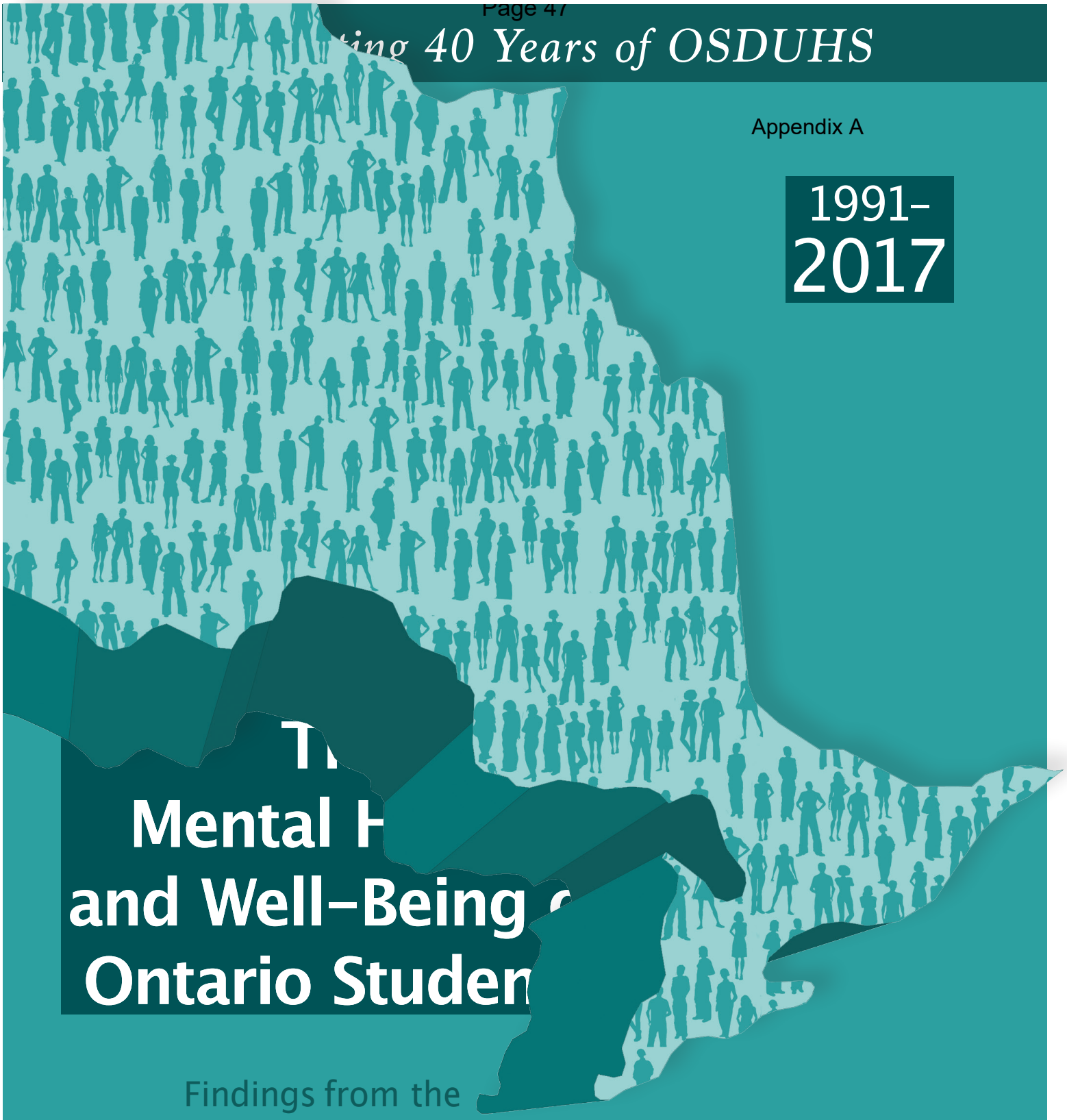
Appendix A

1991–
2017



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Findings from the
Ontario Student Drug
Use and Health Survey

SUMMARY

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The 2017 OSDUHS Mental Health and Well-Being Report Summary

The Study

The Centre for Addiction and Mental Health's *Ontario Student Drug Use and Health Survey* (OSDUHS) has been conducted every two years since 1977, making it the longest ongoing school survey of adolescents in Canada, and one of the longest in the world. The 2017 cycle of the OSDUHS marked the study's 40th anniversary. A total of 11,435 students in grades 7 through 12 from 764 classes in 214 schools in 52 boards participated in the 2017 OSDUHS. The survey was administered in schools across Ontario by the Institute for Social Research, York University between November 2016 and June 2017.

This report describes physical health indicators, mental health indicators, bullying, gambling and related problems, video gaming and related problems, and other risk behaviours among Ontario students in 2017 and changes since 1991, where available. Although the OSDUHS began in 1977, most mental health and physical health measures were introduced in the survey in the early 1990s. **New indicators** in this descriptive report include parental support, experiencing a concussion, experiencing a traumatic life event (nonspecific), cyberbullying others, gambling on video games, and problematic technology use. All data presented are based on students' self-reports derived from anonymous questionnaires administered in classrooms.

Home Life

- One-in-five (20%) Ontario students report living with a single parent or no parent (birth, adoptive, or step). One-in-seven (14%) students report splitting their time between two or more homes.
- Over one-third (39%) of students report that they rarely or never talk to their parents about their problems or feelings.
- Nearly half (43%) of secondary school students have a part-time job. Five percent work more than 20 hours per week.

School Life

- Almost half (47%) of students report that they like school very much or quite a lot. One-third (34%) of students like school to some degree. About 19% do not like school very much or at all.
- ➢ The percentage of students who report that they like school very much or quite a lot has significantly increased since the 1990s.
- Although most students feel safe in their school, one-in-eight (13%) express worry about being harmed or threatened at school.
- One-in-six (17%) students report being suspended or expelled from school at least once in their lifetime.

- About one-in-five (19%) students report low subjective social status at school (i.e., feeling that other students exclude them and do not respect them).

- Over one-quarter (29%) of students believe that their mental health affects their school grades a "great deal" or "quite a lot."

Physical Health

- Although the majority (62%) of students rate their health as excellent or very good, about 9% (an estimated 78,200 Ontario students in grades 7–12) report fair or poor physical health.

➢ Ratings of fair or poor physical health have been stable in recent years, and the current estimate resembles estimates seen in the early 1990s.

- Only one-quarter (23%) of students met the recommended daily physical activity guideline (defined as a total of at least 60 minutes of moderate-to-vigorous activity per day) during the past seven days. At the other extreme, about one-in-eleven (9%) students were physically inactive on each of the past seven days.

- Nearly half (45%) of students do not engage in physical activity in a physical education class at school.

- Almost two-thirds (64%) of students spend three hours or more per day in front of an electronic screen in their free time ("screen time" sedentary behaviour).

➢ The percentage of students who are screen time sedentary has significantly increased since 2009, which was the first year of monitoring, from 57% to 64%.

- Over one-quarter (28%) of students are classified as overweight or obese (an estimated 236,000 Ontario students).

➢ The percentage of students classified as overweight or obese has remained stable in recent years, but there has been a significant increase since 2007 (23%), the first year of monitoring.

- Less than half (39%) of students report that they usually get eight or more hours of sleep on an average school night. Therefore, most students (61%) are not getting at least eight hours of sleep.

- About 7% of students report always or often going to bed or school hungry. This percentage represents about 60,000 students in Ontario.

➢ There was a small, but significant, increase between 2015 and 2017 in the percentage of students reporting going to bed or school hungry, from 5% to 7%.

Body Image

- Almost two-thirds (64%) of students are satisfied with their weight. One-quarter (24%) believe they are "too fat," and one-in-eight (12%) believe they are "too thin."

➢ The perception of being "too fat" has remained stable in recent years, but there has been a significant increase since 2001 (19%), the first year of monitoring. The increase in this perception over time is evident among females (from 24% in 2001 to 31% in 2017), but not among males.

- One-third (35%) of students are not attempting to change their weight. Another 29% are attempting to lose weight, 22% want to keep from gaining weight, and 14% want to gain weight.

Injuries and Related Behaviours

- Almost half (43%) of students were treated for an injury at least once during the past year (representing about 345,700 Ontario students).

➢ The percentage of students reporting a medically treated injury has remained stable in the past few years, but it is currently significantly higher than in 2003 (35%), the first year of monitoring.

- Over one-third (36%) of students report experiencing a concussion in their lifetime. One-in-seven (15%) report experiencing a concussion in the past year (about 130,700 students in Ontario). Of the specific causes asked about, playing hockey or another team sport were among the most commonly reported causes of a concussion.

- One-quarter (24%) of students report that they do not always wear a seatbelt when in a motor vehicle (about 199,500 Ontario students).

- One-third (33%) of drivers in grades 10–12 report texting while driving at least once in the past year. This percentage represents an estimated 85,300 adolescent drivers.

➢ The percentage of adolescent drivers reporting texting while driving has not significantly changed since 2013 (36%), the first year of monitoring.

- About 8% of drivers in grades 10–12 (about 22,000 adolescent drivers) report being involved in a collision as a driver at least once in the past year.

Health Care Utilization

Physician Health Care Visit

- One-third (34%) of students did not visit a doctor for their physical health, not even for a check-up, during the past year.

Mental Health Care Visit

- One-quarter (25%) of students visited a mental health care professional (such as a doctor, nurse, or counsellor) for a mental health matter at least once during the past year. This estimate represents about 235,100 students in Ontario.

➢ The percentage of students reporting visiting a mental health professional has remained stable in the past few years, but it is currently significantly higher than in 1999 (12%), the first year of monitoring.

Seeking Support for a Mental Health Problem

- About 3% of students report seeking help either by calling a telephone counselling helpline or over the Internet at least once in the past year. This estimate represents about 32,900 Ontario students.

- Almost one-third (31%) of students report that, in the past year, there was a time they wanted to talk to someone about a mental health problem, but did not know where to turn. This estimate represents about 299,800 Ontario students.

