

Fraser Region Aboriginal Youth Suicide Prevention Collaborative

Suicide Prevention, Intervention and Postvention Initiative

December 2012



ACKNOWLEDGMENTS

Prepared by by Kahui Tautoko Consulting Ltd for the Fraser Region Aboriginal Youth Suicide Prevention Collaborative.

This report was adapted from the document *Strengthening the Safety Net: a Report on the Suicide Prevention, intervention and Postvention Initiative for BC* (2009). It has been adapted for a Fraser region perspective.

The Fraser Region Aboriginal Youth Suicide Prevention Collaborative wishes to acknowledge the First Nations Health Authority, Fraser Health Authority and First Nations and Inuit Health for their contributions to the development of this report.



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EXECUTIVE SUMMARY

Aboriginal Suicide is a Major Issue

First Nations youth suicide accounts for 38% of all deaths between the ages of 10-19, and, the suicide rate of First Nations youth in Canada is 6 to 7 times the rate of mainstream youth, which in turn, is the highest rate of any group in mainstream society. Aboriginal people in Canada have suffered from much higher rates of suicide than the general population. The overall suicide rate among First Nation communities is about twice that of the total Canadian population; the rate among Inuit is still higher — 6 to 11 times higher than the general population.

For Aboriginal people, suicide is an affliction of the young. From the ages of 10 to 29, Aboriginal youth on reserves are 5 to 6 times more likely to die of suicide than their peers in the general population. Over a third of all deaths among Aboriginal youth are attributable to suicide. Although the gender difference is smaller than among the non-Aboriginal population, males are more likely to die by suicide, while females make attempts more often. At present, about 4,000 people in Canada per year die by suicide, of whom between 6 to 10 per cent are Aboriginal.

In BC, while suicide rates have declined since 1993 the Aboriginal rate is still over twice the rate of the non-Aboriginal population. In the Fraser region, while data is not readily available, a study by the BC Coroner's office revealed that 22 Aboriginal people had died by suicide over the period 2007 – 2012 with over half of these being persons under 29 years of age and the majority in Hope, Abbotsford and Surrey.

The BC Representative for Children and Youth noted in their November 2012 report on Youth at Risk of Suicide and Self-harm - "every child has a right to succeed – some require more help than others" and that the impact of child and youth deaths from suicide are "very significant in Aboriginal and First Nations communities, where suicide rates among youth are five to six times higher than those of non-Aboriginal youth". The Representative acknowledged the tremendous challenges faced by some Aboriginal communities, and believes that much more must be done to support them as they work to improve the well-being of their children and youth.

Key Drivers for High Suicide Rates

Although much of the literature on suicide in the general population is relevant to the experience of Aboriginal people, there are specific cultural, historical, and political considerations that contribute to the high prevalence, and that require the rethinking of conventional models and assumptions. In general, risk factors for suicide among Aboriginal youth are similar to those for suicide in the general population of young people. These factors include:

- depression
- hopelessness
- low self-esteem or negative self-concept
- substance use (especially alcohol)
- suicide of a family member or a friend
- history of physical or sexual abuse
- family violence
- unsupportive and neglectful parents
- poor peer relationships or social isolation, and
- poor performance in school.

Two overlapping patterns of vulnerability to suicide can be identified in the existing literature:

1. severe depression is a key contributor to many suicides; and
2. life crises, substance abuse, and personality traits of aggressive impulsivity may play an important role in many suicides, especially among youth.

Other factors that have been identified as circumstances in the lives of those who commit suicide are a lack of stable living arrangements; exposure to domestic violence in the home; sustained substance use; learning disabilities from a lack of attachment to school. Some who injure themselves do so within 24 hours of experiencing a significant romantic conflict.

Risk Factors

From the perspective of prevention, the contributors to suicide can be thought of in terms of risk factors that increase the likelihood of suicidal behaviour, and protective factors that reduce it. These risk and protective factors include: the physical and social environments; individual constitution, temperament, or developmental experiences; interpersonal relationships; alcohol and substance abuse; suicidal ideation and previous suicide attempts; and co-existing psychiatric disorders. The individual factors that affect suicide in Aboriginal people are no different than those found in other populations and communities, but the prevalence and interrelationships among these factors differ for Aboriginal communities due to their history of colonization, and subsequent interactions with the social and political institutions of Canadian society.

The role of social and cultural factors in suicide, including: social structure and economic factors; specific cultural traditions; the impact of cultural change; and the consequences of forced assimilation and dislocation are evident in Aboriginal communities. In particular, the impact of the residential school system, systematic out-adoption, and other culturally oppressive practices on the mental health and well-being of Aboriginal individuals and communities are examined. Although direct links to suicidality are difficult to demonstrate, the potential trans-generational links between these social practices and suicide are traced.

These drivers were noted not only in BC and Canada, but also in Native American, New Zealand and Australian studies on suicide and in particular among indigenous youth.

This information allows for the identification of youth in the community who may be at greater risk for suicide; namely, those who have mental health problems (especially depression, but also substance abuse, anxiety, or conduct problems associated with impulsive and aggressive behaviour), those suffering FASD; those with a history of physical or sexual abuse; people with a friend or family member who has attempted suicide; those with poor relationships with parents, and poor school attendance or performance. Providing mental health services, mobilizing social support, and increasing community involvement for these youth and their families should reduce their risk of suicide. Early interventions with families and communities to support the healthy development of infants and children may reduce the prevalence of personality disorders and other mental health problems, which are more difficult to address in adolescents or adults.

However, this portrait of individual vulnerability and resilience is only half of the picture. Suicidal behaviour affects large numbers of young people in some Aboriginal communities, but not in others. This makes it clear that there are social forces at work at the levels of communities, regions, and nations that are of central importance. Understanding of the role of larger social factors is therefore crucial to identifying the most important contributors to suicide for any specific Aboriginal population, community, or individual.

Protective Factors for Developing Resilience

Protective factors that contribute to individual resilience include family harmony and cohesion, involvement in family activities, good communication and feeling understood by one's family, good peer relations, and school success. First Nations youth, Elders, leadership and communities have raised the call for action on increased rate of First Nations suicides, especially by young people.

The BC Provincial Health Officer's report (2007) identified that First Nations bands that had six "protective factors"¹ present experienced no youth suicides:

1. Evidence of particularly bands taking steps to secure Aboriginal title or their traditional lands
2. Evidence of securing certain rights of self-government and some degree of community control
3. Evidence of some control over educational services
4. Evidence of some control over police and fire protection
5. Evidence of some control over health delivery services
6. Evidence of having established within their communities certain officially recognized cultural facilities to help preserve and enrich their cultural lives.

Those Bands that had a majority of these factors in place experienced vastly lower rates of suicide. The PHO also reported that a national Canadian study had identified that the two most common 'causes' of suicide were the rapid disintegration of traditional values (e.g. an aim of Indian Residential Schools) and the breakdown of both the nuclear and the extended family.

Protective factors for individuals identified in other literature including the Canadian Association for Suicide Prevention's guidelines include:

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and non-violent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

Responses and Interventions

At both national and provincial levels, work has been done to specifically address the issue of suicide on many levels. The *Blueprint for a National Suicide Prevention Strategy* (2004) was outlined by the Canadian Association for Suicide Prevention. As well, the *National Aboriginal Youth Suicide Prevention Strategy* (2007) provided recommendations focusing on Aboriginal youth across Canada.

1. Chandler and Lalonde, 2008

In BC, provincial efforts for suicide prevention, intervention and postvention have included:

- *Looking for Something to Look Forward to...A five year retrospective review of child and youth suicide in BC (2008)* by the Child and Youth Death Review Unit, BC Coroners Service
- *Working with the Client Who Is Suicidal (2007)* by the BC Ministry of Health and the Centre for Applied Mental Health Research and Addictions
- Seminal work in child and youth suicide and Aboriginal youth suicide by Dr. Jennifer White (1998, 2003, 2005, 2007)
- *Postvention is Prevention* workshops by the BC Council for Families (2005)

The National Aboriginal Youth Suicide Prevention Program (NAYSPS) was an upstream investment in suicide prevention initiated in 2005. The NAYSPS and some provincial strategies criteria call for youth involvement and recognition of Traditional Healing, yet these important components have not been fully respected and implemented. Both federal and provincial funding and other resources need to increase to meet this continuing crisis. Elders and Traditional Healers want to and are ready to work – particularly with youth - in a sustainable way.

Suicide prevention should be understood as part of a larger, multi-faceted mental health promotion strategy that is the responsibility of the whole community, First Nation, or region². In its *Choosing Life: Special Report on Suicide Among Aboriginal People*, the Royal Commission on Aboriginal Peoples insisted that only a comprehensive approach to suicide prevention will improve the situation in Aboriginal communities. Such an approach includes plans and programs that³:

- provide suicide crisis services;
- promote broad preventive action and community development; and
- address long-term needs for self-determination, self-sufficiency, and healing.

The Commission further notes that a suicide prevention strategy with the best chance of making a difference is better conceptualized as a “mental health” or “community wellness” promotion strategy. This suggests the following general guidelines for a suicide prevention strategy:

1. Programs should be locally initiated, owned and accountable, and embodying the norms and values of Aboriginal culture. Although it is crucial to develop local solutions rather than those imposed by external agencies, useful help from the latter should not be rejected when a meaningful partnership can be negotiated.
2. Suicide prevention should be the responsibility of the entire community, requiring community support and solidarity among family, religious, political, or other groups. Given the importance of community, there is a need for close collaboration among health, education, other community services, and local government. The bureaucratic structures that have evolved in government and urban services are fragmented and sometimes competitive.

2. Aboriginal Healing Foundation, 2007

3. Royal Commission on Aboriginal Peoples, 1995

This can have disastrous effects in Aboriginal communities, not only through lack of continuity of care for vulnerable individuals, but because of the demoralizing effect on the lack of integration on the whole community.

3. A focus on children and young people (up to their late 20s) is crucial, and this implies involvement of the family and the community.
4. The problem of suicide must be addressed from many perspectives, encompassing biological, psychological, socio-cultural, and spiritual dimensions of health and well-being.
5. Programs that are long-term in focus should be developed along with “crisis” responses. A comprehensive approach to the problem of suicide should be integrated within larger programs of health promotion, family life education, community and cultural development, and political empowerment.
6. Evaluation of the impact of prevention strategies is essential. While a program’s continued existence is often taken as an indicator of its success, it is always important to examine the workings of a program and its wider impact to detect any unforeseen or harmful effects.
7. Training of community mental health workers in individual and family counselling (particularly for grief), appropriate social intervention, and community development methods is essential.



Strategizing for the Future

One of the most critical goals of any suicide prevention strategy is to bring together all communities, governments, organizations and resources with their key stakeholders to work together to prevent death by suicide, and to assist, educate and comfort those impacted by suicidal behaviours. Cultural safety and community renewal approaches should be emphasized when engaging in suicide prevention, intervention and postvention with Aboriginal populations. The PIP initiative identified and described current programs, services or supports and strengths of programs, services and supports as indicated by respondents.

- For **prevention**: capacity building, collaboration, and community education programs were highly represented across many populations;
- For **intervention**: gatekeeper training, peer or group support, phone counselling, and risk assessments were highly represented across many populations.
- For **postvention**: critical incident management and phone counselling were highly represented across different populations.

