# Brant Suicide Prevention Protocol

## Purpose

Suicide is a collective issue that requires collaborative efforts to create effective solutions. Stakeholders recognize that safety from suicide rests on our ability to ask and talk about suicide openly, that conversations about suicide are encouraged and will be met with compassionate, non-judgmental and informed responses.

The purpose of the Suicide Prevention Protocol is to reduce the incidence and impact of suicide by facilitating regular open conversations about suicide to improve coordination and integration of services, practices and planning related to suicide prevention, intervention and postvention.

Through collaborative efforts, the Brant community will:

- promote well-being;
- reduce stigma related to mental health and suicide;
- increase suicide alertness through training opportunities;
- consider best practices for service development and service changes;
- advocate for positive changes to modifiable risk factors;
- develop a common understanding of available resources;
- identify clear pathways to services

For information on community resources and pathways, **refer to:**

- Appendix 1, **Primary Pathways to Suicide Care** and
- Appendix 2, **Community Support Services.**

Note: *Together to Live, Centre of Excellence* and *Suicide Safer Communities, Living Works* websites were used in the development of revisions to this Protocol.

## Background/Rationale

In 2013 – 2014, MCYS implemented a 3 year Youth Suicide Prevention Program and supported communities with funding to further suicide prevention. Contact Brant received the funding for three years on behalf of the Brant community. The Brant Children and Youth Services Committee led this initiative, and with the former Mental Health and Suicide Awareness Committee, created a Suicide Prevention Committee.

The Brant Suicide Prevention Committee collaborated with Haldimand and Norfolk to develop *a Brant, Haldimand Norfolk Youth Suicide Prevention, Intervention and Postvention Protocol* (September 2014), authored by David Diegel. The Protocol included a great deal of research information, and formed and strong base for this revised *Brant Suicide Prevention Protocol*.

Warning signs and risk factors for individuals who may be contemplating suicide can differ by culture. Stakeholders' attitudes about suicide and their role in prevention can also be affected by culture.

In Canada, suicide is the second leading cause of non-accidental death among children and youth. Although the original focus was children and youth, the Brant Suicide Prevention Committee and this revised Protocol address children, youth and adults.

# Table of Contents

## Brant Suicide Prevention Protocol

## Guiding Principles

1. Well-being and resiliency, suicide prevention, suicide intervention and suicide postvention are everyone's responsibility.
2. Suicidality is an interaction of multiple factors including biological, psychological and social components. Risk factors and protective factors are important considerations.
3. A caring community culture is important in creating a suicide safer community. Brant stakeholders will:
    - Promote inclusivity and respect for differences, including race, religion, gender, and sexual identity.
    - Support early identification and pathways to service; and
    - Engage children, youth, families and adults to be actively involved in the development of initiatives and programming to support a caring community.
4. Stakeholders will work towards meeting and attaining a Suicide Safer Community designation.
5. Brant is a distinctive community with unique factors influencing child/youth and adult suicide rates, overall mental health issues and service delivery.
6. Brant service providers will respect the different mandates, philosophies and legislative responsibilities that are integral to each organization delivering services.

## Commitments by Stakeholders

1. Participate in planning, coordination, implementation and evaluation of community mobilization of wellness and resiliency, suicide prevention, suicide intervention and suicide postvention through such avenues as the Suicide Prevention Committee or Children and Youth Services Committee.
2. Integrate internal organizational planning regarding suicide prevention with community stakeholders on a regular and consistent basis so as to not overlap or contradict in terms of messaging or activities.
3. Share and coordinate opportunities for staff development in suicide awareness and mental health awareness, and include broader stakeholders wherever possible (e.g., families, youth, volunteers, etc.)
4. Respect that the various service providers working with children, youth and adults have different mandates, philosophies and legislative responsibilities that are integral to the ability of each sector to deliver services.
5. Commit to provide and develop programs that are based on current Best Practices; evaluate and adapt services based on evidence.
6. Support and implement this Protocol to create a suicide safer community.
7. Be engaged with individuals, organizations and stakeholders to collaboratively strategize, create, implement, and sustain efforts re a Suicide Safer Community through addressing the 9 pillars: Leadership/Steering Committee; Background Summary; Suicide Prevention Awareness; Mental

Health and Wellness Promotion; Training; Suicide Intervention and On-going Clinical/Support Services; Suicide Bereavement; Evaluation Measures; and Capacity Building/Sustainability.

## Practice Guidelines

Wellness and resiliency, suicide prevention, suicide intervention and suicide postvention services are a continuum of supports. Coordination by community stakeholders will ensure Brant has a continuum of supports. Identification of risk and protective factors for suicide is important in supporting individuals and in community planning.

1. **Wellness and Resiliency**

   Brant has recognized the importance of services that promote mental wellness and build resiliency by educating and supporting the development of good coping and mental well-being skills. This can keep an individual from requiring further services.

   Life promotion is based on the belief that everyone is capable of finding their own path to a holistic and meaningful life; it sets the goal of helping people find that place where they're able to flourish despite the challenges they face. It honours individuality and builds resilience through an individual's personal strengths, available resources and relationships with those around them.

   - **On the continuum of suicide prevention planning and services, Brant will attempt to serve as many community stakeholders as possible at the wellness and prevention end of the continuum through educational opportunities and promotion.**
   - **Brant stakeholders will collaboratively work together to educate and promote resilience and protective factors that sustain well-being and support positive mental health therefore reducing the risk of suicide.**
     Refer to Appendix 3 – Risk and Protective Factors.
   - **Brant stakeholders will collaboratively work together to ensure consistent messaging, and promote wellness and resiliency.**

2. **Prevention**

   Early identification and treatment of mental health is the most effective method for the prevention of suicide.