Use of Drugs for Medical Reasons

- One-in-six (18%) students report the medical use of prescription opioid pain relievers (e.g., Tylenol #3, Percocet) in the past year. About 3% of students used prescribed drugs for ADHD (e.g., Ritalin, Adderall, Concerta) in the past year. About

4% of secondary school students used prescribed tranquillizers/sedatives (e.g., Valium, Ativan, Xanax) in the past year.

➢ The percentage of students who report medical use of prescription opioid pain relievers has remained stable in recent years, but has significantly decreased since 2007 (41%), the first year of monitoring. The percentage who report medical use of ADHD drugs has not significantly changed since monitoring first began in 2007. The percentage who report medical use of tranquillizers/sedatives has remained stable since the 1990s.

- About 5% of secondary school students report they were prescribed medication for anxiety, depression, or both conditions in the past year. This estimate represents about 37,600 secondary school students in Ontario.

Mental Health

Self-Rated Mental Health

- While the majority (54%) of students rate their mental health as excellent or very good, almost one-in-five (19%) rate their mental health as fair or poor.

➢ The percentage of students who rate their mental health as fair or poor today is significantly higher than estimates seen between 2007 (the first year of monitoring) and 2013 (about 11%-13%).

Low Self-Esteem

- About 7% of students report low self-esteem (feeling very unsatisfied with oneself).

Elevated Stress

- About 30% of students report experiencing an elevated level of stress or pressure in their lives.

Psychological Distress

- Over one-third (39%) of students indicate a moderate-to-serious level of psychological distress (symptoms of anxiety and depression). One-in-six (17%) students indicate a serious level of psychological distress (representing about 159,400 students).

➢ Both measures of psychological distress remained stable between 2015 and 2017, but are significantly higher today than in 2013, the first year of monitoring.

Traumatic Event

- About one-third (35%) of secondary school students report experiencing a traumatic or negative event (nonspecific) in their lifetime. This estimate represents about 252,100 secondary school students in Ontario.

Suicidal Ideation and Suicide Attempt

- One-in-seven (14%) students had serious thoughts about suicide in the past year (an estimated 118,000 Ontario students), and 4% report a suicide attempt in the past year (an estimated 33,400 Ontario students).

➢ The percentage reporting suicidal ideation has been stable in recent years, and is currently similar to the estimate seen in 2001 (11%), the first year of monitoring. There has been no change over time in the percentage reporting a suicide attempt.

Symptoms of ADHD

- One-in-five (20%) students report symptoms of ADHD (such as trouble with organizing, completing tasks, remembering obligations). This percentage represents about 186,000 Ontario students.

➢ The percentage of students reporting symptoms of ADHD significantly increased between 2015 and 2017 (from 16% to 20%).

Antisocial Behaviour and Bullying

Antisocial Behaviour

- About 7% of students report engaging in antisocial behaviour (defined as three or more of nine specific behaviours) during the past year (about 62,300 students).

➢ The percentage of students engaging in antisocial behaviour is significantly lower today than in the early 1990s.

Violent Behaviour

- About 5% of students report that they assaulted someone at least once in the past year, and a similar percentage (6%) report carrying a weapon in the past year (about 50,500 students).

➢ The percentage of students reporting assaulting someone and the percentage reporting carrying a weapon have both shown significant declines since the early 1990s.

School Violence

- One-in-nine (11%) students report physically fighting on school property at least once during the past year (representing about 105,900 students).
- About 6% of students were threatened or injured with a weapon on school property at least once during the past year (representing about 50,700 students).

➢ Both of these indicators have remained stable in recent years, but show significant declines since the early 2000s, when monitoring first began.

Bullying at School

- One-in-five (21%) students report being bullied at school since the beginning of the school year (representing about 197,400 students). The most prevalent form of bullying victimization at school is verbal (17%), while 2% report that they are primarily bullied physically, and 2% of students are victims of theft/vandalism.
- One-in-nine (11%) students report bullying others at school since September. The most prevalent form of bullying others at school is through verbal attacks (10%), followed by physical attacks (1%), and theft/vandalism (less than 1%).

➢ The percentage of students reporting being bullied at school did not significantly change since the last survey in 2015, but the current estimate is significantly lower than all estimates between 2003 (the first year of monitoring) and 2013.

➢ Similarly, the percentage reporting bullying others at school in 2017 is significantly lower than all estimates between 2003 and 2013.

Cyberbullying

- One-in-five (21%) students report being bullied over the Internet in the past year. This estimate represents about 191,600 students.

- One-in-ten (10%) students report bullying others over the Internet in the past year.

➢ The percentage reporting being cyberbullied has remained stable since 2011 (22%), the first year of monitoring.

Gambling, Video Gaming, and Technology Use

Gambling Activities

- Of the gambling activities surveyed in 2017, the most prevalent is betting money on a dare or private bet (12%), followed by betting in sports pools (10%). The least prevalent activity is casino gambling (less than 1%).

- Gambling money on video games is reported by about 8% of students. Gambling money over the Internet is reported by about 4% of students.

- One-third (31%) of students report gambling at one or more activities in the past year (about 258,300 Ontario students). About 2% of students gambled at five or more activities in the past year (about 19,200 students).

➢ The percentage of students reporting any gambling activity in the past year has remained stable in recent years, but is significantly lower today compared to 2003 (57%), the first year of monitoring. Similarly, multi-gambling activity is significantly lower today than in 2003 (6%).

➢ The percentage reporting any Internet gambling has remained stable since 2003.

Gambling Problem

- About 7% of secondary school students indicate symptoms of a low-to-moderately severe gambling problem. About 2% indicate a high-severity gambling problem (representing about 12,200 secondary school students in Ontario).

Video Gaming

- One-quarter (23%) of students play video games daily or almost daily. About one-in-ten (9%) students play video games for five hours or more per day.

- One-in-eight (12%) students (an estimated 107,200 in Ontario) report symptoms of a video gaming problem (preoccupation, tolerance, loss of control, withdrawal, escape, disregard for consequences, disruption to family/school).

➢ The percentage of students reporting symptoms of a video gaming problem remained stable in recent years and the current estimate is similar to the estimate in 2007 (9%), the first year of monitoring.

Technology Use

- The majority (86%) of students visit social media sites daily. One-in-five (20%) students spend five hours or more on social media daily.

➢ The percentage of students who report spending five hours or more on social media per day is significantly higher in 2017 than in 2015 (16%) and 2013 (11%), the first year of monitoring.

- Almost one-third (30%) of secondary school students spend five hours or more per day on electronic devices (smartphones, tablets, laptops, computers, gaming consoles) in their free time.

- About one-in-six (18%) secondary school students report symptoms that may suggest a moderate-to-serious problem with technology use (preoccupation, loss of control, withdrawal, problem with family/friends). About 5% of secondary school students report symptoms that may suggest a serious problem with technology use (representing about 33,300 secondary school students).

Coexisting Problems

- About half (48%) of secondary school students report none of the following four problems: psychological distress, antisocial behaviour, hazardous/harmful drinking, or a drug use problem. About 36% of secondary school students report one of these problems, 10% report two of these problems, 4% report three, and 2% report all four problems.

Sex Differences

- There are many differences between males and females regarding mental health and well-being. Males are significantly more likely than females to report:
  - engaging in daily physical activity
  - getting at least eight hours of sleep
  - wanting to gain weight
  - using ADHD drugs medically
  - engaging in antisocial behaviour
  - carrying a weapon
  - fighting at school
  - being threatened/harmed at school
  - gambling money
  - playing video games daily and spending more hours playing video games, and
  - symptoms of a video gaming problem.
- Females are significantly more likely than males to report:
  - fair or poor physical health
  - being physically inactive
  - the belief that they are too fat
  - wanting to lose weight
  - using prescription opioid pain relievers medically
  - seeking mental health counselling
  - unmet need for mental health support
  - using prescription tranquillizers medically
  - being prescribed medication for anxiety, depression, or both
  - fair or poor mental health
  - low self-esteem
  - elevated stress
  - symptoms of psychological distress
  - experiencing a traumatic event
  - suicidal ideation and attempt
  - symptoms of ADHD
  - worrying about being harmed or threatened at school
  - being bullied at school
  - being cyberbullied
  - spending more hours daily on social media
  - spending more hours daily on electronic devices, and
  - symptoms of problematic technology use.

Grade Differences

- Grade is also significantly related to mental health and well-being. Generally, poor physical health indicators (e.g., sedentary behaviour), health risk behaviours (e.g., not wearing a seatbelt, texting while driving), mental health problems (e.g., fair or poor self-rated mental health, stress, psychological distress), excessive social media and technology use, and coexisting problems significantly increase with grade. Daily physical activity, experiencing a concussion, getting at least eight hours of sleep, bullying and physical fighting at school are more prevalent among younger students and decline in later adolescence.

Regional Differences

The survey design divided the province into four regions: Greater Toronto Area (Toronto, Durham Region, York Region, Peel Region, and Halton Region); Northern Ontario (Parry Sound District, Nipissing District and farther north); Western Ontario (Dufferin County and farther west); and Eastern Ontario (Simcoe County and farther east).

The following regional differences were found:

- Compared with the provincial average, **Greater Toronto Area** students are significantly *more* likely to report being physically inactive, symptoms of a video gaming problem, and symptoms of a serious problem with technology use. Compared with the provincial average, they are significantly *less* likely to report meeting the daily physical activity guideline, getting at least eight hours of sleep on a school night, experiencing a concussion in the past year, being prescribed medication for anxiety or depression, and to rate their mental health as poor or fair.

- Compared with the provincial average, **Northern** Ontario students are *more* likely to report getting at least eight hours of sleep on a school night, and being prescribed medication for anxiety or depression.

- Compared with the provincial average, **Western** Ontario students are *more* likely to report experiencing a concussion in the past year, being cyberbullied, texting while driving, and to rate their mental health as fair or poor.

- Compared with the provincial average, **Eastern** Ontario students are *more* likely to report meeting the daily physical activity guideline, and experiencing a concussion in the past year. Compared with the average, they are significantly *less* likely to report bullying others at school, being cyberbullied, and symptoms of a video gaming problem.

An overview of results according to Ontario's Local Health Integration Networks (LHINs) is also provided in the report.