Among **children and youth**, collaboration, capacity building, community education, cultural awareness, interdisciplinary teams, liaising with schools, outreach and physician education were all reported as current practices in prevention. Cognitive behavioural therapy (CBT), crisis stabilization, dialectical behavioural therapy (DBT), gatekeeper training, group therapy, peer or group support, phone counselling, risk assessments, use of specialists and safety planning were reported as current practices in intervention. Community response teams, critical incident management, school district protocols, referral to hospices, and referrals to other organizations and service providers (psychiatrists, general practitioners) were reported as current practices in postvention.

Among **adults**, awareness programming, capacity building, collaboration, community education and outreach were reported as current practices in prevention. CBT, crisis stabilization, DBT, gatekeeper training, group or peer support, group therapy, use of specialists and safety planning were all reported as current practices in intervention. Advocacy, bereavement teams, phone counselling, support groups, and referrals were reported as current practices in postvention.

Among **older adults**, capacity building, community education, and outreach were reported as current practices in prevention. Peer or group support, phone counselling, risk assessment, and referrals were reported as current practices in intervention. No current practices were reported for postvention among older adult populations.

Among **all populations**, capacity building, collaboration, community education and outreach were reported as current practices in prevention. Phone counselling, risk assessment and referrals were reported as current practices in intervention. Advocacy, bereavement teams critical incident management, referral to hospices, phone counselling, referrals and support groups were reported as current practices in postvention.

Among **vulnerable and/or high risk populations**, awareness programming, capacity building, community education, cultural awareness, interdisciplinary teams, liaising with schools and outreach were reported as current practices in prevention. Gatekeeper training, peer or group support, phone counselling, risk assessment and use of specialists were reported as current practices in intervention. Critical incident management was reported as one current practice in postvention.

Applying the BC Suicide PIP Framework in the Fraser Region

Evidence of strategies developed in other countries and in other Provinces across Canada, reveals that the BC Suicide PIP framework is well-founded in many evidence-based research reports, studies and evaluations of other suicide prevention approaches. Application of this framework to informing an Action Plan in the Fraser region may be represented in the model overleaf.

This model identifies that within the Fraser region, a continued leadership role on work on the youth suicide agenda continue, based on the proven and accepted BC Suicide PIP framework and that all future tasks and activities can be aligned to this framework. The Fraser Region: Aboriginal Suicide PIP Action Plan should incorporate the following tasks and activities. Such an Action Plan has plenty of examples to draw on such as the Maori Youth Suicide Strategy of New Zealand (1999) or the Inuit Strategy (2008) for reference and focus:

For School-Based strategies:

- Identify current school based interventions and determine gaps and opportunities. This will need to include extensive school engagement and inclusion.
- Organize education, training and resources for schools (such as a toolkit of resources and guidelines). The Zuni Life Skills Development Curriculum has been cited as very effective, as has the "Let's Live" school-based awareness and intervention program. Further ideas are reported by the Native Mental Health Research Team's report.

For Culturally Appropriate Services:

- Identify existing mental health promotion and resource personnel from within FHA and within Aboriginal communities to help support training.
- Identify gate-keepers in Aboriginal communities and connect them with the resource personnel.
- Identify existing culturally-based services and programs (CBSPs) in Aboriginal communities that may be funded by NAYSPS, AS CIRT funding or other resources from FNIH and FHA and FNHA. This should include existence of Critical Incident Stress Management teams and associated supports.
- Identify gaps and plan to address the gaps. Strategies and literature from New Zealand's Suicide Prevention Strategy support a strong focus on cultural interventions and building resiliency in the indigenous population.

For gate-keeper training:

- Plan and arrange training with the “resource personnel” and educators available for each Aboriginal community and setting (urban included). This should include AS CIRT and ASIST training, CISM development within communities and drawing on various existing training programs that are available and identified in this report.
- Develop and disseminate a “toolkit” of guidelines and resources for gatekeepers as part of the training. Resources and programs are identified in this report including ideas from Alaska and a Native American model in Massachusetts as well as Gitxsan First Nations in the northern region.

For Physician and Health professional training:

- Work with mental health professionals and Divisions of Family Practice in the Fraser region to develop and provide training workshops for physicians, NPs and their staff.
- Provide training for Nurses and other lead employees in First Nations / Aboriginal health centres.

For Coordination of Services:

- Establish a more formalized Steering Committee for the Fraser Region’s Aboriginal Youth Suicide Action Plan from the existing collaborative group that is currently meeting - with TOR, purpose and membership defined. Include an oversight role of monitoring and evaluation.
- Include commitment to resources including project coordination support and logistical aid noting that in Australia it was noted that without dedicated coordinator resources the work of collaborative groups is unsuccessful.
- Clarify and strengthen the linkage between the Tripartite PIP Planning Group and the provincial Suicide Prevention Working Group and the Fraser Region Steering Committee. Inter-governmental efforts through partnerships, accords and strategies that have been developed in BC (or which are being developed now such as the BC Aboriginal Mental Health Plan) identify strong government support. This needs to be leveraged for the benefit of the Fraser Region Steering Committee’s work.
- Create a service coordination role within the Project Team to oversee linkages between prevention efforts, intervention efforts and postvention efforts.
- Create a “school engagement” function of the Steering Group so that a specific focus can be maintained for working with schools where most youth are primarily spending their time and being influenced by peers and media (including internet).

For Postvention Strategies and Supports:

- Develop a toolkit (guideline) for postvention and organize workshops and training so that Aboriginal communities are better informed and prepared in case of crisis.

Action Plan

This document includes an Action Plan, tasks and proposed outputs for the 6 priority areas of the BC Suicide Prevention PIP Framework along with a proposed budget to implement the Action Plan of \$1.3m per annum. It is proposed that this cost be shared among key stakeholders and others if possible.

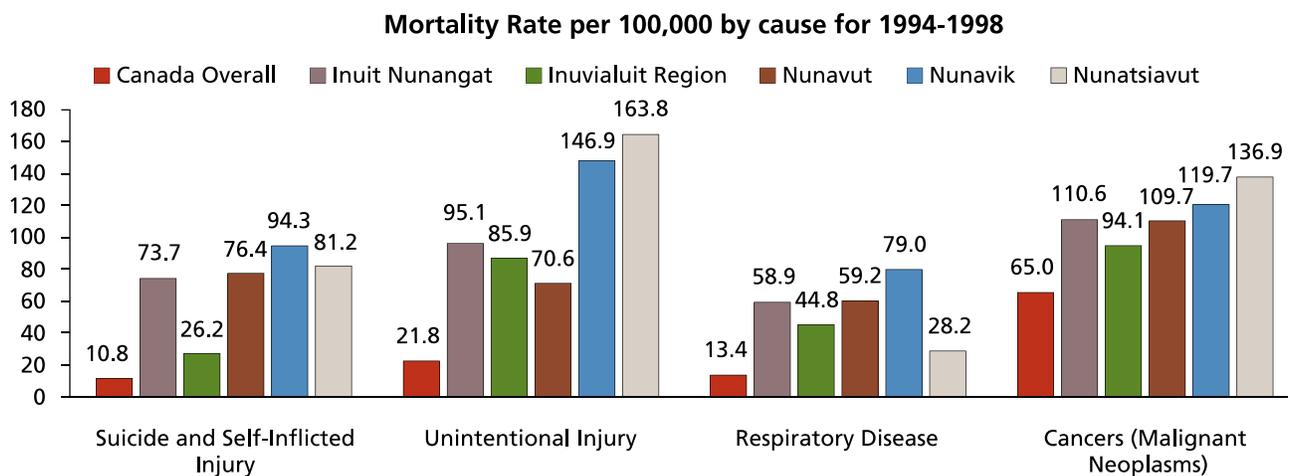


INTRODUCTION

A National Crisis

First Nations youth suicide accounts for 38% of all deaths between the ages of 10-19, and, the suicide rate of First Nations youth in Canada is 6 to 7 times the rate of mainstream youth, which in turn, is the highest rate of any group in mainstream society. Aboriginal people in Canada have suffered from much higher rates of suicide than the general population. The overall Canadian rate has declined, while in some Aboriginal communities and populations, rates have continued to rise for the last two decades. Although there are enormous variations across communities, bands, and Nations, the overall suicide rate among First Nations communities is about twice that of the total Canadian population; the rate among Inuit is still higher — 6 to 11 times higher than the general population.

Figure 1: Mortality Rates for Inuit Nunangat 1994 – 1998



Certain causes of death are impacting Inuit⁴. The rate for suicide/self-inflicted injury in Inuit Nunangat is 6.8 times that of the national average. The Age-Standardized Mortality Rate due to suicide/self-inflicted injury was 6.8 times higher in residents of Inuit Nunangat as compared to Canada as a whole.

For Aboriginal people, suicide is an affliction of the young. From the ages of 10 to 29, Aboriginal youth on reserves are 5 to 6 times more likely to die of suicide than their peers in the general population. Over a third of all deaths among Aboriginal youth are attributable to suicide. Although the gender difference is smaller than among the non-Aboriginal population, males are more likely to die by suicide, while females make attempts more often.

At present, about 4,000 people in Canada per year die by suicide, of whom between 6 to 10 per cent are Aboriginal. Few data on attempted suicide are available for any Aboriginal group. Access to data is affected by concerns over ownership and autonomy. In recent decades, suicide rates among Aboriginal people in Canada have averaged more than three times the rate of the general population. Suicide occurs much more commonly among the young than the elderly, and the rates among the young in many communities are continuing to rise. Although the gender difference is smaller than among the non-Aboriginal population, males are more likely to die by suicide, while females make attempts more often. Suicides most often occur in association with heavy alcohol consumption, and are carried out by highly lethal means (hanging and firearms).

There are wide regional variations in suicide rate. Compared to the general population, suicide in Aboriginal adolescents may be more likely to occur in clusters. While suicide clusters command most of the attention of media and observers, this obscures the fact that some communities have lower than average rates while others have higher rates. Suicide is just one indicator of distress in communities. For every suicide there may be many more people suffering from depression, anxiety, and other feelings of entrapment, powerlessness, and despair. At the same time, every suicide has a wide impact affecting many people—family, loved ones, and peers who find echoes of their own predicament, and who sometimes may be prompted to consider suicide themselves in response to the event. The circle of loss, grief, and mourning after suicide spreads outward in the community. In small Aboriginal communities where many people are related, and where many people face similar histories of personal and collective adversity, the impact of suicide may be especially widespread and severe.

4. Inuit Tapiriit Kanatami, July 2010

The Situation in British Columbia

The Provincial Health Officer’s Report on Aboriginal Health “Pathways to Health and Healing – 2nd Report on the Health and Wellbeing of Aboriginal People in British Columbia” (2007) highlights information on suicide rates in BC. From 1993 to 2006 the suicide death rate for the Status Indian population in BC fell from 3.5 per 10,000 to 1.7 per 10,000, however the 2006 figure was still over twice the rate for other residents (1.7 per 10,000 compared to 0.7 per 10,000). The declining trends for both populations were statistically significant. Suicide deaths were the fourth highest overall cause of death in the Status Indian population under age 75.

The Situation in the Fraser Region

The PHO report (2007) identified that suicide rates were higher than the rates for all health authorities and in BC as a whole. In Fraser Health the provincial gap was approximately two times higher between the populations.