   Prevention programs offer learning strategies to reduce and prepare for the possibility of suicidal thoughts and behaviours, and work to increase protective factors.

   Universal Prevention targets all community stakeholders (children/youth and their parents, adults and professionals) aims to reduce suicide risk by improving the physical, mental, emotional, and spiritual health and well-being of the community.

   Selective Prevention targets those who show suicide risk factors (e.g., mood, anxiety, substance use, history of maltreatment, etc.) and focuses on

screening and prevention activities. Teaching adaptive skills are aimed at reducing known risks of suicide.

Targeted Prevention, for those showing signs of high suicide risk (suicidal thoughts, severe depressive symptoms, etc.), aims to reduce risk factors and increase protective factors that decrease the chance of suicide.

- **Brant will consider the influence of factors such as cultural heritage and values, community resources and support networks that impact and shape one's mental health.**
- **Brant will collaboratively work together to ensure consistent messaging, as well as plan and coordinate prevention services.**

**3. Intervention**

Suicide intervention refers to direct services and supports to prevent a person from attempting to take their own life intentionally.

Specialized treatment is aimed at individuals at risk of mental health issues and/or diagnosed with mental health issues, including those in acute mental health crisis where a suicide attempt may have been made. Connection to evidence-based mental health treatment in a timely manner is critical, as well as crisis/emergency response. Clear pathways to treatment services are needed to ensure that a person is connected to appropriate services and supports. Refer to Appendix 1, Primary Pathways to Suicide Care.

Suicide awareness programs teach people to recognize the warning signs indicating that an individual may be at risk for suicide and how to respond, including that the person should not be left alone. Community mental health partners assess suicide risk in an individual and provide treatment intervention.

Note regarding Non-Suicidal Self-Injury:
Self-injury, self-mutilation or deliberate self-harm is defined as intentionally and often repetitively inflicting bodily harm to oneself without the intent to die (e.g., cutting, burning, head banging, picking or interfering with healing of wounds, hair pulling). The relationship between self-injury and suicide is complicated. Research indicates self-injury is behaviour separate and distinct from suicide; however, the self-destructive nature of self-injury may lead to suicide. Individuals who injure themselves intentionally are to be taken seriously and should be connected to mental health professionals.

- **Threats to self-harm and suicidal behaviour must be taken seriously every time.**
  **Consider:**
  - Any suicide ideation or attempt
    Note: A prior suicide attempt is the strongest predictor of suicide.
  - Verbal or written threats to suicide
  - Internet, social media or blog messages to suicide
  - A plan and/or means to carry out a suicide attempt

- Change in behaviour (withdrawal, loss of interest in activities, abuse of alcohol/drugs, reckless behaviour, self-injury, lack of interest in personal appearance, disturbed sleep, change of loss of appetite/weight, complaints on physical health, giving away items of significance, change in performance)
- Change in feelings (hopeless, desperate, angry, worthless, lonely, sad, helplessness, statements that 'no one can do anything to help now/can't do anything right/wishing they were dead')

➢ **Involved professionals should help each individual develop a Safety Plan that identifies situational changes that disable the difficult situation and plan, personal strengths to build on, and a support network and emergency contact(s).**

Note: The *Be Safe* phone app may be useful in developing a Safety Plan, especially for young people, available at mindyourmind.ca/besafe - Brant.
Also refer to the *Community Safety Plan Protocol*, available through Contact Brant's website, www.contactbrant.net.

➢ **Following a suicide attempt, a follow-up meeting with the individual, family and involved professional may be required to plan transition back to home/school/work/community life and review the individual's suicide Safety Plan to ensure appropriate supports are in place.**

➢ **Recognize the risk alerts or invitations of suicide. "Talk about it!"**
Recognizing and responding to individuals with suicidal ideation or behaviour in order to prevent thoughts from becoming acts is important. The ability to identify at-risk individuals and help them find the appropriate services and supports is key. A person almost always signals to others that they are struggling.

**To this end, Brant partners will coordinate and promote suicide alertness training for all community members** (e.g., SafeTALK, ASIST, ASK, Suicide to Hope)

➢ **For those not trained in suicide prevention, connect the individual immediately to someone that is a trained suicide alert helper or emergency response services (e.g., 911).**

➢ **For those trained in suicide prevention, identify individuals who may be at risk of suicide, verify this risk by talking to the individual, and connect the individual to required supports (e.g., mental health services, hospital, Integrated Crisis Response).**

➢ **Support a person at imminent risk of suicide safe until appropriate help can be found (e.g., stay with them, call for help) while maintaining your own safety.**

- **Brant will collaboratively work together to ensure consistent messaging, as well as plan and coordinate intervention services.**

**4. Postvention**

Programs, services and intervention for survivors following a death by suicide assist in alleviating the emotional distress and help prevent suicide contagion. It's estimated that for every suicide victim, there are between 6 and 28 individuals, including family and friends, who are directly affected by the death; in a school setting, the reach of a suicide can be even greater. Individuals impacted by suicide are at risk of post-traumatic stress disorder, depression, suicidal thoughts, substance abuse and a worsening of pre-existing conduct problems.

Postvention strategies for those impacted by suicide should be based on four principles: support, learn, counsel and educate.

Friends and family of the deceased will experience the most acute loss and will require ongoing support. They may experience conflicting emotions such as feelings of loss, guilt, rejection, and betrayal, making it difficult to focus on their regular activities, as well as have an increased sense of vulnerability. They should be at the centre of postvention efforts.