Percentage Reporting Selected Mental Health and Well-Being Indicators by Sex, 2017 OSDUHS (Grades 7–12)

Indicator	Total %	(95% CI)	Estimated Number†	Males %	Females %	
fair or poor self-rated physical health	**8.7**	(7.7-9.7)	78,200	6.6	10.9	*
daily physical activity (60 mins. activity daily past week)	**23.0**	(21.7-24.4)	207,000	29.5	16.2	*
physically inactive (no days of activity in past week)	**8.9**	(7.8-10.2)	80,300	6.7	11.4	*
sedentary behaviour (3+ hours of screen time daily)	**64.2**	(61.8-66.5)	539,100	63.4	65.1	
overweight or obese	**28.0**	(26.1-29.9)	236,000	29.8	26.0	
8 or more hours of sleep on an average school night	**39.2**	(37.1-41.3)	349,400	42.2	35.9	*
often or always go to bed or school hungry	**6.7**	(5.9-7.7)	60,000	7.1	6.3	
medically treated injury (past year)	**42.5**	(39.9-45.2)	345,700	43.2	41.8	
concussion (past year)	**14.8**	(13.7-16.0)	130,700	15.4	14.2	
medical use of opioid pain relievers (past year)	**17.6**	(15.6-19.9)	148,800	15.9	19.5	*
not always wear a seatbelt when in motor vehicle	**23.7**	(21.4-26.1)	199,500	22.8	24.6	
texting while driving (G10-12 with licence, past year)	**32.5**	(29.0-36.2)	85,300	32.8	32.2	
mental health care visit (past year)	**24.5**	(22.0-27.3)	235,100	22.0	27.2	
sought counselling over phone or Internet (past year)	**3.4**	(2.3-5.1)	32,900	2.1	4.8	*
unmet need for mental health support	**31.2**	(27.5-35.2)	299,800	20.9	42.2	*
medical use of tranquillizers/sedatives (past year)††	**3.6**	(2.8-4.6)	23,700	2.6	4.7	*
medical use of ADHD drugs (past year)	**2.9**	(2.1-4.1)	28,300	4.2	1.6	*
prescribed medication for depression/anxiety/both††	**5.2**	(4.2-6.6)	37,600	3.0	7.6	*
fair or poor self-rated mental health	**18.8**	(17.2-20.5)	180,900	11.9	26.2	*
low self-esteem	**6.5**	(5.5-7.7)	61,400	4.5	8.6	*
elevated stress	**30.4**	(27.7-33.3)	289,900	20.0	41.5	*
moderate-to-serious psychological distress (past month)	**38.7**	(34.9-42.6)	361,300	26.8	51.3	*
serious psychological distress (past month)	**17.1**	(14.9-19.4)	159,400	9.1	25.5	*
experienced a traumatic event (lifetime) ††	**35.2**	(32.8-37.7)	252,100	27.7	43.0	*
suicidal ideation (past year)	**13.6**	(12.4-15.0)	118,000	8.5	19.0	*
suicide attempt (past year)	**3.9**	(3.0-4.9)	33,400	2.5	5.3	*
symptoms of ADHD (past 6 months)	**20.1**	(18.2-22.2)	186,000	16.5	24.0	*
antisocial behaviour (3+/9 behaviours in past year)	**6.9**	(5.8-8.1)	62,300	8.7	5.0	*
carried a weapon (past year)	**5.7**	(4.2-7.5)	50,500	8.6	2.7	*
physical fight at school (past year)	**11.4**	(9.7-13.3)	105,900	16.8	5.6	*
threatened/injured with weapon at school (past year)	**5.5**	(4.5-6.6)	50,700	7.7	3.2	*
worried about being harmed or threatened at school	**13.0**	(11.3-14.8)	123,900	10.7	15.4	*
been bullied at school (since September)	**21.0**	(19.3-22.9)	197,400	17.7	24.5	*
bullied others at school (since September)	**11.1**	(10.0-12.4)	104,100	12.0	10.2	
been cyberbullied (past year)	**20.5**	(18.8-22.3)	191,600	16.4	24.9	*
cyberbullied others (past year)	**9.7**	(8.3-11.3)	100,100	9.7	9.7	
any gambling activity (past year)	**31.3**	(29.5-33.2)	285,300	37.8	24.6	*
any online gambling (past year)	**3.5**	(2.6-4.6)	31,500	5.1	s	
multi-gambling activity (5 or more activities in past year)	**2.1**	(1.4-3.2)	19,200	2.9	s	
high gambling problem severity (past 3 months)††	**1.8**	(1.4-2.2)	12,200	2.5	s	
video gaming problem (past year)	**11.7**	(9.5-14.2)	107,200	16.6	6.5	*
5 or more hours per day on social media	**20.1**	(17.4-23.1)	194,300	14.9	25.8	*
problematic technology use (serious) ††	**4.9**	(3.3-7.2)	33,300	3.2	6.6	*
3 or all 4 coexisting problems††	**5.7**	(4.7-6.9)	41,500	5.9	5.5	

Notes: the total sample size is 11,435 students; some estimates based on a random half sample; CI=confidence interval; † the estimated number of students is based on a population of about 917,800 in grades 7–12 in Ontario, and have been rounded down; * indicates a significant sex difference ($p<.05$) *not* controlling for other factors; †† among grades 9–12 only; medical drug use is defined as use with a prescription; "coexisting problems" refers to the following four problems: psychological distress, antisocial behaviour, hazardous/harmful drinking, and drug use problem.

Percentage Reporting Selected Mental Health and Well-Being Indicators by Grade, 2017 OSDUHS (Grades 7–12)

Indicator	G7	G8	G9	G10	G11	G12	
fair or poor self-rated physical health	4.7	5.3	8.1	9.4	10.0	11.7	*
daily physical activity (60 mins. activity daily past week)	31.9	29.9	28.8	21.6	18.3	14.4	*
physically inactive (no days of activity in past week)	5.0	3.5	6.3	7.1	12.3	15.0	*
sedentary behaviour (3+ hours of screen time daily)	53.2	59.8	61.2	69.0	66.4	69.5	*
overweight or obese	21.9	25.7	26.1	29.7	33.7	28.1	*
8 or more hours of sleep on an average school night	72.3	60.8	41.8	30.4	26.5	21.1	*
often or always go to bed or school hungry	5.5	5.3	6.7	8.9	5.5	7.6	
medically treated injury (past year)	41.8	42.5	46.4	43.2	46.9	36.7	
concussion (past year)	16.2	22.0	12.3	13.7	14.1	12.8	*
medical use of opioid pain relievers (past year)	12.1	12.0	13.1	20.0	23.5	22.5	*
not always wear a seatbelt when in motor vehicle	18.8	14.6	25.1	28.3	31.2	23.9	*
texting while driving (G10-12 with licence, past year)	--	--	--	s	18.1	42.6	*
mental health care visit (past year)	28.9	28.7	24.2	22.5	22.1	23.6	
sought counselling over phone or Internet (past year)	2.1	2.8	s	3.9	1.6	4.3	
unmet need for mental health support	25.5	24.0	30.7	29.5	32.9	38.3	
medical use of tranquillizers/sedatives (past year)††	--	--	3.2	3.2	4.6	3.4	
medical use of ADHD drugs (past year)	4.7	2.8	2.4	s	3.0	1.8	
prescribed medication for depression/anxiety/both††	--	--	4.5	2.6	4.0	8.6	
fair or poor self-rated mental health	8.9	11.4	17.5	21.8	20.0	26.0	
low self-esteem	4.8	4.2	7.7	6.8	6.6	7.4	
elevated stress	14.9	17.1	25.3	35.5	40.9	37.8	
moderate-to-serious psychological distress (past month)	24.9	32.8	31.2	39.9	46.8	47.0	
serious psychological distress (past month)	9.4	12.0	15.0	17.9	19.8	22.4	
experienced a traumatic event (lifetime)	--	--	30.6	31.9	32.6	42.9	
suicidal ideation (past year)	8.9	11.7	14.7	14.3	11.0	17.5	
suicide attempt (past year)	s	2.9	4.4	4.9	1.9	5.4	
symptoms of ADHD (past 6 months)	16.2	12.7	17.3	19.9	24.0	25.1	*
antisocial behaviour (3+/9 behaviours in past year)	4.2	6.6	4.5	8.4	7.6	8.3	
carried a weapon (past year)	4.5	3.9	5.5	6.7	6.5	5.8	
physical fight at school (past year)	20.5	16.9	14.4	8.2	9.6	5.3	*
threatened/injured with weapon at school (past year)	6.2	6.9	5.1	7.2	3.5	4.9	
worried about being harmed or threatened at school	14.3	16.6	16.6	11.7	8.4	12.1	
been bullied at school (since September)	27.4	28.8	22.7	20.6	18.3	15.0	*
bullied others at school (since September)	11.1	13.2	12.6	11.3	8.8	10.7	
been cyberbullied (past year)	21.7	22.1	24.7	19.9	20.9	16.3	
cyberbullied others (past year)	9.8	9.2	9.3	11.3	10.0	8.7	
any gambling activity (past year)	27.2	29.4	28.1	31.1	32.3	36.2	
any online gambling (past year)	2.6	3.1	3.1	4.0	s	2.8	
multi-gambling activity (5 or more activities in past year)	s	s	s	s	s	s	
high gambling problem severity (past 3 months)††	--	--	s	s	s	s	
video gaming problem (past year)	11.2	10.8	9.6	11.1	16.4	10.7	
5 or more hours per day on social media	11.5	15.0	22.9	20.6	24.2	22.1	
problematic technology use (serious) ††	--	--	3.6	4.5	s	3.2	
3 or all 4 coexisting problems††	--	--	1.3	6.0	5.1	9.1	*

Notes: * indicates a significant grade difference (p<.05) *not* controlling for other factors; 's' indicates estimate suppressed due to unreliability; †† among grades 9–12 only; medical drug use is defined as use with a prescription; "coexisting problems" refers to the following four problems: psychological distress, antisocial behaviour, hazardous/harmful drinking, and drug use problem.