The BC Coroner’s Service produced data identifying suicide rates for Aboriginal people in the Fraser Region during the period 2007 – 2012 (January 2007 to May 31, 2012) which revealed the following rates. This revealed that there had been 22 deaths of Aboriginal persons by suicide during this period being 9 Females and 13 males with an average age of 32.3 years:

Gender	2007	2008	2009	2010	2011	2012*	Total
Female	2	2	2	-	2	1	9
Male	4	1	3	2	3	-	13
Total	6	3	5	2	5	1	22

*up to May 31, 2012

The study also identified that 12 of the 22 suicides were of people under the age of 29 years and that the majority had occurred in Abbotsford, Hope and Surrey.



Methodology Report

In October 2012 Fraser Health Authority (FHA) requested that a summary of key literature and documents be undertaken from a series of reports and publications provided by FHA to the writers. As required by FHA, no further literature was reviewed apart from that provided. Further the writers were asked to align the document summary with the BC Suicide Prevention, Intervention and Postvention (PIP) Framework and Planning Template. The writers read and summarized each of the documents that were provided for this report within the required framework aiming to bring together relevant evidence or literature that supported the key themes. A full list of all reports is contained in the Reference section at the back of this report.

It is intended that this literature summary will inform the development of a comprehensive strategy by Fraser Health for addressing Aboriginal suicide.



THE BC SUICIDE PIP FRAMEWORK & PLANNING TEMPLATE

The Suicide Prevention, Intervention and Postvention (PIP) Initiative for BC draws on the experiences of other provinces, literature on the topic, plans developed in BC and community responses and input.

The Suicide Prevention, Intervention and Postvention (PIP) Initiative for BC

In April 2008, the Suicide PIP Initiative for BC began as a strategic effort to address suicide. The first goal of the Suicide PIP Initiative for BC was to develop and promote a Framework and Planning Template for local, regional and provincial efforts addressing suicide across the lifespan. The second goal was to ensure that the Suicide PIP Initiative for BC is grounded in a Community Development approach where the knowledge and experience of stakeholders at all levels (academics, decision makers, practitioners and users) from communities throughout the province is actively sought and integrated.

The following are the objectives of the Suicide PIP Initiative:

1. To complete a snapshot survey of key informants to gather information on existing suicide prevention, intervention and postvention services, programs and projects across BC;
2. To complete an evidence-informed practice review (including international, national and provincial expertise) of academic and non-academic literature.
3. To identify suicide prevention, intervention and postvention priority areas through the snapshot survey and evidence-informed practice review.
4. To incorporate snapshot survey and evidence-informed practice review findings into a Framework and Planning Template. The Framework should consider process and outcomes for groups to develop, improve and evaluate their programs, services and supports.

5. To create a representative working group of key BC stakeholders who will advise on the development of a PIP Project Charter, Vision and Framework for BC.
6. To develop a work plan for the project and secure multi-year funding to support a Project Manager and the ongoing operation of a Provincial Suicide PIP Steering Committee.

Support of the Canadian Association for Suicide Prevention

The Canadian Association for Suicide Prevention (CASP) supports PIP and endorses British Columbia's Suicide Prevention Strategy titled *Strengthening the Safety Net: Suicide Prevention, Intervention and Postvention Initiative for BC*. The Suicide Prevention, Intervention and Postvention Initiative for BC represents an outstanding achievement of collaboration between government, community, survivors, clinicians, regional health authorities, researchers, self-help organizations and consumers, police services, and mental health and crisis service agencies. The CASP Blueprint for a Canadian National Suicide Prevention Strategy was first released in 2004 and recently revised in 2009 and was intended to guide and support the development of federal and provincial/territorial action to address suicide. British Columbia now joins Quebec, Alberta, Manitoba, New Brunswick, Nova Scotia and Nunavut in creating a provincial strategy. The British Columbia Strategy highlights many important priorities that add to the suicide prevention landscape in Canada including the importance of culturally relevant services and cultural safety and importance of investing in school based mental health promotion; risk factor prevention initiatives and strengthening the availability of bereavement and postvention supports and resources.

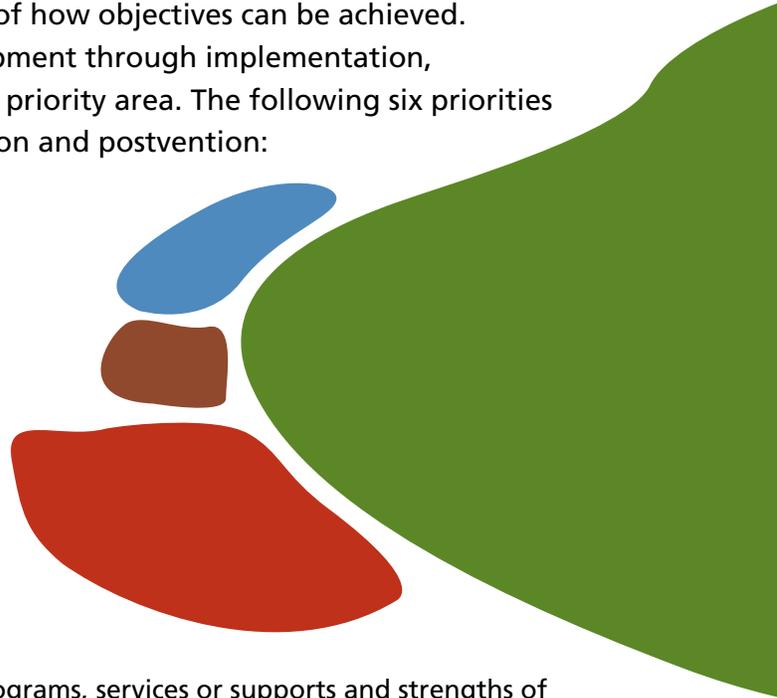
From the process completed with an Aboriginal Health and Wellness Facilitator, a review of research on suicides among Aboriginal populations and information provided by service providers working with Aboriginal populations, it was also determined by the PIP initiative that any approach should be community driven. Some of the potential approaches that were suggested for communities to consider for best fit included:

1. Building consensus through formal and informal community based consultations
2. Community Asset Mapping to identify community issues, needs, strengths and barriers
3. Looking directly to the evidence for planning purposes by using the annotated bibliography

Priority Areas in the BC PIP Suicide Framework

The Suicide PIP Framework includes information on targeted audiences, impacted audiences, key partnerships, suggested systems-level and program-level activities, development opportunities, signs of success and examples of programs. A Planning Template is an action-oriented tool that integrates priorities from the Suicide PIP Framework and provides a detailed description of how objectives can be achieved. It provides guidance for programs, from development through implementation, improvement and evaluation stages in a specific priority area. The following six priorities were identified in suicide prevention, intervention and postvention:

1. School-based programs
2. Gatekeeper training
3. Physician and health professional education
4. Culturally appropriate services
5. Coordination of services
6. Postvention programs and resources



Current Practices

The PIP initiative identified and described current programs, services or supports and strengths of programs, services and supports as indicated by respondents.

- **For prevention:** capacity building, collaboration, and community education programs were highly represented across many populations;
- **For intervention:** gatekeeper training, peer or group support, phone counselling, and risk assessments were highly represented across many populations.
- **For postvention:** critical incident management and phone counselling were highly represented across different populations.

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Among **adults**, awareness programming, capacity building, collaboration, community education and outreach were reported as current practices in prevention. CBT, crisis stabilization, DBT, gatekeeper training, group or peer support, group therapy, use of specialists and safety planning were all reported as current practices in intervention. Advocacy, bereavement teams, phone counselling, support groups, and referrals were reported as current practices in postvention.

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Among **vulnerable and/or high risk populations**, awareness programming, capacity building, community education, cultural awareness, interdisciplinary teams, liaising with schools and outreach were reported as current practices in prevention. Gatekeeper training, peer or group support, phone counselling, risk assessment and use of specialists were reported as current practices in intervention. Critical incident management was reported as one current practice in postvention.

Planning and Coordination⁵

According to the Aboriginal Healing Foundation, a comprehensive suicide prevention program requires a central coordinating group to ensure that there are no gaps in the system and there is no duplication. This group should involve representatives from major sectors of the community: youth, respected Elders, caregivers, professionals (from health, social services, and education), local government, and others. Inter-agency collaboration should be encouraged in order to fully utilize the strengths of all concerned, resulting in a comprehensive strategy responsive to the changing needs of individuals and the community. Together they may create or adapt programs that reflect the true nature of the community. The immediate effect of such collaboration will be a coordinated response to suicide prevention. The long-term effects will be the strengthening of the community and cultural identity, as well as the emergence of local control that will improve the health of both individuals and communities. This coordinating group should also link with and supervise a research team who can help design and carry out evaluations on the prevention activities and programs.

⁵.Aboriginal Healing Foundation, 2007

Prevention

Primary suicide prevention strategies for Aboriginal communities should include the activities listed below:

1. Peer counselling in which a group of youth are trained in basic listening skills and are identified as resource people for other youth in crisis;
2. A school curriculum that incorporates learning about positive mental health, the recognition of suicide, substance use, and other problems as serious mental health issues, as well as cultural heritage as a source of healthy coping mechanisms;
3. Recreational and sports programs for children and young people to combat boredom and alienation, and to foster peer support and a sense of belonging;
4. Workshops on life skills, problem solving, and communication for children and young people; much of this can be given by youth counsellors who could provide positive role models;
5. Family life education and parenting skills workshops for new parents and adults;
6. Support groups for individuals and families at risk (e.g. young mothers, recovering substance abusers, ex-offenders who have returned to the community after serving time);
7. Cultural programs and activities for the community at large (e.g. recording and transmitting the traditions of elders, camping on the land, ceremonial feasts, Aboriginal language courses);
8. Collaboration between community workers in health, social services, and education to promote integration of services;
9. Training in mental health promotion and suicide risk factor awareness for lay and professional helpers;
10. Opening lines of communication by creating opportunities for community members to express their perspectives. While many of these activities and programs can be implemented through the school or clinic, this would be greatly facilitated by the development of a community drop-in centre where these activities could take place.

Intervention

The following types of programs and services address the needs for intervention with individuals at high risk for suicide and should form part of a comprehensive prevention strategy:

1. Training of primary care providers (e.g. nurses, physicians, social workers, etc.) in suicide detection and crisis intervention, as well as in treatment of depression, anxiety disorders, substance use, and other psychiatric disorders.

2. Development of a regional crisis hotline based outside the community to provide some confidentiality; but workers should have knowledge of the community in order to respond appropriately and have community contacts who are available to intervene quickly when necessary.
3. Development of a crisis centre based in the community or in an adjoining community to provide a safe place, “time out,” and an opportunity for intensive intervention. It can be staffed by lay helpers and “big brothers” or “big sisters,” along with available professional assistance.
4. Immediate availability of crisis intervention for those at acute risk. This must address not just the affected youth themselves but their family and social networks as well. Family therapy and social network interventions fit the family- and community-centred values of many Aboriginal people.
5. Development of assessment and intervention services for parents of youth at risk (e.g. individual, couple, or family interventions for substance use, family violence, effects of residential school experiences, relocations, etc.). Some of these services may be difficult to provide in an ongoing way in remote communities. Limitations of local resources may be offset by the use of telehealth and the development of regional crisis intervention teams able to support and work collaboratively with people within the community.

