Preventing Youth Suicide: A Guide for Practitioners

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Contents

Guide to Aboriginal Specific Content

Although this guidebook contains information applicable to both Aboriginal and non-Aboriginal youth populations, the Aboriginal specific content is highlighted here for easier access.

Preventing Youth Suicide

Child and youth mental health practitioners in collaboration with other allied human service providers have an important role to play in the prevention of suicide and suicidal behaviour among youth.

The purpose of this guide is to provide practitioners with high-quality, up-to-date information on the topic of youth suicide prevention.

Intended Audience

This material has been written for child and youth mental health practitioners working in British Columbia. It may also be of relevance to youth-serving practitioners, health providers, Aboriginal leaders, school personnel and journalists.

Information for youth and for parents can be found through links on the MCFD website at: http://www.mcf.gov.bc.ca/suicide_prevention/index.htm

The information contained here is meant to support practitioners with up to date resources. It is not meant to replace existing Ministry for Children and Family Development policy or existing standards of care for working with children and youth at risk for suicide.

This updated and consolidated summary of information was previously provided on multiple pages of the Ministry of Children and Family Development (MCFD) website.

Contact Information

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Crisis Response Services

Individuals who live in BC and who are looking for immediate support for themselves, a friend or family member can call 1 800 SUICIDE (784-2433)

The following websites also provide resources, information and online support to those in distress http://www.youthinbc.com/ or http://www.youthspace.ca/ or http://www.yourlifecounts.org/#

For a complete list of all crisis line numbers in BC go to http://www.crisislines.bc.ca/index_files/Page338.htm

Crisis Support for Aboriginal Residential School Survivors

A National Indian Residential School 24-hour Crisis Line provides support for residential school survivors. Call 1-866-925-4419

Support for GLTBQ youth in BC

Prideline is open weeknights (Monday to Friday) from 7pm to 10pm. It is staffed by trained volunteers who can provide information, support, and referrals to gay, lesbian, transgendered, bisexual, queer and questioning youth.

Vancouver/ Lower Mainland: 604 684-6869
1 800 566-1170 (toll-free) in BC

Additional information on community resources, events and support services for GLTBQ youth and their families and friends is available on the Qmunity Gab youth website http://www.qmunity.ca/youth/gab-youth-services/

Background

Glossary of Terms

A great deal of time and energy has been devoted to bringing more precision to the terms used for describing a broad range of suicidal behaviours.[1] In the absence of a common understanding across research and practice contexts about the meaning of some basic terms, the potential for misunderstanding and confusion remains high. While multiple perspectives continue to be debated in the field, a few key terms are worth clarifying.

Suicide – intentional, self-inflicted death

Suicide attempt – any non-fatal, self-inflicted action taken with the intention of killing oneself, regardless of lethality

Suicide ideation – thoughts of harming or killing oneself

Suicidality/suicidal behaviours – all aspects of suicidal thoughts, behaviours and actions, including death

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[2]

The phrase "died by suicide" is considered to be the most clear and non-judgemental way to describe a death by suicide. Many people working in the field, as well as those who have lost a loved one to suicide, recommend using "died by suicide" over other commonly used phrases, including "committed suicide" (which implies a crime), "successful suicide" (which has a positive connotation) or "completed suicide" (which implies an accomplishment). Given the changing nature of our understanding of suicide, it is very likely that over time many of these terms will undergo further shifts and transformations.

Suicide Statistics

Canada

Rates of suicide among Canadian youth, aged 15 to 19, tripled between the 1950s and the 1980s. Much of this jump was accounted for by an increase in suicides among young males. Since the 1980s rates of suicide among Canadian youth have started to plateau, with a slight decline observed in the last two decades.[3] See Table 1 below.

Table 1. Age specific suicide rates among Canadian youth 15 to 19 (both sexes):

Year	Rate per 100,000
1950	3.3
1960	3.3
1970	7.0
1980	11.4
1990	11.6
2000	10.9
2008	9.2

Sources: Health Canada (1994). *Suicide in Canada: Update of the report of the task force on suicide in Canada*. Ottawa, ON: Health Canada.
Statistics Canada (2012). Suicides and suicide rate, by sex and by age group. Retrieved January 23, 2012 from http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth66a-eng.htm?sdi=suicide

First Nations, Inuit and Métis

Rates of suicide among Aboriginal 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. Unintentional (motor vehicle collisions) and intentional (suicide) injuries are the leading causes of death among Aboriginal youth.[4] Over a third of all deaths among Aboriginal youth are attributable to suicide.[5] At the same time, it is important to acknowledge that there is considerable variation in suicide rates across Indigenous communities. [6]

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

Suicide Among Gay, Lesbian, Bisexual, Transgendered, Queer (GLBTQ) Youth

Rates of suicide among GLBTQ youth are difficult to establish since sexual orientation is not always systematically documented by coroners at the time of death and many young people are not “out” at the time of their suicide. At the same time a growing body of research confirms that sexual minority youth are at increased risk for depression and suicidal behaviours compared with their heterosexual peers.[7] Negative social responses, peer victimization, harassment and discrimination - which are all part of a broader pattern of societal homophobia[8]- collectively contribute to elevated rates of suicidal behaviours among GLBTQ youth.[9]

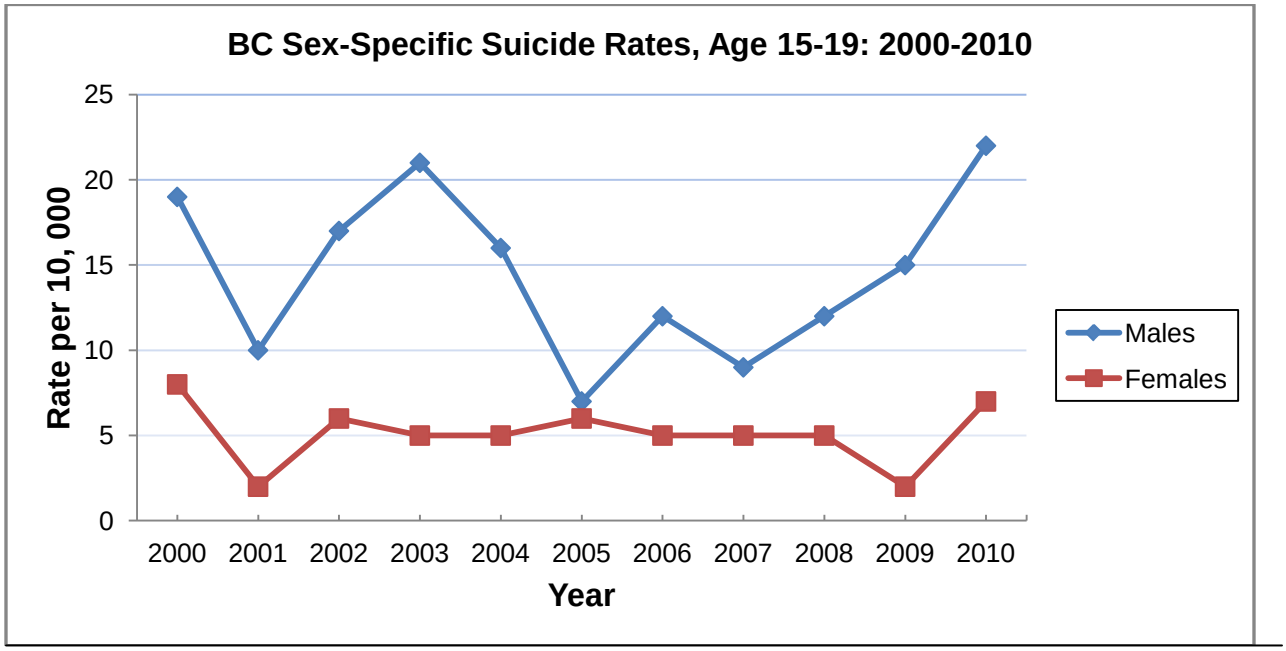
British Columbia

After motor vehicle fatalities, suicide is the second leading cause of death among youth aged 15 to 24 in British Columbia. Over the five-year-period, from 2004-2008, there were 82 suicides among BC youth aged 15 to 19. According to preliminary data provided by BC Vital Statistics, in 2008 there were 13 suicide deaths (4.5 per 100,000) among those 15 to 19 years of age in BC. Eight of these suicides (approximately 60 per cent) were males.

Each year in BC there are approximately three male youth suicides for every female youth suicide. The clear exception to this pattern was in 2005 when the number of female suicides, age 15 to 19, almost equalled the number of male suicides in this age group.

Figure 1 shows rates of suicide among BC males and females, aged 15 to 19 over the period, 2000 – 2010.

Figure 1



Data produced March 22, 2012 by Informatics, KMT, BC Ministry of Health using BC Vital Statistics mortality data. Data should not be compared to numbers published by the BC Coroners' Service due to time lags in receipt of completed investigations and differences in reporting practices.

Two valuable websites that summarize the number of suicides in British Columbia each year are the British Columbia Coroners Service and British Columbia Vital Statistics.

The BC Coroners Service website lists suicides by age, gender, method, month and municipality.
http://www.pssg.gov.bc.ca/coroners/publications/docs/stats-suicide.pdf

The BC Vital Statistics Annual Report includes a Detailed Cause of Death by Gender and Age. Suicides are listed under the following ICD-10 codes: X60-X84, Y870.
http://www.vs.gov.bc.ca/stats/annual/2007/index.html

Suicide Among Aboriginal Peoples in BC

Rates of suicide among Aboriginal youth in BC vary dramatically across communities. Good evidence exists to suggest that those communities with high levels of "cultural continuity factors" (including: self-government, land claims, education, health care, cultural facilities, police and fire service and Indigenous language use) have lower rates of youth suicide compared with those communities with fewer of these factors.[10]

Fact Sheet on Aboriginal Youth in BC
http://www.health.gov.bc.ca/mhd/pdf/fact_sheets/ab_youth_suicide.pdf

Health and Well Being of the Aboriginal Population in BC (2006)
http://www.health.gov.bc.ca/library/publications/year/2007/Aboriginal_Population_Interim_report_Final.pdf

Suicidal thoughts and behaviours

Thoughts of suicide and suicide attempts are relatively common among BC youth. According to the most recent 2008 McCreary Adolescent Health Survey (http://www.mcs.bc.ca/pdf/AHS%20IV%20March%2030%20Final.pdf), approximately 5 per cent of all BC youth, grades seven to 12, made a suicide attempt in the previous year and 12 per cent seriously considered it. [11]

This represents a decrease over time. Specifically, since 1992, the percentage of youth who seriously considered suicide dropped from 16% to 12% in 2008. The percentage who actually attempted suicide also decreased from 7% to 5%.

Non-suicidal self injuries (NSSI)

NSSI are behaviours that involve the intentional destruction of bodily tissues, using methods that are not socially sanctioned, which take place without conscious intent to die. Estimates of NSSI among youth range from 14 to 40 per cent in community populations.[12]

According to the 2008 MCreary Adolescent Health Survey, 22% of females and 12% of males in BC (grades 7 to 12) reported that they had deliberately cut or injured themselves, with no intention to die, at some point in their lives. Eleven percent reported engaging in self-injurious behaviour at least twice and another six percent reported doing so three or more times.[13]

To learn more about responding to and treating non-suicidal self injurious behaviours among youth, go to Interdisciplinary National Self-Injury Network Canada (http://www.insync-group.ca/professionals.php).

Risk and Protective Factors

Suicide and suicidal behaviours (including suicide attempts, plans and thoughts) among adolescents are influenced by multiple, interacting risk and protective factors that encompass biological, psychological, familial, interpersonal, social, historical and political dimensions.

Risk factors are those factors and social conditions that are associated with an elevated risk for suicide and suicidal behaviour. Recent reviews of the empirical literature confirm that there are a number of factors that have been linked to suicide and suicidal behaviours among youth.[14] [15] [16] [17] [18]

- Older adolescents and males are statistically more likely to die by suicide than females, children or younger adolescents.
- Research suggests that suicide and suicidal behaviours among youth are strongly associated with certain mental health problems, particularly mood disorders, anxiety disorders, substance use disorders, eating disorders and disruptive disorders. Co-occurring disorders are also very common among suicidal youth.
- Previous suicidal behaviour, including prior suicide attempts, planning and/or rehearsal, are significant risk factors for further suicidal behaviour.
- Hopelessness, aggression, recklessness, purposelessness, social withdrawal and impulsivity have been linked to suicidal behaviour.
- Family factors, including high levels of parent-child conflict, parental mental illness and a family history of suicidal behaviour can elevate the risk for suicide among youth.
- Many youth who die by suicide have a history of childhood physical and/or sexual abuse.
- Stressful life events, which typically precipitate suicidal acts, further contribute to suicide risk among youth, especially in combination with existing vulnerabilities. These commonly include interpersonal conflict, rejection, failure, humiliation, and loss.
- Exposure to a peer suicide is also a potential risk factor among some youth with pre-existing vulnerabilities.
- Sensationalized media reports about suicide and having access to the means for suicide are additional risk factors for youth suicide.
- Among Aboriginal youth, a number of additional risk factors have been identified, many of which can be traced to the enduring negative legacy of colonization, residential schools and policies of assimilation, including cultural dislocation, loss of land and language, racism, and multi-generational trauma [19] [20]
- Homophobia, peer victimization and discrimination contribute to elevated risks for suicide and self-harm among sexual minority (GLBT) youth[21] [22]

Table 2 summarizes the risk and protective factors for suicide among youth (*particularly relevant to Aboriginal youth)

KEY CONTEXT	PREDISPOSING FACTORS	CONTRIBUTING FACTORS	PRECIPITATING FACTORS	PROTECTIVE FACTORS
Individual	• previous suicide attempt • depression. substance abuse, anxiety, bipolar disorder or other mental health problems • hopelessness • persistent and enduring suicidal thoughts • history of childhood neglect, sexual or physical abuse	• rigid cognitive style • poor coping skills • limited distress tolerance skills • substance misuse • impulsivity • aggression • hypersensitivity/ anxiety	• loss • personal failure • victim of cruelty, humiliation, violence • individual trauma • health crisis	• individual coping, self-soothing and problem solving skills • willingness to seek help • good physical and mental health • experience/feelings of success • strong cultural identity and spiritual beliefs* • living in balance and harmony*
Family	• family history of suicidal behaviour /suicide • family history of mental disorder • early childhood loss/ separation or deprivation	• family discord • punitive parenting • impaired parent-child relationships • invalidating interpersonal environment • multi-generational trauma and losses *	• loss of significant family member • death of a family member, especially by suicide • recent conflict	• family cohesion and warmth • positive parent-child connection • positive role models • active parental supervision • high & realistic expectations • support and involvement of extended family & Elders * connection to Ancestors*
Peers	• social isolation & alienation	• negative attitudes toward help seeking • limited/conflicted peer relationships • suicidal behaviours among peers	• interpersonal loss or conflict • peer victimization • rejection • peer death by suicide	• social competence • healthy peer modeling • peer friendship, acceptance & support
School	• history of negative school experience • lack of meaningful connection to school	• reluctance/uncertainty about how to help among school staff	• failure • expulsion • disciplinary crisis • school-based harassment	• success at school • interpersonal connectedness/ belonging • supportive school climate • school engagement • anti-harassment policies and practices
Community	• multiple suicides • community marginalization* • socioeconomic deprivation*	• sensational media portrayal of suicide • access to firearms or other lethal methods • uncertainty about how to help among key gatekeepers • inaccessible community resources	• high profile/ celebrity death, especially by suicide • conflict with the law/incarceration	• opportunities for youth participation • availability of resources • community ownership* • control over local services* • culturally safe healing practices * • opportunities to connect to land and nature*
Sociopolitical	• colonialism* • historical trauma* • cultural stress* • interlocking oppressions	• racism* • sexism • classism • ableism • heterosexism	• social exclusion* • social injustice*	• social capital * • social justice* • social safety net • social determinants of health

Developed by Jennifer White (2012)

Important Considerations Regarding Risk Factors:

1. Knowledge about suicide risk factors is often distilled from "psychological autopsy" studies. Such studies rely on retrospective analyses to identify those factors most strongly associated with a suicidal outcome.
2. Research into suicide risk is valuable for the way that it sheds light on common factors associated with elevated risk among some young people.[23]
3. Risk factor research has also been criticized for converting complex and dynamic human experiences and social conditions into de-contextualized, individual-level, static, and unitary variables.[24] [25] [26]
4. Traditional approaches to studying and documenting suicide risk factors typically focus on individual-level risks which can potentially mask the role of social, structural and institutional factors in perpetuating social inequities and injustice which influence mental health and suicide. [27] [28]
5. Risk factors are cumulative and they interact in complex ways making it impossible to describe a singular profile of a "typical" suicidal youth.
6. Risk factors for suicide are dynamic, often fluctuating, and they vary in their severity which means that certain combinations of risk factors may elevate risk in some individuals but not in others.
7. Risk factors exist at multiple levels and are very often deeply embedded in social, historical, political and institutional practices that exist "outside the person"[29]
8. It is important to consider multiple, less well-documented forms of risk, including the effects of oppressive social practices and historical relations of power on certain groups and populations in western society. These include for example, the negative historical effects of colonization on Indigenous youth[30] or the damaging effects of homophobia and heterosexist biases on sexual minority youth.[31] [32]

Protective Factors

Protective factors refer to those factors and experiences that appear to reduce the likelihood of suicide despite exposure to risk.[33] Protective factors are important focal points in any youth suicide prevention strategy and include "reasons for living," spiritual practices, and other hope-activating circumstances that support resilience, promote community healing, and strengthen practices of solidarity that sustain individual and community well-being.[34] [35] [36]

While protective factors are less well-established through research, preliminary evidence suggests that the following factors may serve to protect youth against a range of social problems[37] [38] [39]: coping and problem solving skills, experience with success and feelings of effectiveness, strong sense of belonging and connection, social support, interpersonal competence, family warmth, support and acceptance, success at school, supportive school climate, school-based anti-harassment policies and practices, strong cultural identity, community self-determination and a commitment to social justice.

Social Determinants of Health

Recent research on the social determinants of health, including for example income distribution, education, employment, early childhood development, and housing, has convincingly established the connection between poor health and inequitable social arrangements and adverse living conditions.[40] Meanwhile, the concept of intersectionality highlights the way that

identity markers such as age, race, gender, sexual orientation and (dis)ability dynamically interact to shape individual lives and realities, creating benefits for some groups while limiting access to opportunities and resources for others.[41] In other words, we live in a world characterized by social inequities, many of which are maintained through institutional arrangements and structural forces that differentially influence individual and group opportunities for education, employment, housing and access to services.[42] For that reason, experiences of despair, suffering and suicidal behaviours among youth cannot be completely understood, nor adequately responded to, by focusing exclusively on person-centred variables such as psychological vulnerabilities or mental health status. A social justice orientation is an important lens to bring to any effort designed to improve individual mental health and social well-being,[43] even though it has largely been underexplored in much of the suicidology research.

In a related point, the concept of social capital has been advanced as a potentially important protective factor for reducing risks for suicide among Aboriginal youth. For example, [44]

Social capital characterizes a First Nation community based on the degree that its resources are socially invested, that it presents a culture of trust, norms of reciprocity, collective action, and participation, and that it possesses inclusive, flexible and diverse networks. Social capital of a community is assessed through a combination of its bonding (within-community relations), bridging (intercommunity ties), and linkage (relation with formal institutions) dimensions.