Percentage Reporting Selected Mental Health and Well-Being Indicators by Region, 2017 OSDUHS (Grades 7–12)

Indicator	GTA	North	West	East	
fair or poor self-rated physical health	9.0	8.7	8.9	7.7	
daily physical activity (60 mins. activity daily past week)	20.6	24.6	24.4	26.4	*
physically inactive (no days of activity in past week)	10.4	8.2	7.0	8.4	*
sedentary behaviour (3+ hours of screen time daily)	66.0	58.0	63.7	62.3	
overweight or obese	27.6	31.3	29.7	25.2	
8 or more hours of sleep on an average school night	36.5	45.5	42.7	38.5	*
often or always go to bed or school hungry	7.8	7.9	5.5	5.6	
medically treated injury (past year)	41.0	47.1	46.0	38.2	
concussion (past year)	11.5	14.4	18.1	18.0	*
medical use of opioid pain relievers (past year)	18.7	17.6	18.6	14.6	
not always wear a seatbelt when in motor vehicle	24.5	17.5	25.1	21.4	
texting while driving (G10-12 with licence, past year)	28.7	30.7	39.8	26.3	*
mental health care visit (past year)	24.3	32.8	24.7	22.4	
sought counselling over phone or Internet (past year)	s	3.9	3.6	2.3	
unmet need for mental health support	32.2	26.4	31.7	29.2	
medical use of tranquillizers/sedatives (past year)††	3.6	4.6	3.3	3.7	
medical use of ADHD drugs (past year)	2.4	4.0	3.7	s	
prescribed medication for depression/anxiety/both††	3.3	11.6	7.7	6.1	*
fair or poor self-rated mental health	16.9	22.6	23.2	17.7	*
low self-esteem	5.9	5.0	8.9	5.4	
elevated stress	30.9	32.3	31.1	27.7	
moderate-to-serious psychological distress (past month)	40.2	36.5	39.2	34.3	
serious psychological distress (past month)	17.4	16.6	18.7	14.0	
experienced a traumatic event (lifetime)	34.9	35.8	38.1	32.5	
suicidal ideation (past year)	14.2	12.4	14.8	11.1	
suicide attempt (past year)	4.0	4.9	3.9	3.1	
symptoms of ADHD (past 6 months)	20.4	16.5	19.5	21.4	
antisocial behaviour (3+/9 behaviours in past year)	7.8	5.8	6.1	5.6	
carried a weapon (past year)	6.0	4.6	6.8	3.5	
physical fight at school (past year)	12.1	11.3	11.3	9.1	
threatened/injured with weapon at school (past year)	5.5	3.4	6.8	4.1	
worried about being harmed or threatened at school	12.5	9.8	13.9	14.0	
been bullied at school (since September)	18.9	21.9	25.3	21.1	
bullied others at school (since September)	12.2	10.4	11.3	7.8	*
been cyberbullied (past year)	20.0	23.0	23.8	16.9	*
cyberbullied others (past year)	10.3	9.5	10.0	7.3	
any gambling activity (past year)	31.3	33.0	32.1	29.7	
any online gambling (past year)	3.8	5.2	3.5	1.7	
multi-gambling activity (5 or more activities in past year)	s	s	s	s	
high gambling problem severity (past 3 months)††	s	s	s	s	
video gaming problem (past year)	13.5	10.4	11.3	7.0	*
5 or more hours per day on social media	21.8	18.8	19.4	16.6	
problematic technology use (serious) ††	7.1	2.7	2.9	1.6	*
3 or all 4 coexisting problems††	5.1	8.0	7.1	5.1	

Notes: GTA=Greater Toronto Area; * indicates a significant regional difference (p<.05) *not* controlling for other factors; 's' indicates estimate suppressed due to unreliability; †† among grades 9–12 only; medical drug use is defined as use with a prescription; "coexisting problems" refers to the following four problems: psychological distress, antisocial behaviour, hazardous/harmful drinking, and drug use problem.

Overview of Trends for Selected Mental Health and Well-Being Indicators Among the Total Sample of Students, OSDUHS

Indicator	Among Grades	Period	Change
% fair or poor self-rated physical health	7, 9, 11	1991–2017	Stable
% daily physical activity (60 mins. per day)	7–12	2009–2017	Stable
% sedentary behaviour (3+ hours screen time daily)	7–12	2009–2017	Increased from 57% to 64%
% overweight or obese	7–12	2009–2017	Increased from 23% to 28%
% medically treated injury	7–12	2003–2017	Increased from 35% to 43%
% medical use of prescription opioid pain relievers	7–12	2007–2017	Decreased from 41% to 18%
% texting and driving (G10-12 with a licence)	10–12	2013–2017	Stable
% antisocial behaviour (past year)	7, 9, 11	1993–2017	Decreased from 16% to 6%
% carried a weapon (past year)	7, 9, 11	1993–2017	Decreased from 16% to 6%
% physical fighting at school (past year)	7–12	2001–2017	Decreased from 17% to 11%
% threatened/injured with a weapon at school	7–12	2003–2017	Decreased from 8% to 6%
% worried about being harmed/threatened at school	7–12	1999–2017	Stable
% been bullied at school (since September)	7–12	2003–2017	Decreased from 33% to 21%
% been cyberbullied (past year)	7–12	2011–2017	Stable

Note: trend analyses are based on a p-value <0.01.

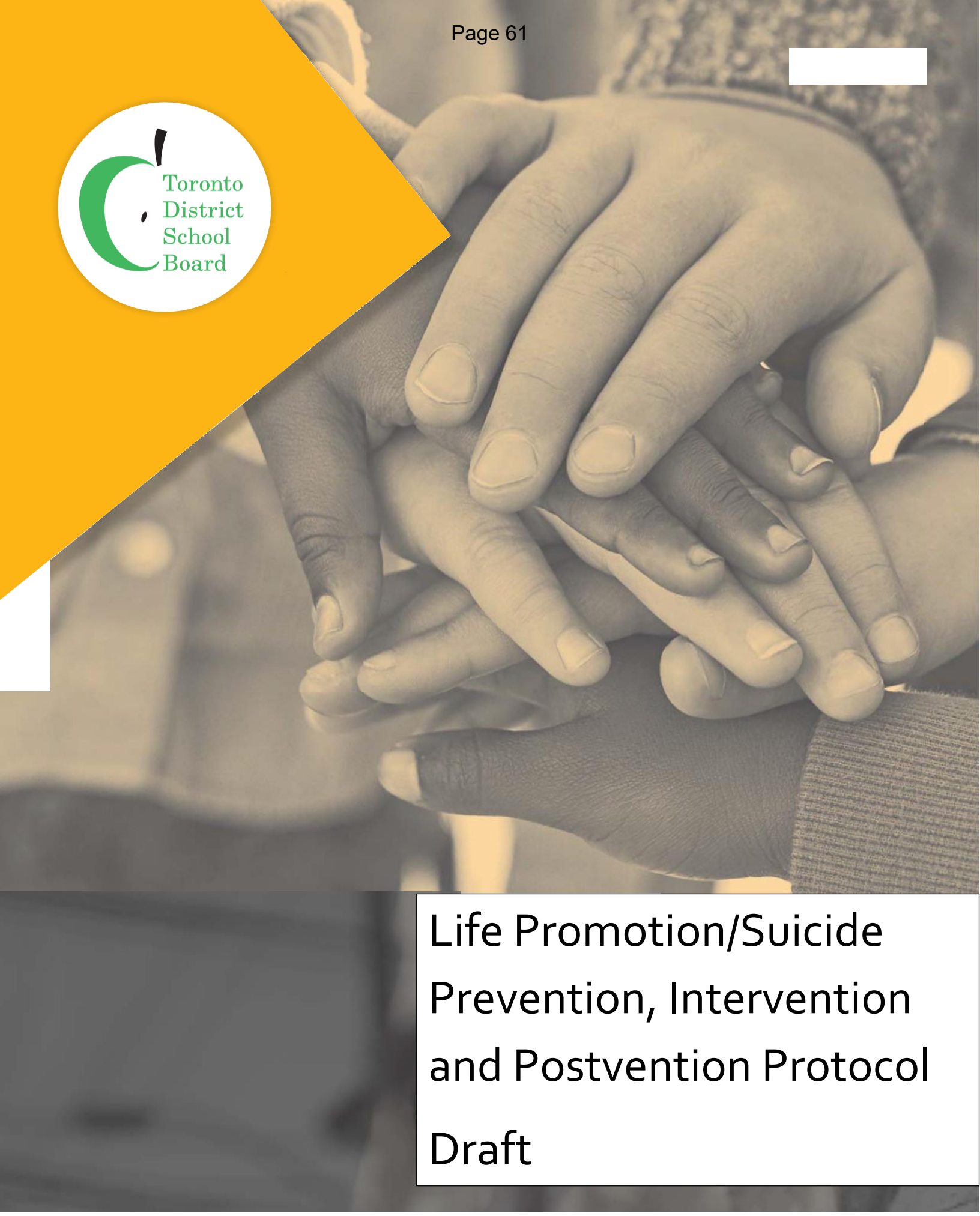
Methodology

The Centre for Addiction and Mental Health's *Ontario Student Drug Use and Health Survey* (OSDUHS) is an Ontario-wide survey of elementary/middle school students in grades 7 and 8 and secondary school students in grades 9 through 12. This repeated cross-sectional survey has been conducted every two years since its inception in 1977. The 2017 survey, which used a stratified (region by school level) two-stage (school, class) cluster design, was based on 11,435 students in grades 7 through 12 in 764 classes in 214 schools in 52 English and French public and Catholic school boards. Excluded from selection were schools on military bases, in First Nations communities, hospitals and other institutions, and private schools. Special Education classes and English as a Second Language (ESL) classes were excluded from selection.

Active parental consent procedures were used. Self-completed paper-and-pencil questionnaires, which promote anonymity, were group administered by staff from the Institute for Social Research, York University in classrooms between November 2016 and June 2017 during regular school hours. Students in French-language schools completed French questionnaires. Sixty-one percent (61%) of randomly selected schools, 94% of selected classes, and 61% of eligible students in those classes completed the survey. The 2017 total sample of 11,435 students is representative of just under one million students in grades 7 to 12 enrolled in Ontario's publicly funded schools.