Postvention

There is a need for routine follow-up of family and friends who have experienced a loss through suicide to identify and help those at risk for suicide themselves. Since Aboriginal communities are closely-knit and many youth find themselves in similar predicaments, suicides often occur in clusters. Therefore, there is a need to develop a crisis team to respond to suicide clusters. This can be done locally and complemented by a regional team with additional resources. The U.S. Centers for Disease Control and Prevention has developed guidelines for the community response to suicide clusters. In brief, these guidelines suggest:

1. A community should review these recommendations and develop their own plan before the onset of a suicide cluster. Communities should be given the opportunity to express their concerns and interests (e.g. town council or community meetings and gatherings).
2. The response to the crisis should involve all concerned sectors of the community: i) a coordinating committee of concerned individuals from school, church, health care, government, law enforcement, helpers, etc.; and ii) a host agency that should coordinate meetings, planning, and actual response in time of crisis.

3. Relevant community resources should be identified including hospital, emergency medical services, school, clergy, parents' groups, suicide hotline, students, police, media, and representatives from agencies not on the coordinating committee.
4. The response should be implemented when a suicide cluster occurs or when one or more deaths from trauma are identified that may impact on the adolescents.
5. The first step in crisis response is to contact and prepare all groups involved.
6. Avoid glorifying suicide victims and minimize sensationalism.
7. High-risk persons should be identified and have at least one screening interview with a trained counsellor, and then be referred for further counselling as needed.
8. Timely flow of accurate, appropriate information should be provided to the media.
9. Elements of the environment that might increase the likelihood of further suicide attempts should be identified and changed.
10. Long-term issues suggested by the nature of the suicide cluster should be addressed.

Both national and local media have a responsibility to take great care with their coverage of suicide issues by adhering to codes of conduct⁶. Guidelines for media reporting of suicide are readily available. Suicidal behaviour must not be dramatized or romanticized, and details on methods should not be provided. A news report should always be accompanied by information about available suicide prevention resources and other means of coping with distress. This can be presented in the form of comments by persons who were previously suicidal but sought help or by caregivers who can offer assistance. The media can contribute to suicide prevention by presenting positive images of Aboriginal culture and examples of successful coping and community development.

6. Royal Commission on Aboriginal Peoples, 1995



The BC Suicide PIP framework outlines key actions that can be taken and this planning framework has been used to structure this report and inform the suggested “next steps”:

Priority Area	Actions
School-based programs focusing on mental health promotion and preventing mental health and substance use problems	<ul style="list-style-type: none"> • Determine which schools and/or school districts have mental health promotion and/or suicide prevention programs and the formal or informal outcomes of those programs • Determine which elements are most important for schools to consider promoting and how those elements are currently addressed • Determine readiness, capacity and awareness of mental health promotion programs among district personnel, school personnel, counsellors, parents and students
Gatekeeper training for all professionals (including health care workers, community leaders, spiritual advisors, and justice system) on how to identify at-risk individuals and improve access to suicide intervention and mental health and substance use resources	<ul style="list-style-type: none"> • Determine the availability and accessibility of local community resources for mental health • Identify key individuals and organizations interested in providing gatekeeper training at local, regional and/or provincial levels • Identify specific potential gatekeepers in specific community settings • Consider community groups outside of the health care sectors that have broad membership and organizational structure to support program delivery • Support gatekeepers and keeping them connected with their community resources
Physician and health professional education on early recognition, risk assessment, clinical assessment, mental health conditions and comorbidities and treatment of suicidal behaviour and/or ideation across the lifespan	<ul style="list-style-type: none"> • Establish partnerships with community and hospital based clinical educators or partnerships with field experts at the regional and/or local levels to administer education to health professionals • Incorporate a discussion on freedom of information and privacy policies in existing health professional training efforts • Review and modify current risk and clinical assessment tools to ensure consistency and comprehensiveness • Consult and engage with families of suicidal persons regarding protection of privacy and freedom of information policies
Culturally appropriate services, cultural safety and diversity training for service providers regarding suicide prevention, intervention and postvention	<ul style="list-style-type: none"> • Provide opportunities for multiethnic/multilingual populations to be involved in programming efforts • Identify opportunities to engage with cultural media to provide messaging regarding mental health and suicide awareness • Develop or improve emotional health components of programs for multiethnic/multilingual populations • Promote self-awareness regarding attitudes and perspectives that challenge cultural safety among service providers

Priority Area	Actions
<p>Coordination of services for suicide prevention, intervention and postvention in the mental health system, the health care system, school/post-secondary systems and the community</p>	<ul style="list-style-type: none"> • Interdisciplinary teams and case approaches such as active case management, integrated case management and assertive community treatment teams • Development of day programs to address suicidality and/or concurrent disorders and crisis stabilization teams/units to address people in acute suicidal states and provide ongoing support • Improved access to psychiatrists and psychiatric services • Promotion of a trauma informed response to suicidal people and their families • Work with communities and regional health authorities to determine the feasibility of expanded services • Exploration of existing continuity of care opportunities among programs • Consider incorporating or pilot testing of interdisciplinary teams or other service improvement through coordination initiatives • Consider follow-up mechanisms and outreach that may or may not include Assertive Community Teams
<p>Development and enhancement of postvention bereavement programs, services and supports for persons touched by a suicide</p>	<ul style="list-style-type: none"> • Disseminate suicide survivor support group information to widespread audiences as well as other local pamphlets and resources • Develop linkages with hospices and hospital based clergy & social workers throughout the province to provide them with information and referrals supports • Support and educate Survivors in Action (or survivors who have become suicide awareness advocates) to help new survivors gain improved access to formal and community supports and educating both the helping agencies and the general public • Develop return to school and work supports after a suicide has occurred

PIP FRAMEWORK - PREVENTION

Overview

Suicide prevention focuses on strengthening resilience, reducing risk factors, and improving protective factors at the individual and community levels⁷. Prevention approaches include but are not limited to:

1. Education and Awareness;
2. Family, Peer Education and Support;
3. Gatekeeper Training;
4. Life Skills Support;
5. Means Restriction; and
6. Mental Health Promotion.

Although there is still a lack of good evaluation studies and demonstrations that suicide prevention programs actually work, even in the general population, recent evidence does suggest that certain specific types of interventions are likely to be effective. There is evidence of benefits from programs or interventions that:

1. restrict access to the means of suicide;
2. provide school-based education to teach coping skills, how to recognize and identify individuals at risk, and how to refer them to counselling or mental health services;

⁷.Government of Nova Scotia, 2006

3. train youth as peer counsellors or “natural helpers;”
4. train other individuals with whom youth come into regular contact (teachers, nurses, primary care providers, clergy, parents) to recognize and refer youth at risk;
5. mobilize the community to develop suicide prevention programs, a crisis intervention team, family support, and activities that bring together youth and Elders to transmit cultural knowledge and values; and
6. ensure that mass media portray suicide and other community problems in appropriate ways.

For individuals already identified as at risk for suicide or suffering from other mental health problems, it is crucial to ensure they have access to adequate mental health services. Depending on the severity of the problem, this includes psychiatry, psychology, counselling, peer support, and indigenous forms of help and healing. Families and friends bereaved by a suicide should also have counselling and other forms of support available. The fact that it is the youth in Aboriginal communities who are most obviously affected by suicide tends to keep the focus primarily on youth. Any intervention that reduces the suffering and improves the well-being of the parents and families of youth will benefit youth as well as contribute to suicide prevention.

The BC Suicide PIP Framework recommends two key focuses for suicide prevention – school-based programs (with many of the interventions outlined above) and culturally-appropriate services.



School Based Programs

PIP DEFINITION: School-based programs focusing on mental health promotion and preventing mental health and substance use problems and disorders for children and youth that integrates behavioural changes, coping skills and social supports.

Document Summary Findings:

The following reports were identified as useful for informing “school-based strategies” and / or those targeting youth. These were reviewed and summarized below for this report.

International Reports & Strategies

Zuni American Indian Tribe: Zuni Life Skills Development Curriculum

The Zuni life skills development programme was designed in collaboration with the Zuni pueblo and included in the curriculum at the Zuni tribal high school (situated in New Mexico, 150 miles from Albuquerque). The programme is described as ‘a culturally tailored intervention programme designed to remedy the behavioural and cognitive correlates of suicide.’ The Zuni Life Skills Development curriculum was structured around seven major units:

- building self-esteem,
- identifying emotions and stress,
- communication and problem-solving training,
- recognising and eliminating self-destructive behaviour,
- suicide information,
- suicide intervention, and
- personal and community goal setting.

The programme actively recognised the particular norms, values, beliefs and attitudes of the Zuni. The programme was delivered by teachers and individuals from the local community and received ongoing support from the community. The curriculum includes the following units and modules:

Who Am I – Building Self Esteem:

- Building community within the classroom
- Working together to get things done
- Building Bridges to Others – Trustworthiness
- Surveying my background and family history

- Building self-esteem through self-awareness
- Building self-esteem through role models
- Observing and Questioning – what is a person?

What am I Feeling – Emotions and Stress?

- Recognizing and talking about feelings
- Learning how to recognize emotions and feelings
- Recognizing and overcoming depression
- Recognizing stress and how it affects feelings
- Recognizing self-talk and how it affects feelings
- Learning to control self-talk and using it to benefit my life
- Recognizing anger and expressing justified anger

How can I communicate with others and solve problems effectively?

- Communicating better through listening
- Speaking concretely about feelings
- Asking open questions
- Problem solving
- Developing coping strategies for dealing with stress

How can I realize self-destructive behavior and find ways to eliminate it?

- Considering the effects of self-destructive behavior in Indian communities
- Viewing substance abuse as self-destructive behavior
- Determining when sex is healthy and when it is self-destructive
- Understanding how dysfunctional families contribute to self-destructive behavior

Why do people attempt suicide?

- Understanding the grief process
- Reviewing the youth suicide problem in Indian communities
- Differentiating between fact and fiction about suicide
- Recognising the emotional and behavioural warning signs of suicide

How can I help my friends who are thinking about suicide?

- Evaluating what to do and what not to do
- Learning about community resources for suicide prevention
- Practicing the 4 step plan for suicide prevention

How can I plan ahead for a great future?

- Reviewing Native American history
- Examining Native American rights and oppression
- Finding our own power
- Making my dream happen
- Dreaming for the future

Evaluation of this program has revealed that it has been highly successful in building resilience to youth suicide and being effective at helping youth to prevent suicide among friends and peers, or to manage crisis after suicide.