- **Utilize the community resources to make referrals to appropriate services. Grieving is an important part of healing and provides an opportunity to learn how to cope with loss.**
- **Ensure professionals involved with the individual are also supported as this is a loss for them as well.**
- **Use common language "died by suicide" rather than 'committed suicide'.**
- **Emphasize coping and community resources. Avoid glorification of the individual or the means of death, or that the death was caused by a specific problem (e.g., relationship breakup, failure, etc.)**
- **Postvention is the first step to continued prevention. Postvention services and community planning should aim to prevent future suicidal acts and reduce the incidence of suicide contagion.**
  - **Involved stakeholders should debrief with each other following supports offered after a death by suicide.**
  - **The Suicide Prevention Committee should consider systemic issues including ways to decrease the risk factors and coordinated response gaps/pressures.**
  - **Reporting guidelines should be shared with local media, and media should be encouraged to use these guidelines to prevent contagion and further harm.** (Refer to Appendix 3)
- **Brant will collaboratively work together to ensure consistent messaging, as well as plan and coordinate postvention services.**

## 5. Risk Factors

There are predisposing, contributing and precipitating factors for suicide. A combination of individual, relational, community, and societal factors contribute to the risk of suicide. Risk factors are characteristics associated with suicide but are not direct causes. Refer to Appendix 3, Risk and Protective Factors.

Risk factors can be classified as Biopsychosocial, Environmental, or Social/Cultural, and may include the following:

- Family history of suicide
- History of trauma and abuse
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Chronic illness
- Easy access to lethal methods
- Difficulty seeking help because of the stigma attached to suicide, mental health, and substance abuse disorders.

➢ **Brant will work collaboratively to identify significant risk factors at both the individual and community level, and coordinate plans to reduce these risk factors wherever possible.**

## 6. Protective Factors

Protective factors buffer individuals from suicidal thoughts and behaviour.

Protective factors may include the following:

- Coping skills; skills in problem solving, conflict resolution, and anger management
- Resiliency
- Strong connections to friends, family, and supportive significant others
- Good health and access to housing and physical health care
- Access to a variety of clinical interventions and support for help seeking; effective clinical care for mental health and substance abuse disorders

- A sense of the importance of health and wellness
- Strong sense of self-worth or self-esteem
- Sense of personal control or determination
- Strong cultural identity or spiritual beliefs
- Hope for the future; optimism
- Sobriety

➢ **Brant will work collaboratively to identify protective factors at both the individual and community level, and coordinate plans to increase these protective factors wherever possible.**

## Information Sharing Guidelines

Each organization will have their own policies and legislative requirements regarding the collection, use and disclosure of personal information. Information sharing is important to support individuals in a coordinated service plan and connect them to appropriate services. Information can be shared with informed consent. **Legislation identifies that information can be shared if there is imminent risk of harm to self or others.**

Consent to disclose personal information should be obtained, when and as required by applicable law. Valid consent does not exist unless the individual knows what they are consenting to, understands the consequences of the intended disclosure, and is aware that they can withdraw consent at any time by giving written or verbal notice. When gathering consent, it can be in written format or received verbally and appropriately documented.

The general intent of legislation regarding accessing/sharing information and protecting privacy is to regulate the collection, use and disclosure of personal information:

- Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA) allow the release of personal information to appropriate partners **if there is imminent threat of harm (health and safety) to self or others**.
- PHIPA defines this further if the professional "believes on reasonable grounds that the disclosure is necessary **for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons**."
- The Child and Family Services Act states that relevant personal information can be shared without consent to **report a child who might be in need of protection**, i.e., to the Brant Family and Children's Services (FACS).
- The Youth Criminal Justice Act (YCJA) enables information in a Youth Criminal Justice Act record to be shared, without consent within the access period, with any professional or other person engaged in the supervision or care of a young person **to ensure the safety of staff, child/youth or others, to facilitate rehabilitation/reintegration of the young person, or**

**to ensure compliance with a youth justice court order** or any order of the provincial director respecting reintegration leave.

The Grand Erie District School Board's *A School and Community Threat/Risk Assessment Protocol,* **summarizes how and when information can be shared, reflecting how safety trumps privacy**:

| Green Light | Yellow Light | Red Light |
|---|---|---|
| Generally speaking, pursuant to freedom of information and privacy acts, relevant personal information CAN be shared under one or more of the following circumstances:<br><br>• with written consent<br>• to avert or minimize imminent danger to the health and safety of any person<br>• to report a child who might need protection under the Child and Family Services Act<br>• by order of the court<br>• to facilitate the rehabilitation of a young person under the Youth Criminal Justice Act<br>• to ensure the safety of students and/or staff under the YCJA<br>• to cooperate with a police and/or child protection investigation | Obtain more information and/or get advice from a supervisor or privacy officer:<br><br>• consent is not provided or is refused but where there may be a health or safety issue for any individual or group(s)<br>• to report criminal activity to the police<br>• to disclose records<br>• where there is a demand or request to produce information for a legal proceeding<br>• when a professional code of ethics may limit disclosure | Information can NEVER be shared under any of the following circumstances:<br><br>• there is a legislative requirement barring disclosure<br>• no consent is given and there is no need to know or overriding health/safety concerns<br>• consent is given but there is no need to know or overriding health/safety concerns |

## Accountability

- **The Suicide Prevention Committee will monitor and report to the community on outcomes regarding this strategy's implementation.**

- **The Suicide Prevention Committee will annually review the Suicide Prevention Protocol and make any recommendations to the Children and Youth Services Committee.**

- **The Children and Youth Services Committee will annually review the Suicide Prevention Protocol and encourage other planning tables to review the Protocol.**

- **Collectively, all member agencies of the Suicide Prevention Committee and the Children and Youth Services Committee will ensure staff in their organization are oriented annually to the Protocol, and will be accountable to each other for this coordinated approach to suicide prevention.**