For more information on the social determinants of health within a Canadian context go to http://www.thecanadianfacts.org/The_Canadian_Facts.pdf

For more information on the concept of intersectionality go to http://wagner.nyu.edu/wocpn/publications/wcpn.intersections.pdf

Important Considerations Regarding Protective Factors

1. Assessing protective factors or "reasons for living" provides an important balance to the focus on risks, vulnerabilities and threats to well-being.
2. In clinical practice, an active and deliberate focus on eliciting youth strengths, capacities and resources is an essential component of any comprehensive assessment practice.
3. Young people, families, communities, and local cultural traditions all provide important resources for healing.
4. Focusing on strengths and opportunities serves to remind youth, families and communities of their own assets which have often been neglected, forgotten or denied.
5. The presence of protective factors does not serve to "cancel out" risk factors, especially when multiple imminent risk factors are present (frequent, intense ideation and strongly expressed intent to die).[45]
6. When conceptualizing community-wide prevention strategies, protective factors at the societal level include the social determinants of health such as early childcare and development, income, job security, housing, access to education, community self-determination, and policies of social justice and inclusion.[46]

Age-Related Considerations

Suicide rates tend to increase with age. This is due in part to the fact that many of the well-known risk factors for suicide, including for example major depressive disorders, increase during adolescence.[47] Co-occurring disorders, especially mood, anxiety and substance abuse disorders are common among adolescents who die by suicide.[48] Certain social stressors exacerbate suicide risk when they co-occur with other vulnerabilities and these stressors (e.g. romantic relationships, educational challenges and pressures) tend to increase during adolescence.[49]

Prevention strategies that attend to the multiple contexts of adolescents' lives (families, peers, school), and which reflect culturally diverse pathways to growth and resilience, are strongly supported.[50] Recognizing the importance of peer belonging and acceptance, supporting increasing independence within the context of loving relationships, and promoting active problem solving approaches among this age group are key strategies to keep in mind.[51]

In many Aboriginal communities, creating opportunities for Elders and youth to come together, supporting the transmission of cultural values, and preserving Indigenous language(s) have also been linked to reduced suicide rates in among First Nations youth in BC.[52] [53]

Though statistically rare, suicide does occur among pre-pubertal children.[54] It is important not to underestimate children's understandings of the meaning of suicide, nor to discount the possibility that children do engage in suicidal behaviour.[55] Other issues to consider when thinking about suicide risk among children include[56] [57]:

- By age nine, children usually have a thorough understanding of suicide
- The younger the child, the less complex and more immediately available the method
- Suicide among children is often associated with parent-child conflict

When assessing suicide risk in pre-pubertal children, keep questions concrete, use a combination of questions and empathic reflections, and match language to the child's level of understanding.[58] For an example of questions that could be used to assess suicide risk in children, go to "Sample Questions to Ask Young Children About Suicide".

Approach

Principles and Values

- Many youth suicides are preventable.
- Reducing emotional distress and suffering, addressing injustice and advancing hope among youth, their families, and communities are key aims.
- A transactional-ecological approach which recognizes the role of broad level social determinants in the emergence of suicide risk stands in contrast to an individualizing or pathologizing approach.[59] [60] [61]
- There is no single answer or simple solution to preventing youth suicide.
- Strategies for preventing suicide should be informed by the research evidence where available.
- Some aspects of suicide and its prevention are not easily captured by traditional research methods and so our knowledge about "what works best" is always imperfect, evolving and subject to change.
- Multiple forms of knowledge, including young people's knowledge, skills and experiences, clinical judgment, "insider knowledge" of those who have attempted suicide, and the unique knowledge that is available to survivors of a loved one's suicide are important to consider alongside the knowledge generated by experts and researchers.
- Problem oriented approaches which focus exclusively on individual risk factors, disorders and deficits and which fail to capitalize on individual, family and community strengths and assets in the generation of solutions are likely to be limited in their effectiveness.
- Young people have a valuable contribution to make and their voices, ideas and wisdom should always be actively elicited and supported.
- Parents and family members are important allies in the prevention of youth suicide.
- Efforts to promote youth and family well-being and reduce risks for suicide should be informed by the concepts of cultural safety and social justice which are predicated on multiple forms of engagement and relational values of respect, trust, justice, and safety[62]
- Elevated rates of suicide, substance misuse, violence and trauma witnessed among Aboriginal communities can be understood as a direct consequence of the history of colonization[63]
- De-colonizing practices, which orient attention to the systems and structures that perpetuate oppression and inequity, particularly among Indigenous youth, families and communities, invite practitioners to understand the social and historical embededdness of problems like depression, despair, and suicide and highlight the need for individual, organizational, and social action
- Praxis – a form of ethically informed, wise action that integrates theory and practice – offers a helpful touchstone for guiding action at the community level.[64]

A Comprehensive Approach

Comprehensive, multi-strategy, ecological-transactional approaches, which are implemented across an array of settings and contexts and developed by/within local communities, are recommended.[65] [66] These community strategies and practices should be informed by current research evidence and should honour and build on local community knowledge, values and traditions.

There is no such thing as a singular "one size-fits-all" approach to preventing youth suicide. Each youth, family and community is unique and close attention must be paid to the particular social, cultural, political and historical context when designing and implementing youth suicide prevention strategies. This is important when working with individual clients or at the community level.

The BC Suicide Prevention Intervention and Postvention (PIP) Initiative is a planning framework for guiding a comprehensive approach to suicide prevention in BC.
http://suicidepipinitiative.wordpress.com/

Comprehensive Approaches in Aboriginal Communities

Comprehensive approaches which reflect holistic views of children, youth, families and communities have also been strongly endorsed by those who seek to reduce risks for suicide among Aboriginal youth. A recently prepared report on preventing suicide among Aboriginal youth summarizes some of the key "research-informed" elements to be included in any community wide approach: [67]

(1) restrict access to common means of suicide;
(2) provide school-based programs that teach coping skills to students, as well as training teachers and staff how to recognize individuals at risk and refer them to counselling or mental health services;
(3) train youth as peer counsellors or 'natural helpers' to those at risk;
(4) train other individuals with whom youth come into regular contact (teachers, nurses, primary care providers, clergy, parents) as 'gatekeepers' so that they can recognize and refer youth at risk;
(5) ensure ready access to a range of mental health services including counseling and psychotherapy;
(6) mobilize the community to come together to develop suicide prevention programs and crisis intervention teams;
(7) provide culturally appropriate support for families to promote positive parenting from early childhood through adolescence;
(8) develop family and community activities that bring youth and elders together to share cultural knowledge, values and perspectives; and
(9) ensure that mass media portray suicide and other community problems in appropriate ways;
(10) improve communication, knowledge translation and coordination of suicide prevention and mental health promotion activities to build on local, regional and national strengths.

One example of a comprehensive, community-wide suicide prevention framework that is grounded in an Indigenous worldview is one that uses the medicine wheel to conceptualize the importance of a holistic, culturally informed approach. Here explicit attention is given to four sources of strength in any healing effort: mental, physical, spiritual and emotional.[68]

To Live to See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults is a practical and comprehensive guide that recognizes the role of historical trauma in the emergence of suicidal behaviour and supports community level action to prevent suicide among Indigenous youth
http://www.sprc.org/library/Suicide_Prevention_Guide.pdf

Traditional and Contemporary Approaches to Youth Suicide Prevention is a document that outlines a comprehensive approach for addressing suicide among Aboriginal youth in Canada which features both culturally informed traditional healing practices and mainstream approaches
http://64.26.129.156/cmslib/general/SP.pdf

Adolescent Suicide Prevention Program Manual is a useful guide that outlines a public health approach to addressing suicide in Native American communities
http://www.sprc.org/sites/sprc.org/files/library/AdolescentSP_ProgramManuaPH_ModelNA_Communities.pdf

A Comprehensive Planning Framework

Having a visual framework or map that can capture the multiple, broad elements of a comprehensive youth suicide prevention strategy can assist practitioners to recognize the breadth of this work, while also enabling them to locate themselves and their particular contributions within this larger view.

Table 3 “Mapping a community wide approach to Youth Suicide” provides one example of how this work might be conceptualized at a community level. It highlights specific topic areas including some of the most promising youth suicide prevention strategies identified in the professional and empirical literature.[69] [70] [71] [72] [73] Note that the horizontal axis represents a continuum of prevention interventions from population-focused mental health promotion efforts to clinical interventions with individuals-at-known risk. A list of key target groups and settings is described along the vertical axis.

As you explore Table 3, be mindful of the fact that the language we use to describe suicide prevention activities is discrete and categorical – giving the false impression that this work is neat-and-tidy – which can sometimes get in the way of thinking about youth suicide prevention practice in a richer, more complex, and holistic way.

Table 3 – Mapping a Community-Wide Approach to Youth Suicide Prevention

Types of Strategies					
		Well-Being Promotion: Promoting Youth Resilience and Strengthening Social Environments	**Education & Early Detection:** Improving Recognition and Promoting Awareness	**Risk Assessment & Treatment:** Working with Individuals and Groups at Known Risk	**Postvention & Bereavement:** Assisting After a Suicide
	Primary Focus	**Whole Populations**	**Potential Interveners**	**Individual/Groups at Risk**	**Survivors of Suicide**
Groups and Settings	**Youth**	Positive youth development Youth skill building Youth participation and engagement	Youth education about suicide	Therapeutic alliance Risk assessment & documentation Crisis response & safety planning Promising psychosocial treatments	Reducing risks for contagion Supporting youth survivors
	Parents and Families	Parent/family support and skill development	Parent education about suicide	Parent involvement in treatment Family interventions for youth at risk	Supporting surviving family members
	Schools	School-based mental health promotion	Screening School gatekeeper training	School based interventions for youth at risk	School-based suicide response protocols
	Communities	Changing social norms Cultural revitalization and community self-determination for First Nations	Education for physicians and hospital emergency room staff Community gatekeeper training	Continuity of care Means restriction	Community-based suicide response protocols Media education
Organizational & System-level Interventions	Professional development	Planning & service coordination	Mobilizing local knowledge & coalition-building	Policies and protocols	Research & evaluation
Sociopolitical Interventions		Social Justice Promotion	Advocacy & Activism	De-Colonization Practices	

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Well-Being Promotion

A comprehensive approach to youth suicide prevention will ideally reflect a dual focus on well-being promotion and risk reduction. Strengthening communities, reducing social inequities, promoting social justice, enhancing social support and improving the specific skills of youth and their parents, are all part of an overall effort to promote the well-being of youth, their families and communities. Several promising approaches to promoting resilience and strengthening social environments are described in this section.

Research on resilience lends justification to those practices that promote change at both the individual and social environmental levels. The concept of resilience reflects three overlapping domains[74]:

- Resilience is the capacity of individuals to navigate their way to resources that sustain well-being
- Resilience is the capacity of individuals' physical and social ecologies to provide these resources
- Resilience is the capacity of individuals and their families and communities to negotiate culturally meaningful ways for resources to be shared

For more information on the evidence base supporting resilience promotion in children, youth and families go to http://www.childhealthpolicy.sfu.ca/research_quarterly_08/rq-pdf/RQ-1-08-Winter.pdf.

Aboriginal Youth Well-Being

The undeniable resilience of Indigenous children and youth, who have maintained health and well-being despite facing a number of cultural assaults and historical adversities, has received much less attention in the mainstream literature. Some Aboriginal scholars have suggested that this absence of attention may be due in part to an overall tendency to ignore, misunderstand or pathologize Aboriginal adolescents' efforts to pursue health and well-being on their own terms.[75]

Ten distinct values that have been linked to the emergence of resilience among Aboriginal peoples have been identified:[76]

- spirituality
- importance attached to child-rearing and the extended family
- respect for age, wisdom and tradition
- respect for nature
- generosity and sharing
- cooperation and group harmony
- autonomy and respect for others
- composure and patience
- relativity of time
- non-verbal communication.

For a summary of the literature on resilience in Aboriginal youth, families and communities go to http://www.cyc-net.org/cyc-online/cycol-1203-resilience.html and http://www.naho.ca/jah/english/jah05_01/V5_I1_Community_04.pdf

See also http://www.pimatisiwin.com/uploads/834803515.pdf

Positive Youth Development Programs

Positive youth development is the phrase used to refer to those programs that are informed by the empirical research in prevention which recognizes that the same set of individual, family, school and community factors can predict both positive outcomes (e.g. success in school) and negative outcomes (e.g. school dropout) among children and youth.[77] Positive youth development is a broad category that encompasses a wide range of programs, including many primary prevention programs that have their origins in the substance abuse prevention field.

There are a number of characteristics and qualities that appear to be protective for a range of youth social problem behaviours including self efficacy, personal agency, self determination and positive self identity. These qualities can be facilitated and reinforced through the following:

- direct teaching and skill building,
- cultivation of relationships that enable the expression of emotional, behavioural and social competence and,
- the development of opportunities for young people to experience meaningful connections with others and their communities.

Positive youth development programs and interventions are enhanced when they are implemented as part of an overall, comprehensive, community wide youth suicide prevention effort. By simultaneously working to reduce risk factors and increase protective factors – within individuals and across social environments – program planners and service providers are embodying the principles of sound prevention practice thus enhancing the possibilities for positive future change.

Many positive youth development programs are guided by the "Five C's"[78] [79]:

1. Competence - Positive view of one's actions in specific areas
2. Confidence - Internal sense of positive self worth and self efficacy
3. Character - Respect for societal and cultural norms, sense of morality, integrity
4. Connection - Positive bonds with people and institutions, such as peers, family, school and community
5. Caring/Compassion - Sense of sympathy and empathy for others

"Sixth C:" Contribution - Engaging in contributions to one's community[80]

While proponents of the positive youth development approach have made an important contribution to the prevention field by focusing on youth strengths instead of deficits, many youth researchers and practitioners argue that positive youth development does not go far enough to recognize the debilitating effects of social and structural oppression that many racialized minority youth experience, including racism, poverty, unemployment, violence, and limited access to resources. A related criticism is that many positive youth development approaches are based on dominant white, middle class values which do not adequately reflect the lived realities of all youth.[81] One way to address some of these limitations is to recognize the role of socio-political and institutional contexts in perpetuating inequities and taking specific actions to reduce oppression and social injustice when conceptualizing and responding to social problems among youth such as youth suicide.

Implementation Ideas and Tools

The McCreary Centre Society has developed a toolkit *From the Inside Out* which is designed to promote and support resiliency in adolescents aged 11 to 14, http://www.mcs.bc.ca/pdf/from-the-inside-out-toolkit.pdf.

An online *Positive Youth Development Resource Manual* which includes training activities, instructions, facilitation tips, handouts, brief power point presentations and references to other positive youth development resources is available through the Assets Coming Together (ACT) for Youth Center of Excellence, http://www.actforyouth.net/?ydManual.

The Centre for Confidence and Wellbeing in the UK includes a number of helpful resources on resilience, http://www.centreforconfidence.co.uk/pp/overview.php?p=c2lkPTU=

Additional Resources on Positive Youth Development

Published Articles and Books

Browne, G., Gafni, A., Roberts, J., Byrne, C. & Majumdar, B. (2004). Effective/efficient mental health programs for school-age children: A synthesis of reviews. *Social Science & Medicine, 58,* 1367-1384.

Catalano, R., Berglund, M., Ryan, J., Lonczak, H. & Hawkins, D. (2004). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. *Annals of the American Academy of Political and Social Sciences, 59,* 98-124.

Howard, C. (2010). Suicide and Aboriginal youth: Cultural considerations in understanding positive youth development. *Native Social Work Journal, 7,* 163-180.

Lerner, R. & Thompson, L. (2002). Promoting healthy adolescent behavior and development: Issues in the design and evaluation of effective youth programs. *Journal of Pediatric Nursing, 17*(5), 338-344.

Lerner, J. V., Phelps, E., Forman, Y., & Bowers, E. P. (2009). Positive youth development. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology* (3rd ed., Vol. 1, pp. 524-557). Hoboken, NJ: Wiley.

Roth, J. & Brooks-Gunn, J. (2003). What exactly is a youth development program? Answers from research and practice. *Applied Developmental Science, 7,* 94-111.

Vo, D. & Park, J. (2009). Helping young men thrive: Positive youth development and men's health. *American Journal of Men's Health, 3(*4), 352-359.

Web Links

Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs, http://aspe.hhs.gov/hsp/PositiveYouthDev99/.

Thrive, The Canadian Centre for Positive Youth Development, http://www.thrivecanada.ca/.

Youth Skill Building

The promotion of youth competencies and the development of specific life skills are relevant for the prevention of youth suicide and suicidal behaviours. Research suggests that youth who respond to stress and crisis with self harming behaviours may be limited in their coping and problem solving abilities, lending support to programs which seek to enhance these skills[82] [83]. Social skills training approaches have been successful in addressing other high-risk youth behaviours such as depression, aggression and substance abuse.

Many youth skill building efforts have been delivered as part of school based curricula however these programs can be adapted for community settings. Focal points for skill building programs for youth can include a range of topics, including:

- self esteem enhancement
- coping skills
- healthy decision making
- self awareness
- interpersonal communication skills
- problem solving
- goal setting
- assertiveness
- conflict resolution and mediation
- stress management
- dealing with loss
- emotion regulation
- distress tolerance
- help seeking
- refuting irrational beliefs
- identifying and responding to distressed peers
- empathy
- moral development
- leadership
- citizenship skills
- cultural sensitivity and awareness
- social justice and diversity

Values-Based Teachings For Aboriginal Youth

Other approaches which explicitly reflect Aboriginal teachings and values have also been summarized in the literature. The "Seven Sacred Values or Teachings" provides one example of a "wise practice" approach to promoting mental health and reducing violence among Indigenous peoples.[84]

> ***Courage****—to speak, to reveal, to reach out, to be open, to be introspective,* ***Honesty****—to know yourself and your own values, biases and beliefs, to speak from the heart and soul, to allow yourself to truly be seen, know and be known,* ***Humility****—we are all in this together and all have inherent value, no one person is greater than any other in spirit, we are all ordinary and extraordinary beings, our greatest task is to learn to be of service,* ***Respect****—coming together and honouring each others place and space, knowing that this is something you must give to get, honouring the smallest to the oldest, walking in beauty,* ***Truth****—our truth is not the only truth, there are many paths to home, we are created equal, no matter how much we learn, there is much we do not know, creating* ***Love****—unconditional acceptance of self and other, accepting and embracing difference, allowing, and gracefully giving of everything we are,* ***Wisdom****—providing an expansive and inclusive view of the world.*

Warrior-Caregivers is a practical resource guide that offers information, guidance and strategies for promoting well-being among First Nations men. It includes several sections devoted to youth issues, skill building, healing, and mobilizing family and community strengths http://www.ahf.ca/downloads/healingmenewebrev.pdf

Other strengths-based, culturally relevant approaches to promoting skills among Aboriginal youth include such strategies as school-based youth engagement strategies, peer mentoring programs, providing support for school-based transitions, and cultural leadership development.[85]

Skill-building Programs for Elementary School Aged Children

A recent study suggests that a universal prevention program, called the Good Behavior Game (GBG) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=201 designed to reduce aggression and disruptive behaviour and promote pro-social behaviours among children in the first and second grades, shows promise in preventing or delaying suicide ideation and attempts in adolescence.[86] Using a game-like structure to promote children's pro-social skills through the use of rewards and incentives and by encouraging teammates to regulate peers based on the pursuit of mutual self interests, the GBG is designed to assist first and second grade classroom teachers set acceptable standards for behaviour and create an integrated approach to behaviour management where all children are supported to learn in a context that is free from aggression and disruption.