Keri Lawson – Te Aho Published in 1998 by Ministry of Maori Development, New Zealand: *A Review of Evidence: A Background Document to support Kia Piki Te Ora o te Taitamariki: Youth Suicide Prevention Strategy,*

Maori suicide is often translated as whakamomori. This is interpreted as 'a deep seated underlying sadness' and 'an in built tribal suffering.' Finally, whakamomori has also been defined as meaning 'grieving without a death.' 'Whakamomori' has gained popular usage as a term for Maori suicide. However, there are cultural understandings of this term in which whakamomori describes a psychological, spiritual and cultural or collective state of being that may or may not result in physical death. It has been found that cultural alienation is a valid explanation for indigenous experiences of being at higher 'risk' for drug and alcohol abuse, mental health problems including depression and suicide, and other adverse behaviours. Eckersley identifies that culture can provide a sense of belonging and purpose, a sense of meaning and self-worth and a moral framework to guide conduct. Similarly, Skegg et al. link the cultural alienation of young Maori to increased suicide risk. La Due confirms a relationship between cultural identity and alcoholism for Native American women, noting that the loss of cultural ties and values contributes to Indian alcoholism, and that women who are away from their traditional centres of support, be it familial, spiritual or communal, appear to be at a higher risk for alcohol abuse. Durie maintains that a secure Maori identity will act to protect against poor health even in the presence of adverse socio-economic conditions. This finding has been derived from preliminary results of the Hoe Nuku Roa: Maori Profiles research project in which it has been identified that Maori in the study associate a secure identity with 'a sense of being Maori and access to cultural markers such as family, Maori land, knowledge of ancestors, Maori language and opportunities to associate with other Maori people.' To date, theories about the impact of cultural loss on individual Native American behaviour has placed indigenous individuals along an acculturation continuum. According to this approach, the outcomes of colonisation present as behaviours that collectively indicate the extent to which the individual has been alienated from their identity as Native American. This is measured according to the degree of traditionality or acculturation that is manifest in the behaviour of the individual.

This report noted that there was well established international research on the patterns, causes and prevention of indigenous youth suicide. The risk factors which place indigenous youth internationally at higher risk of suicide include factors that are also implicated in Maori youth suicide. These factors are social disadvantage, family breakdown, drug and alcohol abuse, mental illness including depression, a history of exposure to suicide and suicide attempts, child abuse, imprisonment, low self-esteem, loss of romantic attachment and peer pressure. The same risk factors also apply to the general New Zealand youth population however, the magnitude and prevalence of the risk factors is where the experiences between Maori, indigenous and non-Maori populations seem to differ. There are additional risk factors which apply only to Maori and other indigenous youth. These are the risk factors relevant to cultural alienation, the impact of history through intergenerational modelling and behavioural transfer, and confusion over identity.

Regarding youth suicide prevention, there is increasing evidence that indigenous peoples who are least susceptible to alcohol and drug abuse, self-destruction, mental illness, and behavioural problems, are those who can demonstrate competency in both traditional and contemporary contexts. In other words, those indigenous people who are culturally competent in both Western and traditional worlds probably have the best chance of survival. This implies that cultural knowledge and behaviour provide a protection against self-destruction. It is also important to note that those prevention programmes that are designed and implemented by the indigenous communities concerned, and that are based on local networks, resources, skills and cultural processes are reporting significant reductions in indigenous youth suicide.

Finally, many of the assumptions that underpin mainstream health, education and social service strategies do not work for indigenous populations internationally. This is equally true in New Zealand and may be substantiated through an analysis of the failure of many mainstream programmes to access Maori and deliver effective services.

Ministry of Youth Affairs, Ministry of Health and Ministry of Maori Development, New Zealand (1999) *New Zealand Youth Suicide Prevention Strategy – Strengthening Youth Wellbeing*

Arising from the background evidence (Te Aho, 1998) the New Zealand Government developed and affirmed a youth suicide prevention strategy involving five key goals (with examples of actions described within each):

1. To strengthen family, sub-tribe, tribes and Maori so that they can contribute towards fulfilling the potential of youth
 - Highlight the significance of Te Tiriti (Treaty) o Waitangi in promoting wellness
 - Challenge discriminatory attitudes and practices to those with mental illness.
 - Increase awareness and application of a Maori holistic approach to wellness
 - Strengthen the role of kaumatua (elders) in the development of approaches

- Increase awareness of the negative effects of alcohol and drug misuse and peer pressure on health and wellbeing.
2. To strengthen the role of Maori youth by enabling them to provide a valued contribution to Maori development.
 - Increase Maori youth participation in Maori health, social, educational, political, economic and tribal development.
 - Encourage Maori youth to play a leadership role in the design, promotion and delivery of development programmes
 3. To increase the role of cultural development as a protective factor for Maori youth:
 - Support gatherings for raising the awareness of traditional beliefs and responses to suicide.
 - Promote a Maori cultural base, including relevant Maori values and concepts
 - Encourage the retention and revival of Maori language and customs
 - Enhance Maori healing practices as valid methodologies and tools of empowerment
 4. To encourage and assist mainstream services to respond appropriately and effectively to the needs of Maori youth through the establishment of partnerships with Maori.
 - Maori workforce development strategies and training in mainstream services.
 - cultural protocols and training programmes
 - Involve family in the case management of Maori within mainstream settings.
 - policy and service delivery for mainstream initiatives developed in partnership with Maori.
 5. To improve our understanding of the causes and true level of suicide amongst Maori youth
 - Encourage the development of 'by Maori for Maori' research
 - Promote the evaluation of suicide prevention programmes and services
 - Developing and disseminating information resources
 - Improve the accuracy of ethnicity recording for Maori for suicide, and hospital admissions for suicide attempts.

National Reports & Strategies

First Nations & Inuit Health – FNIH, 2008: *The National Aboriginal Youth Suicide Prevention Strategy – NAYSPS and the FNIH: Guide to the National Youth Suicide Prevention Strategy 2008 (A guide to support delivery of NAYSPS)*

Research shows that unique determinants are involved and that many First Nations youth face unique risk factors; more risk factors at once; and risk factors that are more severe than that of non-Aboriginal people. For many First Nations youth, the root causes of suicide include factors that go beyond their control. Suicide becomes a way to communicate distress and an escape when there seem to be few other options. Rates of First Nations youth suicide are linked to:

- The erosion of conditions that promote a strong sense of identity;
- Colonization and rapid cultural change;
- Trans-generational grief associated with the residential school system and the child welfare system; and,
- Being members of a marginalized and economically disadvantaged group.

The Assembly of First Nations, the First Nations and Inuit Health Branch of Health Canada, and others worked together to create the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). All of the activities funded through the Strategy will be evidence-based and recognize traditional cultural knowledge; build on existing structures and processes; and respect federal, provincial, and territorial mandates.

The ultimate goal of the NAYSPS is to reduce risk factors and promote protective (preventive) factors against suicide. Funding was allocated in the 2005 Federal budget in the amount of \$65 million over five years. Ultimately it is expected that the NAYSPS will meaningfully contribute to the improved health status of First Nations youth, families, and communities. The general program objectives as they apply to First Nations are to:

- Increase awareness and understanding of preventing suicide among First Nations youth;
- Strengthen key protective factors such as a strong sense of identity, meaning and purpose, and resilience;
- Strengthen and help create collaborative approaches and links within and across governments, agencies, and organizations;
- Improve and increase efforts to respond to crisis, and to intervene more effectively in preventing suicide and suicide clusters following a suicide-related crisis in First Nations communities;
- Develop and carry out locally driven community plans for preventing suicide in First Nations communities; and,
- Enhance the development of knowledge regarding what works in preventing suicide among First Nations youth.

There are four main elements of the NAYSPS.

- 1. Primary Prevention:* National activities that focus on public education to raise awareness and decrease stigma related to talking about suicide and mental health promotion to increase resiliency and reduce risk
- 2. Secondary Prevention:* Activities that focus on supporting collaborative, community-based approaches to preventing suicide
- 3. Tertiary Prevention:* Activities that focus on increasing the effectiveness of responding to and stabilizing crisis, and of after-care for survivors
- 4. Developing Knowledge:* National activities that will improve what we know about what works in preventing suicide among First Nations youth.

Implementation of the four main program elements is led at the community, regional and national level in order to focus activities where the most benefit can be achieved.

Anticipated Outcomes (Strategy Outcomes)

Indicators of key activities that were aimed to be delivered over the five-year program included:

- More trained gatekeepers such as natural helpers, police, health care and social service providers, and teachers in communities;
- More youth and community engagement;
- More communities that have inter-agency teams in place working on local plans;
- Having collaborative protocols for responding to crisis in place in all provinces and territories;
- More support/professionals for communities in crisis;
- More local professionals and community members trained to provide services for responding to crises;
- More available and accessible information, tools, and resources;
- Improved knowledge for youth suicide rates among off-reserve Aboriginal people;
- Increased knowledge and less stigma associated with preventing suicide in Aboriginal communities;
- More First Nations and Inuit communities with community-wide plans for preventing suicide; and
- Increased evidence to develop more effective programs for preventing suicide and prevention practices.

Providing people, families, and communities with these types of activities was aimed at improving the continuum of services and supports available to Aboriginal people. It allowed for the following outcomes over the five-year strategy:

- More Aboriginal youth, families, and communities taking part in projects, activities, and services that prevent suicide;
- More Aboriginal people taking part in delivering projects, activities, and services for preventing suicide;
- More awareness and practice of healthy behaviours among Aboriginal youth;
- More community ownership and capacity to identify and address youth suicide and other mental health issues; and
- Improved access to quality, well-coordinated programs and services for Aboriginal youth, families, and communities.

Examples of Youth Suicide Initiatives supported by NAYSPS:

A program managed with the support of Crisis Youth Workers. The project's goal is to build community capacity within the eleven participating communities for dealing with suicide issues through training and team building. This has been accomplished by implementing workshops that incorporate culturally relevant programming and tools, and the development of a Critical Incident Stress Management Team (CISM) that is comprised of twenty youth from each of the participating communities. There are three core components to the training program used for suicide prevention, intervention and aftercare. The first component is a packaged course flexible enough to incorporate cultural and traditional approaches to support the training. The cultural training includes self-awareness, healthy life style, language development, arts, cultural teachings and crafts. Two programs called the Grandmother and Grandfather of Tradition are part of regular workshop delivery. The second component of the training is geared to building capacity for peer leadership with youth. This includes CISM training, Safe Talk, and the sharing of Elders' teachings and knowledge. The third component is the delivery of monthly training in the communities that provides a range of skills development in the prevention and intervention areas.

A second example is operated by the Kenora (Anishinabe) Chiefs Advisory (Ontario) and is a program managed by the Manager of the Mental Health and Addictions Program with support from six front-line workers. The project's goal is to build community capacity by providing peer support training to teenagers. This training is based on the teen experience and reality of daily life

Sts'ailes Community School Outreach Program

The Chehalis Community School Youth Outreach Program provides youth outreach services for the students of Chehalis community school. Helping students deal with personal, school, and family issues, this program is one of the best support services available to students. It has made a true difference in their lives.

Program activities include:

- facilitated talking circles
- coached sports teams (e.g. soccer, volleyball, baseball and basketball)
- connections to Big Brothers and Big Sisters
- spirit days
- school dances
- social skills development programs
- an in-school mentoring program
- weekly girls group
- team meetings for kids at risk

in communities. It is a two-tiered approach of suicide prevention and of helping at-risk teens cope and build resilience in experiencing life challenges. The project is called the United Voices Program and offers communications skills training for youth. The program concentrated on helping youth build resilience and cope with issues that could lead to more serious mental health problems. Some of the skill building concentrated on methods of dealing with day to-day struggles of life as a teen. This included teaching effective ways to: manage relationships, deal with school and family stresses, recognize when it is imperative to talk to someone, and to recognize when someone else is in distress.

Assembly of First Nations, April 2009: First Nations Youth & Mental Wellness: A report on the NAYSPS program

The Assembly of First Nations (AFN) noted that First Nations youth face higher risks of mental illness than other youth in Canada...