# Primary Pathways to Suicide Care

Appendix 1

**EMERGENCY**

**SUICIDE ATTEMPT**

Call **911**

**Go to:** Hospital Emergency Department
Brant Community Healthcare System (Brantford General)
225 St. Paul Ave., Brantford, ON, N3R 5Z3

**SUICIDE PLAN**

**SUICIDE IDEATION**

**MENTAL HEALTH CRISIS**

Call **911**

**Brant Crisis Line:** **519-759-7188** or **1-866-811-7188**
(Child/Youth/Adult)

**Six Nations Crisis Line:** **1-800-445-2204**

**Walk-in Mental Health Clinic:** (Child/Youth/Adult)
St. Leonard's Community Services
225 Fairview Drive, Brantford
11:00 a.m. to 8:00 p.m. - 7 days a week

**MENTAL HEALTH CONCERN**

**SUICIDAL IDEATION**

**SUICIDE PLAN**

**Contact Brant** **519-758-8228**
(ages 0 – 18)

**Walk-in Mental Health Clinic:** (Child/Youth/Adult)
St. Leonard's Community Services
225 Fairview Drive, Brantford
11:00 a.m. to 8:00 p.m. - 7 days a week

**SUICIDE OR MENTAL HEALTH**

- **PREVENTION**
- **INFORMATION**
- **TRAINING**

| | |
|---|---|
| **Contact Brant** | 519-758-8228 |
| **Woodview Mental Health and Autism Services** | 519-752-5308 |
| **St. Leonard's Community Services** | 519-754-0253 |
| **Grand Erie District School Board** | 519-754-1606 ext. 287210 |
| **Brant Haldimand Norfolk Catholic District School Board** | 519-756-6505 ext. 413 |
| **Canadian Mental Health Association** (CMHA) | 519-752-2998 |

# Community Support Services

Appendix 2

| Service Provider | Description | Contact Information |
|---|---|---|
| **Aboriginal Health Centre De Dwa Da Dehs Nye>s** | Culturally appropriate preventative and primary health care for aboriginal people. | 519-752-4340 |
| **Brant County Health Unit** | Healthy living and safety services, including school support services | 519-753-4937 |
| **Brant Family and Children's Services (FACS)** | Parenting support to families; Family Resource Centres; Child protection services. | 519-753-8681 |
| **Brant Native Housing** | Support services and subsidized housing for native families | 519-756-2205 |
| **City of Brantford Social Services** | Financial assistance through Ontario Works; Subsidized housing through Housing Dept. | 519-759-7009<br>519-759-3330 |
| **Community Legal Clinic** | Legal information and legal representation. | 519-752-8669 |
| **Contact Brant** | Access for children's mental health and developmental services including Autism; call for information, intake/referral, & service coordination | 519-758-8228 |
| **Family Counselling Centre of Brant** | Counselling and support for families and children | 519-753-4137 |
| **Grand River Community Health Centre** | Primary health care and social work supports for vulnerable community members | 519-754-0777 |
| **Nova Vita Domestic Violence** | 24 hour crisis line. Safe, emergency shelter for women and children. Counselling and safety plan assistance. Group counselling for men | 519-752-HELP<br><br>519-752-4357 |
| **Ontario Disability Support Program** | Long term financial assistance | 1-866-729-2228 |
| **Sexual Assault Centre** | 24 hour crisis line and ongoing support and counselling | 519-751-3471 |
| **Brant Haldimand Norfolk Catholic District School Board (BHNCDSB)** | Student support services;<br>Mental Health Lead | 519-756-6505 |
| **Grand Erie District School Board (GEDSB)** | Student support services;<br>Mental Health Lead | 519-756-6301 |
| **Conseil scolaire de district catholique Centre-Sud** | Support services; Sainte-Marguerite-Bourgeoys is the local French Catholic school | 519-756-4750 |
| **St. Leonard's Community Services** | Immediate crisis support and/or counselling for individuals experiencing an addictions, mental health or situational crisis. | 519-759-7188<br>24/7 crisis support |
| **Victim Services of Brant** | Emotional support to victims and survivors. Practical assistance via accompaniment to appointments and court. | 519-752-3140. After hours call 519-756-7050 |
| **Woodview Mental Health and Autism Services** | Counselling for children and youth age 0 – 18, and their families.<br>Referrals are made through Contact Brant. | 519-752-5308<br>For referrals:<br>519-758-8228 |
| **YMCA Employment, Education and Immigrant Services** | Immigrant services that support successful settlement and integration into the community; literacy and basic skills programs. | 519-752-4568 |

# KEY MESSAGES FOR MEDIA

From the **Youth Suicide Prevention: School Board Leadership Package** by School Mental Health – ASSIST Summer 2013; Page 71, Appendix 6: Media reporting guidelines (From the Canadian Association for Suicide Prevention)

## Media Guidelines

News stories, articles, and dramatic presentations on the subject of suicide have come under question in the last few years. The concern has been that such presentations may have stimulated some persons to attempt suicide. There is confusion about how the subject of suicide should be treated to minimize this danger.

As a service to the news media and to the people making public presentation on the subject of suicide, the American Association of Suicidology and the Canadian Association for Suicide Prevention (CASP) offer the following guidelines. These are intended to be general statements to aid in a responsible presentation of information about suicide.

To **discourage imitative or copycat suicides,** it is important to **avoid or minimize**:

- Reporting specific details of the method
- Descriptions of a suicide as unexplainable e.g., “He had everything going for him.”
- Reporting romanticized versions of the reasons for the suicide(s), e.g., “We want to be together for all eternity.”
- Simplistic reasons for the suicide, e.g., “Boy commits suicide because he has to wear braces.”