Please visit the OSDUHS webpage for reports and FAQs:

www.camh.ca/osduhs



Toronto District School Board

Life Promotion/Suicide Prevention, Intervention and Postvention Protocol

Draft

Toronto District School Board

Suicide Intervention Protocol Flow Chart

for immediate, current safety risks

A Suicidal Ideation

Contemplating death by suicide and planning actions that can result in death

Do not leave the individual alone.

- Listen to individual in a caring, non-judgemental way
- Inform principal/supervisor or designate
- Consult School Social Worker
- Contact parent/guardian/ support person
- Consider culturally relevant and responsive supports in the TDSB and in the community

If unsure about the individual's safety, the Principal/Designate or Supervisor will:

- Immediately advise or update parent/guardian/support person
- Arrange for the school Social Worker to assess the individual for imminent risk

If the safety of the individual CANNOT be ensured:

- Consult with Social Work & Attendance Manager
- Arrange for assessment at *What's Up Walk-in* or at a hospital, as appropriate
- Ensure that other staff are informed, as appropriate

B 3rd Party Disclosure

Information that someone may be at risk of suicide

The recipient of the 3rd party disclosure will:

- Inform principal/supervisor or designate immediately
- Try to locate the individual

Principal/Designate or Supervisor will:

- Consult the school Social Worker
- Contact parent/guardian/ support person, as appropriate
- Consider culturally relevant and responsive supports in the TDSB and in the community
- Inform other staff, as appropriate

If individual is located, follow the steps for:

A Suicide Ideation

or

C Suicide Attempt

If individual is NOT located:

- Call 911
- Ask someone to direct emergency personnel
- Inform Superintendent or Manager

C Suicide Attempt

The present expression of an active intent/plan to imminently end one's life

Do not leave the individual alone.

- Listen to individual in a caring, non-judgemental way
- Ensure 911 is called
- Ensure that first aid is provided
- Ensure that potentially dangerous items are secured
- Ensure that the principal/supervisor or designate is informed immediately
- Ensure that staff directs emergency personnel when they arrive
- Ensure area is clear of bystanders

Principal/Designate or Supervisor will:

- Ensure individual is transported to hospital
- Contact parent/guardian/ support person
- Inform Superintendent or Manager who will inform their direct Supervisor
- Consult the school Social Worker
- Inform other staff, as appropriate
- Ensure Communications staff are contacted if media are involved

Try to remain calm…

School Social Worker: Phone number:

Your Learning Centre Social Work Manager: Phone number:

Table of Contents

Introduction: Life Promotion/Suicide Prevention, Intervention and Postvention Protocol

In the *Toronto District School Board* (*TDSB*) it is important that we centre student voice and agency and allow what we know about our students in terms of their identities, abilities and lived experiences to shape the work that happens in our schools and board. *Creating a Culture for Student and Staff Well-Being* is a goal of the *Multi-Year Strategic Plan*. Staff who act as caring adults in our schools, Professional Support Staff including Social Workers and Psychologists, Guidance Counsellors, and Caring and Safe School staff support students and their families. The *TDSB* operates on the following guiding principles when responding to suicidal prevention, intervention and postvention:

- All expressions of suicidal thoughts or actions will be taken seriously and responded to in a timely manner with great respect and sensitivity
- The safety and well-being of all students is our primary consideration
- The identities of students and their cultural background needs to drive supportive programming to promote positive student mental health and well-being
- Respect for equity, diversity and inclusive practices is paramount

It is important to recognize that those who struggle with mental health problems have personal strength and resilience, and the potential to overcome difficulties to ultimately survive, thrive and strive to create a life worth living. We understand that mental health is a complex concept that impacts each of us in different ways. The safety of all our students and staff is of utmost importance. It is also important that, as school leaders, we need to identify and address biases and systemic barriers (i.e. race, gender) while recognizing and addressing our own emotional responses during a potential crisis situation involving a student. It is important that *TDSB* staff is trained to effectively support and respond to ensure the ongoing safety of those who may be struggling.

Among those who struggle with mental health problems are individuals who are considering suicide. They are of particular and urgent concern.

> "Youth suicide is a complex emotionally-charged and sadly prevalent problem in Canada. It is the second leading cause of death amongst young people accounting for roughly 17-20% of adolescent mortality. Virtually all school boards in Ontario will be faced with students who are at risk for suicidal behaviour and most will at one time or another need to respond to a student's death by suicide. Given this reality it is important to be prepared." (School Mental Health Assist, 2013, [p.4])

Suicide has devastating effects on those who are left behind. Research shows that for every person who has died by suicide, many other people are affected. For vulnerable youth there is an increased risk of copying this behaviour (contagion) or suffering post-traumatic stress disorder or depression. Signs and symptoms of risk may vary based on the individual.

Suicide can often be connected to a student's social identity and systemic barriers and bias. Issues can be connected to various "isms" and "phobias" (i.e. racism, classism,

homophobia, Islamophobia) and corresponding micro-aggressions that may marginalize students, families and community members. It is important to consider culturally relevant supports for students and families when responding to suicide. Identity and suicide can be connected. However factors relating to suicide are complex, and could impact students with a broad range of backgrounds.

- One in seven (14%) students had serious thoughts about suicide in the past year (an estimated 118,000 Ontario students), and 4% report a suicide attempt in the past year (an estimated 33,400 Ontario students) (CAMH, 2017).

- Populations including First Nations, Metis and Inuit, individuals who identify as Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (2SLGBTQ) are more at risk of suicidal ideation or attempts (Government of Canada, 2018).

- First Nations youth die by suicide five to six times more often than non-Aboriginal youth (Canadian Institute of Child Health, 2000). It is important to note that this statistic is reflective of predominantly rural and under-served communities that have been impacted from long-term discrimination from various systems of government and society. The effects of colonization are at the root of youth Indigenous suicide; these effects include the intergenerational impact of residential schools, cultural genocide and assimilation. Today, Indigenous youth and children still continue to face on-going issues of racism and discrimination (both systemically and socially).

  Communities with strong cultural continuity where Indigenous languages are spoken and taught, and where community sovereignty is recognized, offer more protection against suicide risk. In Toronto, some Indigenous youth and families struggle with the daily realities of isolation and discrimination; however, Toronto also has a strong, diverse and supportive Indigenous community that offers a variety of culturally-based mental health supports for youth. In the TDSB we understand the significance of culturally responsive care; information on services and community resources for Indigenous youth and families can be accessed through the TDSB Urban Indigenous Education Centre.

- Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (2SLGBTQ) students are also at greater risk of acting on suicide ideation. Peer victimization, a lack of acceptance, and rejection from family can negatively impact LGBTQ students. Studies show that 33% of Lesbian, Gay, and Bisexual students have attempted suicide in comparison to 7% of the general student population (Saewyc,2007,[79-87]). And, in 2010, 47% of Transgender youth in Ontario reported thinking about suicide (Scanlon et al, 2010). Protective factors for supporting LGBTQ students include family acceptance[1] (Veale et al, 2015) affirming students in their self-identified identity[2] (Hidalgo et al) and creating positive and inclusive school climates. Schools do this by addressing bullying

and harassment, engaging in staff professional development, embedding LGBTQ identities into the curriculum, and supporting the creation of LGBTQ focused student groups.

In the TDSB it is of utmost importance that all students and staff experience a sense of safety, belonging and acceptance based on their identity. The mental health and well-being of all members of the TDSB community are our shared priority to support overall achievement, well-being and success in school and personal endeavours.

Life Promotion / Suicide Prevention / Intervention / Postvention

Reducing suicide rates requires a combination of life promotion/suicide prevention, intervention and postvention strategies. The purpose of this document is to increase awareness about:

- effective strategies for schools to use in **suicide prevention** and to focus on the **promotion** of mental health and well-being
- effective strategies for staff to use in identifying warning signs of suicide ideation, assessing risk and providing appropriate **interventions**
- effective strategies and evidence-informed practices to provide **postvention** support in the aftermath of a death by suicide or attempt

The content of this protocol is based on current research and best practice, recognizing that everyone at the TDSB has a role to play in promoting positive mental health for all students.

Promotion of Mental Health and Well-Being:

Effective ways to reduce the risk of suicide in schools is to:

- create safe, inclusive, welcoming school environments
- recognize that students face systemic barriers and biases based on their identity
- engage culturally relevant supports for students and families
- challenge systemic inequities in support of students
- focus on engaging students and staff in their school community
- develop and nurture open, trusting relationships with students
- foster social, emotional, and behavioural competence
- promote the reduction of stigma related to mental health problems
- teach effective coping strategies for managing feelings of distress
- build resilience through problem-solving skills and self-awareness
- support collaboration with community mental health partners

Teaching effective coping strategies and building resilience among students require staff and students to have an understanding of “Mental Health Awareness.” The six strands of Inclusive Design, in particular The Environment as Third Teacher, Designing Instruction, Student Voice and Community Engagement, can serve as a model to create the conditions for positive student well-being. Mental Health Awareness refers to an understanding of the various components of mental wellness, how to identify risk factors

and warning signs in those who are struggling with mental health problems, and how to appropriately respond to assist individuals to receive professional support.

Board-wide mental health literacy promotes a climate in which individuals can safely address personal vulnerabilities while building protective factors such as positive relationships. Education about mental health and well-being includes promoting healthy physical habits (healthy eating, daily exercise/movement and adequate sleep), normalizing distress, teaching stress-management strategies, and engaging students/staff to understand how they can support each other. An effective way to support individuals is to ensure they have connections and a sense of belonging within the school/work place and the community.

Everyone Has a Role in Life Promotion/Suicide Prevention

Part of being a member of a healthy school community is recognizing that **everyone** has a role to play in supporting the mental health of others, and a responsibility to act when they encounter an individual who is expressing or demonstrating a mental health problem. Different members of a healthy community have varying needs in relation to training and knowledge about suicide ideation or attempt:

- **Awareness** - All staff can benefit from professional development about risk factors, warning signs, and appropriate responses to disclosure of suicide ideation or attempt. All staff should be aware of the *Suicide Intervention Protocol Flow Chart*.
- **Literacy** – Administrators need more in-depth training as they support the use of the Suicide Intervention Protocol. It can also be offered for self-selected individuals in a school or work location who are willing to provide consultation and support when crises occur.
- **Expertise** - Professional Support Services staff must maintain current skills and knowledge with respect to suicide assessment and support.