- Thirty percent of First Nations people have felt sad, blue or depressed for two or more weeks. (First Nations Regional Longitudinal Health Survey, 2005).
- Suicide and self-inflicted injuries are the leading causes of death for First Nations youth and adults up to 44 years of age. (A Statistical Profile on the Health of First Nations in Canada for the Year 2000, Health Canada, 2003).
- First Nations youth commit suicide about five to six times more often than non-Aboriginal youth.

... but First Nations youth and communities have obvious successes in preventing youth suicide.

First Nations cultures, resilience, and youth involvement and empowerment are all factors in making a difference in communities. Incidents of suicide tend to be lower in communities that have high levels of cultural continuity as expressed by self-control over land claims, self-government, education and cultural practices.

The AFN passed a resolution in July 2008⁸ to assist in the promotion of the AFN Youth Action Plan in their respective communities. The Chiefs-in-Assembly agreed to partner with First Nation youth in their communities to work collaboratively with other stakeholders identified in the AFN Youth Action Plan as active participants. The Chiefs-in-Assembly use the AFN Youth Action Plan to guide their efforts in addressing First Nation youth concerns.

⁸.AFN Resolution, July 2008

Native Mental Health Research Team, July 1999: *Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities:*

The Native Mental Health Research Team report identified that consensus in the literature on youth suicide prevention emphasized that rather than teaching the topic of suicide exclusively to students, schools should provide a health education curriculum for all students that builds basic skills useful for managing a variety of health and social issues. This type of curriculum should enhance ability to cope with stress or distressing emotions, problem solving, interpersonal communication and conflict resolution – all measures that help to build self-esteem and deal with emotional conflict and crisis.

Younger children (under 12 years) are an important target group for primary prevention since many contributors to youth despair begin to have an effect during childhood. This implies attention to and support for the family. Family life education, family therapy and emotional support of youth and children is recommended.

“Lets Live” is a school-based awareness and intervention program that meets some of the RCAP (1995) guidelines for suicide prevention approaches, and developed by BC Council for Families in 1992. It is taught in grades 8-12 using 5 theme-driven lesson plans. It provides guidelines for educators to raise awareness in the classroom as well as responding to a crisis.

BC Reports & Strategies

The BC Ministry for Children and Family Development: *Child and Youth Mental Health Plan for BC (2003) and Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC (2008)*

The Child and Youth Mental Health Plan was developed in 2003 by the Ministry for Children and Family Development. The Child and Youth Mental Health Plan consisted of 4 components:

- **Risk reduction** – Formal efforts to prevent or delay onset of mental health problems in children and youth, or mitigate the impact of mental health problems;
- **Capacity building** – Strengthening the positive influence of families and communities to promote and support the mental health of children and youth;
- **Treatment and support** – Ensuring access to a continuum of timely, evidence-based, and effective services for children and youth with mental health problems and their families; and
- **Performance improvement** – Strengthening the infrastructure to support a responsive, efficient and accountable child and youth mental health system.

Since development of the *Child and Youth Mental Health Plan for BC (2003)*, significant progress has been made on the 4 components. Some short-term recommendations provided in the progress update report, *Promises Kept, Miles to Go (MCFD, 2008)* included:

- Strengthening mental health promotion and **risk reduction initiatives**;
- Embedding client and family resources into infrastructure;
- Working closely and collaborating with different BC Ministries;
- Improved management of concurrent disorders;
- Improving wait times;
- Providing additional resources for residential facilities; and
- Regional leadership and accountability for child and youth mental health services.

BC Ministry for Healthy Living and Sport: *Model Core Program Paper for Mental Health Promotion and Mental Disorders Prevention (2009).*

The BC Ministry for Healthy Living and Sport (now the Ministry of Health) have defined core public health functions for BC. The core public health functions define and describe the public health activities of a comprehensive public health system. The process included establishing a set of evidence-based core programs (based on model core program papers); implementing a continuous quality improvement mechanism for their delivery through the health authorities; and strengthening the provincial infrastructure to support public health capacity to deliver effective services.

The model core program paper for the mental health disorders and the prevention of mental disorders describes the following objectives:

1. Enhance protective factors that contribute to positive mental health in individuals, families, workplaces and communities
2. Prevent and/or reduce the social, environmental, and individual risk factors that influence the occurrence of mental disorders.
3. Reduce the incidence, prevalence and recurrence of mental disorders as well as the severity and impact of the illness on individuals, families and society.

BC Ministry of Health Services: *Working with the Client Who Is Suicidal (2007).*

In 2007, in partnership with the BC Ministry of Health, the Center for Applied Mental Health and Addictions Research (CARMHA) developed a comprehensive manual entitled "*Working with the Client Who Is Suicidal*". The manual aimed to improve clinical competency in addressing adults who are suicidal. The manual was divided in 4 categories:

1. General considerations for working with suicidal clients
2. Identifying and assessing suicidal risk
3. Safety and treatment planning and ongoing monitoring of suicidality and
4. Enhancing linkages between adult mental health and addiction services in the community.

This comprehensive resource provides extensive guidance to support clinicians and service providers who are involved in working with suicidal persons.

BC Ministry of Public Safety and Solicitor General: *Looking for something to look forward to... A five year retrospective review of child and youth suicide in BC (2008).*

Recently, efforts have been taken to address suicides among children and youth in British Columbia. The Child Death Review Unit of the BC Coroner's Service completed a death review of suicides among children from the period 2003-2007. The review process resulted in 17 recommendations developed and targeting provincial ministries and provincially focused organizations to engage in activities geared towards suicide prevention, intervention and postvention for children and youth. Critical components of the strategy were that responses to the recommendations needed to be: collaborative; youth- and family-centred; culturally safe; multi-level, and informed by current knowledge.

Culturally Appropriate Services

DEFINITION: Culturally appropriate services, cultural safety and diversity training for service providers regarding suicide prevention, intervention and postvention including:

- Improved translation services, expanded language capacity or improved awareness of existing services
- Coping skills training and workshops for emotion regulation and coping
- Providing stigma reduction, mental health awareness and education messages through TV, newspapers, and radio
- Gay, lesbian, bisexual and transgendered (GLBT) resiliency training administered by GLBT agencies and/or service providers



Document Summary Findings:

The following reports were identified as useful for informing “culturally appropriate services” and / or those targeting youth. These were reviewed and summarized below for this report.

International Reports & Strategies

Harder et al: *Indigenous Youth Suicide: A Systematic Review of the Literature: (2012)*

A systematic review of the literature on indigenous youth suicide (IYS) was conducted and published in the *Journal of Aboriginal and Indigenous Community Health* in 2012. This literature review reaffirmed that suicide is an important and tragic public health concern and IYS has been called a “crisis and an epidemic”. According to the World Health Organization (WHO), every year about one million people die from suicide and 10–20 million attempt suicide around the world. The global mortality rate from suicide is 16 per 100,000, which equates to about one death every 40 seconds.

Suicide is fast becoming a youth phenomenon localized among those between the ages of 15–24. Young people all over the world are committing suicide at unprecedented rates, replacing unintentional injuries as the number one cause of death among this age group. This so-called epidemic of youth suicide is most prominent among Indigenous peoples, who are overrepresented in every suicide statistic. Between 1987 and 1991, the rate of suicide among the Inuit of Canada was 3.9 times greater than that of the general population (Royal Commission, 1995). This rate was drastically higher among the Inuit youth of Quebec who were some 20 times more likely to commit suicide than their majority counterparts. During this same period, Aboriginal youth of British Columbia completed suicide nearly 4.5 times more often than the majority of the youth population (104.8 per 100,000 vs. 24.0 per 100,000) (Chandler and Lalonde, 1998). Indigenous populations in the United States, New Zealand, and Australia also exhibit uncharacteristically high levels of suicidal behaviour. According to statistics from the Center for Disease Control (CDC) between 2002–2006, American Indian/Alaskan Native (AI/AN) had the highest suicide rates among all ethnic groups in the United States. The Maori of New Zealand have had higher rates of suicide than their non-Maori peers each year. Similarly, Indigenous Torres Strait Islanders of Australia complete suicide at a higher rate than the remaining age group from the state as a whole.

One of the most promising theories as to the reason for these high indigenous suicide rates is the *cultural continuity theory*, which suggests that lack of cultural connectedness may explain why Indigenous youth commit suicide at such alarming rates. This theory proposes that a tight-knit and productive cultural community may buffer against IYS. Literature articles were assessed about the Sami people of Scandinavia; the Maori of New Zealand, Native Hawaiians, and Aboriginal populations of North America and New Mexico.

Interpretation of Risk and Protective Factors Analysis

A comparison of risk factors predisposing suicidal ideation, attempts, and completions identifies remarkable consistency in the variables of importance. First, the two strongest risk factors consistently emerging are **depression** and **having a friend attempt or commit suicide**. The next strongest predisposing factors were **conduct disorder** and **substance or alcohol abuse**. Finally, having a **psychiatric disorder**, other than depression, and suffering from previous childhood abuse also increase the likelihood of attempting suicide. The variable most strongly buffering against suicide was high support, whether social or familial. The importance of culture was more profound for suicide attempts than for suicidal ideation. Personality variables of high self-esteem and having an internal locus of control further reduced the risk of suicide.

Emphasis on Culture as a Protective Factor

The three main trends that emerged from the literature on the subject of culture as a protective factor were -

1. a lack of empirical research (very few studies examined this aspect)
2. the need for a unified definition of culture; (everyone had a difficult interpretation as some define it as cultural activities while others may define it as a form of self-governance) and
3. the effects of culture depended upon which level the construct was analyzed (history of each indigenous people; language; cultural knowledge paradigms).

Two studies measured cultural continuity as the degree to which bands along the west coast of British Columbia have been able to fight for and maintain a strong sense of culture by challenging the government to allow them to live in, govern, and perform cultural rituals on their native lands. The idea is that bands undertaking an active role in maintaining and preserving their culture will reduce youth suicide by providing a thread between self and culture, thus promoting the development of a strong sense of self. While difficult to quantify and evaluate empirically, their general findings suggest that this is the case.

Valuing, maintaining, and participating in traditional cultural and spiritual practices had mixed effects on buffering against suicide. One study found that being embedded within one's culture and valuing traditional spirituality led to fewer suicidal tendencies over time, although this relationship was complex and most pronounced when cultural identification was endorsed at an earlier age. Similarly, actively participating in spiritual practices on a regular basis was found to buffer against suicide. The endorsement of enculturation and traditional spirituality at age 10, but not at subsequent assessments, was found to decrease the risk of current and future suicidal tendencies suggesting that the beneficial effects of culture may be limited to certain developmental stages. Importantly, this effect was partially explained by reductions in depression, negative life events, anger and alcohol use, and through an enhanced sense of self-worth.

This study indicates the need to assess pathways to suicidal tendencies among Indigenous youth. A life-course perspective needs to be adopted in order to better understand how culture attenuates the risk of suicidal tendencies conferred by factors such as poverty, genetics, psychopathology, social disadvantage, discrimination, and stressful events.

This review of the literature relevant to Indigenous youth suicide indicates that suicidal behaviour among Indigenous youth is a complex issue. The evidence suggests that it is not only having a sense of culture that buffers against the negative pathways of suicide, but rather the act of engaging in culturally relevant activities with respected others in the community.