In addition, the print media can reduce the imitative effect by:

- Printing story on **inside page**
- If story must appear on first page, print it **below the fold**
- Avoid the word “suicide” in the **headline**
- Avoid printing a **photo** of the person who committed suicide

It is important to report a suicide in a **straightforward** manner so that the suicide does not appear exciting. Reports should not make the suicidal person appear admirable, nor should they seem to approve of the suicide.

To encourage prevention of suicide, it is helpful to:

- Present **alternatives** to suicide, e.g., calling a suicide prevention centre, getting counselling, etc.
- Whenever possible, present examples of **positive outcomes** of people in suicidal crises.
- Provide information on community **resources** for those who may be suicidal or who know people who are.
- Include a list of **clues** to suicidal behavior, for example, the warning signs of suicide and what to do:

**Warning Signs of Suicide**

- Suicide threats
- Statements revealing a desire to die
- Previous suicide attempts
- Sudden changes in behaviour (withdrawal, apathy, moodiness)
- Depression (crying, sleeplessness, loss of appetite, hopelessness)
- Final arrangements (such as giving away personal possessions)

**What to Do**

- Discuss it **openly** and frankly
- Show **interest** and **support**
- Get professional help
- Call your local Crisis/Distress Line

Guidelines for Public Awareness and Education Activities

**Definitions** Appendix 4

| | |
|---|---|
| Suicide | Intentional, self-inflicted death |
| Suicide attempt | Any non-fatal, self-inflicted action taken with the intention of killing oneself, regardless of lethality. |
| Suicidal Gesture | Any behaviour or action that might be–or might have been, in the case of successful completion thereof–interpreted as indicating a person's desire or intent to commit suicide |
| Suicide ideation | Thoughts, images or fantasies of harming or killing oneself |
| Suicidality/suicidal behaviours | All aspects of suicidal thoughts, behaviours and actions, including death |
| Self-Harm (Non-suicidal self-injury) | Behaviours which involve the deliberate destruction of body tissue, which are not socially sanctioned, and which take place in the absence of an intention to die. This includes things such as “cutting” |
| Prevention | Efforts to reduce the risk of suicidal thoughts or behaviours, and ultimately death by suicide. |
| Universal programs | Efforts that target everyone regardless of their level of risk |
| Targeted prevention | Efforts that target a group we know for whatever reason is at higher risk (e.g., targeting those with a previous attempt, those with mental illness for early identification and intervention |
| Intervention | a direct effort to prevent person(s) from attempting to take their own life intentionally |
| Postvention | An intervention strategy aimed at attending to the needs of those who require assistance after a suicide. |
| Cluster or Contagion | Multiple suicides within a defined geographical area and falling within an accelerated time frame may represent a cluster. Sometimes they happen because of a statistical anomaly |
| Died by suicide, death by suicide | Non-judgemental, preferred terms to describe a death by suicide |

## Some Resources for More Information

Appendix 5

**Bereaved Families of Ontario -** 905-318-0070; www.bfo-hamiltonburlington.on.ca

**Be Safe -** free phone app; helps develop a Safety Plan; mindyourmind.ca/besafe - Select Region: Brant

**Canadian Mental Health Association Brant** – Education and support services for persons with serious mental illness and their families; 519-752-2998
www.brant.cmha.ca

**Centre of Excellence** – Together to Live offers a tool kit for addressing youth suicide
http://www.togethertolive.ca

**Centre for Suicide Prevention** - http://suicideinfo.ca

**Community Information Database Brant Haldimand Norfolk**
www.info-bhn.ca or call: 2-1-1 any time/365 days per year

**Contact Brant** – connection to services for children and youth ages 0 – 18; information on community resources and suicide prevention training (ASIST, SafeTALK, ASK)
www.contactbrant.net; 519-758-8228

**Hopemore** – for information on local resources www.hopemore.ca

**Kids Help Phone Line** – 24/7 service: 1-800-668-6868; www.kidshelpphone.ca

**Living Works** - Train-the-Trainer: ASIST, SafeTALK, ASK; Suicide Safer Communities
www.livingworks.net; www.livingworks.net/community/suicide-safer-communities

**Mind Your Mind** - http://www.mindyourmind.ca

**Parents for Children's Mental Health** - building the capacity of families raising children/youth with mental health illness to advocate for/access mental health services
www.pcmh.ca

**St. Leonard's Community Services** – Integrated Crisis Services 519-759-7188 or 1-866-811-7188; Walk-in Mental Health & Addictions Clinic, 225 Fairview Drive
www.st-leonards.com

**Woodview Mental Health and Autism Services** – Children's Mental Health Lead Agency offers a broad spectrum of services for children, youth (ages 0 – 18) and their families facing mental health challenges. Call Contact Brant for referrals: 519-758-8228
www.woodview.ca

***Your Guide*** Brant – a publication 3 times annually listing workshops, courses, groups and events that are free for children, youth and their families.
www.contactbrant.net/yourguide

The following is taken from the 2014 Suicide Prevention Protocol.