Implementation Ideas and Tools

FRIENDS for Life is an example of a school based early intervention and prevention program that is focused on preventing anxiety and depression and promoting resilience among children and youth through a number of specific skill building efforts. In BC, the Ministry of Children and Family Development (MCFD) partners with the Ministry of Education, participating school districts and independent schools to provide the FRIENDS program. For more information, please visit: http://www.mcf.gov.bc.ca/mental_health/friends.htm.

Strategies for Healthy Youth Relationships provides a number of curriculum resources, materials for parents, and guidelines for youth service providers for reducing violence and risk-taking behaviour within schools and communities http://www.youthrelationships.org./index.html

The Search Institute also provides a number of downloadable resources for asset building in young people, http://www.search-institute.org/downloads.

The American Indian Life Skills Development/Zuni Life Skills Development is a school-based, culturally responsive, skill-building curriculum that may be suitable for other Indigenous populations with appropriate modifications
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=81

Additional Resources on Youth Skill Building

Published Articles and Books

Crooks, C., Chiodo, D., Thomas, D., & Hughes, R. (2010).Strengths-based programming for First Nations youth in schools: Building engagement through healthy relationships and leadership skills. *International Journal of Mental Health and Addictions, 8,* 160-173.

Fitzpatrick, K., Witte, T. & Schmidt, N. (2005). Randomized controlled trial of a brief problem orientation for suicidal ideation. *Behaviour Therapy, 36*(4), 323-333.

Gould MS, Velting D, Kleinman M, Lucas C, Thomas JG, Chung M. (2004). Teenagers' attitudes about coping strategies and help seeking behavior for suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(9), 1124-33.

LaFramboise, T. & Howard-Pitney, T. (1995). The Zuni life skills development curriculum: Description and evaluation of a suicide prevention program. *Journal of Counseling Psychology, 42(*4), 479-485.

LaFramboise, T. & & Hayes, L. (2008). The Zuni life skills development program: A school/community based suicide prevention intervention. *Suicide and Life Threatening Behavior, 38*(3), 343-353.

Liebenberg, L. & Ungar, M. (Eds.) (2008). *Resilience in action: Working with youth across cultures and contexts.* Toronto, ON: University of Toronto Press.

Thompson, R. (2006). Nurturing future generations: *Promoting resilience in children and adolescents through social, emotional and cognitive skills* (2nd ed.). New York: Routledge/Taylor & Francis.

Tuttle J, Campbell-Heider N, David TM. (2006). Positive adolescent life skills training for high risk teens: Results of a group intervention study. *Journal of Pediatric Health Care, 20*(3), 184-91.

Wilcox, H., Kellam, S., Brown, H., Poduska, J., Wang, W., & Anthony, J. (2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence, 95*(Suppl 1), S60-S73.

Zenere, F. & Lazarus, P. (2009). The sustained reduction of youth suicidal behaviour in an urban, multicultural school district. *School Psychology Review, 38*(2), 189-199.

Web Links

Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University http://www.childhealthpolicy.sfu.ca/research_quarterly_08/index.html.

FRIENDS for Life http://www.mcf.gov.bc.ca/mental_health/friends.htm

Youth Participation and Engagement

Youth participation has been defined as "a constellation of activities that empower adolescents to take part in and influence decision making that affects their lives and to take action on issues they care about." [87] There are a range of ways in which young people can be engaged in planning and decision-making processes from adult-initiated, shared decision making to youth-initiated and youth directed activities.[88] Youth participation and engagement are guiding principles *and* strategies for action. Youth have knowledge, ideas and lived experiences that are relevant for the promotion of well being and social justice. By actively involving youth in the design and implementation of programs and giving them meaningful opportunities to participate in responding to issues that affect them, local programs and policies are made more relevant, organizations are strengthened, and the health of the community is enhanced.

Building on youth's existing knowledge, skills, and experiences, youth participation efforts provide opportunities for young people to mobilize for social change. By creating opportunities for genuine democratic participation, public engagement and collective action, youth can challenge oppressive social practices (e.g. racism, heterosexism, colonization) within their schools and communities, many of which are linked to risks for suicide. In this way, youth participation and engagement strategies typically go beyond traditional youth development approaches through a more explicit emphasis on social justice.

Such social justice oriented youth participation efforts recognize youth as active "agents" of social change which is in contrast to thinking of youth as service recipients or "assets".[89] Through careful mentorship, coaching and support, youth build on their existing strengths and learn important skills such as critical engagement, sociopolitical analysis, democratic participation, social and community problem solving, and mobilizing for systemic change.

Implementation Ideas and Tools

The Free Child Project website offers numerous resources and examples of youth-led activism projects http://freechild.org/youth_activism_2.htm

For a Canadian toolkit designed to support the engagement and empowerment of Aboriginal youth go to http://youthrelationships.org/documents/Engaging%20and%20Empowering%20Aboriginal%20Youth%20-%20Toolkit%20for%20Service%20Providers.pdf

The Ontario Public Health Association has produced a toolkit to support youth engagement which is understood to be a key strategy for promoting youth health and wellbeing http://www.youthengagement.ca/sites/default/files/OPHAYouthEngagementToolkit-April2011.pdf

The Commonwealth Secretariat has produced a practical guidebook, which includes multiple tools and strategies for promoting youth participation http://www.thecommonwealth.org/Shared_ASP_Files/UploadedFiles/983621CB-D789-48B3-A84C-F2CB6023E458_Four-ToolsforAdolescentandYouthParticipation.pdf

Additional Resources on Youth Participation and Engagement

Published Articles and Books

Checkoway, B. & Gutierrez, L. (Eds.). (2006). *Youth participation and community change.* Philadelphia, PA: Haworth Press.

Driskell, D. (2002). *Creating better cities with children and youth: A manual for participation.* Paris: UNESCO.

Ginwright , S. & James, T. (2002). From assets to agents of change: Social justice, organizing and youth development. *New Directions for Youth Development, 96*, 27-46.

Gurstein, P., Lovato, C., Ross, S. (2003). Youth participation in planning: Strategies for social action. Canadian *Journal of Urban Research, 12*(2), 249-274.

Morsillo, J. & Prilleltensky, I. (2006). Social action with youth: Interventions, evaluation and psychopolitical validity. *Journal of Community Psychology, 35*, 725-740.

O'Donoghue, J., Kirshner, B. & McLaughlin, M. (2002). Introduction: Moving youth participation forward. *New Directions for Youth Development, 96,* 15-24.

Web Links

Ontario Public Health Association http://www.youthengagement.ca/

McCreary Centre Society http://www.mcs.bc.ca/youth_engagement

Parent/Family Support Programs

Research points to the protective functions of close parental bonding, healthy parent-child communication, and effective family functioning in reducing risks for a range of child and youth mental health problems.[90] Such findings also suggest that parent education and family support programs, which are designed to improve parents' overall problem solving, communication and conflict resolution skills, and improve family relationships and strengthen bonds, can make an important contribution in the overall youth suicide prevention effort. Social support for parents, may in itself, be an important factor in promoting parental effectiveness.

In a review of effective positive youth development programs, 60 per cent of the effective programs used family or parent strategies, combined with other school or community based strategies, to promote positive youth development.[91] Parent strategies included direct parent training or education strategies, many of which were implemented at the school, as well as home based strategies designed to enhance the youth's acquisition of new skills and learning. Many of the effective programs combined school based and family focused strategies, e.g. while students are learning new skills at school, parents are frequently the target of efforts designed to promote family competence and enhance parent self-effectiveness.

Several family-level protective factors have been found to positively influence adolescent health and well-being including: positive parent-child relationships, positive discipline methods, close supervision, and communication of prosocial values and expectations. [92]

Core principles of effective family-focused preventive interventions have been distilled from the existing research and they are summarized below:[93]

- Comprehensive, multi-component interventions are more effective than single component programs
- For families with relationship problems, family-focused programs are more effective than either child-focused or parent-focused programs
- Strategies for improving family relations, communication and parental monitoring hold the most promise
- Programs that generate cognitive, affective and behavioural changes in the ongoing family dynamics and environment are likely to lead to enduring change
- Increased intensity of the intervention may be required for those families who experience more risks and greater challenges
- Family focused interventions should be age appropriate
- Intervening with families at specific times of need and/or when participants are most receptive to change is important
- For those families with multiple risks and challenges, it is best to intervene early (i.e. prenatally or early childhood)
- Programs should be tailored in order to be culturally relevant
- Incentives like providing food, child care and transportation are recommended
- Trainer competency and interpersonal characteristics (warmth, empathy, humour) are keys to success
- Interactive and experiential learning strategies are most effective
- Supporting families through collaborative approaches that capitalize on their strengths and empower them to generate their own solutions can reduce drop-out

Strengthening the Well-Being of Indigenous Families and Communities

In First Nations communities, the well-being of youth is inextricably tied to the healthy functioning of parents, extended family members and the community as a whole. A recent review of the literature[94] on promoting mental health among First Nations children and youth found that the most promising approaches had the following elements in common:

- models and approaches are comprehensive and consider activities that strengthen cultural identity
- they identify and promote existing and traditional sources of strength with First Nations communities
- they incorporate traditional healing methods
- they rely on local control and are self directed by First Nations communities

Guided by these observations, and operating from a perspective which reflects Aboriginal beliefs and views (i.e. holistic, interconnected, respect the laws of nature, recognize the role of the Creator), strategies which are designed to strengthen extended family networks, which promote healing across generations, and which enable parents and families to support and nurture their own children are considered the most promising.

Canadian research suggests that programs designed to support young Indigenous children's development are more likely to be successful when programs are well-coordinated and guided by the following principles: [95]

- Service models are holistic and population-based, providing developmental, social, health, and cultural programs as well as 'special needs', 'children-at-risk' and 'special needs' supports
- Programs are co-located with cultural meeting places and community kitchens, serving as a 'hook' for attracting and retaining a broad representation of community members
- Community members are extensively involved from the beginning of delivering training program staff, planning and implementing services, serving as a hook for sustained community commitment to and participation in the programs.
- Families are conceptualized as the central organizing focus for delivery of services, such that the well-being of young children is seen as dependent upon and contributing to family well-being. Family centered practice is a preferred model in most Aboriginal communities.

Implementation Ideas and Tools

One family skills training program that has been found to significantly reduce problem behaviours, conflict with the law, alcohol and drug abuse in children and to improve social competencies and school performance (each of which are relevant to the prevention of youth suicide) is the *Strengthening Families Program (SFP)*.
http://www.strengtheningfamiliesprogram.org/

Information on *Strengthening Families for the Future*, a Canadian program modeled after the Strengthening Families Program, is available at:
http://www.camhx.ca/Publications/CAMH_Publications/strengthen_families.html

For a seven session outline of *SFP for Parents and Youth 10 to 14* go to
http://www.extension.iastate.edu/sfp/inside/curr.php.

Additional Resources on Parent and Family Support Programs

Published Articles and Books

Connors, E. & Maidman, F. (2001). A circle of healing: Family wellness in Aboriginal communities. In I. Prilleltensky, G. Nelson & Peirson (Eds.), *Promoting family wellness and preventing child maltreatment: Fundamentals for thinking and action*, (pp. 349-416). Toronto, ON: University of Toronto Press.

Glover, G. (2001). Parenting in Native American families. In N. Boyd Webb (Ed.), *Culturally diverse parent-child and family relationships: A guide for social workers and other practitioners* (pp. 205-231). New York: Columbia University Press.

Kruesi M., Grossman, J., Pennington, J., Woodward, P., Duda, D., & Hirsch, J. (1999). Suicide and violence prevention: Parent education in the emergency department. *Journal of the American Academy of Child & Adolescent Psychiatry. 38*(3),250-5.

Lazzara, K. & Poland, S. (2001). Managing crisis: Intervention skills for parents. In M. Fine & S. Lee (Eds.), *Handbook of diversity in parent education* (pp.337-372). San Diego: Academic Press.

Pollack, W. (2004). Parent-child connections: The essential components for positive youth development and mental health, safe communities and academic achievement. *New Directions for Youth Development, 103*, 17-30.

Toumborou, J. & Gregg, M. (2002). Impact of empowerment-based parent education programs on the reduction of youth suicide risk factors. *Journal of Adolescent Health, 31*(3), 277-285.

Web Links

BC Council for Families http://www.bccf.ca/

Parent Support Services of BC http://www.parentsupportbc.ca/

U.S. Office of Juvenile Justice and Delinquency Prevention Model Programs Guide http://www.ojjdp.gov/mpg/Common%20Sense%20Parenting%20(CSP)-MPGProgramDetail-826.aspx

First Nations Child and Family Caring Society of Canada http://www.fncfcs.com/

Spirit of the Children Society http://www.sotcs.ca/home.html

Hook and Hub: Coordinating Programs to Support Indigenous Children's Early Learning and Development http://www.ecdip.org/docs/pdf/WIPCE%20Hook%20and%20Hub.pdf

School-Based Mental Health Promotion

Many positive youth development and mental health promotion programs are implemented in a school context. These programs are designed to support the development of specific skills in youth while also strengthening the overall social environment of the school to increase opportunities for belonging, acceptance and support.

Whole school approaches recognize that the total school environment (i.e. curriculum, policies, relationships, school culture, values, leadership) strongly influences overall student health and well being, including mental well-being. Whole school approaches typically include one or more of the following features:

- based on a holistic view of health
- emphasizes multiple approaches to promoting student health and well-being
- addresses social and environmental determinants of health
- involves multiple partners and players

Schools are a natural site for students to learn important social, emotional and relational skills. Eight core skills that enable students to live healthy, productive and meaningful lives have been identified by the Collaborative to Advance Social and Emotional Learning (CASEL)[96]:

1. Communicate effectively
2. Ability to work cooperatively with others
3. Emotional self control and self expression
4. Empathy and perspective taking
5. Optimism, humour and self awareness
6. Ability to plan and set goals
7. Solving problems and resolving conflicts thoughtfully and non-violently
8. Bringing a reflective, learning-to-learn approach to all domains of life

Research suggests that these social and emotional skills can be taught to students through systematic approaches that include the following elements[97]:

1. Identify the skill and provide a clear rationale for its use
2. Model and teach the specific skill
3. Provide opportunities for students to practice the skill and receive feedback
4. Establish prompts and cues on how to apply the skill outside the learning context

Implementation Ideas and Tools

MindMatters is an Australian program that uses a whole school approach to mental health promotion and suicide prevention. The program aims to enhance the development of school environments where young people feel safe, valued, engaged and purposeful. Social and emotional well-being have been linked to young people's schooling outcomes, their social development, their capacity to contribute to the workforce and the community and to reducing the rate of youth suicide. http://www.mindmatters.edu.au/default.asp

Oregon Resiliency Program, Strong Teens Curriculum is a curriculum developed to promote emotional resiliency with adolescents in grades nine to 12. The *Strong Teens* curriculum is

aimed specifically at concerns and content relevant to adolescents or high school aged students. The *Strong Teens* lessons are designed to be easy to implement in school settings. There are 12 brief lessons that are designed to be taught once a week for 12 consecutive weeks. The lessons are designed to take 45 to 50 minutes each. These lessons are carefully designed and scripted for ease of implementation. The curricula were developed using evidence based concepts, instructional strategies and activities.
http://strongkids.uoregon.edu/strongteens.html

Collaborative for Social and Emotional Learning is a collaborative that works to advance the science and evidence based practice of social and emotional learning (SEL). The material on their website emphasizes the benefits of preschool through high school SEL programming; how SEL coordinates with other educational movements; research and training in implementation; assessment; school and district leadership development; educational policies; and communications. http://www.casel.org/about/index.php

The UCLA Center for Mental Health in the Schools is an American clearinghouse that provides access to a number of resources for promoting child and youth mental health and addressing psychosocial concerns using school-based interventions. http://smhp.psych.ucla.edu/

A recent Australian publication highlights a number of promising strategies for engaging Indigenous youth in culturally appropriate educational programs, *Schools: A Sentinel Site or Change* at http://www.aifs.gov.au/nch/pubs/reports/telstra2/schools.pdf

Additional Resources on School Based Mental Health Promotion

Published Articles and Books

Elias, M. & Weissberg, R. (2000). Primary prevention: Educational approaches to enhance social and emotional learning. *Journal of School Health, 70*(5), 186-190.

Patton, G., Glover, S., Bond, H., Godfrey, C., Di Pietro, G. & Bowes, G. (2000). The Gatehouse Project: A systematic approach to mental health promotion in secondary schools. *Australian and New Zealand Journal of Psychiatry 34*(4), 586–593.

Weare, K. (2000). *Promoting mental, emotional and social health: A whole school approach.* London: Routledge.

Weare, K. (2005). What do we know about promoting mental health through schools: *International Journal of Health Promotion and Education, 12*(3/4), 14-18.

Weissberg, R., Caplan, M. & Harwood, R. (1991). Promoting competent young people in competence enhancing environments; a systems based perspective on primary prevention. *Journal of Consulting and Clinical Psychology, 59*(6), 830-841.

Weist, M., et al. (2005) Developing principles for best practice in expanded school mental health. *Journal of Youth and Adolescence, 34*(1), 7-13.

Wyn, J., Cahill,H., Holdsworth, R., Rowling, L., & Carson.S. (2000). MindMatters, a whole school approach promoting mental health and well being. *Australian and New Zealand Journal of Psychiatry 34* (4), 594–601.

Web Links

Advances in School Based Mental Health Journal
http://www.schoolmentalhealth.co.uk/index.htm

UCLA School Mental Health Project http://smhp.psych.ucla.edu/

McCreary Centre Society Report on Promoting Positive Mental Health Among BC Youth
http://www.mcs.bc.ca/pdf/making_the_right_connections.pdf

The *Joint Consortium for School Health* is a Canadian organization dedicated to advancing comprehensive school health http://eng.jcsh-cces.ca/

Changing Social Norms

There is some evidence to suggest that population level interventions which target a whole community can make an important contribution to the overall suicide prevention effort. Specifically, a community wide, multi-layered intervention that focused on reducing modifiable risk factors and enhancing protective factors was implemented by the US Air Force over the period 1990 – 2002.[98] Strategies included reducing the stigma around help-seeking, improving understanding of mental health issues and changing policies and social norms. Results indicate that in following the multi-layered intervention, which targeted the whole community, there was a sustained decline in rates of suicide and other adverse outcomes, including accidental death, homicide and family violence.

Locally coordinated approaches to youth suicide prevention which are informed by a community wide, ecological perspective have also shown promise.[99] [100] Through a combination of gatekeeper training, discipline specific education for particular professional groups and protocol development, it has been shown that the capacity and competency of all community members to detect suicidality among youth can be strengthened.

Additional Resources on Changing Social Norms

Baber, K. & Bean, G. (2009). Frameworks: A community-based approach to preventing youth suicide. *Journal of Community Psychology, 37*(6), 684-696.

Wexler, L. (2006). Inupiat suicide and culture loss: Changing community conversations for prevention. *Social Science & Medicine, 63*, 2938-2948.

Community Self Determination and Control for First Nations

Issues of community self determination and cultural relevance are of particular importance when planning and implementing youth suicide prevention programs in an Aboriginal community. In a series of studies conducted in British Columbia comparing community level characteristics of First Nations communities, researchers have identified variables that appear capable of differentiating communities with high rates of suicide from those communities with a suicide rate closer to zero.[101] These variables include self government, land claims, control over education, health, police/fire and child protection and cultural facilities. Communities with low rates of youth suicide possess valuable and legitimate knowledge that can be shared with other communities.

Addressing suicide in First Nations communities requires the development and implementation of systemic strategies that go beyond reducing symptoms in individuals to recognizing and embracing the broader ecological, cultural and interpersonal contexts that provide the base for enduring health and well-being. Approaches which emphasize cultural safety, community self-determination and decolonization hold the greatest promise.