Further resources related to promoting healthy schools are below:

- *Video: Promoting Mental Health: Developing a Shared Language from **CAMH** Health Promotion Resource Centre*
  https://vimeo.com/130580621
- *Leading Mentally Healthy Schools*
  https://smh-assist.ca/blog/leading-mentally-healthy-schools/
- *Supporting Minds*
  http://edu.gov.on.ca/eng/document/reports/health.html
- *Everyday Mental Health Classroom Resource*
  https://smh-assist.ca/emhc/
- *Bounce Back*
  https://www.healthunit.com/bounce-back
- *Stress Lessons*
  https://psychologyfoundation.org/Public/Programs/Stress_Lessons1/Stress_Lessons.aspx

Life Promotion / Suicide Prevention: Warning Signs for Risk of Suicide

When an individual is struggling with her/his mental well-being there is an increased risk of that person considering suicide. Early identification of those at risk for suicidal behaviour is a critical factor in prevention. Disclosures of suicidal ideation may be explicit or implicit requests for help. School staff members (e.g. teachers, office staff, caretakers, lunchroom supervisors, bus drivers, professional support services staff, education or special needs assistants) and peers may be the first to recognize that an individual is at-risk of considering suicide.

Board employees, although not expected to be mental health professionals, are in an optimal position to notice changes in behaviour and other “warning signs,” and to assist struggling individuals to access supports and intervention.

It is important to note that expressions of suicide often represent difficulty in coping with a specific situation or circumstance that the individual perceives to be unbearable or psychologically painful. As such, thoughts of suicide or suicide attempts do not always represent a desire to die, but rather to escape a situation that seems hopeless. Persons in extreme distress may lose the ability to think clearly in finding solutions. It is helpful that those who intervene recognize that the challenge is the difficult situation that the individual faces, and not the person her/himself; it is important to understand that it is the “thinking errors" (irrational patterns of thinking) that are causing the individual to feel distressed and act in self-defeating ways.

Any TDSB employee who feels concerned about the well-being and safety of any individual has an obligation to act on the concern through following the *Suicide Intervention Protocol*. The presence of any of the following warning signs and risk factors warrant timely attention:

- A verbal disclosure of suicidal ideation
- A diagnosed mental health problem
- A history of previous suicide attempts
- A history of sexual assault
- A report from a friend or family member that an individual 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”)
- Poor attendance, missed assignments, lack of interest or participation
- Loss of ability to focus, not interested in appearance, loss of enjoyment
- Signs of depression such as sleeplessness, loss of appetite, social withdrawal, lost interest in usual activities, change in routine behaviours
- Loss of a family member or a friend to suicide
- Actions such as giving away possessions, ‘putting affairs in order’, withdrawal from family or friends
- A sudden decrease in emotional expression; particularly, a movement from depression or agitation to remarkable and uncharacteristic calm

Students with special needs may require a customized approach

Some students with special needs, by function of their challenges, may habitually make comments when they become anxious or agitated that can suggest thoughts of suicide. In these situations, consult with TDSB Professional Support Services staff to better understand the function of the behaviour and develop recommendations for teaching the student better ways to communicate what he or she needs. The recommendations may be included in a plan to keep the student safe (or could result in the creation of such a plan). The school Social Worker can assess the student's level of suicidal risk.

Suicide Intervention Protocol

This section supports the Suicide Intervention Protocol Flow Chart. It provides TDSB staff with information on how to respond to any individual, who demonstrates suicidal thoughts and behaviour, including:

- **Suicidal Ideation** – contemplating death by suicide and planning actions that can result in death
- **Third Party Disclosure** – information that someone else may be at risk
- **Suicide Attempt** – the present expression of an active intent/plan to imminently end her/his life

Please Note: See APPENDIX A Non-Suicidal Self- Injury (NSSI) for guidance in managing a situation where an individual has engaged in Self-Injury (e.g. cutting for stress relief) or see APPENDIX B Responding to Disclosures of Previous Suicidal Ideation or Attempt for which there are no current or immediate safety risks.

A. Responding to Suicidal Ideation

If you are concerned that someone is thinking about suicide:

- **Do not leave the individual alone**

Stay with the person and **listen** non-judgmentally to her/his feelings. Understand that individuals can have thoughts of suicide and not act on them. Do not try to change their thinking or "talk them out of" their feelings or thoughts.

- Inform principal/supervisor or designate
- Consult with the school Social Worker (it is important to seek guidance rather than act in isolation)
- Contact the parent/guardian/support person (unless there is a risk that this contact will further endanger the individual)
- Consider culturally relevant and responsive supports in the TDSB and in the community

PRINCIPAL/SUPERVISOR OR DESGINATE WILL:

- Arrange for the school Social Worker to assess the individual for imminent risk

If the safety of the individual CANNOT be ensured:

- Consult with Learning Centre Manager of Social Worker & Attendance
- Arrange for assessment at *What's Up Walk-in* or at a hospital as appropriate www.whatsupwalkin.ca/service-providers/ (note that translation services are available onsite)
- Inform other staff members as appropriate

B. Responding to a Third Party Disclosure

- Try to locate the individual in the school or work setting, at home, by phone or text or through social media
- Immediately inform the supervisor/principal or designate
- Inform other staff as appropriate to assist you in locating the person (e.g. ask School Based Safety Monitor, Office Administrator, peers or anyone who may know the whereabouts of the individual)

PRINCIPAL/SUPERVISOR OR DESIGNATE WILL:

- Consult the school Social Worker
- Contact parent/guardian/support person as appropriate (unless there is a risk that this contact will further endanger the individual)
- Inform other staff as appropriate

If the individual is located, follow the steps for:

A) Suicidal Ideation
or
C) Suicide Attempt

If the individual is NOT located:

- Call 911 and share the third party disclosure and any contact information for the missing individual
- Ask someone to direct emergency personnel
- Inform the Superintendent of Education or Manager of Social Work and Attendance

C. Responding to a Suicide Attempt

Do not leave the individual alone.

- Listen to the individual in a caring, non-judgmental way
- Ensure that someone calls 911, if appropriate
- Ensure that first aid is provided as needed
- Ensure that potentially dangerous items are secured
- Ensure that the Principal/Supervisor or designate is informed
- Ensure that someone directs emergency personnel
- Ensure the area is cleared of bystanders

PRINCIPAL/SUPERVISOR OR DESIGNATE WILL:

- Ensure that the individual is transported to hospital supported by TDSB staff
- Contact the parent/guardian/ support person (if the student is under the age of 18 and if the parent/guardian does not respond supportively, report this concern to the Children's Aid Society)

- Inform the Superintendent of Education or the Learning Centre Manager of Social Work and Attendance who will inform their direct supervisor
- Consult the school Social Worker to assist with follow-up in school
- Inform other staff as appropriate
- Ensure Communications Staff are contacted if media are involved

D. Follow-Up: Suicide Attempt Intervention

Planning for Ongoing Safety
When an individual returns after an active suicide attempt, considerations need to be made to ensure her/his safety, such as:

Developing a Coping Plan (see APPENDIX D Coping Plan for Student Expressing Risk of Suicide)

A Coping Plan should be created through a conversation between the individual and the trained Professional Support Services staff person. It is important for the individual to be involved to increase a sense of personal ownership.

A Coping Plan can be verbal or written as preferred by the individual and include:

- Disabling any suicide plans (e.g. securing potentially dangerous items, protect the individual from environments of potential risk or triggers to suicide ideation)
- Identifying positive stress relief strategies and sources of emotional comfort
- Linking the individual to supports and resources.

Development of a Return to School Plan will help the student feel supported when they return. (see *APPENDIX E: Guidelines for Return to School Plan*). This plan could include:

- co-ordination of a daily check-in with a caring adult staff member/alternate
- monitoring of well-being throughout the day
- modification of the daily schedule if needed
- counselling (either through TDSB staff or a community mental health partner)
- ongoing connection with the parent/guardian/support person
- referral to a Mental Health and Addictions Nurse (see School Support Team Manual – Special Education Appendix Y & Z link below) http://tdsbweb/_site/ViewItem.asp?siteid=100&menuid=43626&pageid=36632d

D. Follow-Up Postvention Responding After a Death by Suicide:

This section of the Protocol provides guidelines for effective strategies and evidence-informed practices in responding to individuals who have been impacted by a death by suicide.

When an individual dies from suicide it is a unique kind of tragic event, requiring some specific actions at the system and school level. While there is no set formula to respond to a death by suicide, postvention should include consideration of the following elements:

The TDSB Crisis Response Team (activated through the Learning Centre Manager of Social Work & Attendance or the School Social Worker) provides support including:

- emotional support for those impacted
- enacting protocols
- providing scripts, with assistance from TDSB Government, Public and Community (Communications) staff, for messaging to staff and to students, letter to the school community, communication for media if needed
- monitoring social media
- completing documentation and reporting requirements

Reporting

- Complete the online Crisis Report form (PR.569A COM) available on the Principals' website.

Some Recommended Actions for the Administrator/Supervisor
(For further detailed guidelines see *APPENDIX G: Administrator's Guide - Immediately Following Death by Suicide*)

- Timely communication is critical. The principal/supervisor should immediately contact their Superintendent of Education and the Government, Public and Community Department (Communications).

- It is important to reach out to the family of the individual who has died. A sudden tragic death of an individual is always traumatic; death by suicide can enhance the sense of loss and devastation for those most personally impacted. Caring, compassionate gestures can make a difference, and a genuine message of sympathy from the school can be helpful.

- It is important to have a conversation with the family to determine their wishes regarding communication about the death. Families may not want the death discussed as suicide and this can make the postvention work challenging. Sometimes, families may allow this only with selected individuals who may be at greatest risk during the postvention period. This conversation may also need to address particular protocols, such as flying the flag at half-staff or not, and how best to support siblings in the coming weeks. Offering families choices in these difficult conversations is essential. It is important to respect the unique individual practices and cultural needs of the family. It may be helpful to have the school Social Worker involved to support these conversations.