## Demographics

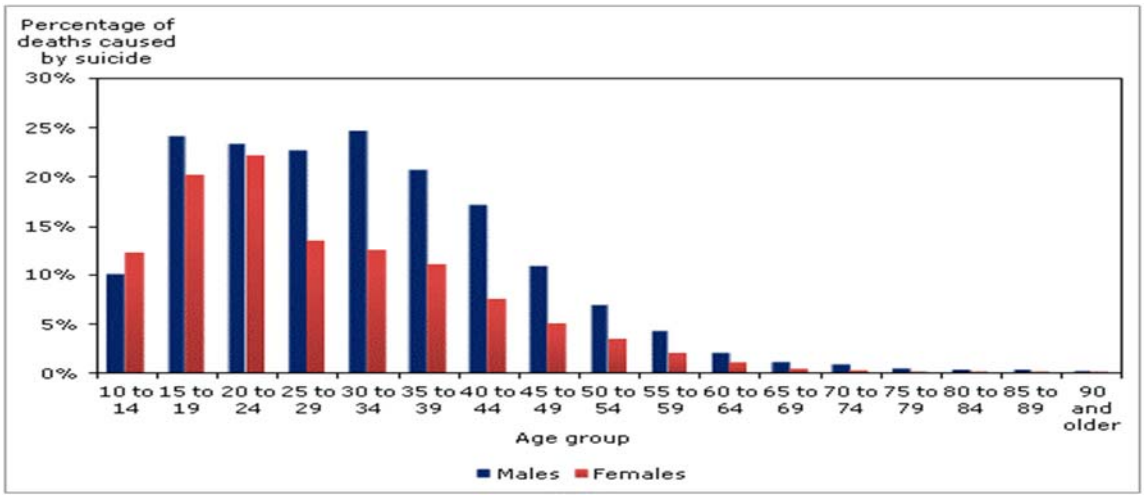
Complete community profiles for Brant can be found at:
http://www.brantford.ca/Community%20Profile/2011-Vol1-CommunityProfile.pdf

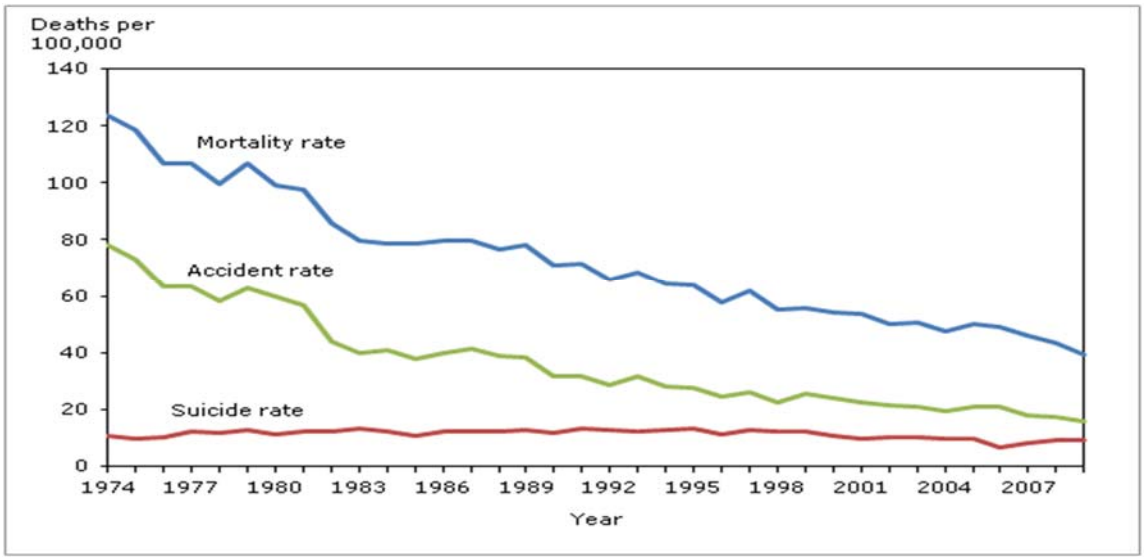
| | Brantford/ Brant County | | Ontario | |
|---|---|---|---|---|
| Characteristics | | % total | | % total |
| Total population by age groups | 135,500 | | 12,851,820 | |
| **0-9 years** | 15,945 | 11.8 | 1,417,015 | 11.0 |
| **10 to 14 years** | 8,565 | 6.3 | 763,755 | 5.9 |
| **15 to 19 years** | 9,430 | 7.0 | 863,635 | 6.7 |
| **20 to 24 years** | 8,385 | 6.2 | 852,905 | 6.6 |
| **25-39 years** | 24,295 | 17.9 | 2,459,815 | 19.1 |
| **40-64 years** | 48,270 | 35.6 | 4,616,370 | 35.9 |
| **65+ years** | 20,615 | 15.2 | 1,878,325 | 14.6 |
| Median age | 40.6 | | 40.4 | |

## Suicide Rates

As of 2009 suicide represented the second leading cause of death among youth ages 15-19. The leading cause of death was accidents. Since 1974 the suicide rate for youth has remained relatively stable at about 10 per 100,000. In 2009 there were 202 individuals ages 15 – 19 who died by suicide. This represented about 23% of all deaths in this age group.

While it may appear that there has been a major increase in the number of youth suicides this is not the case. What has happened is that the number of accidental deaths has dropped dramatically as reflected by a drop in the mortality rate for this group. In 1974 the mortality rate by accident was 78.17 per 100,000 and by 2009 the rate was 15.99/100,000. The overall mortality rate was 123.54 per 100,000 in 1974 and was 39.45 in 2009. As a result, in 1974, 9% of deaths of youths were as a result of suicide and by 2009 this had grown to 23%, while the overall number of deaths by suicide remained constant. (Stats Can, Catalogue 82-624-X)




Based on the suicide rates for Canada (Source: Statistics Canada, CANSIM, table 102-0551) the number of suicides among children/youth in Brant is low, estimated at one per year. However, it is often discussed that there is an under reporting of self-harm cases by hospitals. In a review of records from a Canadian teaching hospital found that deliberate self-harm was under-recorded by 63% in data for self-poisoning. (Admissions Component of Statistics Canada Catalogue no. 82-003-X Health Reports). The under reporting of these cases reduces the awareness of the scope of the issue.