Recognizing the value of Indigenous knowledge(s) is a pre-requisite in any de-colonizing effort aimed at supporting Aboriginal health, well-being and self-determination. Unique characteristics of Indigenous knowledge systems include:[102]

- Intimately connected to the place, land, languages, customs, traditions and ceremonies
- Contain linguistic categories, rules and relationships unique to each knowledge system
- Have localized content and meaning
- Customs exist with respect to acquiring and sharing knowledge

The Aboriginal Healing Foundation has published a number of high quality research reports on suicide prevention, community healing and therapeutic approaches.
http://www.ahf.ca/publications/research-series

Implementation Ideas and Tools

A working paper on *Current Approaches to Youth Suicide Prevention* has been produced by the Culture and Mental Health Research Unit . This paper includes a number of links to Indigenous youth suicide prevention programs
http://www.namhr.ca/pdfs/Suicide-Prevention.pdf

Aboriginal Affairs and Northern Development Canada describe a number of First Nations, Inuit and Métis "success stories" from across the country
http://www.aadnc-aandc.gc.ca/eng/1100100014455/1100100014459

This website provides links to *What is Working What is Hopeful: Supporting Suicide Prevention Strategies Within Indigenous Communities*. http://www.douglas.qc.ca/uploads/File/what-is-working-report.pdf

The National Aboriginal Health Organization has developed an *Assessment and Planning Toolkit for Suicide Prevention in First Nations Communities.* It provides a step-by-step framework to guide First Nations individuals and organizations in assessing need and developing a suicide prevention plan for their community. It also contains information and research on suicide prevention to increase awareness and encourage discussion.
http://www.naho.ca/publications/topics/suicide-prevention/

The Honouring Life Network was developed by the National Aboriginal Health Organization. The site offers culturally relevant information and resources on suicide prevention.
http://www.honouringlife.ca/

Additional Resources on Community Self-Determination for First Nations

Published Articles and Books

Alcantara, C. & Gone, J. (2007). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies, 31*, 457-477.

Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35*(2), 191-219.

Chandler, M. J. & Lalonde, C. (2004). Transferring whose knowledge? Exchanging whose best practice?: On knowing about Indigenous knowledge and Aboriginal suicide. In D. Beavon & J. White (Eds.), *Aboriginal policy research: Setting the agenda for change*, vol.II, (pp.111-123), London, ON: Althouse Press.

Chino, M. & DeBruyn, L. (2006). Building true capacity: Indigenous models for Indigenous communities. *American Journal of Public Health, 96*(4), 596-599.

Health Canada (2003). *Acting on what we know: Preventing suicide in First Nations youth. A report of the Suicide Prevention Advisory Group*. Ottawa, ON: Health Canada. Available at http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/index-eng.php.

Isaak, C. et al. (2010). Community-based suicide prevention research in remote on-reserve first nations communities. *International Journal of Mental Health and Addictions, 8*, 258-270.

Kirmayer, L., Boothroyd, L., Laliberte, A. & Simpson, S. (1999). *Suicide prevention and mental health promotion in First Nations and Inuit communities. Culture and Mental Health Research Unit, Report No. 9.* Montreal, QC: Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry.

KIrmayer, L & Valaskalis, G. (2009). *Healing traditions: The mental health of Aboriginal peoples in Canada.* Vancouver: UBC Press.

Kral, M.J., & Idlout, L. (2009). Community wellness and social action in the Canadian Arctic: Collective agency as subjective well-being. In L.J. Kirmayer & G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 315-334). Vancouver, BC: University of British Columbia Press.

MacNeil, M. (2008). An epidemiologic study of Aboriginal adolescent risk in Canada: The meaning of suicide. *Journal of Child and Adolescent Psychiatric Nursing, 21*(1), 3-12.

Mussell, B., Cardiff, K. & White, J. (2004). *The mental health and well-being of Aboriginal children and youth: Guidance for new approaches and services*. Chilliwack, BC: Sal 'i' shan Institute. Available at http://www.childhealthpolicy.sfu.ca/research_reports_08/rr_pdf/RR-8-04-full-report.pdf.

Royal Commission on Aboriginal Peoples (1995). *Choosing life: Special report on suicide among Aboriginal people.* Ottawa, ON: Communication Group.

Smye, V. & Mussell, B. (2001). *Aboriginal mental health: What works best: A discussion paper.* Vancouver, BC: Mental Health Evaluation and Community Consultation Unit.

Tait, C. (2008). Ethical programming: Towards a community centred approach to mental health and addiction programming in Aboriginal communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6*(1), 29-60.

Wexler, L. (2006). Inupiat youth suicide and culture loss: Changing community conversations for prevention. *Social Science and Medicine, 63*, 2938-2948.

White, J. & Jodoin, N. (2004). *Aboriginal youth: A manual of promising suicide prevention strategies.* Calgary, AB: Centre for Suicide Prevention. Available at http://www.suicideinfo.ca/csp/go.aspx?tabid=144.

White, J. (2007). Working in the midst of ideological and cultural differences: Critically reflecting on youth suicide prevention in Indigenous communities. *Canadian Journal of Counselling, 41*(4), 213-227.

Web Links

Network for Aboriginal Mental Health Research (NAMHR) http://www.namhr.ca/index.php

The Healthy Aboriginal Network http://www.thehealthyaboriginal.net/

Preventing Native Suicide, Children's Mental Health Research Policy Unit
http://www.childhealthpolicy.sfu.ca/research_quarterly_08/video_research_quarterly/volume3-4video.html

Sayt K'üülm Goot – Of One Heart: Preventing Aboriginal Youth Suicide Through Youth and Community Engagement
http://www.rcybc.ca/Groups/Archived%20Reports/cyo_of_one_heart_web.pdf

Education and Early Detection

A number of youth suicide prevention efforts are dedicated to increasing recognition of youth at potential risk for self harm and suicide. Most of these efforts are educational in nature and they are aimed at increasing the awareness of warning signs and risk factors for suicide among those who live, work and play in close proximity to youth – often referred to as gatekeepers. The most common audiences for these educational and training efforts include youth/peers, parents, school staff, family physicians, emergency room staff and other community gatekeepers like youth workers, police, probation officers, recreation leaders and youth volunteers.

- A number of effective and promising youth suicide prevention programs are summarized in the Children's Mental Health Research Quarterly, produced by the Children's Health Policy Centre: http://www.childhealthpolicy.sfu.ca/research_quarterly_08/rq-pdf/RQ-4-09-Fall.pdf.
- A series of helpful short videos to accompany the Children's Mental Health Research Quarterly on the topic of youth suicide prevention have also been developed: http://www.childhealthpolicy.sfu.ca/research_quarterly_08/video_research_quarterly/volume3-4video.html.
- The Suicide Prevention Resource Center (SPRC) also provides an up-to-date summary of research informed suicide prevention strategies. Access their registry of evidence based practices in suicide prevention as well as relevant fact sheets that describe specific programs: http://www.sprc.org/featured_resources/bpr/index.asp.
- The Substance Use and Mental Health Service Administration (SAMHSA) provide a database of interventions for the prevention and treatment of mental health and substance use problems (National Registry of Evidence-based Programs & Practices [NREPP]). For a description and rating of suicide prevention programs, visit http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=suicide%20prevention

Parent Education About Suicide

There is very little research on parents' knowledge about suicide, despite the fact that parents are well positioned to observe significant changes in their child's behaviour. Signs of depression or suicidal ideation – in contrast to some of the more highly visible mental health problems of adolescence, like substance abuse or disruptive disorders – can frequently go undetected by parents. By ensuring that parents are knowledgeable about the risk factors and warning signs of depression and suicide in children and adolescents, we increase the likelihood that symptoms of distress among their own sons and daughters as well as the *friends* of their children will be more easily recognized, thus extending the overall network of adult vigilance, care and support to benefit even more potentially vulnerable youth.

Implementation Ideas and Tools

There are a number of useful websites on the topic of youth suicide prevention that are specifically aimed at parents, including:

- http://ww3.suicideinfo.ca/youthatrisk/ForParents/tabid/637/Default.aspx
- http://www.yellowribbon.org/Msg-to-Parents.htm
- http://www.nasponline.org/resources/crisis_safety/suicideprevention.aspx
- http://www.cprf.ca/publication/pdf/family_09_eng.pdf

Additional Resources on Parent Education

Published Articles and Books

Brent D., Baugher M., Birmaher, B., Kolko, D. & Bridge J. (2000). Compliance with recommendations to remove firearms in families participating in a clinical trial for adolescent depression. *Journal of the American Academy of Child & Adolescent Psychiatry. 39*(10):1220-6.

Kruesi M., Grossman, J., Pennington, J., Woodward, P., Duda, D., & Hirsch, J. (1999). Suicide and violence prevention: Parent education in the emergency department. *Journal of the American Academy of Child & Adolescent Psychiatry.38*(3),250-5.

Maine, S., Shute, R. & Martin, G. (2001). Educating parents about youth suicide: knowledge, response, suicidal statements, attitudes and intention to help. Suicide and Life-Threatening Behavior, 31(3), 320-332.

Youth Education About Suicide

Suicide prevention education for youth includes activities designed to improve young peoples' ability to recognize suicide risk in a peer and initiate getting help. These efforts are typically implemented in school contexts. The target audience is peer responders and the goal is to increase recognition and responsible action among youth who encounter a potentially distressed or suicidal peer (i.e. tell an adult). These curriculum based programs are ideally supported by other complementary prevention and intervention efforts including youth skill building, screening, school in-service training and parent education, as well as school administrative policies and crisis intervention and treatment services.

Traditionally, programs of this sort have been known as suicide awareness programs or curriculum based suicide prevention programs and the evidence for their effectiveness has been mixed.[103] Part of the problem may be that these programs have been implemented in isolation and the intentions have not always been clear, leading to poor program designs, unrealistic expectations and inappropriate evaluation targets.

Proponents of peer recognition and response training (or curriculum-based) approaches for youth typically justify these programs on the following, empirical grounds:[104]

- Most suicidal youths confide their concerns more often to peers than adults
- Distressed youth (e.g. depressed, substance abusers) prefer peer supports over adults
- Some adolescents, particularly males, do not always respond to troubled peers in empathic or helpful ways suggesting that they may benefit from more explicit coaching and guidance about how to help
- As few as 25% of peer confidants tell an adult about their troubled or suicidal peer
- School personnel are consistently among the *last* choices of adolescents for discussing personal concerns

Recent evaluations of school based suicide prevention programs assessed students' knowledge and attitudes following a school based suicide prevention curriculum. Results suggest that the programs were effective in increasing knowledge and influencing attitudes in the desired direction and no undesirable effects of the programs (e.g. increased levels of hopelessness) were detected.[105] [106] Another school based suicide prevention program, which included a screening an educational component, led to a reduction in self reported suicide attempts among participating students.[107]

Despite these promising findings, a recent (2009) systemic review of school based suicide prevention programs[108] suggests a need for caution as many evaluation studies published between 1987 – 2007 were judged to have a number of methodological flaws, leading the reviewers to conclude that the current scientific foundation regarding school based suicide prevention programs remains limited. Limited evidence means that more studies are required - which is different from concluding that there is evidence of ineffectiveness.

Recent efforts have pointed to the importance of moving beyond information transmission activities when engaging young people in conversations about how to prevent youth suicide. Specifically, strategies that recognize young people as active, knowledgeable, and capable and which draw on their own knowledge, skills and experiences may be preferable to those that treat them as passive recipients of others' expert knowledge.[109]

Implementation Ideas and Tools

Research informed, curriculum based approaches to youth suicide prevention are detailed in the *School Based Suicide Prevention Programs Guide*, developed by the Louis de la Parte Florida Mental Health Institute at the University of South Florida. This useful *Guide* is available at http://theguide.fmhi.usf.edu/.

The UCLA Center for Mental Health in Schools has prepared a comprehensive set of tools and tips to guide those implementing a school based suicide prevention awareness program: http://smhp.psych.ucla.edu/qf/suicide_qt/.

The *Signs of Suicide* (SOS) Program is one example of a promising school based suicide prevention program that combines suicide awareness curricula with a brief screening tool for depression and suicide risk. The program is typically implemented during one or two classroom periods. The curriculum teaches high school students to respond to the signs of suicide as a mental health emergency, using the "ACT" approach which stands for Acknowledge, Care and Tell. For more information on this program visit http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/

SAFE: TEEN teaches school staff, parents and students to recognize and respond appropriately to the warning signs that a student may be suicidal. More than curriculum or "gatekeeper" training, SAFE: TEEN changes the entire school environment by assisting educators to:

- Develop written policies and procedures for responding to suicidal warning signs, gestures, threats, attempts and completions.
- Facilitate collaboration between the school and community caregivers.
- Train every member of the school staff, not only teachers and counselors. No one can predict to whom a troubled teen will turn for help.
- Educate parents to take all talk of suicide seriously and know how to respond effectively to their child's depression.
- Train all students to understand the causes of suicidal despair, recognize the warning signs and to intervene appropriately with an at-risk friend. Students learn why some secrets are just too serious to keep.

For a list of reviewed and recommended educational videos on the topic of youth suicide that might be suitable for inclusion in a classroom based context, visit http://www.suicidology.org/web/guest/stats-and-tools/videos.

Here in British Columbia, a school based suicide awareness program called "Reaching Out" has recently been developed by the Crisis Intervention and Suicide Prevention Centre of BC. For more information about this program visit http://www.crisiscentre.bc.ca/programs-services/community-education/choices2-reaching-out/

Additional Resources on Suicide Prevention Education for Youth

Published Articles and Books

Aseltine, R. & DeMartio, R. (2004). An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health, 94*(3), 446-451.

Ciffone, J. (2007). Suicide prevention: An analysis and replication of a curriculum based high school program. *Social Work, 52*(1), 41-49.

Hennig, C., Crabtree, C. & Baum, D. (1998). Mental health CPR: Peer contracting as a response to potential suicide in adolescents. *Archives of Suicide Research, 4*(2), 169-187.

Kalafat, J. (1996). Planning and evaluating integrated school-based services. *Special Services in the Schools, 11*(1/2), 209-224.

Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist, 46*(9), 1211-1223.

Miller, D. N., Eckert, T. L., and Mazza, J. J. (2009). Suicide prevention programs in the schools: A review and public health perspective. *School Psychology Review*, 38, 168-188.

Portzky, G. & Heeringen, K. (2006). Suicide prevention in adolescents: A controlled study of the effectiveness of a school based psycho-educational program. *Journal of Child Psychology and Psychiatry, 47*(9), 910-918.

Stuart C, Waalen J., Haelstromm E. (2003). Many helping hearts: An evaluation of peer gatekeeper training in suicide risk assessment. *Death Studies, 27*(4) 321-333.

White, J. & Morris, J. (2010). Precarious spaces: Risk, responsibility and uncertainty in youth suicide prevention education. *Social Science & Medicine,* 71, 2187-2194.

Web Links

Oregon Youth Suicide Prevention Program - School Based Suicide Prevention Program
http://www.oregon.gov/DHS/ph/ipe/ysp/response.shtml

School Based Screening

School based screening is a strategy that is designed to increase detection and promote help seeking among potentially suicidal youth. Given that the majority of young people spend a great deal of time at school, classroom or school wide approaches for identifying potentially suicidal adolescents have been increasingly recommended as important youth suicide prevention strategies.[110] [111] Most suicide screening strategies are brief, self report tools that can be administered easily and efficiently. Those students who score in the high risk range are subsequently interviewed to get a more complete understanding of their level of risk.

A recent study found that two-thirds of students who were referred for follow up care after the implementation of a school based screening program did access services at the one year follow up, lending support to the idea that school based screening programs can be effective in identifying vulnerable youth and facilitating important linkages to mental health and other help giving services.[112]

It is also important to be aware of potential concerns and cautions regarding the use of screening programs, including the potential for false positives, the concern about increased workload among school based personnel,[113] the fluctuating nature of suicide risk and the lack of research on the use of these tools with racialized minority students.[114]

Implementation Ideas and Tools

The Teen Screen is an example of one screening program that can be implemented in the school and community context. For a list of principles and considerations underlying quality screening programs visit http://www.teenscreen.org/programs/schools-communities.

Additional Resources on School Based Screening

Published Articles and Books

Gould, M., Marrocco, F., Hoagwood, K., Kleinman, M., Amakawa, L. & Altschuler E. (2009). Service use by at-risk youths after school based suicide screening. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(12), 1193-1201.

Gould, M.S., Marrocco, F. A., Kleinman, M.,Thomas,J. G., Mostkoff, K., Cote,J. & Davies, M. (2005). Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled *trial. JAMA,* 253, 1635-1643.

Hallfors, D., et al. (2006). Feasibility of screening adolescents for suicide risk in “real world” high school settings. *American Journal of Public Health, 96(*2), 282-287.

Joe, S. & Bryant, H. (2007). Evidence based suicide prevention screening in schools. *Children & Schools, 29(*4), 219-227.

Pena,J. B. & Caine, E. D. (2006). Screening as an approach for adolescent suicide prevention. *Suicide and Life-Threatening Behavior, 36,* 614-637.

Shaffer, Q, Scott, M., Wilcox, H., Maslow, C., Hicks, R., Lucas, C. P, Garfinkel, R. & Greenwald, S. (2004). The Columbia Suicide Screen: Validity and reliability of a screen for youth suicide and depression. *JAAAP, 43,* 71-79.

School and Community Gatekeeper Training

The strategy of educating school and community gatekeepers – a diverse group which include teachers, school administrators, counsellors, youth workers, police officers, coaches, probation officers, foster parents, volunteers and others who have regular, typically "non-clinical contact" with youth – is a key strategy in the development of any comprehensive youth suicide prevention effort. Such ongoing proximity to youth places these adults in a unique position to be able to detect potential signs of depression and suicide risk in students.

Content of gatekeeper training programs usually include:

- Exploration of beliefs and values about suicide
- Dispelling myths about suicide
- Warning signs – for an example of a mnemonic device (IS PATH WARM) for remembering empirically informed warning signs of suicide visit http://www.suicidology.org/web/guest/stats-and-tools/warning-signs
- Engaging with a person at risk for suicide
- Risk assessment
- Safety planning
- Resource and referrals

Skills addressed in gatekeeper training programs usually include:

- Recognizing risk
- Developing rapport and cultivating trust
- Active, nonjudgmental listening and support
- Empathy
- Asking the question, "Are you considering suicide?"
- Asking specific follow up questions to better understand risk levels
- Working collaboratively on a safety plan
- Knowing who and how to access additional support

A recent evaluation of a relatively brief suicide prevention gatekeeper intervention suggested that gatekeeper training can lead to enhanced suicide-specific intervention skills for the majority of participants. Learning and retention of skills may be strengthened even further through the use of role plays, supportive feedback and other active learning strategies.[115]

Implementation Ideas and Tools

For detailed information on available community gatekeeper training opportunities, visit LivingWorks http://www.livingworks.net/ or QPR http://www.qprinstitute.com/.

Additional Resources on School and Community Gatekeeper Training

Published Articles and Books

Baber, K. & Bean, G. (2009). Frameworks: A community-based approach to preventing youth suicide. *Journal of Community Psychology, 37*(6), 684-696.

Capp, K., Deane, F. & Lambert, G. (2001). Suicide prevention in aboriginal communities: Application of gatekeeper training. *Australia and New Zealand Journal of Public Health, 25*(4), 315-321.

Chagnon, F., Houle, J., Marcoux, I. & Renaud, J. (2007). Control group study of an intervention training program for youth suicide prevention. *Suicide and Life Threatening Behavior, 37*(2), 135-144.