National Reports & Strategies

The National Aboriginal Youth Suicide Prevention Strategy – NAYSPS (First Nations & Inuit Health – FNIH, 2008)

The groups that are eligible to receive NAYSPS funding⁹ include First Nations health authorities or band councils; First Nations Tribal Councils; Provincial or territorial organizations; First Nations land claimant organizations; Governments of the territories if funding is targeted to First Nations in the northern territories and First Nations show involvement, partnership, and support in planning and development of activities; Incorporated and non-profit First Nations groups and organizations; Other incorporated and non-profit groups and organizations if they show involvement and support of First Nations to deliver elements of the strategy.

First Nations communities that met the criteria were considered for community-based funding to support:

- Planning to have Community Circles or Embrace Life Committees or another collaborative approach to development and implementation of community-driven and community-wide suicide prevention plans;
- Meaningful youth involvement from the beginning of the project and throughout;
- Support from a range of people from the community, including community members, youth, Elders, health professionals and other local caregivers, schools, community leaders, and police;
- Capacity to start and deliver the project with available support. This includes identifying resources in the plan to support human resources that can coordinate community planning and activities for preventing suicide.

9.FNIH, 2008 Guide to Youth Suicide Prevention

Assembly of First Nations 2009: *Working Together to Address Suicide in Aboriginal Communities*

In April 2009, the AFN produced a report outlining successful community activities and strategies being used by various First Nations across Canada to address suicide prevention under the NAYSPS program. The report identified that First Nations have always strived to work collectively in creating and supporting communities where members are provided with all means necessary to live a healthy life. Throughout history, First Nations have been faced with a range of challenges and vast change; yet, the importance placed on working toward creating a community where members are encouraged to prosper, remains unchanged. In many First Nations communities, the tremendous challenge of effectively responding to and preventing suicide can be extremely difficult and overwhelming. Communities are often faced with obstacles that hinder accessibility, availability and support of resources that assist in increasing community capacity to respond to suicides and suicide clusters. However, there are successes that First Nations communities have had with either responding to, or preventing suicide. In addition, we are learning that there are numerous communities that have had very few, and in some cases no, completed suicides in recent memory. As we become more familiar with the approaches communities are using in working collectively to responding to suicide risks, activity and clusters; it is becoming obvious that we must begin to share the stories of communities working together toward prevention and resiliency. This resource is the beginning of the AFN's efforts to work with communities in sharing stories of prevention and resiliency. It highlights examples of thriving collaborative, community-based, suicide prevention projects that are funded through the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). These projects remind us that our chances of success are greater when we work together, engage our youth, and root our healing approaches in our community's knowledge.

The AFN passed a resolution on September 10, 2009 to support the renewal of the National First Nations Suicide Prevention Program (NAYSPS) with the essential condition that leadership by Youth and Traditional Healers and Elders must be implemented with dedicated funding to First Nations youth suicide prevention programs. They also agreed to support the establishment of a Manitoba First Nations Suicide Prevention and Healing Centre to assist in suicide prevention, intervention and postvention education and counselling for individuals, families and care helpers.

AFN Advisory Group of Youth Suicide Prevention, 2002/2003

In July 2001, a Suicide Prevention Advisory Group was jointly appointed by the then National Chief Coon Come of the AFN and former Minister of Health Alan Rock. The purpose was to review existing research and formulate a series of practical, doable recommendations to help stem the tide of youth suicides occurring in First Nations communities across Canada. The group achieved this goal and identified key issues and developed recommendations for action which fell into 4 themes:

1. Increasing knowledge about what works in suicide prevention – examples:

- Allocating specific research funding for this area
- Ensuring systematic evaluation occurs for all future suicide prevention programs
- Ensuring pilot programs are sustainable

2. Developing more effective and integrated health care services at national, regional and local levels for example:

- NIHB program is reviewed to determine how well it is meeting needs of communities in crisis
- NIHB funds include funding for traditional practitioners as part of mental health services
- Community Crisis guidelines are produced

3. Supporting community-driven approaches for example:

- Health Canada provides guidelines and links to resources
- Establish demonstration projects
- Make a pool of facilitators available to communities knowledgeable in FN cultures and skilled in community development

4. Creating strategies for building youth identity, resilience and culture for example:

- Promoting the role of youth peer counsellors, natural healers and role models
- Positive media campaigns for youth



Inuusiqatsiarniq Inuit Youth Suicide Prevention Strategy - Guide to Implementing the National Aboriginal Youth Suicide Prevention Strategy 2008

Suicide prevention and mental wellness are the number one health priority for Inuit. Suicide prevention involves finding ways to strengthen and build protective factors and reduce risk factors associated with suicide. There are many factors that contribute to elevated rates of suicide. Without a coordinated approach to addressing suicide prevention among Inuit, there is no indication that the problem will fix itself. From an Inuit perspective, for a suicide prevention strategy to be successful, it must have a major focus on Inuusiqatsiarniq. This means having a focus on the positive, and working together to encourage and foster healthy lifestyles and overall well-being in a holistic way. In order to facilitate positive change, we have to approach it in a life-affirming and positive manner. We need to celebrate and embrace life! The Inuusiqatsiarniq Strategy is the name given to the Inuit-specific approach developed by Inuit to implement the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) in Inuit communities. Ultimately, in the long-term, it is expected that the strategy will meaningfully contribute to the improved health status of Aboriginal youth, families, and communities.

Strategy Elements

The Inuusiqatsiarniq Strategy supports Inuit working together to take a coordinated approach. A major focus of the Strategy is to support community-based approaches to suicide prevention. Communities will be supported to design and implement suicide prevention plans. The Inuusiqatsiarniq Strategy supports activities in five priority areas:

- 1. Wellness (promotion and prevention)** - Wellness related activities include activities that improve or increase protective factors (promotion) and reduce risk factors (prevention) such as promotion of Inuit youth self-esteem and positive identity; support for increased awareness of risk factors (and how to help); and culturally relevant and youth-specific tools to foster risk assessment, healthy families and parenting, and Inuit youth leadership will be developed and made available.
- 2. Management (crisis response planning)** - Management-related activities include the stabilization of communities in crisis and promote improved care and treatment of people in need of help such as review and improvement of existing crisis protocols to better meet individual community needs; support for natural caregivers and neighboring communities to provide support to communities in crisis; and training to build community capacity to deal with a local crisis.
- 3. Maintenance (sustainable programs over the long term)** – Support for activities that contribute to the ongoing wellness movement among Inuit including follow-up components, identifying further action to be taken and creating sustainable activities.

4. Knowledge/Monitoring/Evaluation (increasing what we know) - These activities help increase what is known regarding what is effective in improving the quality of life for Inuit youth including an evaluation component. Community-based participatory research activities engage the community (i.e. youth, elders, traditional healers) in developing and answering research questions. Research must respect the principles of OCAP (i.e. Inuit Ownership, Control, Access and Possession of/to information collected) and be widely disseminated through existing networks.

5. Human Resources (investing in people) - Investing in people (volunteers, frontline workers, youth, adults, parents, Elders, communities, organizations and governments) to better understand the issues and realities related to Inuusiqatsiarniq. Information, resources and supportive learning environments to help community members to understanding of suicide risk factors.

Native Mental Health Research Team, July 1999: Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities:

This report sets out the rationale and guidelines for suicide prevention in Native communities as part of a larger multi-faceted mental health promotion strategy that is the responsibility of the whole community, band or region. The report recommends that a comprehensive program is coordinated by a central group to ensure there are no gaps or duplicated efforts.

Primary prevention strategies (improving mental wellness of the population) should include:

- Training youth to act as peer counsellors
- A school curriculum with mental health and cultural heritage components
- Recreational and sports programs
- Workshops on life skills, problem solving and communication
- Parenting skills workshops
- Support groups for individuals and families at risk
- Cultural programs for the community at large
- Collaboration between community workers in health, social services and education
- Training in mental health promotion for lay and professional helpers

Intervention services (also known as 'secondary prevention' interventions with potentially suicidal individuals either before they injure themselves or during a crisis (e.g. distress hotlines)) should include:

- Training of primary health care providers
- Development of a regional crisis hotline
- Development of a crisis centre

- Availability of immediate crisis intervention
- Assessment and intervention services for parents of youth at risk

Postvention services should help families and friends cope with loss due to suicide. This should also include development of a crisis response team to respond to suicide clusters (e.g. suicide pacts). The US Centers for Disease Control guidelines for response to suicide clusters is recommended by the Native Mental Health Team.

Recommendations of the Native Mental Health Research Team included:

1. Coordination as part of the larger mental health promotion strategy. One key example of a proven strategy - Community-Based Suicide Prevention Program (CBSPP) – grants for communities with guidelines such as a Coordinators Handbook.
2. Central coordination group with representatives from all sectors of community and government (and with a role of overseeing research and evaluation)
3. Prevention strategies (as identified above)
4. Intervention strategies (as identified above)

Ministry of Youth Affairs, Ministry of Health and Ministry of Maori Development, New Zealand (1999) *New Zealand Youth Suicide Prevention Strategy – Strengthening Youth Wellbeing*

This strategy was developed to focus specifically on Maori youth suicide prevention and complemented a wider strategy for youth in general in New Zealand. Key strategies have a strong cultural foundation and incorporate traditional Maori interventions and beliefs.

Community and Culturally-Based Interventions

The fundamental characteristic of this approach is that the community at risk knows best how to respond to its own problems, and that each community has the potential capacity to build on its strengths and use these to address internal problems – provided that the right conditions for community action are created. This approach is completely compatible with current developments in public health. It is also completely compatible with Maori health development where the agenda is determined by Maori for Maori and emphasises family (family), hapu (sub-tribe) and iwi (tribal) development. There is a further emphasis on the use of cultural traditions and practices as a means to strengthen indigenous youth against suicide.

Government commitment and active support

The New Zealand strategy acknowledges that the Alaska Youth Suicide programme works because the United States federal government is committed to the prevention of youth suicide in Alaska. Without dedicated commitment to reduce youth suicide in New Zealand, Kia Piki Te Ora O Te Taitamariki will not work. There has to be a commitment to address the issue of Maori youth suicide from within Maori communities in order for a national Maori youth suicide prevention strategy to work. This includes a commitment to the concept of rebuilding cultural processes as a valid form of Maori suicide prevention.

Relocating the design of prevention strategies into the hands of those most affected by them

Maori must be instrumental in the design of strategies at the local level for the prevention of Maori youth suicide. This needs to be accompanied by active Maori involvement in all aspects of planning and management of the response to Maori youth suicide. This approach has been identified by the Ottawa Charter for Health Promotion and confirmed by the Jakarta Declaration. For Maori, the right to be instrumental in Maori youth suicide prevention is sourced in the Treaty of Waitangi and the precedent for self-determination contained within the Treaty. This means that prevention efforts must actively recognise the behavioural and attitudinal patterns of Maori and indigenous youth. The cultural realities of the consumers must be the focal point of any intervention design if effectiveness is a serious consideration.

Understand historical factors that create a suicide risk for indigenous youth

An historical analysis requires that those designing responses to Maori and indigenous youth suicide understand their own histories so that history has meaning as a significant factor in the prevention of youth suicide.