Communication with staff needs to occur with considerable sensitivity as soon as possible. Some staff who worked closely with the individual may struggle with guilt or considerable grief and may require personal follow-up. Guidance regarding how to appropriately share this tragic news (i.e. community letters) can be accessed by the Government, Public and Community Relations Department (Communications) and the process can be supported by the school Social Worker**.**

- Share factual information with students in a sensitive way, in small groups, within the classroom. **Large group assemblies or via announcements are not recommended ways to inform the school community.**

- Avoid oversimplified explanations for suicidal behaviour. Individuals often try to understand "why" an individual chose to act on suicidal ideation. Focussing on this question may create further distress and is not helpful.

- Be aware that students may have first learned about the death through social media and misinformation may have been conveyed.

- Be mindful of how you speak about the individual who has died from suicide; avoid judgemental comments (I.e. "what a selfish thing to do"), use of the term "committed" suicide, or romanticized/glamourized references (i.e. "finally his pain is over," "she is in a better place," "she is an angel now").

- Provide counselling support for students or staff who may need/want it. Be aware some students prefer speaking with their peers.

- Support students and staff who may want to attend a memorial event (i.e. funeral, celebration of life or vigil).

- Postvention can be stressful work. Be attentive to your self-care as a leader, and model this for others.

- Keep in mind that in times of crisis, people are usually best supported by those with whom they have pre-existing, caring, trusting relationships.

- Give careful consideration to requests to memorialize the student, respecting cultural practices, ensuring equitable ways of acknowledging all student deaths, honouring the community's need to grieve while being mindful of the potential risk of contagion for vulnerable students.

- Debriefing the event is helpful to ensure that all necessary actions have been taken as well as an opportunity to reflect on the process and to address the emotional needs of the team (see *APPENDIX H: Debrief of Incident*)

Managing the Risk of Contagion

A recent Canadian study (Colman and Swamson, 2013) confirmed that young people are particularly susceptible to the idea of suicide, and that those who know someone who has died by suicide are much more likely to consider or attempt suicide themselves. The effect appears to be strongest for 12-13 year olds (six times higher rates of suicidal ideation/behaviour) but 14-18 year olds are also at heightened risk (three times higher rates of suicidal ideation/behaviour). It is for this reason that we sometimes see clusters of suicidal behaviour in a school or community. After a death by

suicide, there is a period of time, up to two years, where schools are at risk for more suicidal behaviour. (Colman & Swamson, 2013)

Suggestions to reduce the risk of contagion include:

- Consult with the TDSB Crisis Response Team (Learning Centre Manager of Social Work and Attendance) to provide support and communication, with consideration for contagion concerns.
- Identify and provide support to vulnerable students quickly following a death by suicide.
- Be clear about the negative impact that high profile events (i.e. memorial assembly) can have on others through contagion. Utilize the *Decision Support Tool designed* by *School Mental Health ASSIST* to assist school administrators in selecting appropriate Mental Health awareness activities (e.g., speakers, videos, social media, and surveys) https://smh-assist.ca/blog/school-mental-health-decision-support-tool-student-mental-health-awareness-activities-school-administrator-version/
- Balance the need to collectively grieve with the need to return the school to normal routines
- Ensure communication of factual information as released by the individual's family
- Develop whole school positive mental health approaches and avoid reactive strategies that are focused on suicide prevention alone
- Learn "how" to talk to students about suicide (see *Appendix F: Talking with Students About Suicide – including Class-level*)

Attending to Staff Well-Being and Self-Care

It is important that careful and compassionate attention is invested to address the emotional aftermath for those who were impacted by the event. It can be anticipated that staff/students whom have been exposed to the suicidal behaviours of others will need follow-up care and support.

It is helpful to remind staff that there is an Employee Assistance Program which is available for staff members who want professional support for themselves.

Go to: **www.workhealthlife.com** and put "Toronto District School Board" into the organization line or you can call **1-800-268-5211**.

Being involved in suicide prevention, intervention, and postvention can be emotionally challenging, and not everyone is comfortable doing this work. Staff involved in supporting related initiatives may feel anxious or overwhelmed by the weight and complexity of this topic. It is important to work in teams, communicate clearly and frequently, and support one another in making effective decisions.

School administrators/supervisors carry a large burden of responsibility at these times, as they oversee support to staff and students, communicate with families and the

media, and work to maintain normal operations for the wider school/work community. It is important that they "widen their net" and seek additional support from the TDSB Crisis Response Team. Leaders who have been involved in responding to a suicide ideation or attempt are encouraged to make time after the incident to debrief with others (e.g. Professional Support Services staff) and reflect on their experiences (see *Appendix H: Debrief of Incident*).

Postvention may be a lengthy process, particularly if there has been some level of contagion involved. Understand that individuals move through the processes of grief and healing at their own pace and in their own way and it will take time for the community to recover.

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- Superintendents of Education
- Mental Health Leads
- Elementary and Secondary Principals, Vice Principals
- Professional Support Services including Social Work, Psychology, child and Youth Services
- Leadership and Learning including Guidance, Special Education, Section 23, Health and Physical Education
- Gender Based Violence Prevention Office
- Urban Indigenous Education Centre
- Clerical staff

Appendix A

Non-suicidal Self-injury (NSSI)

Non-suicidal self-injury (NSSI) is a deliberate act of harming oneself <u>without</u> suicidal intent. It is a complex issue that is often misunderstood as a desire to die, when in actuality it is used as a coping mechanism to manage overwhelming feelings.

Dealing with a student around NSSI may elicit an emotional response in you, so please pay attention to your own feelings and well-being.

What should you know about NSSI?

- Typical forms of self-harm in youth include cutting, burning, bruising, and scratching.
- Remember that many students who self-injure do it privately and work hard to keep it a secret; it can be very difficult for staff to ascertain whether or not a student actually engages in self- harm.
- It is very important to recognize that NSSI and suicide are distinct, and engagement in **NSSI does not necessarily imply that a student is suicidal**. We know that many youth who engage in NSSI appear to be functioning very well socially and academically.
- It is important to **assess the risk** and severity of the situation and to determine whether or not the student is also experiencing suicidal ideation.ie. school social worker

It is important to remain calm.
If you notice signs that a student may be self-harming and you are uncomfortable continuing, consult with the School Social Worker for next steps.

Respond immediately to all medical or risk of suicide ideations. Refer to Suicide Intervention Protocol Flow Chart: If imminent safety is not a concern then:

Engage the student using a non-judgmental caring manner

Acknowledge that you have noticed some signs that they may be self-harming but are unsure what they may mean for the student.

Support the student to explore ways of coping that are safe and healthy

Understand that students are using NSSI to try to manage overwhelming feelings of anxiety, distress, sadness or anger

Reassure the student that we all cope differently. Sometimes individuals do things (like cutting) to release their stress.

Express concern for the student's well-being and explore appropriate supports. i.e. Counselling, support people/parents/friends/caring adults, apps, on-line support http://sioutreach.org/

Appendix B

Responding to Disclosures of Previous Suicidal Ideation or Attempt

There may be times when an individual discloses that at some point in the past she/he thought about or actually attempted suicide. Although this information can seem alarming, it does not require an emergency response such as calling 911 unless the individual indicates an immediate intention to act on suicide ideation in the present.

If the individual does not have any intent or plan to act on suicide ideation at the present it is advised that:

- Listen non-judgmentally
- Acknowledge their resilience that they have moved through this challenging time in the past
- Recommend that the individual seek medical attention as needed (i.e. Attempted overdose may result in need for medical intervention)
- Review the person's coping strategies and support network
- Provide comfort and confidence in their ability to manage these thoughts of suicidal ideation
- Ask the individual if they are currently thinking of suicide and if, they are, do they have a plan of how they would kill him/herself
- Ask why the individual is talking about this now
- Develop a Coping Plan (see ***Appendix D Coping Plan for a Student Expressing Risk of Suicide***) with the individual to help them deal with thoughts of suicidal ideation

Arrange for the school Social Worker to assess the individual for imminent risk

Please note:

If the individual is not in any immediate danger it is not necessary to call 911 or Children's Aid Society. If unsure, refer to the ***Suicide Intervention Protocol Flow Chart*** *located at the beginning of* this document and consult with the school Social Worker.

Appendix C

Tips for Meeting with a Student at Risk of Suicide

The Following are some dos and don'ts to consider when interviewing a student for suicidal risk

DO:

- Connect the student with a trusted caring adult who knows the student
- Find a quiet and private place to talk
- Take time to hear the student
- Remain calm and demonstrate a caring manner – offer water, tissues, a blanket etc.
- Establish rapport with your words and body language
- Listen carefully without interruption or judgement. It is okay to sit in silence.
- Validate the student's concerns and pain.
- Recognize and consider the students identity and their cultural ways of knowing
- Paraphrase what the student is trying to say to indicate your understanding
- Promise privacy but not confidentiality. You must inform someone if there is a potential risk to the student or others. You cannot keep suicidal thought or behaviour a secret.
- Keep the student's perspective in mind (no matter how unrealistic). It is the student's perception that reveals his/her thoughts and feelings.
- Ask the question outright if the student does not mention suicidal thoughts (e.g." I am concerned about your safety. Have you been thinking of hurting yourself?" or "Have you had thoughts of killing yourself?" or "Are you feeling suicidal?" "Do you have a plan of how you would kill yourself?")
- Let the student know that your first priority is to keep him/her safe.
- Remember you work as part of a student support team. Know when to "widen the net" and ask for support.
- Practice self-care

DO NOT:

- Leave the student unattended
- Panic. You do not need to fix anything, by listening you offer compassion and caring
- 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
- Argue about suicidal behaviour
- Promise to keep suicidal thoughts or behaviours a secret
- Ignore the student's need to talk
- Give up if the student just shrugs or is uncommunicative. She/he may say more given additional time.
- Make promises or remarks that might be unrealistic
- Assume that the person isn't the suicidal type; anyone can be suicidal
- Discount the student's problems or distress as minor or suggest she/he will get over it or that everything will be all right
- Act alone. Always reach out for support- "widen the net"

Appendix D

Coping Plan for a Student Expressing Risk of Suicide

The development of a Coping Plan is initiated by the School Social Worker with collaboration of the student, parents and caring staff adult depending on the age of the student. As much as possible, the student should have input into the development of the Coping Plan. With the student's knowledge it would be important to involve the parent/caregiver/designate in the Coping Plan.