Cross, W., Matthieu, M., Lezine, D. & Knox, K. (2010). Does a brief suicide prevention gatekeeper training program enhance observed skills? *Crisis, 31*(3), 149-159.

Davidson M. & Range L. (1999). Are teachers of children and young adolescents responsive to suicide prevention training modules? Yes. *Death Studies, 23*(1), 61-71.

Isaac, M., Elias, B., Katz, L., Belik, S., Deane, F., W. Enns, M., Sareen, J. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. The Canadian Journal of Psychiatry, 54(4), 260-268.

King, K. & Smith, J. (2000). Project SOAR: A training program to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health, 70*(10), 402-407.

Neimeyer, R. & MacInnes, W. (1981). Assessing paraprofessional competence with the Suicide Intervention Response Inventory. *Journal of Counseling Psychology, 28*(2), 176-179.

Tierney, R. (1994). Suicide intervention training evaluation: A preliminary report. *Crisis, 15*, 69-76.

Turley, B. & Tanney, B. (1998). *SIFTA Evaluation Report.* Melbourne: Lifeline Australia.

Wyman, P.A., Brown, C.H., Inman, J., Cross, W., Schmeelk-Cone, K., Gou, J. & Pena, J. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*(1), 104-115.

Physician/Hospital Staff Education

Youth in psychological distress often present themselves to their family physicians and many also show up at hospital emergency departments in times of crisis. Ensuring that the medical and nursing staff who deal with these young people and their parents are equipped with the best possible information regarding how to assess and minimize risks for self harm is the cornerstone of this strategy.

Two distinct educational efforts aimed at health professionals have been promoted in the suicide prevention literature:

1) Education and training for primary care practitioners (PCPs) regarding the recognition and management of depression and suicidal ideation
2) Education and training for hospital emergency department staff regarding the importance of including means restriction education to parents and adult caregivers of suicidal youth.

Physician Education

Many young people visit their primary care providers when they are in emotional distress. With ongoing education and skill development, primary care providers (PCPs) can make an important contribution to the overall youth suicide prevention effort through early identification, treatment of common mental health disorders, and through the provision of information, counselling, care coordination and referrals. [116] Evidence suggests that PCP's can increase their knowledge and improve their practices in the recognition and treatment of depression which can have an effect on overall suicide rates, although the specific effects on youth depression and suicide have not yet been established.[117] [118] Training efforts need to be repeated on a regular basis.

A recent study found that even a relatively brief training (90-minute) intervention on youth suicide in primary care clinics led to a significant increase in PCP's rates of inquiry about suicide and case detection. Participating physicians were taught two questions to include in the standard psychosocial interview:

"Have you ever felt that life is not worth living?"
"Have you ever felt like you wanted to kill yourself?"

When faced with answers in the affirmative, PCPs were prompted to ask an additional set of follow up questions and probes regarding planning, preparation and attempts.[119]

Recommendations for enhancing physician education include:[120]

- Provide opportunities for learning about mental health, adolescent psychiatry and suicide during medical school and residency programs
- Offer ongoing training and collaboration with mental health specialists
- Develop more computerized tutorials or toolkits on the topic of adolescent suicidality
- Incorporate interactive learning strategies such as role-plays
- Address organizational barriers (i.e. lack of time, limited referral sources)
- Enhance understanding of cultural barriers, including language, mental health stigma and discrimination

Training for Emergency Department Personnel

- Many suicidal youth show up at hospital emergency departments and further risks for suicidal behaviour can be reduced if parents/caregivers of these youth receive education on means restriction from trained hospital emergency department staff
- Knowledge gains among health professionals can be achieved through a simple mail out campaign, but a more interactive educational session is more likely to have a greater impact on their actual practice[121]

Implementation Ideas and Tools

The British Columbia Ministry of Health in partnership with the Centre for Applied Research in Mental Health and Addictions (CARMA) recently produced a series of resources to support suicide prevention activities, including *Working With the Suicidal Patient: A Guide for Health Care Professionals* available from the CARMA website at http://www.carmha.ca/publications/index.cfm?fuseaction=publications.showByClass&topic=13.

Suicide Prevention Toolkit for Rural Primary Care Providers
http://prevention.mt.gov/suicideprevention/PrimaryCarePhysiciansMasterFile.pdf

Primary Care Toolkit- Patient Management Tools
http://www.sprc.org/for-providers/primary-care-tool-kit-tools

Additional Resources on Physician Education/Hospital Staff Education

Published Articles and Books

Appleby, L., Amos, T., Doyle, U., Tomenson, B. & Woodman, M. (1996). General practitioners and young suicides: A preventive role for primary care. *British Journal of Psychiatry, 168,* 330-333.

Fendrich M., Kruesi M., Wislar J., Pokorny S., Dontes A. & Erickson T. (1998). Implementing means restriction education in urban EDs. *American Journal of Emergency Medicine, 16*(3), 257-61.

Kutcher, S. & Chehil S. (2007). *Suicide risk management: A manual for health professionals.* Malden, MA: Blackwell Publishing.

Pfaff, J, Acres, J. & McKelvey, R. (2001). Training general practitioners to recognize and respond to psychological distress and suicide ideation in young people. *Medical Journal of Australia, 174*, 222-226.

Rutz, W. (2001). Preventing suicide and premature death by education and treatment. *Journal of Affective Disorders 62*(1), 123-129.

Taliaferro, L. & Borowky, I. (2011). Physician education: A promising strategy to prevent adolescent suicide. *Academic Medicine, 86*, 342-347.

Wintersteen M. (2010). Standardized screening for suicidal adolescents in primary care. Pediatrics.125, 938–944.

Web Links

Harborview Injury Prevention and Research Center
http://depts.washington.edu/hiprc/practices/topic/suicide/doceduc.html

Risk Assessment

Child and youth mental health professionals who have existing clinical competencies and specialized skills are well positioned to provide therapeutic care and follow up to individuals and groups identified to be at risk for suicide. This level of targeted clinical intervention requires skills and competencies in assessment, crisis intervention, safety planning and treatment, as well as collaboration with others, including family members.

The main purpose of this section is to quickly summarize some key concepts and principles regarding the effective assessment and treatment of suicidal youth. Child and youth mental health practitioners are strongly encouraged to familiarize themselves with the empirical and professional literature in this area.

Several excellent resources that provide an overview of effective clinical approaches for assessing and treating suicidal clients, including youth, have recently been developed.

Recommended readings

American Academy of Child and Adolescent Psychiatry (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 40(*7), 24S-51S.

Berman, A., Jobes, D. & Silverman, M. (2006). *Adolescent suicide: Assessment and intervention* (2nd Ed.). Washington, DC: American Psychological Association.

Bridge, J., Goldstein, T. & Brent, D. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry, 47*(3), 372-394.

Gould, M., Greenberg, T., Velting, D. & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 3860405.

Gutierrez, P. (2006). Integratively assessing risk and protective factors for adolescent suicide. *Suicide and Life Threatening Behavior, 36*(2) 129-135.

Jobes, D. (2006). *Managing suicidal risk: A collaborative approach.* New York: Guilford Press.

Joiner, T. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press.

Kutcher, S. & Chehil, S. (2007). S*uicide risk management: A manual for health professionals.* Malden, MA: Blackwell Publishing.

Macgowan, M. (2004). Psychosocial treatment of youth suicide: A systematic review of the research. *Research on Social Work Practice, 14*(3), 147-162.

Miller, Rathus & Linehan, M. (2007). *Dialectical therapy with suicidal adolescents.* New York: Guilford Press.

Reeves, A. (2010). *Counselling suicidal clients.* Thousand Oaks, CA: Sage.

Rogers, J. & Soyka, K. (2004). “One size fits all”: An existential constructivist perspective on the crisis intervention approach with suicidal individuals. *Journal of Contemporary Psychotherapy, 34*(1), 7-21.

Rudd, M.D., Joiner, T. & Rajab, M. (2001). *Treating suicidal behavior: An effective time limited approach.* New York: Guilford Press.

Steele, M. & Doey, T. (2007). Suicidal behaviour in children and adolescents Part 2: Treatment and prevention. *Canadian Journal of Psychiatry, 52*(6 Suppl 1), 35S-45S.

Wenzel, A., Brown, G. K. & Beck, A. T. (2008). *Cognitive therapy with suicidal patients: Scientific and clinical applications.* Washington, DC: APA Books.

Additional suicide risk assessment and treatment resources developed specifically for counselors and mental health practitioners can be found on the Suicide Prevention Resource Center website at http://www.sprc.org/featured_resources/customized/social_worker.asp.

A number of useful clinical tools including suicide risk assessment and depression scales which have been designed for use with adolescent populations are available at http://teenmentalhealth.org/for-health-professionals/clinical-tools/

Therapeutic Alliance

Building a strong therapeutic alliance with the young person is one of *the* most important components of therapeutic work with suicidal clients. It is also an explicit expectation outlined in the Child and Youth Mental Health policy on suicide prevention, intervention and postvention. It is a stance or attitude that is characterized by warmth, trust, empathy and care and serves to instil hope in the client. For youth, who often drop out of treatment prematurely or do not follow through with formal treatment recommendations, developing a strong therapeutic alliance from the outset is critical.[122] [123]

Developing an empathic connection by explicitly recognizing the level of pain and desperation the suicidal youth is experiencing is key to developing a strong alliance**.**[124]

Other key issues to address that can serve to strengthen the therapeutic alliance include[125]:

- identify opportunities for youth involvement in treatment planning and decision making
- clearly outline the rules of and exceptions to confidentiality
- clarify issues of availability and accessibility after hours

Personal and professional characteristics that can enhance the therapeutic relationship include flexibility, warmth, appropriate self disclosure, empathy, sense of humour and maintenance of professional authority.[126]

Other specific strategies for enhancing the therapeutic alliance when working with youth include:[127] [128]

1. Provide a clear rationale for the treatment approach
2. Enhance motivation to attend sessions
3. Attend to and repair relational ruptures
4. Reduce interpersonal distance while maintaining role expertise (e.g. face-to-face seating instead of sitting behind a desk)
5. Provide flexibility in session length
6. Encourage clients to come to treatment with a friend who will wait for them and with whom they can leave at the end of a session.
7. Provide comfort in the office setting (e.g. allowing food/drink during the session).
8. Allow for changes in routine (e.g. leaving the office, going for a walk).
9. Develop therapeutic rapport with parents and caregivers
10. Practice cultural safety

For more information on cultivating a therapeutic alliance and “joining the patient” check out the Guidelines for Clinicians at the Aeschi Group website
http://www.aeschiconference.unibe.ch/pdf/Guidelines.pdf

Recommended readings

Michel, K. & Jobes, D. (Eds.) (2010). Building a therapeutic alliance with the suicidal patient. Washington, DC: American Psychological Association.

Risk Assessment & Documentation

Suicide risk assessment represents the cornerstone of effective therapeutic work with suicidal youth. Several suicide risk assessment instruments, checklists and scales are available.[129] [130] It is important to note that some standardized scales can generate a high number of "false positives" and should never be used alone or as a substitute for a thorough clinical assessment.

The best strategy is to develop a comprehensive, systematic and collaborative approach to assessing suicide risk that considers empirically validated risk factors and incorporates clinical knowledge and judgment.[131]

When judging the quality of a particular assessment framework, consider the following:

Core Features	Key Questions
Systematic Multi-Faceted Ecological	• Is the overall approach thorough, extensive and multifaceted? • Are self-report instruments always used in conjunction with a clinical interview? • Does the risk assessment take sufficient account of the larger ecological context and consider potential sociocultural constraints?
Research - Informed	• Is it informed by the current research evidence? • Does it reflect the most up-to-date literature?
Collaborative and Strengths-Based	• Is the process collaborative and strengths-based? • Are young people engaged as knowledgeable and capable?
Developmentally & Culturally Appropriate	• Is it sufficiently attuned to developmental and cultural considerations? • Is the language matched to the child/youth's level of understanding? • Is the approach culturally safe?
Fluid Understanding of Risk	• Is risk understood as fluctuating and dynamic? • Are chronic (distal, enduring and static) and acute (proximal, episodic and variable) risk factors identified and addressed?
Focus on Protective Factors	• Are buffers (protective) factors against suicide thoroughly explored? • Is active consideration given to a range of protective factors across a number of social contexts?
Thorough Exploration of Current Suicidal Thinking	• Is current suicide ideation thoroughly examined beyond "yes/no" tickable boxes? • Does the assessment of current suicidality include an explicit consideration of suicidal desire, capability and intent?
Reflects Input from Collateral Informants	• Are collateral sources of information consulted and included? • Is this information included in the clinical record?
Risk Formulation	• Does the assessment process include the explicit step of risk formulation (i.e. minimal, mild, moderate, severe)? • Are clinically significant warning signs of imminent risk (i.e. within minutes/hours/days) considered in the analysis of risk? • Does the proposed treatment and safety plan match the level of suicidality?

Clear Documentation	• Does the documentation reflect a comprehensive, multi-modal assessment? • Does the recommended treatment plan correspond to the level of risk identified in the risk formulation?

Examples of quality suicide risk assessment approaches can be found at Practical Tools. (http://www.mcf.gov.bc.ca/suicide_prevention/practical_tools.htm)

The purpose of a comprehensive suicide risk assessment is to estimate the risk for suicidal behaviour based on a careful weighing of the clinically relevant risk and protective factors. In recent years, there has been an increased emphasis placed on distinguishing between pervasive and enduring risk factors ("chronic") and more episodic and variable ("acute") risk factors in order to recognize the "fluid quality" of suicide risk and to be sensitized to issues of short-term vs. long-term risk.[132]

- Chronic risk factors tend to be static and enduring and create an overall vulnerability and susceptibility to suicide and suicidal behaviour (e.g. multiple suicide attempts, enduring maladaptive coping and cognitive styles)[133]
- Acute risk factors tend to be more episodic and variable and include triggering events, precipitants, suicide ideation and intent, and symptoms (e.g. depression, anxiety)[134]

It is also important to consider the clinical and practical significance of specific warning signs for suicide. Warning signs tend to be concrete, observable and subjective (e.g. talking about suicide or feelings of being trapped). Warning signs point to the potential for a heightened risk for suicide in the near term (i.e, within minutes, hours, or days). This is in contrast to acute or chronic risk factors which tend to be associated with suicide risk in the medium or longer term (i.e. days to weeks to years) [135]

Warning signs for suicide include:

- hopelessness,
- feeling trapped
- rage/anger/seeking revenge
- acting reckless or engaging in risky activities
- increasing alcohol or drug use,
- withdrawing from family friends/family/society
- anxiety/agitation
- inability to sleep/sleeping all the time
- dramatic mood changes
- no reasons for living/no sense of purpose in life

In general, as suicide intent and symptom severity escalates, the more elevated the risk for potential suicide and suicidal behaviour.[136] Youth who have a number of risk factors (e.g. depression and substance abuse) and who have a previous history of suicidal behaviour and report having current and specific thoughts of suicide should be considered at high risk.

Most approaches to suicide risk assessment underscore the importance of systematically eliciting information across a number of key domains.[137] [138] [139]

- predisposing vulnerabilities (e.g. depression, substance use, previous history of suicidal behaviour)
- precipitating factors (e.g. conflict, breakup of relationship, health crisis)
- mental status, including affective, cognitive and behavioural states
- current level of suicidal thinking and planning (e.g. capability, desire, intention)[140]
- protective factors (or contraindications), (e.g. coping skills, hopeful attitude towards the future, strong social support)

Ongoing attention should be paid to the current level of suicidal intent (i.e. desire for death), reasons for suicide and issues of lethality. A consideration of the young person's level of engagement and willingness to follow through with treatment recommendations is also highly recommended.

One way to approach a comprehensive suicide risk assessment is to use a series of broad, overlapping categories as prompts, which taken together, can guide your questioning and systematic inquiry. This, and other similar approaches, can also be adapted to provide the structure for your clinical record-keeping. For example:

1. Is the young person a member of a group known to be at elevated risk? (e.g. male, older adolescent, Aboriginal youth, person living with a mental illness, GLBT youth)
2. What are the relevant historical or predisposing factors that need to be taken into account? (e.g. previous history of suicidal behaviour, history of psychiatric diagnoses, family history of suicide, history of childhood maltreatment, cultural stress and historical trauma)
3. What are some of the precipitating factors? (e.g. stressful life events, relationship breakup, conflict with a family member, failure, disciplinary crisis)
4. What are some of the warning signs of potential imminent risk? (e.g. thoughts of suicide, substance abuse, purposelessness, anxiety/agitation, impulsivity, aggression, social withdrawal, mood change, hopelessness)
5. What is the level of current suicidal thinking and planning? (e.g. duration, specificity and intensity of ideation, level of planning, behavioural rehearsal, suicidal desire, capability, intent)[141]
6. What are some specific protective factors (e.g. coping and problem solving skills, supportive family, relational connections and social support, plans for the future, willingness to ask for help, community networks of belonging and social capital)[142][143]

Risk Assessment with Young Children

When assessing risk for suicide in *pre-pubertal children*, consider the following[144]:

- children's cognitive development
- verbal skills
- concepts of time
- causality
- understandings of death/suicide

Sample Questions to Ask Young Children about Suicide[145]:

- Did you ever feel so upset that you wished you were not alive or wanted to die?
- Did you ever do something that you knew was so dangerous that you could get hurt or killed?
- Did you ever try to hurt yourself or kill yourself?
- Did you tell anyone that you wanted to die or were thinking about killing yourself?
- Did you do anything to get ready to kill yourself?
- Did you think that what you did would kill you?
- Do you think about killing yourself more than once or twice a day?
- Have you tried to kill yourself since last summer/since school began?
- What would happen if you died? What would that be like?
- How do you remember feeling when you were thinking about trying to kill yourself?
- How is the way you felt then different from the way you feel now?

Estimating Risk Levels

After a careful weighing of risk and protective factors, clinicians then need to estimate the current level of suicide risk. The following categories are often used to conceptualize different risk zones: none, low, moderate, high or imminent.[146] The estimation of risk is both science and art and experienced clinicians recognize the importance of attending to the whole person, understanding suicide risk within a dynamic context and being thorough and persistent in eliciting specific information.

Six key cautions are worth noting[147]:

1. Just because a young person denies suicide ideation, the suicide risk assessment process should not come to an end.
2. When a young person has multiple, enduring risk factors that place them at high risk on an ongoing basis, it is important to carefully attend to the presence of specific warning signs which may signal imminent risk
3. The absence of a history of suicide attempts does not mean that the individual is not at risk.
4. The presence of only a few risk factors does not mean suicide can be ruled out.
5. Clinicians cannot dismiss high suicide risk when client reports no ideation.
6. The presence of protective factors does not serve to "cancel out" risk factors, especially when multiple imminent risk factors are present (frequent, intense ideation and strongly expressed intent to die).[148]

Treatment Plan

The treatment plan developed by the clinician needs to correspond to the estimated level of risk. At a minimum, a treatment plan needs to address the following, all of which should be documented in the clinical record:[149]

- Site of treatment (inpatient or outpatient)
- Members of therapeutic team (including adjunct therapies)
- Overall approach to treatment (individual, group and/or family therapy)
- Treatment goals
- Primary treatment and risk management strategies
- Safety and crisis response plans

Documentation

Maintaining a clear record that documents the risk assessment, estimation of risk, approach to safety planning, treatment goals and clinical consultations is an important aspect of good clinical care. Documentation is important for the following reasons[150]:

1. To convey relevant information to other professionals
2. To serve as a quality assurance checklist
3. To provide protection against malpractice
4. Good clinical documentation rests on good clinical care

5. Even if good clinical care has been provided, if the documentation is poor, the risk for litigation rises

Despite the additional time involved in adequately documenting a suicide risk assessment, outpatient clinicians are strongly encouraged to document their suicide risk assessment and treatment plans as soon as possible following clinical evaluation of the child or youth.[151] Overly simplistic "yes/no" tickable boxes (i.e. Is the person suicidal?) and subjective rating scales (from 1 to 5) are generally poor substitutes for a thorough risk assessment and a step-by-step account of subsequent clinical judgment and planning.