| | Total | Male | Female |
|---|---|---|---|
| **2011 Brant Population** | | | |
| Total Population | 136,035 | 66035 | 70000 |
| 10-14 | 8615 | 4430 | 4185 |
| 15-19 | 9480 | 4735 | 4745 |
| | | | |

| Suicide Rates All Canada per 100,000 | | | |
|---|---|---|---|
| All ages | 10.8 | 16.3 | 5.4 |
| 10-14 | 1.5 | 1.2 | 1.8 |
| 15-19 | 9 | 12.5 | 5.4 |
| **Estimated Suicides Brant - based on 2011 Census data** | | | |
| All ages | 14.7 | 7.1 | 7.6 |
| 10-14 | 0.9 | 0.5 | 0.5 |
| 15-19 | 1.0 | 0.5 | 0.5 |

Statistics provided by Office of the Chief Coroner, Ontario Forensic Pathology Service:

**Number of Suicide Deaths in Ontario vs. Other Areas**

| Year | Ontario | Hamilton | Niagara County | Haldimand Norfolk | Brant |
|---|---|---|---|---|---|
| 2005 | 1151 | 51 | 65 | 12 | 21 |
| 2006 | 1109 | 36 | 42 | 14 | 10 |
| 2007 | 1123 | 49 | 49 | 10 | 20 |
| 2008 | 1079 | 52 | 45 | 9 | 17 |
| 2009 | 1238 | 70 | 50 | 13 | 5 |
| 2010 | 1215 | 47 | 33 | 7 | 23 |
| 2011 | 1222 | 47 | 65 | 10 | 10 |
| 2012 | 1243 | 48 | 47 | 10 | 12 |
| 2013 | 1300 | 71 | 52 | 13 | 19 |
| 2014 | 1324 | 54 | 64 | 19 | 15 |

## Factors that Impact Suicide

Perhaps the single most important predictor of suicide among youth is depression. Over half of children and teens who suffer from depression will eventually attempt suicide at least once (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001). Depression is one of the most consistent predictors of suicidal thoughts, attempts, and deaths by suicide in both young males and females (Eskin et al., 2007, Gröholt et.al. 2000; Thompson et. al 2005).

Previous suicidal behaviour is also a predictor of suicide or suicidal behaviour. Youth who have a history of suicide attempts, planning and/or rehearsal are at significant risk for further suicidal behaviour. (BC Ministry of Children and Family Development, 2013)

Approximately one quarter of Canadian youth aged 13 to 18 have seriously contemplated suicide at some point in their lives (Manion & Lee, 2004). For every youth who has seriously considers suicide, approximately one half go on to make a suicide attempt (Suicide Prevention Resource Centre,2006).

Gender is also a key predictor of suicide risk among youth. While females are more likely to contemplate suicide (suicide ideation) males are more likely to die by suicide. In Canada it is estimated that girls between the ages of 15 and 19 were three times as likely to have suicidal ideation as young males (Cheung, 2006). However, young males (ages 15-19) have a suicide rate of 12.5 per 100,000 compared to females 5.4 per 100,000.

With regard to gender, female youth report more difficulties addressing stress than males, which tends to be associated with higher levels of depression and attempted suicide in females (L. Armstrong, 2011).

Research has identified that health harming behaviours are a significant risk factor for suicidal ideation. These behaviours include activities such as smoking, substance abuse, restrictive eating, binging or purging, physical fighting and risky sexual behaviour. (Afifi, Cox, & Katz, 2007; Becker & Grilo, 2007; Hallfors et al., 2004; Stein et. al. 2004; Watt & Sharp, 2001).

Risk taking behaviours are also an indicator of increased suicide risk. Alcohol abuse and binge drinking are associated with increased acute suicide risk (Stoelb & Chiriboga, 1998). Long-term illegal drug use has also been shown to be associated with recurring suicide ideation (Hallfors et al., 2004) and thus an increased risk of suicide.

Self-esteem among youth is a predictor of suicidal ideation, even when depression is taken into account. Youth with low self-esteem have a higher rate of suicidal ideation (Kelly et al., 2001).

Youth who feel that they “don’t belong”, who have limited support systems or who are isolated from activities have higher rates of suicide and suicide ideation. (Ledgerwood, 1999; Moscicki, 1995; Statistics Canada, 2004). Youth who have a high level of social support are more likely to have a “protective factor” from suicidal ideation (Bearman & Moody, 2004; Eskin et al., 2007)

It has been identified that children/youth who come from families with a history of mental illness and a family history of suicide have a higher risk of suicide themselves (Esben et. al. 2002). This same study indicates that the greatest risk factor for suicide is mental illness of the youth themselves.

Young people are more likely to die by suicide if a parent has died, whether from suicide or other causes, they have a family history of mental illness or unemployment, the parent is single, the mother has emigrated, the father had a poor education, a sibling had been admitted for a mental illness, or the individual had a history of mental illness or limited schooling. The low socioeconomic position of a parent was confounded by aggregation of mental illness and suicide in the family.

It has been identified that on a community level, barriers to health care/mental health services and the stigma associated with seeking help for mental health issues can increase the risk of suicide among youth. (Oklahoma Suicide Prevention Toolkit, Taking Action in Your Community). This is particularly true in rural and remote communities that have restricted access to these services. Youth are less likely to have transportation to larger communities and may be fearful that the person they are seeking help from knows them or their parents.

The ease of access to lethal means is another risk factor for youth. In countries where there is easy access to firearms the use of firearms tends to be the most common method of suicide. (Oklahoma Suicide Prevention Toolkit, Taking Action in Your Community). In countries with restricted access to firearms suicide rates tend to be lower and attempted methods tend to be less fatal.

Bullying is not a part of normal development and exposure to bullying is harmful and can increase the risk of suicidal ideation and/or behaviours in youth (Kim & Leventhal, 2008).