The Principal or designate may be involved in developing the Coping Plan, particularly in elementary schools. At the secondary level, he or she might participate only if practical and if comfortable for the student. At minimum, the Coping Plan should be shared with Principal or designate to ensure that the school is able to offer the supports identified in the plan. The circumstances that lead a student to thoughts of suicide are not necessarily eliminated by one intervention. The process of developing coping strategies and ways to manage emotional distress working towards wellness can take some time.

The Coping Plan can bring a sense of structure, safety and comfort for the individual. It is an opportunity to make a concrete transparent plan that will help connect the individual to support and resources including Identified caring adults in the school, at home, community resources and supports. To ensure that the plan is supported at home it is important that the Coping Plan be shared with family or support person identified by the student.

School staff must be prepared as students experiencing risk of suicide return to school quickly. Resuming normal routines, being supported by peers and remaining in contact with caring adults who are aware of the situation and can monitor the student's safety can be helpful for students who are recovering from suicidal ideation.

Coping Plan (To be completed with a student and shared either on paper or electronically)

(with permission adapted from Sunnybrook Health Sciences)

This card is to help you identify what helps you cope. Everyone has their own way of coping so it is important that you try what you think might work for you. It may take some time and involve trying different ideas. There are some suggestions listed for most questions.
Be creative. Don't give up.

What are my warning signs?

- ☐ isolation
- ☐ grumpiness
- ☐ sleeping a lot
- ☐ not eating
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

What activities calm and comfort me?

- ☐ watch a movie
- ☐ exercise
- ☐ listen to or play music
- ☐ read
- ☐ play a game
- ☐ connect to someone
- ☐ play with a pet
- ☐ _____
- ☐ _____
- ☐ _____

What strengths can I use to help me right now?

- ☐ caring for other people
- ☐ hard working
- ☐ remembering my past successes
- ☐ focusing on one thing at a time
- ☐ _____
- ☐ _____

What skills can I learn to lower my distress?

- ☐ mindful practice
- ☐ deep breathing
- ☐ relaxing my body
- ☐ write in a journal
- ☐ _____
- ☐ _____

What did I do in the past that might be helpful now?

- ☐ call help line
- ☐ research coping strategies
- ☐ meeting with someone and talking
- ☐ _____
- ☐ _____

What do I want to add to my life?

- ☐ happiness
- ☐ fun
- ☐ friendship
- ☐ _____
- ☐ _____

Who can I contact for support i.e.: parent, teacher, coach, friend or… someone who I think will listen.

Who?_____

When?_____

How?_____

Who?_____

When?_____

How?_____

Who?_____

When?_____

How?_____

Appendix E

Guidelines for Return to School Plan

These guidelines will assist staff in preparing for student re-entry to school after a mental health crisis. In addition to maintaining contact and meeting regularly with the student, the caring adult facilitating the re-entry should do the following:

1. Become familiar with the basic information, including:
   - The student's strengths, supports, and resources
   - How the student's risk status was identified
   - What precipitated the high risk behaviour
   - If the student is currently taking medication(s) and what it is

2. Serve as primary link between home and school, with student/family consent:
   - Call or meet with family
   - Meet with student, family, and relevant school staff about what services or support the student will require at school
   - Facilitate referral for family or individual support outside school

3. Serve as liaison with teachers and staff members, with permission:
   - Educate teachers/staff about warning signs of a potential crisis
   - Meet with staff connected to the student to review re-entry plan
   - Explore academic concerns and options
   - Modify student's schedule or course load as required
   - Work with teachers to arrange make-up work or extensions without penalty
   - Monitor student's progress

4. Follow up on attendance concerns:
   - Discuss concerns and identify available supports with student
   - Meet with teachers to discuss needed supports and expectations
   - Consult with Professional Support Services staff, if appropriate. Student/family consent will be needed to do so.
   - Monitor daily attendance using sign-in or planned check-in procedures
   - Make home visits if needed to support attendance – this may be critical in first few weeks of returning to school

5. If student is hospitalized, obtain consent to speak with the Social Worker or teacher from the hospital regarding issues such as:
   - Delivery of class assignments and work
   - Attending treatment planning or discharge conference
   - Receive any plans or recommendations from hospital

Note that students are often admitted and discharged in less than a 3-day period. They often will have little or no information from the hospital. It would be ideal to have the Student/Family sign a consent form to have the hospital share information with the school Social Worker. Student and family should be encouraged to share what recommendations or school plan they have from the hospital, but re-entry plan must usually be created without additional information, in these situations.

Appendix F

Talking with Students about Suicide (Including Class-level)

Adapted from the Hamilton Wentworth District School Board
"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 problems, 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 Professional Support Services 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 that 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
Youth suicide is complex and is the result of many converging factors. 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 behaviour 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 behaviour
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
http://www.whatsupwalkin.ca/service-providers/; http://www.mentalhealthto.ca

Help Students Develop a List of Caring Adults in Their Lives
If suicide is raised in a classroom discussion, remind students that caring adults are available to support them. Parents, extended family members, and religious leaders can be a source of support and help. In the school there are Professional Support Services staff, Guidance staff, and Administration. Other school staff often play a crucial caring adult role with students. For example an Office Administrator, Caretaker or School Based Safety Monitor is frequently the supportive adult that students connect with on a daily basis. These relationships are paramount to a student feeling cared for and part of a community.

Remind students to **talk to an adult if concerned about a friend**. Assure students if a friend has expressed despair it is important to reach out and get help even if they may have to break confidentiality. When hopelessness is overwhelming it is important to expand the network of support.

Be Aware Of the Risks

- 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 individuals**. We never know what is in each student's "emotional" back pack. Their experiences, life situations and challenges all play into how they may respond to any situation.

- Discussing the means of how someone died by suicide **increases risk** for vulnerable individuals.

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

- 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 important to focus on positive mental health and coping strategies along with the importance of help seeking behaviours.

- Talking 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 that 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.

- 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) educators can consult with the School Social Worker regarding appropriate responses. It is important that educators talk about ways of healthy coping, and where to get help when students or their peers are struggling.

Students Online and Social Media

Increasingly there are a variety of mediums such as websites, chat rooms and blogs that promote suicidal ideation. Students can access content regarding suicide ideation which may increase their vulnerabilities. It is not recommended that students view stories or videos about suicide for school projects or in class.

The rapid spread of rumours and details of deaths by suicide on social media is often difficult to manage.

Social media may also hold potential benefits for suicide prevention intervention and postvention. **Our focus is on information which strengthens coping strategies, instills hope and reinforces resiliency. Information which decreases stigma and encourages help-seeking through trusted, caring adults is reinforced**.

It is important to providing grade/age appropriate information which focus on positive coping strategies and help-seeking.

Appendix G

Administrator's Guide - Immediately Following a Death by Suicide

A. Immediate Response (beginning within first few hours of the news of someone's death)

- The principal or designate will ensure that the Superintendent of Education is advised and in turn will contact the Learning Centre Executive Superintendent.
- Contact the Manager of Social Work and Attendance to activate the Crisis Response Team (begin to pull together as much information as possible regarding the student).
- If information is not received directly from the family, contact the family to 'confirm' nature of death and level of information to be shared with the school community. (Reconnect immediately with the Superintendent of Education if the family suggests a connection between the school and the 'reason' for the death).
- If possible give advance notice to staff that an individual died from suicide e.g. if information is known in the evening or on the weekend develop method to inform staff to allow them time to process the information
- Invite all staff to an emergency staff meeting to discuss further details, available supports and next steps. Connect with TDSB Government, Public and Community Relations (Communications) Department regarding sending a letter home. Contact the teachers, guidance counsellor, and any other staff (e.g. coach, EA, etc.) who taught or worked with the student and his/her siblings. If possible speak with them in person prior to meeting as a group.
- Adjust the attendance register to ensure 'absence' phone calls are not sent home to the parents of the deceased.
- Connect with Superintendent of Education to discuss immediate response

B. Subsequent Response (within 24 hours of the news of the death)

The principal or designate will:

- Ask caretakers to lower the school flag (as outlined in **PR 682 Flag Protocol**).
- Arrange for staff meeting to share information with ALL staff (be certain to include all staff from the school i.e. caretakers, office assistants, educational assistants etc.) Introduce the Crisis Response Team
- Share plan of how information will be shared with students and the school community
- Organize a space in the school for the Crisis Response Team (order food, and drinks and tissue) to work and meet with students, teachers and parents (if applicable).
- Begin to identify vulnerable students that need immediate support. Encourage staff to indicate to administration if they are concerned about particular students are especially vulnerable at this time.
- Connect with Government, Public and Community Relations (Communications) Department to develop a media plan with your Superintendent of Education.

Resources to Assist with Postvention

https://smh-assist.ca/blog/mental-health-literacy-for-educators-helping-children-and-youth-after-tragic-events/

https://www.mentalhealthcommission.ca/English/initiatives/11889/tool-kit-survivors-suicide-loss-and-postvention-professionals

http://www.sprc.org/resources-programs/after-suicide-toolkit-schools

Appendix H

Debrief of Incident

Principal (or designate) will schedule a meeting to debrief the intervention within two weeks of the incident. The purpose of the meeting is to ensure that appropriate supports are in place for staff, students and their families and to discuss next steps. The Debriefing is meant to include those who were most directly involved in the intervention.

The following questions may be used to guide the Debriefing:

- Start with a check-in with everyone in the room.
  How is everyone doing?

- Is there additional follow-up required with the parent/guardian/support person?

- Was the Coping Plan that was developed helpful for the student/family and school staff?
  Are there changes that need to be made to the Coping Plan?

- What enhancements/changes could be made to our school Well-Being plan to create and support a culture of positive mental health and well-being?

- What have we learned from the incident?

- Is there any additional follow-up that needs to occur since the incident occurred?

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