In outpatient settings, documentation of suicide risk should be undertaken as follows[152]:

- Initial interview
- Emergence or re-emergence of suicide ideation, plans or attempts
- Significant changes in the client's condition or treatment plans

To summarize, key principles to keep in mind when assessing risk for youth suicide include:

1. To find out if suicide is a concern, we need to ask individuals directly
2. It is not possible to predict individual suicides but we can estimate risk levels based on a thorough assessment
3. Approaches to assessing risk need to be developmentally appropriate and matched to the age and cognitive understanding of the child or youth
4. The perspectives of parents, caregivers and other sources of collateral information should be actively sought out
5. Risk assessment requires an active consideration of chronic and acute risk factors and protective factors
6. In general, the greater the level of suicide intent and symptom severity, the higher the potential risk
7. Risk status should be re-evaluated on a periodic basis
8. Treatment and risk management plans should correspond to the level of assessed risk
9. Document all clinical decisions and treatment plans
10. A strong therapeutic rapport provides the foundation for all subsequent therapeutic work.

Additional Resources on Risk Assessment

Published Articles and Books

Barrio, C. (2007). Assessing suicide risk in children: Guidelines for developmentally appropriate interviewing. *Journal of Mental Health Counselling, 29*(1), 50-66.

Goldston, D. (2000). *Assessment of suicidal behaviors among children and adolescents.* Bethesda, MD: National Institute of Mental Health.

Jobes, D. (2006). *Managing suicidal risk: A collaborative approach.* New York: Guilford Press.

Kleepsies, P. & Dettmer, E. (2000). An evidence based approach to evaluating and managing suicidal emergencies. *Journal of Clinical Psychology, 56*(9), 1109-1130.

Rudd, M.D. (2006). *Assessment and management of suicidality.* Sarasota, FL: Professional Resource Press.

Rudd, D. (2008). Suicide warning signs in clinical practice. *Current Psychiatry Reports, 10*, 87-90.

Murray, B. & Wright, K. (2006). Integration of a suicide risk assessment and intervention approach: The perspective of youth. *Journal of Psychiatric and Mental Health Nursing, 13*(2), 157-164.

Shea, S. (2002). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counsellors.* New York: Wiley.

Simon, R. & Shuman, D. (2006). The standard of care in suicide risk assessment: An elusive concept. *CNS Spectrums: The International Journal of Neuropsychiatric Medicine, 11*(6), 442-445.

Web Links

The British Columbia Ministry of Health in partnership with the Centre for Applied Research in Mental Health and Addictions (CARMA) recently produced a series of resources to support suicide prevention activities for adult populations.
http://www.carmha.ca/publications/index.cfm?fuseaction=publications.showByClass&topic=13

Crisis Response and Safety Planning

Crises, including intense and urgent suicidal thoughts, are largely time limited and context specific. With the passage of time and the mobilization of appropriate resources and safety precautions (which may on occasion include hospitalization), practitioners can assist children or youth to return to pre-crisis levels of functioning.

Crisis response is one component in the overall assessment and treatment plan. Developing basic competence in recognizing and effectively responding to a young person in a suicidal crisis is essential for all child and youth mental health practitioners. Crisis response strategies need to be both clinically sound as well as practically relevant to the particular treatment setting.

A helpful way of conceptualizing suicide and organizing initial responses to a person in a suicidal crisis[153] has been developed to support those who work with individuals in crisis. In this model, four characteristics of suicide are identified which, taken together, provide the practitioner with the mechanisms for building rapport, understanding the nature of the suicidal crisis and structuring the risk assessment process. Four characteristics of suicide are listed below**.**[154]

1. Suicide is viewed as an *alternative*, a solution to a problem or a feeling of intense emotional pain that the person feels is not resolvable by any other means.
2. A person who is thinking about suicide is in *crisis.*
3. The thinking of most suicidal individuals is characterized by *ambivalence*, and many people have the awareness that two feelings exist simultaneously: the wish to live versus the wish to die or escape.
4. Suicide is an act of *communication.*

A seven stage model for effectively working through a crisis includes the following[155]:

1. Assess lethality and safety needs
2. Establish rapport and communication
3. Identify major problems
4. Deal with feelings and provide support
5. Explore possible alternatives
6. Formulate an action plan
7. Provide follow up

While crisis intervention skills are foundational competencies for all child and youth mental health practitioners to possess, it is equally important to pay attention to the unique context of each individual young person when responding to suicidal crises. In other words, standardized, “one-size-fits-all” approaches can sometimes be experienced as de-humanizing and distancing by persons in distress. By focusing on the unique meaning of the crisis while at the same time upholding the standard of care for treating suicidal persons, clinicians are more likely to cultivate the trust that is required for ongoing therapeutic rapport.[156]

Safety planning is another important clinical tool.[157] Safety plans should be incorporated into the overall treatment plan based on the risk assessment process. A safety plan is different from a "no-suicide contract" because it offers a vehicle for negotiating the action to be taken by the suicidal person depending on his or her level of subjective distress and suicidality. Even though "no-suicide contracts" are often used in clinical practice, there is no evidence to support their efficacy as a deterrent to suicidal behaviour.

Some of the specific limitations of no-suicide contracts are summarized below[158] [159]:

- lack of evidence to support their use as a deterrent to client suicide or self-harm
- provides no guarantee of safety
- not a legal document
- may provide false reassurance
- may lower clinician vigilance
- may be an attempt to replace a thorough suicide risk assessment

Safety planning, a proactive and collaborative process which actively involves the child or youth is recommended. The primary purpose is to create a plan that the youth will utilize during times of suicidal crisis, rather than providing the clinician with a sense of reassurance. Practitioners need to work with the child or youth to ensure that they will feel comfortable carrying out whatever plan is negotiated. When developing safety plans with youth at potential risk for suicide, the following principles are important to keep in mind:

- Collaborative in spirit
- Proactive, i.e. explicitly anticipates a future suicidal crisis
- Individually tailored
- Oriented towards a no-harm decision
- Capitalize on existing social support
- Limits to confidentiality are made explicit
- Time limited
- Sources of 24 hour back up identified
- Document contingencies and decisions
- Dynamic and evolving

Here is one example of a safety plan[160]:

When I am feeling overwhelmed and thinking about suicide, I'll take the following steps:

1. Take a deep breath and try to identify what's troubling me right now.
2. Write down all of the feelings (sad, mad, lonely, helpless, scared, etc.) as a record for later.
3. Try and do things that help me feel better for at least 30 minutes (e.g. have a bath, phone a friend, walk the dog, listen to music).
4. Write down individual negative thoughts and provide an alternative response that changes the perspective.
5. If suicidal thoughts continue, I will call my emergency contact person who is…… at …….
6. If that person is not available, I will call the 24-hour crisis line at……. or the 1-800-SUICIDE line.
7. If I still feel suicidal and out-of-control, I will go to the nearest hospital emergency department.

For more detailed descriptions and additional resources on safety planning and suicide prevention, including key components of safety plans, helpful examples, as well as steps to guide brief interventions with suicidal persons, check out the PowerPoint presentation developed by Gregory Brown, PhD, *Brief Interventions with Suicidal Individuals: Safety Planning and Beyond* at http://www.mirecc.va.gov/visn19/2nd_Annual_Traumatic_Brain_Injury_TBI_Suicide_Prevention_Conference.asp

Coping with Suicidal Thoughts is designed to assist individuals experiencing suicidal ideation and while it is written for adults, it offers a sample safety plan outline that could be adapted for youth. Copies of this document can be downloaded at no cost from: http://www.comh.ca/publications/pages/cwst/, on the Consortium for Organization Mental Health (COMH) website. COMH is a part of the Centre for Research in Mental Health and Addiction (CARMHA).

Treatment

Promising Psychosocial Treatments

A recent review of the outcome based psychotherapy research literature suggests that the therapeutic relationship is *the* most important ingredient in any therapeutic change effort. More specifically:[161]

This line of research suggests that it is not what psychological ingredients are delivered but how they are delivered that is crucial.

Meanwhile, recent, systematic reviews of the literature on the treatment of youth suicidal behaviour suggest that due to methodological limitations, no one treatment approach can be said to be "well established".[162] [163] [164] At the same time, some treatments do appear to show promise. For example a recent Canadian review[165] systematically examined the evidence on treatments for suicidal children and adolescents and found that:

> *Dialectical behaviour therapy (DBT) is helpful when available…and fluoxetine combined with cognitive behaviour therapy (CBT) has been helpful for suicidal ideation as well as depressed mood… Interpersonal therapy (IPT) is useful for depressed adolescents but has not yet been shown to benefit suicidal ideation or behaviour. There is a small amount of evidence that family therapy is beneficial in reducing suicidal ideation in teenagers without major depressive illness* (p. 40S).

In another review[166], both developmental group psychotherapy and family communication and problem solving, while limited, did lead to statistically significant differences between treatment and comparison groups. Other promising psychosocial approaches that led to observed reductions in suicide attempts or deliberate self harm (even though they were *not* statistically significant) were characterized by the following features:

- Short term interventions in outpatient settings
- Involved family members in treatment
- Involved some form of cognitive behavioural therapy (CBT)

According to this reviewer eight tentative statements (based on promising, not efficacious research), with implications for reducing suicide attempts and indirect markers of suicidality (i.e. threats, ideation) among youth can be made[167]:

1. Developmental group psychotherapy (which included elements of problem solving, cognitive behavioural therapy, dialectical behavioural therapy and psychodynamic group psychotherapy) was superior to the comparison group in reducing self harm.
2. Family communication and problem solving were more likely to reduce suicide ideation than were the comparison conditions, but only among those without major depression.
3. Family interventions (i.e. brief 5-session intervention) did not reduce suicidality among youth with major depression.
4. Short term, outpatient treatments were effective in reducing suicide attempts or deliberate self harm among suicide attempters.
5. Outpatient treatment was an effective alternative to hospitalization in two studies.
6. CBT and problem solving were included in many of the interventions that reduced the direct and indirect markers of suicidality.

7. Dialectical behavioural therapy (DBT) was helpful in reducing a number of indirect markers of suicidality among youth who were diagnosed with borderline personality disorder.
8. Short term interventions that involved families increased youth's compliance with treatment recommendations.

Additional Resources on Promising Psychosocial Treatments

Comtois, K. & Linehan, M. (2006). Psychosocial treatments of suicidal behaviors: A practice friendly review. *Journal of Clinical Psychology, 62*(2), 161-170.

Donaldson, D., Spirito, A. Esposito-Smythers, C. (2005). Treatment for adolescents following a suicide attempt: Results of a pilot trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(2), 113-120.

Daniel, S. & Goldston, D. (2009). Interventions for suicidal youth: A review of the literature and developmental considerations. *Suicide and Life Threatening Behavior, 39*(3), 252-268.

Huey, et al. (2004). Multi-systemic therapy effects on attempted suicide by youths presenting psychiatric emergencies*. Journal of the American Academy of Child & Adolescent Psychiatry, 43(*2), 183-190.

Klomek, A. & Stanley, B. (2007). Psychosocial treatment of depression and suicidality in adolescents. CNS Spectr, 12(2), 135-144.

Macgowan, M. (2004). Psychosocial treatment of youth suicide: A systematic review of the research. *Research on Social Work Practice, 14*(3), 147-162.

Mann, J., et al. (2005). Suicide prevention strategies: A systematic review. *JAMA, 294*(16). 2064-2074. Available at http://jama.ama-assn.org/cgi/content/abstract/294/16/2064.

Steele, M. & Doey, T. (2007). Suicidal behaviour in children and adolescents. Part 2: Treatment and prevention. *Canadian Journal of Psychiatry, 52*,35S-45S.

Web Links

Aeschi Group Movement for Improving the Therapeutic Approach to the Suicidal Person
http://www.aeschiconference.unibe.ch/index.htm

Indigenous Healing Practices

No randomized controlled studies have been conducted to evaluate treatments for suicidal Aboriginal youth.[168] Therapeutic approaches to working with Aboriginal youth often represent an integrated blend of western approaches and Indigenous healing practices[169]. Several writers emphasize the importance of understanding Aboriginal worldviews when engaging in any healing practices with Indigenous peoples[170]. Such approaches go beyond therapeutic "techniques" and do not easily fit into models or frameworks that emphasize "evidence-based practices." When working with Indigenous peoples, a number of issues take on particular salience. These include: balance, connectedness, spirituality, connection with nature, ceremony and tradition.[171]

> *Most Native People believe that they are more than just the cognitions that flow endlessly through the realm of awareness…If we inflict a system that is based only on cognitions, in the logocentric Euro-American tradition, we are committing hegemony (imposing a different worldview on someone) on the patient who believes otherwise*.[172]

The National Aboriginal Health Organization's (NAHO) First Nations Centre has published a number of reports which describe the role of traditional knowledge in facilitating healing for First Nations people http://www.naho.ca/firstnations/traditional-knowledge/

Additional Considerations for Working with Aboriginal Clients in a Respectful Way[173]

1. Reflect on motives for wanting to work with Aboriginal people.
2. Review current therapeutic approaches and consider how they may need modification in an Aboriginal context.
3. Build relationships with Aboriginal colleagues, agencies, organizations, Elders, professional peers and the First Nations communities with which your clients have membership.
4. Take a holistic approach to case management.
5. Gather information from the client and referring source as well as cultural consultants.
6. Discuss barriers that may impede effectiveness.
7. Make contact with the child or youth and identify who will be involved in the initial meeting.
8. Explore the range of therapeutic options that are effective with Aboriginal children and youth
9. Follow up and seek feedback.
10. Evaluate.

Recommended Readings on Indigenous Healing Practices

Duran, E. (2006). *Healing the soul wound: Counselling with American Indians and other native peoples.* New York: Teachers College Press.

McCormick, R. (2009). Aboriginal approaches to counselling. In L. Kirmayer & G. Valaskalis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada*. Vancouver: UBC Press.

Tait, C. (2008). Ethical programming: Towards a community centred approach to mental health and addiction programming in Aboriginal communities. *Pimatisiwin: A Journal of Aborginal and Indigenous Community Health, 6*(1), 29-60.

Vicary, D. & Bishop, B. (2005). Western psychotherapeutic practice: Engaging Aboriginal people in culturally appropriate and respectful ways. Australian Psychologist, 40(1), 8-19.

Waldram J. (Ed.) (2008). *Aboriginal healing in Canada Studies in therapeutic meaning and practice.* Ottawa: Aboriginal Healing Foundation.

Wesley-Esquimaux, C. & Snowball, A. (2010). Viewing violence, mental health and addictions through a wise practice lens. *International Journal of Mental Health and Addictions, 8*, 390-407.

Parent/Family/Caregiver Involvement in Treatment

The success of any treatment with suicidal adolescents is heightened when parents/caregivers and other family members are actively enlisted to support the treatment goals. Specific strategies include[174] [175]:

- Enlist parents/caregivers as allies and active partners in keeping the young person safe
- Strengthen their ability to provide support and protection
- Validate, provide reassurance and recognize parents are doing the best they can.
- Support parents/caregivers to instil hope, reinforce treatment goals, and promote skill-building efforts
- Actively involve family members/caregivers in the monitoring and risk assessment process by telling them what to look for and how to recognize the importance of potentially suicidal behaviours
- Mobilize family support and problem solving, and help parents/caregivers to initiate and adhere to follow-up treatment, and promote linkage to follow-up care
- Ensure family members/caregivers understand the importance of reducing access to potentially lethal means of suicide, e.g. medications, firearms, etc.
- Clarify the limits on information-sharing and remind family members/caregivers that if suicide risk is suspected, confidentiality will be breached and parents will be told.
- Communicate interest in what family members/caregivers have to say.
- Clearly define a role for the family/caregivers in the treatment process.
- Bring a cultural safety lens to the work with families and caregivers

Following a young person's suicide attempt, many parents and caregivers are understandably shocked, frightened and upset. Providing emotional support and reassurance, offering education about depression, mental health and suicide risk, explaining relevant legislation, letting parents/caregivers know what to expect in terms of treatment options and assisting parents/caregivers to take specific actions to reduce future attempts and reinforce treatment goals, are all important aspects of sound clinical care.

Recommended Reading

Asarnow, J., Berk, M.,& Baraff, L. (2009). Family intervention for suicide prevention: A specialized emergency department intervention for suicidal youth. *Professional Psychology, Research and Practice, 40* (2), 118-125.

For more information visit
http://ww3.suicideinfo.ca/Default.aspx?tabid=722&SkinSrc=[L]Skins\Print\Print

F.O.R.C.E Society for Kids Mental Health http://www.bckidsmentalhealth.org/

Family and School Interventions for Youth at Risk

Children of depressed parents are at heightened risk for depression and other forms of psychopathology. Depression is a risk factor for suicide and suicidal behaviour. **Family focused** group interventions that target the offspring of depressed parents are designed to reduce risk factors, promote competencies and increase awareness of depression in family members. While the effect of these types of intervention on the specific outcome of suicide related behaviour among youth is not entirely clear, they have been shown to be effective at reducing depressive symptoms among adolescents of depressed parents, which makes it a promising youth suicide prevention strategy to pursue.[176]

- Engaging with depressed parents, providing psycho educational materials, teaching strategies for enhancing resilience in children, linking information to families' particular illness experience and providing long term support and follow up, represent a promising and comprehensive approach to reducing risks for depression among children and youth.[177]

In recent years, school based, indicated prevention programs that target youth-at-risk have become more common. These approaches are based on enhancing social support and building skills. Rigorous program evaluations, several of which are based on strong experimental designs, have recently been conducted to assess the effectiveness of school based, indicated prevention programs for potential high school dropouts. Results indicate that brief, skill based, social support enhancement interventions can be effective in reducing risks for suicide both immediately after the program, 10 weeks later and at nine month follow up.[178] [179] [180]

Implementation Ideas and Resources

Reconnecting Youth: A Peer Group Approach to Building Life Skills (http://nrepp.samhsa.gov/ViewIntervention.aspx?id=96) has been characterized by the American Substance Abuse and Mental Health Services Association (SAMHSA) as a "model program". Reconnecting Youth (RY) is a school based prevention program for youth in grades nine through 12 (14 to 18 years old) at risk for school dropout. These youth also may exhibit multiple problems, such as substance abuse, aggression, depression or suicide risk behaviors. Reconnecting Youth uses a partnership model involving peers, school personnel and parents to deliver interventions that address the three central program goals: decreased drug involvement, increased school performance and decreased emotional distress.

Kaiser Permanente Center for Health Research Youth Depression Treatment and Prevention Programs is available at http://www.kpchr.org/public/acwd/acwd.html.

Additional Resources on Family- and School-Focused Interventions with Youth at Risk

Published Articles and Books

Beardslee, W., Gladstone, T., Wright, E. & Cooper, A. (2003). A family based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Pediatrics, 112*(2), 119-131.

Clarke, G., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W., O'Connor, E. & Seeley, J. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry, 58*, 1127-1134.