Cyberbullying is more strongly related to suicidal thoughts in children and adolescents than traditional bullying, according to a new analysis published in JAMA Pediatrics. This study found that children who experienced bullying were 2.2 times more likely to think about suicide and 2.5 times more likely to attempt it than peers who were not bullied. Children who were cyberbullied were 3.2 times more likely to contemplate suicide than their peers (The Globe and Mail, Tuesday, Mar. 11 2014).

Cyber-bullying because of the anonymous nature allows for bullying to be more aggressive and continuous. Studies have shown correlations between cyberbullying and low self-esteem and depression among victims (Tokunaga, 2010).

While not all children/youth that self-harm go on to attempt suicide there are a significant number who do. Self-harm is a major issue and risk factor for suicide among children/youth. In an Ontario study of children/youth age 12 – 17 it was found that approximately 1% of all hospital ER presentations by children/youth were the result of self-harm. Of these, two thirds were for self-poisoning and one quarter were for self-cutting. Incidence rates were higher for girls, low-income neighbourhoods and rural communities. Medical agents were used in just over 93% of cases. The incidence rate increases by age within this group.

| Hospital ER Visits for Self-Harm - Incidence rate per 100,000 | | | | | | |
|---|---|---|---|---|---|---|
| | Age 12 | Age 13 | Age 14 | Age 15 | Age 16 | Age 17 |
| Female | 77.9 | 215.7 | 501.6 | 659.1 | 713.2 | 679.2 |
| Male | 47 | 76.1 | 129.4 | 204.8 | 266.4 | 322.7 |

Emergency Department Presentations for Self-Harm Among Ontario Youth -J. Bethell, S. Bondy, W.Y. Wendy Lou, A. Guttman, A. Rhodes, Canadian Journal of Public Health, March/April , 2013

Youth are faced with a number of issues that can cause increased stress. Some of these issues are unique to teenagers and their stage of life. This stress can lead to emotional and mental health issues, which, in some cases, lead to suicide:

| | | |
|---|---|---|
| Balancing relationships with divorced or separated parents | Balancing school, work, social life and family relationships | Bullying |
| Challenges in relationships at home | Changing bodies/hormones | Changing family dynamics |
| Change of schools | Choosing a career | Choosing a college/university |
| Dating and relationship break-up | Difficulties at school | Social media |
| Facing an environment that may encourage drugs, alcohol, and sex | Getting a part-time job | Getting good grades for college/university |
| Learning about sexual identity | Learning to accept themselves with or without talents and abilities | Social struggles |
| Stress of extra-curricular activities and expectations from parents and coaches | The natural separation from parents that starts to occur | Traumatic experiences (historical or present) |
| Best Practices in School-based Suicide Prevention: A Comprehensive Approach 2014, Province of Manitoba | | |

Youth who are part of the LGBT community are at a higher risk of bullying and victimization. The combined effect of LGBT status and high levels of at-school victimization are associated with the highest levels of health risk behaviours. LGBT youths reporting high levels of at-school victimization, reported higher levels of substance use, suicidality, and sexual risk behaviours than heterosexual peers reporting high levels of at-school victimization. (Bontempo DE1, D'Augelli AR., 2002)

Rates of suicide among indigenous children/youth aged 10-29 (First Nations, Inuit and Métis) in Canada are estimated to be 5 to 6 times higher than youth in the general population. Over a third of all deaths among indigenous children/youth are attributable to suicide. (The First Nations and Inuit Health Branch, Health Canada provides more information on this topic http://www.hc-sc.gc.ca/fniah-spnia/promotion/suicide/index-eng.php)

Although factors such as mental health issues and previous suicidal behaviour are the strongest predictive factors of child/youth suicide there is evidence that socio-economic factors do play a role in predicting mental health status of child/youth and thus potential for suicide risk. There is a strong relationship between poverty and child/youth mental health problems. A child/youth from a family living in poverty is three times as likely to have a mental health problem as a child/youth not living in poverty. This same pattern holds true for children/youth living in poorer neighbourhoods (E. Lipman, M. Boyle, 2008). Parental factors that can increase risk among children/youth include unemployment, low income, poor schooling and divorce. This is particularly true when poverty increases barriers to

mental health treatment and given that untreated depression and substance abuse are major causes of adolescent suicide. (Spring 2010, Fact Sheet, Youth Suicide , Southern California Academic Center of Excellence on Youth Violence Prevention, University of California, Riverside)

Unemployment or part-time employment has been linked to higher rates of mental health issues, including harmful drug use, anxiety disorders and depression especially among youth ages 15-24 (Morrell et al, 1994).

Youth in rural/remote communities are at a higher risk of suicide than their urban counterparts. (How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants a Component of the Initiative Canada's Rural Communities: Understanding Rural Health and Its Determinants September 2006). Other factors identified as contributing to rural suicides include gender roles that discourage male help-seeking behaviour, limited access to clinical services, the strong sense of isolation, the conservative nature of some rural communities, issues of sexual identity conflict, and readier access to firearms.

In a recent study of rural youth in Ontario it was identified that rural youth report more suicidal thoughts than urban youth. Perceived social support accounted for rural and urban differences, while difficulties coping with daily stressors accounted for gender differences, in self-reported suicidal ideation. It is suggested that the highest risk is for young females who feel isolated and have poor coping skills. (L. Armstrong, 2011)

## Protective Factors

Youth who are engaged in activities such as school, school activities, community/church activities, sports etc. are likely to have lower rates of depression, less participation in risk behaviours, enhanced self-esteem and higher levels of social support (Bartko & Eccles, 2003; Mahoney & Schweder, 2002). As a result, they have lower rates of suicide and suicide ideation.