Eggert, L., Thompson, E., Randell, B. & Pike, K. (2002). Preliminary effects of brief school based prevention approaches for reducing youth suicide – Risk behaviours, depression, and drug involvement. *Journal of Child and Adolescent Psychiatric Nursing, 15*(2), 48-64.

Fisher, P., Masia-Warner, C. & Klein, R. (2004). Skills for social and academic success: A school based intervention for social anxiety disorder in adolescence. *Clinical Child and Family Psychology Review, 7(*4), 241-249

Langelier, C. (2001). *Mood management leader's manual: A cognitive behavioral skills building program for adolescents.* Thousand Oaks, CA: Sage

Merry, S., McDowell, H., Hetrick, S., Bir, J. & Muller, N. (2004). Psychological and/or educational interventions for the prevention of depression in children and adolescents. *Cochrane Database of Systematic Reviews, 1*.

Continuity of Care

Engaging youth who are at risk for suicide can be particularly challenging for several reasons[181] [182]:

- Adolescent clients are not typically self referred for mental health treatment
- Adolescents in emotional distress do not always seek help from professional caregivers
- Many youth report that they would turn to a friend first when faced with a mental health problem
- Many young people in a suicidal crisis do not follow through on treatment recommendations
- Many others drop out of treatment prematurely

By recognizing that there are some specific actions that can be taken to effectively assess risks for suicide and promote treatment adherence (i.e. facilitate specific and timely referrals to community based mental health services), hospital staff and community based mental health service providers can work together to develop a stronger, more integrated system that will benefit suicidal youth and their families and caregivers.

Community hospital protocols, which represent a partnership between community based mental health agencies and hospitals, can be developed to promote safe and effective care for suicidal youth who present at Hospital Emergency Departments. The purpose is to ensure timely and appropriate referrals are made to community service providers.

- For an example of a Hospital Emergency Department Protocol developed in Australia visit http://www.health.nsw.gov.au/pubs/2004/emergency_dept.html.

Means Restriction

Recent reviews of the evidence confirm that the presence of firearms in the home represents an independent risk factor for suicide among young people. Specifically, studies undertaken in the United States which compared youth suicide victims with community controls found that guns were four to five times more likely to be found in the homes of those who died by suicide, even after adjusting for confounding variables like psychopathology.[183] While in Canada, the relative risk of youth suicide as a result of firearms being kept in the home is less than the United States, it is still important to consider and strengthen opportunities to modify the environments of potentially high risk youth wherever possible.

- Findings from other countries also suggest that means restrictions efforts can have an important impact on reducing suicidal behaviour and suicide rates.[184] [185]
- These measures include reducing access to domestic gas, gun possession control efforts, reducing carbon monoxide emissions from vehicles, reducing the size of analgesics packages, installing bridge barriers and safer prescribing practices.

At a more practical level, teaching parents and adult caregivers of at risk, vulnerable youth about the importance of keeping their homes safe and limiting access to potential means of suicide is another specific strategy that holds promise. In one study, researchers were able to follow adult caretakers, whose children and youth (aged six to 19) had attended the Emergency Department (ED) in the previous two months for a mental health assessment, to determine if receiving means restriction education at the time of their ED visit made a difference in their future actions regarding limiting access to lethal means. Findings revealed that training in means restriction was significantly associated with new action to limit access to firearms, prescriptions and over-the-counter medications, but not alcohol.[186]

The Harvard School of Public Health has a useful website dedicated to the topic of means restriction at http://www.hsph.harvard.edu/means-matter/.

Postvention and Bereavement

In the field of suicide prevention, the term "postvention" has been coined to refer to those activities and processes that are undertaken *after* a suicide has taken place. A coordinated and thoughtfully informed postvention response that is guided by the professional and empirical literature is designed to identify youth at potential risk, reduce risks for imitative suicidal behaviour and subsequent mental health problems, and facilitate healthy expressions of grief.

Current Knowledge About Postvention[187] [188]

- Postvention strategies are directed at peer survivors of a youth suicide as they can be at heightened risk for psychological distress and imitative suicidal behaviours
- Current evidence regarding the effectiveness of postvention strategies is scarce
- A coordinated community response is an important part of an effective postvention response
- Tentative support exists for the effectiveness of post-suicide screening efforts in facilitating detection of those at potential risk
- Proximity to the person who died by suicide might not be the only factor to consider in determining potential risk for imitative suicidal behaviour, other factors include perceived similarities to the deceased – including age, gender and ethnicity[189]
- It is possible to identify and respond to youth at risk following an outbreak of suicides and suicidal behaviours through a standardized and systematic approach to detecting risk and by facilitating referrals for immediate crisis response

Implementation Ideas and Tools

For a detailed description of postvention principles and guidelines to follow after a suicide death check out the helpful information found on pages 69–133 prepared by the Texas Suicide Prevention Council, Texas Youth Suicide Prevention Project (2009). While this document was prepared for an American context, the postvention information has international relevance. http://texassuicideprevention.org/docs_pdf/24215-Mental_Health_09_Suicide_Prev_Book_Complete_FINAL.pdf.

For information regarding the risks and benefits of establishing memorials in schools and communities for youth who have died by suicide, visit http://www.tlcinst.org/Memorials.html.

Additional Resources on Postvention

Hanssens, L. (2008). Clusters of suicide: The need for a comprehensive postvention response to sorrow in indigenous communities in the northern territory. *Aboriginal and Islander Health Worker Journal, 34*(2), 25-33.

Understanding and Reducing Contagion

Contagion refers to the observed phenomenon of one person's suicide leading to other suicides, often referred to as imitative or "copy-cat suicides"[190] [191]. In such cases, the initial suicide appears to have a triggering effect on some specific individuals, especially those who have pre-existing vulnerabilities, including for example, a history of suicidal behaviour, depression and those who have perceived similarities to the person who died.

Strategies for Minimizing Contagion

- Avoid romanticizing someone who has died by suicide
- Educate reporters about the importance of responsible media reporting
- Identify potentially high risk individuals (e.g. friends of the person who died by suicide and/or those with previous suicidal behaviour)
- Assess and provide active follow up to those identified at high risk
- Notify family members of the need to be vigilant, since suicidality can fluctuate

Reducing Risks for Suicide Through Social Networking Sites

In recent years there have been increased concerns about the potential for social networking sites like Facebook to contribute to suicide contagion. For example, after the death of a young person by suicide, Facebook sites often become emotionally charged gathering sites for young people to express their thoughts, ideas and questions, raising concerns about the potential for these sites to inadvertently glamorize the person who died. There is also a concern that repeated and detailed online discussions about suicide can act as "natural advertisements" for suicide as a way of coping with emotional distress, especially among those youth who may already be vulnerable.

Despite limited research in this area, some useful practical recommendations developed by others can provide some guidance.[192]

A comprehensive manual which provides guidelines for "online postvention" has been developed by the National Suicide Prevention Lifeline
http://www.sprc.org/library/LifelineOnlinePostventionManual.pdf

For more information about innovative solutions to facilitating postvention responses in online communities, read pages 130–132 of the comprehensive suicide prevention and postvention toolkit prepared by the Texas Suicide Prevention Council, Texas Youth Suicide Prevention Project (2009). http://texassuicideprevention.org/docs_pdf/24215-Mental_Health_09_Suicide_Prev_Book_Complete_FINAL.pdf

To report suicidal content on Facebook go to
http://www.facebook.com/help/contact.php?show_form=suicidal_content

After a Suicide: Reducing Risks in Online Communities[193]

After a suicide, a person's MySpace page or Facebook profile will stay online – often becoming a memorial for that person. While this can be a good place for friends and family to express their sorrow, we know that left unchecked, these pages can also become areas where further suicidal ideation can occur. Below we outline steps that should be taken after a suicide.

1. Identify the moderator of the person's online accounts (usually parents or friend of the deceased).
2. Provide the letter below to explain how social networking sites can impact further suicidal ideation.
3. Someone in the community should monitor the comments posted after the suicide – watching out for any red flag language (e.g. "I am going to join you soon," "I can't take life without you.") and be prepared to contact those users if necessary.
4. Work with school counsellors and principals to help them understand the impact a person's online presence can have.

Letter to Give to Parents

Dear parents and family members of [insert person's name]

Thank you for this chance to work together to help prevent suicide. We are so sorry to hear about the recent losses in your community, high school, and homes. While there is nothing we can do to erase these tragedies, it is our hope that we can help other families in your community from experiencing a similar situation. The message posted on a Facebook page and/or group (or MySpace page or in any public space) regarding suicide is an important part of preventing further deaths. While the language should honour the person and comfort those left behind, it is important to make sure that those reading the page see suicide as preventable. Please have a look at the message crafted for your child's Facebook or MySpace (or other social-networking) pages below, and let me know if you have any questions or need further assistance.

Recommended posting to social networking site following a youth death by suicide

With help, this loss of life might have been avoided. The best way to honour (person's name) is to seek help if you or someone you know is struggling. If you're feeling lost, desperate, or alone – please visit http://www.youthinbc.com/ or http://www.youthspace.ca/ or call 1 800-SUICIDE (784-2433). The call is free and confidential, and crisis workers are there 24/7 to assist you. You can also visit http://lifeline-gallery.org/ which is a site that offers stories of hope and healing.

Sensationalized media reports are believed to exacerbate risks for imitation and contagion. Suggestions for working with the media to follow responsible reporting guidelines are included are included within Media Education.

Supporting Youth Survivors

Young people who have lost a friend, romantic partner, or family member to suicide are often left with a range of feelings including shock, sadness, confusion, guilt, anger, and helplessness. Occasionally well-intentioned adults try to conceal the cause of death, particularly when dealing with young children, mistakenly thinking that the news of a suicide death would be too difficult for them to manage. What young people want most is to be treated with respect, which means providing them with the truth about how their loved one died. In these difficult circumstances, children and youth are best served through kindness, honesty, and openness.

For guidance on explaining suicide to young children or talking to children after a suicide death in the family go to http://www.tlcinst.org/PTRCtalking.html

A DVD, entitled “Left 2 Live” was recently produced by the BC Council for Families, in collaboration with the School of Child and Youth Care at the University of Victoria. This DVD chronicles the experience of young people who have lost a friend or loved one to suicide, and provides practical advice to caregivers and professionals about how to support youth who are bereaved by suicide http://www.bccf.ca/professionals/Left-2-Live

A website dedicated to supporting adolescents who have lost someone to suicide is at http://www.teensuicidegrief.org/home_en.html

Another website aimed at supporting siblings who have lost a sister or brother to suicide is at http://siblingsurvivors.com/

Supporting Family Survivors

Family members and loved ones who have experienced a loss to suicide (survivors) commonly experience overwhelming feelings of despair, confusion, shame, guilt, hopelessness and isolation. Anger towards formal institutions and systems of care (e.g. mental health, hospital, school) may be especially intense, especially if family members believe that their loved one was not well served by the helping system.

Clinical practitioners will also experience a range of complex emotions if a client of theirs dies by suicide. For information on "clinician survivors" visit "When a Client Dies by Suicide"

A booklet, entitled *Hope and Healing* (http://www.health.gov.bc.ca/library/publications/year/2007/HopeandHealing.pdf), which was published by the BC Ministry of Health in partnership with the Centre for Applied Research in Mental Health and Addictions (CARMA), offers practical suggestions to survivors and those who care about them.

Initiated by survivors of suicide in British Columbia, the *Survivor Advocate Listserve* is for people ("suicide survivors") who have been affected by the suicide of family member, friend or colleague and who are now involved in Suicide Prevention in some way. The purpose of the group is to network and share ideas for a common cause. Professionals working in partnership with suicide survivors in Suicide Prevention are also welcome to join. The group is primarily Canadian, but others are welcome to participate.

To join the Survivor Advocate Listserve, send an email to: SurvivorAdvocates-subscribe@yahoogroups.com

Note: This group is NOT a bereavement support group. Lists of Survivor Support Groups are located at http://www.suicideprevention.ca/ or contact your local Mental Health Centre.

On-Line Bereavement Support and Additional Resources

For friends and family members who have lost a loved one to suicide go to http://www.yourlifecounts.org/?page_id=882

http://www.survivorsofsuicide.com/help_heal.shtml

For an online resource dedicating to supporting survivors of suicide go to The Alliance of Hope for Suicide Survivors website at http://www.forsuicidesurvivors.org/

For other helpful guidelines on how to support family members following a suicide death, see pages 113–118 of a comprehensive suicide prevention and postvention toolkit prepared by the Texas Suicide Prevention Council, Texas Youth Suicide Prevention Project (2009). http://texassuicideprevention.org/docs_pdf/24215-Mental_Health_09_Suicide_Prev_Book_Complete_FINAL.pdf

For helpful resources for family members grieving the loss of a family member from a murder-suicide death, visit the website of the Community Awareness and Support (CAAS) Centre, an American non-profit organization founded by a survivor of a murder-suicide at http://www.caascenter.org/index.html

The American Association of Suicidology has also published a Handbook for Survivors of Suicide http://www.suicidology.org/c/document_library/get_file?folderId=229&name=DLFE-73.pdf

The American Foundation for Suicide Prevention has compiled a list of recommended readings for survivors of suicide
http://www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=FF1F73F3-01DF-26E3-05AB12DF557FCA0E

School and Community Protocols

Schools and communities are advised to develop proactive strategies, outlining the specific steps to be taken in the event of a youth death by suicide. By engaging relevant community representatives and service providers in a collaborative planning process communities and schools will be able to develop an approach that reflects their own unique community context and needs.

- The BC Council for Families recently produced a helpful planning document that outlines a step-by-step guide for developing a postvention response plan entitled, *Suicide Postvention is Prevention: A Proactive Planning Workbook for Communities Affected by Youth Suicide.* http://www.bccf.ca/professionals/networks/suicide-prevention
- Some School Districts have collaborated with Child and Youth Mental Health Services to develop specific protocols that will guide their actions in the aftermath *of a youth suicide. Such protocols typically spell out the respective roles and responsibilities of schools* and mental health centres when responding to the needs of students at risk for suicide and they include contact information for local resources. These protocols are best prepared in advance of any crisis.

The BC Ministry of Education has developed a document to guide responses in the aftermath of a sudden or unexpected death, http://www.bced.gov.bc.ca/specialed/rci/resteams.htm.

Helpful guidelines for responding to crises in the schools have been developed by the UCLA School Mental Health Project, http://smhp.psych.ucla.edu/pdfdocs/crisis/crisis.pdf.

Media Education

Responsible media coverage contributes to the reduction of suicide contagion, therefore, in the event of a suicide in the community media should be encouraged to follow existing media guidelines regarding accurate and responsible reporting of a completed suicide.

- The Canadian Psychiatric Association recently produced a policy paper on Media Guidelines for Reporting Suicide, which is available at http://publications.cpa-apc.org/media.php?mid=733&xwm=true.

- Other media guidelines, based on the research literature, are available at http://www.who.int/mental_health/prevention/suicide/resource_media.pdf

The Canadian Association for Suicide Prevention and Center for Disease Control suggest the following guidelines for media reporting suicide:

AVOID
• Details of the method
• The word “suicide” in the headline
• Photo(s) of the deceased
• Admiration of the deceased
• The idea that suicide is unexplainable
• Repetitive or excessive coverage
• Front page coverage
• Exciting reporting
• Romanticized reasons for the suicide
• Simplistic reasons for the suicide
• Approval of the suicide

CONVEY
• Alternatives to suicide (i.e. treatment)
• Community resource information for those with suicidal ideation
• Examples of a positive outcome of a suicidal crisis (i.e. calling a suicide hotline)
• Warning signs of suicidal behaviour
• How to approach a suicidal person

CDC Guidelines available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm

CASP Guidelines available at: http://casp-acps.ca/Publications/MEDIA%20GUIDELINES.doc

Organizational & System-Level Interventions

Organizational interventions or system level support refers to all of the ongoing activities that enable and sustain a comprehensive approach to youth suicide prevention. These include professional development efforts, service coordination and planning, policy initiatives and research and evaluation. Through proactive planning and the careful cultivation of local capacity, communities will be able to develop a long range plan for addressing youth suicide and suicidal behaviours.

Professional Development Training

Child and youth mental health clinicians, and other allied professionals, have an ongoing responsibility to maintain their competency in assessing and treating suicidal youth and their families. Staying up-to-date with the published research and clinical literature, attending professional conferences and workshops, knowing where and how to access specialized knowledge and expertise, accessing regular supervision, receiving feedback on therapeutic assessment and intervention skills, understanding relevant policies and legislation and incorporating practice guidelines into one's clinical practice are all important components for maintaining clinical competency in this area. Attending advanced level clinical training, either online or through face-to-face training seminars, on a regular basis is also highly recommended.

Elements of competent and ethical care in the treatment of suicidal individuals include[194]:

- Sufficient informed consent
- Adequate assessment of risk
- Empirically supported treatments
- Appropriate risk management

Suicidology experts in the United States have identified a series of specific clinical competencies related to the assessment, treatment and management of suicidal clients. A list of these competencies can be found at http://www.sprc.org/featured_resources/trainingandevents/training/core.asp.

- LivingWorks has developed a one day training session for clinical practitioners who will be working with suicidal clients on a longer term basis called suicideCare http://www.livingworks.net/SC.php.

- A half day workshop called "Tattered Teddies: A Workshop About Suicide in Children" has been developed by the Centre for Suicide Prevention. This interactive workshop prepares practitioners to work with young children at risk for suicide using practical and developmentally sensitive approaches. For more information visit http://www.suicideinfo.ca/csp/go.aspx?tabid=169.

- An on-line course to become a "Suicide Intervention Specialist" is now available from QPR at http://www.qprinstitute.com/Joomla/index.php?option=com_content&view=article&id=242&Itemid=107

- River of Life is an on-line suicide prevention curriculum aimed at preventing youth suicide among Aboriginal youth http://www.riveroflifeprogram.ca/

- The Training Institute for Suicide Assessment and Clinical Interviewing provides information to mental health practitioners on the development of suicide prevention skills, crisis intervention skills and advanced clinical interviewing skills http://www.suicideassessment.com/.

Planning and Service Coordination

Some of the most promising prevention and treatment strategies for reducing risks for suicide among youth have been outlined in other sections. Simply having knowledge about "what works", no matter how strong or compelling the research evidence is, is not enough to lead to significant changes in suicide prevention and intervention practices.[195] Practice is influenced by much more than the possession of knowledge and thus strategies designed to support practitioners to practice in a more "evidence based way" need to go beyond simplistic "knowledge transfer" efforts.[196] Active strategies that are designed to foster engagement, promote dialogue, encourage reflection, facilitate shared leadership and enable critique are recommended.[197]

Another important consideration for community planners is the understanding that youth suicide prevention cannot be seen as an exclusively "professional endeavour". To enable communities to "own" the issue of youth suicide prevention, opportunities also need to be created for youth, parents and concerned community citizens to get involved. Community participants need to be given the opportunity to actively engage with the youth suicide prevention agenda.[198] This means they must be provided with meaningful opportunities to participate in the emerging plans, which may include challenging and/or questioning the relevance and appropriateness of the suicide prevention program's goals and objectives.

The way that the problem of suicide is framed is also an important consideration. For example, an exclusive focus on individuals can often conceal from view some of the social, historical and political factors that contribute to elevated suicide risk. This is particularly significant when addressing suicide in Indigenous communities. As others have pointed out:[199]

> *…given the widespread social problems faced by Aboriginal people in Canada, viewing suicide strictly as the outcome of a psychiatric disorder is not only incomplete but actually may aggravate the situation... Psychiatric explanations are stigmatizing, and so add to the feelings of estrangement, devaluation, and powerlessness that contribute to suicidality. A psychiatric approach directs attention to the pathological individual rather than to basic social problems that demand remediation. Nor can psychiatric labelling be displaced from the individual to the community. Labelling whole communities as "sick" is a metaphor that may contribute to pervasive demoralization and that evades the social and political issues.*

- For a series of useful resources on planning and implementing community-based suicide prevention programs go the Suicide Prevention Resource Center at http://www.sprc.org/taking_action/plan.asp

The Action Alliance for Suicide Prevention also has a number of useful reports, links to resources, and program examples http://actionallianceforsuicideprevention.org/?page_id=9

Mobilizing Local Knowledge and Coalition Building

Creating opportunities for input from a number of diverse perspectives is identified as an important strategy for building broad commitment to the issue of youth suicide prevention.[200] Some youth suicide prevention practices (e.g. media education, gatekeeper training, means restriction, etc.) are best addressed by a broad range of professionals and community members working together. Other youth suicide prevention efforts, like clinical assessment and treatment programs for example, are therapeutic services that are delivered by professional practitioners who have specialized knowledge, skills and interests. Not every component of the local youth suicide prevention effort requires the direct involvement of every individual or group with a vested interest.

In order to advance a *comprehensive* approach that recognizes that clinical services and treatment approaches are but one aspect of the overall youth suicide prevention effort, we need to find ways to creatively engage the broader community.[201] The view being promoted here is that community driven youth prevention plans will be more effective than "ready-made solutions" imported from outside if they:

- evolve out of a consideration of multiple knowledges and realities[202]
- reflect the interests of a range of professionals and community members who have respectfully engaged with one another through fair and equitable dialogue[203]
- recognize that young people have valuable insights, knowledge and wisdom

For ideas about how to initiate and sustain community wide prevention efforts in your community, check out the *Communities That Care* program material http://www.sdrg.org/ctcresource/ or through the US Department of Health and Human Services and Substance Abuse and Mental Health Services Administration (SAMHAA) website at http://ncadi.samhsa.gov/features/ctc/resources.aspx.

For a toolkit on community mental health promotion go to http://www.cmha.ca/mh_toolkit/intro/index.htm

Proactive Policies and Protocols

It is important to develop a locally coordinated, systematic service delivery response network that will ensure that youth at risk for suicide receive timely assessments, effective care, efficient follow up and careful monitoring.[204] Many communities have opted to develop proactive protocols and policies that spell out the respective functions and responsibilities of each service delivery agency. Partners that are most commonly included are hospital emergency departments, community based mental health centres, schools, police, crisis response programs and child protection offices.

The process of developing these protocols is valuable in itself since it typically provides an excellent opportunity for agency representatives to meet together to discuss their particular service mandates, clarify criteria for referrals, provide updates on their programs and share common concerns.

For example guidelines on developing organizational policies and protocols for responding to suicidal behaviour, visit
http://www.communities.qld.gov.au/resources/communityservices/community/documents/principles-for-developing-protocols.pdf

The JED Foundation which is dedicated to reducing suicide on college campuses has also developed several resources and institutional protocols
http://jedfoundation.org/professionals/programs-and-research/framework

Research and Evaluation

Communities are advised to monitor the effects of their local prevention program efforts by setting clear and realistic goals, identifying indicators of progress[205], and carefully monitoring processes (e.g. referral rates, level of youth participation) and outcomes (suicide attempts and deaths).[206] Quantitative measures (e.g. percent of trained gatekeepers who correctly identify the level of suicide risk in a simulated interview) and qualitative measures (e.g. young people's description of their experience receiving professional mental health services) are both important to monitor.

Multiple dimensions of a local youth suicide prevention program can be tracked and monitored over time including individual client level (e.g. changes in suicide risk level over time), individual program level (e.g. number of referrals, satisfaction with services) and community or local service delivery network level (e.g. local knowledge about resources, media reports, and citizen participation).

A number of excellent materials including, toolkits, practical advice and educational resources for evaluating community based suicide prevention programs are located at http://www.sprc.org/search/apachesolr_search/evaluation%20tools

An evaluation framework for monitoring and evaluating suicide prevention activities in Aboriginal communities, including an example logic model, is available at http://www.socialsciences.uottawa.ca/crecs/eng/documents/EvaluationFramework-NAYSPS-07-10-26.pdf

Sociopolitical Interventions

Policy and practice interventions that are aimed at recognizing and transforming the macro-level social conditions that contribute to inequities and oppression are key to any prevention effort. Anti-racism, critical consciousness, de-colonization, youth activism and social change movements are interrelated efforts that together, speak to the growing recognition across a number of sectors that there can be no mental health without social justice. [207] [208]

> "levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice… both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status"[209]

By situating our understanding of suicidality within a socio-political and historical context, and by resisting the temptation to individualize problems like suicide (which places the onus for change on individuals), we are likely to have a more complete appreciation for the structural challenges and historical realities that many people are up against. In other words, social and economic deprivation as well as political and historical forces of oppression contribute to experiences of hopelessness and suicidal despair, particularly for those on the margins. Any prevention framework that neglects these factors will be inadequate.

From local, grassroots efforts to formal policy interventions, taking a stand against stigma, discrimination, poverty, and injustice in all its forms, is what characterizes these efforts. Examples include: gay/straight alliances in schools, anti-racist pedagogies in classrooms, critical consciousness raising in communities, institutional policies and practice frameworks that address de-colonization and intersectionality, anti-poverty movements, and the use of popular theatre, social networking sites and other creative tactics to mobilize resistance against injustice.

Several high-level priorities for promoting social justice and mental health have been identified and include:[210]

- social, cultural and economic conditions that support family and community life
- education that equips children to flourish both economically and emotionally
- employment opportunities and workplace pay and conditions that promote and protect mental health
- partnerships between health and other sectors to address social and economic problems that are a catalyst for psychological distress
- reducing policy and environmental barriers to social contact.

Readings on Social Justice, Advocacy and De-Colonizing Practices

Aldarondo, A. (Ed.). (2007). *Advancing social justice through clinical practice*. Mahwah, NJ: Lawrence Erlbaum Associates.

Prilleltensky, I. & Prilleltensky, O. (2006). *Promoting well-being: Linking personal, organizational and community change*. Hoboken, NJ: John Wiley & Sons, Inc.

Raphael, D. (2009). *Social determinants of health.* Toronto: Canadian Scholars Press.

Farmer, P. (2005). *Pathologies of power: Health, human rights, and the new war on the poor.* Berkeley, CA: University of California.

Tuhiwai Smith, L. (1999). *Decolonizing methodologies: Research and Indigenous peoples.* London: Zed Books.

Toporek, R., Gerstein, L. Fouad, N, Rosircar, G. ,& Israel, T. (2005). (Eds.), *Handbook for social justice in counseling psychology: Leadership, vision, and action*. Thousand Oaks, CA:Sage.

Web links

Cultural pathways to decolonization by Bill Mussell
http://heretohelp.bc.ca/publications/aboriginal-people/bck/2

WHO Report on Mental health, resilience and social inequities.
http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Unique Challenges

Working directly with individuals who are at heightened risk for suicide and suicidal behaviour can be very challenging on a number of levels. Losing a client to suicide can be one of the most difficult and painful experiences a professional will ever have to face. Those practicing in rural and remote contexts often face unique challenges related to issues of isolation and limited resources. Ethical and legal challenges, including issues of confidentiality and informed consent, always need to be managed when working with individuals at risk for suicide.

Rural and Remote Practice

Providing clinical services in rural settings can be both challenging and rewarding.[211] [212] On one hand, isolated practitioners have very few, if any, local referral agencies and alternative professionals for providing client care. Rural practitioners often wear many hats. Other specific challenges include:

- Isolation and burnout
- Staff turnover and return to urban areas
- Few referral sources or other professionals
- Lack of adequate supervision
- Need for broader training experiences
- Limits of competence
- Dual relationships with supervisors or clients
- Confidentiality in small towns
- Specialized population groups

On the other hand, rural and remote practitioners have the opportunity to assume diverse roles and more responsibility early in their careers, often providing a wide variety of services to a broad client base with a full range of presenting problems. For clinicians with such a wide scope of practice, it can be very difficult to remain up-to-date about current best practices in specialized topic areas, such as suicide. Part of the challenge then, is to prioritize knowledge areas according to need in the community and level of safety required. Since suicide is a relatively rare, but serious event, suicide risk assessment is likely one area of practice that requires more in-depth training and adequate supervision. Although access to regular clinical supervision has often been limited in the past, new technologies such as telehealth videoconferencing, distance learning, the internet and email are able to augment telephone and face-to-face meetings. These same technologies can also help individual clinicians feel an increased sense of connection with up-to-date information and a personal support network.

In order to adequately address the barriers faced by remote and rural mental health clinicians, extra care must be taken by individuals and institutions to understand and address the special issues involved. The literature supports the use of technology, such as videoconferencing, to provide regular and ongoing supervision with experienced and expert clinicians, as well as support and consultation from colleagues in the field. Improving supervision, support and consultation will assist local clinicians in better assessing and treating suicidal clients. Professional development activities, such as distance learning, internet research, access to peer reviewed e-journals, and face-to-face training opportunities are all ways of ensuring clinicians working in isolated areas are kept current in the areas most relevant to the community needs.

Cultural Safety and Diversity Competency

Cultural competencies are the identified knowledge, skills and attitudes that child and youth mental health practitioners need in order to practice ethically and sensitively with diverse cultural populations. Organizational development, which considers the institutional and systemic issues that create barriers and limit access to culturally diverse groups, is another important focal point for improving overall cultural competency.

Providing therapeutic care that is "culturally safe" is an additional component for effective practice.[213] [214] Where the cultural safety approach departs from the traditional cultural competency model is in its analysis of existing institutional power relations that serve to perpetuate inequities.[215] In this way, it resembles a decolonizing approach to practice. By inviting practitioners to reflect on the ways in which their *own* cultural identities, worldviews and assumptions impact on the therapeutic relationship, the traditional emphasis on understanding the unique cultural characteristics of the "exotic other" gives way to a more critically conscious, self-reflective stance that includes a consideration of structure, individual agency and power.

Becoming aware of one's own identity as a bearer of culture is an important first step. Cultural safety requires more than simply being sensitive or having an awareness of cultural differences. It involves recognition that certain groups enjoy certain unearned rights and benefits and includes an analysis of power imbalances, historical relations of power, and institutional and systemic forms of discrimination and racism.

Summary of Cultural Safety

- Involves actions that recognize, respect and nurture clients' unique cultural identities and safely meets their needs, expectations and rights[216]
- Enables safe service to be defined by those receiving the service[217]
- Moves beyond cultural awareness and sensitivity to address structural factors that perpetuate inequities and disadvantage
- Requires high levels of clinician self-awareness and critical self-reflection

Recommended Readings on Cultural Safety and Diversity Competency

Duke, J, Connor, M., McEldowney, R. (2009). Becoming a culturally competent health practitioner in the delivery of culturally safe care: A process oriented approach. *Journal of Cultural Diversity,16*(2), 40-49.

Hart, A., Hall, V. & Henwood, F. (2003). Helping health and social care professionals to develop an 'inequalities imagination': A model for use in education and practice. *Journal of Advanced Nursing, 41*(5), 480-489.

Ramsden, I. (1992). Teaching cultural safety. *New Zealand Nursing Journal. 85*(1), 21-23.

Smye, V. & Browne, A. (2002). Cultural safety and the analysis of health policy affecting Aboriginal people. *Nurse Researcher, 9*(3), 42-56.

For additional information on cultural safety, visit
http://www.naho.ca/documents/naho/english/Culturalsafetyfactsheet.pdf

Ethical and Legal Considerations

Confidentiality

Confidentiality is of central importance in any therapeutic relationship as it provides the foundation for the development of trust and protects children and youth's rights to privacy. Confidentiality is not absolute however. When suicide risk is suspected, children and youth and their parents/caregivers need to understand that the clinician will take specific actions – including telling parents to protect and promote the client's safety. Children and youth need to be explicitly told that their privacy will not be protected under these circumstances. Children and youth and their family members should always be fully informed about the limits to confidentiality at the outset of treatment. These principles and the rationale behind them should be re-visited throughout the course of treatment, especially during periods of crisis and heightened suicidal ideation.

Other exceptions to confidentiality include[218]:

1. When there is an imminent danger to an identifiable third party
2. When you suspect abuse or neglect of a child
3. When a disclosure is ordered by the court or required by other legislative acts

Ontario's and British Columbia's information and privacy commissioners recently produced a Practice Tool to support decision making in situations where individuals may be at risk of suicide. A quote from this document makes our ethical and legal responsibility unambiguously clear, "… life trumps privacy, and our laws reflect that reality".

For a copy of the tool visit http://www.oipc.bc.ca/pdfs/Policy/ipc-bc-disclosure-edu.pdf

Informed Consent

Thoroughly informing children and youth and their parents/caregivers about the treatment process is an ethical and legal requirement. Taking time "up-front" to explicitly outline the treatment process, including limits to confidentiality, the rationale for treatment including any risks or benefits, as well as treatment alternatives, is an essential element of providing competent clinical care.[219]

A recent article revisits the topic of informed consent with suicidal children and youth and includes a number of helpful recommendations, including[220]:

- a clear and succinct statement of risks in psychotherapy for suicidal patients should be included in the informed consent statement and process
- children and youth should be made aware that one of the primary targets in treatment is the reduction of suicidal behaviours

When working with younger children, we have an ethical obligation to treat children with dignity and respect which means providing them with as much information as they are deemed capable of absorbing. This has been referred to elsewhere as "assent" to treatment (instead of consent).[221]

Elements of Informed Consent[222]

1. Statement about the purpose and nature of treatment
2. Specific therapeutic goals and procedures
3. Alternative choices
4. Risks/benefits
5. Potential duration
6. Costs/method of payment
7. Cancellation policy
8. Limits to confidentiality
9. Clinician qualifications
10. Boundaries
11. Complaint procedure

Protection from Harm

If a youth, aged 16 or older, is assessed to be at imminent risk for suicide and is refusing to be admitted to hospital as a voluntary patient, it may be appropriate to consider involuntary hospitalization in a designated mental health facility. For youth under the age of 16, parents/legal guardians are the only individuals who can provide consent for a voluntary admission to hospital.

All four criteria, as outlined in the *Mental Health Act*, for admitting someone as an involuntary patient must be met. These are:

1. The person is suffering from a mental disorder that seriously impairs their ability to react appropriately to his or her environment or to associate with others.
2. The person requires psychiatric treatment in or through a designated facility.
3. The person requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others.
4. The person is not suitable as a voluntary patient.

For more information on the Mental Health Act in BC go to
http://www.health.gov.bc.ca/mhd/mentalhealthact.html and
http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

If a child or youth is judged to be at risk for self harm and the parents/caregivers are unable/unwilling to provide consent to treatment, then the youth may be "in need of protection" based on the *Child Family and Community Services Act*. Steps for making a report to child protection authorities, as outlined in the *BC Handbook for Action on Child Abuse and Neglect* should be followed.
http://www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf

When a Client Dies by Suicide

Clinicians who experience the loss of a client to suicide will be significantly impacted both personally and professionally. Supervisors and colleagues should encourage those practitioners who have been most affected by the death to access individual supervision and counselling services in order to adequately debrief and process the trauma. In addition, many clinicians find family and friends to be excellent sources of support. It is important to recognize that clinicians in any discipline and at all levels of experience will inevitably be shaken by the suicide death of a client. This is not considered a weakness, but rather a normal reaction to a traumatic event.

Common Reactions to Losing a Client to Suicide

- Sense of "failing the patient"
- Guilt and shame
- Questioning professional competence
- Symptoms of grief and loss, e.g. depressed mood, poor sleep, irritability
- Fear of public criticism
- Isolation and withdrawal

The Clinician Survivor Task Force of the American Association of Suicidology (AAS) has a useful section of their website dedicated to supporting therapists who have lost a client to suicide, http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm.

Other helpful resources for clinicians who have lost a client to suicide include:

Weiner, K. (Ed.) (2005). *Therapeutic and legal issues for therapists who have survived a client suicide.* New York: Haworth Press.

Practical Tools

This section provides users with quick and easy access to practical tools that have been developed to assist with the following:

1. recognizing suicide risk
2. assessing suicide risk
3. responding to suicide risk and deaths

Note: You are strongly encouraged to carefully read the more detailed information provided on the websites listed here. While many of these tools and guidelines can be used as part of a comprehensive approach to suicide risk assessment, they are not meant to replace the role of the clinical interview and/or professional judgment.

Tools to Support Recognition of Suicide Risk

IS PATH WARM is a helpful device for recognizing the warning signs of suicide. This empirically based tool, developed by the American Association for Suicidology, can be used as an educational resource when training gatekeepers to recognize potential signs of suicide. http://www.suicidology.org/web/guest/stats-and-tools/warning-signs

Responding to People at Risk For Suicide: How Can You and Your Organization Help? is a practical guide to promote awareness of the warning signs of suicide and how to help produced by the Queensland Government (Australia). http://www.communities.qld.gov.au/resources/communityservices/community/documents/responding-to-people.pdf

Tools to Support Assessment of Suicide Risk

Tool for the Assessment of Suicide Risk in Adolescents (TASR-A) is a clinical evaluation tool developed by Dr. Stan Kutcher for documenting imminent risk of suicide among youth following a clinical interview. http://teenmentalhealth.org/for-health-professionals/clinical-tools/

Suicide Risk Assessment: A Resource for Health Care Organizations is a comprehensive guide that is designed to help Canadian health care organizations with understanding and standardizing the practice of high-quality suicide risk assessment http://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf

The *Suicide Assessment Five-step Evaluation and Triage (SAFE-T)* is a helpful pocket card that guides clinicians through the process of suicide risk assessment through the use of five key steps. http://library.sprc.org/item.php?id=512

The Suicide Risk Assessment and Management Protocol: Emergency Department was developed in Australia in recognition of the important role played by hospital emergency departments in the management and treatment of suicidal individuals. http://www.health.nsw.gov.au/pubs/2004/emergency_dept.html

Working With the Suicidal Patient: A Guide for Health Care Professionals is a useful step-by-step guide for assessing and managing suicidal behaviour in adults. It was

designed for health care providers, including those that may be working in an acute care/emergency setting. While it was developed for use with adults, it provides relevant guidelines for youth and emphasizes family involvement in safety plan and intervention. http://www.comh.ca/publications/pages/wwsp/

Tools to Support Organizational Responses to Suicidal Behaviours

Principles for Developing Organizational Policies and Protocols for Responding to Clients at Risk of Suicide and Self Harm is a practical tool developed by the Queensland Government (Australia) to support the development of proactive organizational policies for responding to clients at risk for self harm.
http://www.communities.qld.gov.au/resources/communityservices/community/documents/principles-for-developing-protocols.pdf

Practice Tool for Exercising Discretion: Emergency Disclosure of Personal Information was recently produced by the Office of the Information and Privacy Commissioner of BC to support decision making when working with individuals at risk for suicide.
http://www.oipc.bc.ca/pdfs/Policy/ipc-bc-disclosure-edu.pdf

Tools to Support Responses After a Suicide

The Hope and Healing Booklet is a practical guide for supporting survivors of a loved one's suicide in BC. http://www.health.gov.bc.ca/library/publications/year/2007/HopeandHealing.pdf

The Lifeline Online Postvention Manual provides guidelines for reducing contagion and constructively responding to a suicide death through social networking sites
http://www.sprc.org/library/LifelineOnlinePostventionManual.pdf

After a Suicide: A Toolkit for Schools was developed to provide direction and guidance to schools and communities following the suicide death of a community member
http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf

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