Recognise the validity of Maori and indigenous expertise

Non-indigenous experts often fail to recognise the limitations of their own expertise where indigenous populations are concerned and then wonder why their strategies, research and approaches fail to reach indigenous peoples, or why there may be discrepancies between theory and practice. Fundamental to any indigenous youth suicide prevention strategy is the need to validate indigenous expertise. This means recognising that indigenous experts in indigenous youth suicide prevention do know what they are talking about – and that part of validating indigenous expertise necessarily challenges the expertise of nonindigenous experts.

Integrate traditional knowledge into contemporary settings

There is a need to ensure that cultural interventions recognise where indigenous youth are placed and work to weave tradition and contemporary realities together to create the conditions for change. This requires a particular type of cultural expertise.

NZ Maori Youth Suicide Strategy [Case Study: Alaska Native Elders Suicide Prevention Project]

The Alaska Native Elders Suicide Prevention Project sought to identify the characteristics of healthy, functioning Native communities where the suicide rates were low. The intent was to identify the core characteristics of healthy Native communities and use these to replicate the conditions in other Native communities as a form of suicide prevention. It was accepted within this approach that Native communities had the capacity to respond to their own needs. It also recognised the diversity of Native communities and villages, and that exemplary Native elders had a vital role to play in the education of Native communities and Native youth. The project identified a need to embrace and teach the young about their histories and traditions and thereby provide guides for conduct and behaviour. It also recognised that it would be impossible to recreate a pure traditional cultural model because of the extent of assimilation of Native communities in Alaska. Finally, the elders found it difficult to place suicide prevention into a context of traditional cultural understanding because they were trying to integrate traditional concepts with contemporary outcomes.

The strategy emphasizes the importance and effectiveness of *Community-Based Suicide Prevention (CBSP)* – elements are discussed below.

Community Support

Community-based suicide prevention (CBSP) projects are becoming embedded in the communities they serve. They get positive activities moving in the community, try to involve as many residents as possible and attempt to organise activities that become a natural and recurring part of the community. This relies on a community infrastructure to augment support and provide opportunities for healthy behaviour and to change the community environment which enables self-destructive behaviours. These programmes include teaching traditional culture and developing community-based support networks providing a range of services such as crisis intervention teams, counselling programmes and support groups.

Beyond Borders: Outreach Mental Health Services in the Fraser Canyon

Fraser Health, Aboriginal communities and organizations in the Fraser Canyon area, MCFD Aboriginal Child & Youth Mental Health, and the Fraser Thompson Indian Services Society work together to provide community outreach mental health services in the Agassiz, Hope, and Fraser Canyon areas. Services are guided by Aboriginal cultural values, traditions, and concepts of mental, emotional, and spiritual wellness. Services range from assessment, consultation, individual & group counselling, case management, and professional consultation & education, to youth mentorship, assistance for families in accessing services, help with transportation issues, social & emotional support, and outreach services.

Mental Health workers in the Canyon area meet bi-monthly to hear presentations on Aboriginal mental health from a rotating schedule of speakers. These meetings are also an opportunity to share information, as well as discuss current initiatives, challenges, and opportunities for partnership in improving the mental wellness of the Aboriginal population of the Fraser Canyon area.

Community Skills Development

Community skills development focuses on educating community residents about the characteristics of suicide and self-destructive behaviour, treatment approaches and how to help in crisis situations. The underlying rationale is that community residents who feel that they have greater control over any community problem will be better placed to take control over self-destructive behaviour. School-based education is important for early intervention.

Agency and institutional Development

This group of interventions refers to direct interaction with formal helping agencies. This may include working with local government to establish curfews, developing agreed role model behaviours among local community leaders, working with the school system to address the special needs of at risk youth, development of referral processes, and working with external agencies to collect information and refer at risk individuals to appropriate treatment programmes.

Program Outcomes

The CBSP programme was evaluated for impact and outcome in 1993. The findings showed a 51% reduction in completed suicides in the CBSP communities, compared with an overall drop in suicide for Alaska Natives of 22%. The CBSP projects were influencing the behaviour of individuals toward pro-active responses to suicide risk among neighbours and family.

Aboriginal Youth Wellness Think Tank Report: Provincial Health Services Authority (PHSA) Aboriginal Health Program (March 2012)

In March 2012 the PHSA hosted a Think Tank at Richmond, BC to continue discussions among youth and service providers, universities, agencies and Health Authorities about youth wellness and the content of an on-line Indigenous Youth Wellness educational tool. This tool is being developed by the PHSA to provide a resource for communities to promote Youth Wellness. The workshop generated ideas on what youth wellness looks like, which produced such thoughts, ideas and themes as:

- Culture
- Healthy mind, body and spirit
- Balance
- Going home
- Community
- Learning
- Healing journey
- Teamwork

- Being active
- Connection
- Drug and alcohol free
- Thinking positively
- Security and safety
- Role modelling
- Safe spaces
- Respecting the land
- Laughter and humor
- Unity
- Resilience

These ideas were themed into several areas:

1. Environmental factors
2. Life Skills
3. Emotional factors
4. Empowerment Factors
5. Relationships
6. Physical Factors
7. Healing Factors
8. Leadership Skills

Discussions were also held around the risk factors that affect or prevent youth wellness:

- Racism
- Violence and bullying
- History
- Residential Schools
- Parenting
- Drugs and Alcohol
- Relationships and Communication (or lack of)
- Oppression



On the subject of suicide, youth provided many ideas on information and tools that would help to prevent suicide such as identifying risk, where to get help, finding safe places, help if someone is thinking about it, what information to provide to someone who is suicidal. The report contains some rich information that will be useful for anyone developing on-line tool kits and information and is full of youth-centred ideas and suggestions.

Resources for Suicide Prevention

Adolescent Suicide Prevention Program Manual (P Serna, 2011) – Native American

This manual describes the Adolescent Suicide Prevention Program (Based in Massachusetts), how it was created, and how it was maintained for sixteen (16) years, from 1989 to 2005. The Program uses a community systems model to form the foundation of the prevention and education component of the Program. This model includes all aspects of the community Tribal leadership, all health care providers, parents, elders, youth, and clients in identifying and implementing solutions that are culturally specific and appropriate for the Tribe.

Darkness Calls, Red Earth Media, The Healthy Aboriginal Network, 2006

A comic book on youth suicide in First Nations communities and video for youth

Men and Suicide: A High Risk Population: Centre for Suicide Prevention, 2011

Toolkit to describe suicidality among men between the ages of 40-60; looks at stats, risk and protective factors, and programs for men in need of support

Plus 65: A Resource Toolkit Specific to Seniors: Centre for Suicide Prevention, 2012

Toolkit that describes suicidality among seniors, focusing on stats, risk and protective factors, and signs that may indicate suicide ideation among seniors

Suicide Prevention and Two Spirited People, NAHO, 2012

A guidebook that describes the risk for suicidality for two spirited people and the experiences and challenges of two spirited people with respect to suicide

Teen Suicide Resource Toolkit: Centre for Suicide Prevention, 2012

Provides information and statistics on youth suicide, with a Canada wide focus; highlights risk and protective factors

Policy and Practice Considerations: Clinical Assessment of Suicide Risk and Clinical Documentation, Dr Jennifer White (funded by MCFD), 2011

Clinical guideline that identifies the key elements of suicide risk assessment with children or youth and their families and the documentation of that process

Preventing Youth Suicide: A Guide for Practitioners: Dr Jennifer White (funded by MCFD) 2011

Provides practitioners with information on the topic of youth suicide

Provincial Suicide Clinical Framework, Quality, Safety and Performance Improvement: BC Mental Health and Addiction Services, May 5, 2010 DRAFT

Strategy for assessing, treating, monitoring and documenting suicide prevention activities across BC Health Authorities

Suicide Prevention: Guidelines for Public Awareness and Education Activities. This guideline is written for those working in the important area of suicide prevention, and to those people who have an interest in public awareness and education for the purpose of preventing suicide. These guidelines were developed over a period of a year and a half. The development was led by Manitoba Health in partnership with the Provincial Working Group on Guidelines for Public Awareness and Education for Suicide Prevention.



PIP FRAMEWORK - INTERVENTION

Suicide intervention refers to the identification, treatment and care of a suicidal individual (BC Suicide PIP Initiative, 2009). Interventions are conducted with the goal of reducing the likelihood that the individual will die of a suicide. Intervention approaches include but are not limited to:

1. Counselling (including Cognitive behavioural therapy, Dialectical behaviour therapy, Interpersonal therapy, Multi-systemic therapy, Problem Solving Therapy);
2. Crisis and distress hotlines (this is supported by the Native Mental Health Research Team also)
3. Education and awareness;
4. Family education and support;
5. Follow-up care;
6. Screening and early identification;
7. Pharmacotherapy; and
8. Psychotherapy.

Gatekeeper Training

DEFINITION: Gatekeeper training for all populations including:

- Peers, health professionals, community leaders, spiritual advisors, within school and post-secondary settings, the workplace, acute care settings and long term care facilities, justice system
- How to identify at-risk individuals and improve access to suicide intervention and mental health and substance use resources

Document Summary Findings:

Literature that was provided and reviewed revealed stories of specific initiatives and projects focused on suicide intervention. These are summarized below.

Gitxsan Project, Northern Region, BC (AFN NAYSPS report):

It took nearly a year to determine the direction and establish a unique training plan that would build skills and expertise for 19 front-line workers. The First Nation Action & Support Team (FAST) project's goal in the first year is to build capacity and skills for the team members to prepare them for responding to crisis situations. Fourteen of the fifteen communities have at least one FAST representative (team member) enlisted. There is approximately a 500 km distance between the furthest communities and this adds to the challenge of working with the communities. Persons selected for the training are a diverse group with the youngest being 20 years of age, to Elders in the senior age range. Employers of selected team members were asked to donate 20 days of paid time to support the work of the FAST member selected; and it has been recently identified that it would be beneficial for team members to have a few more days working as a team. The training consists of the following elements - Train the trainers; Suicide risk symptoms; Intervention; Dealing with difficult people; Developing a process and procedures in responding to crisis; Clinical assessments process; Dealing with the health of the team; Crisis response; Personal development; Who should be called; Building schedules so that someone is always on call; Through the Pain and Building of cultural and traditional components.

Applied Suicide Intervention Skills Training (ASIST)¹⁰

ASIST is a two-day, interactive workshop designed by Livingworks Education, a public service corporation, to prepare all caregivers including professionals, paraprofessionals, and lay people to intervene in a suicide crisis. ASIST is currently the most widely used suicide intervention workshop in the world. It has been in place for nearly 25 years, is multilingual and employs over 3,000 trainers worldwide. This workshop talks about attitudes and how they affect one's work as

¹⁰.Aboriginal Healing Foundation, 2007

Seabird Island: Provision of Mental Health and Substance Use Services

The Seabird Island and affiliated bands serve a population of over 8,000 individuals and families living both on and off reserve. With a team including the Manager, coordinator of Health Services, Psychologist (6 days per month), part time Registered Clinical Counsellor (RCC), Community Health Nurses & LPNs and a Physician – the service aims to address Mental Health and Substance Use problems including depression, suicide prevention and addiction. The service is still trying to attract a psychiatrist to provide additional support to the team and has identified a need for a Concurrent Disorders Therapist. There are a number of aboriginal staff trained at Sto:lo Nation in Crisis Response and intervention however the team still needs development and support to improve their response and effectiveness.

a caregiver (a caregiver in this case is anyone whose work—professional or volunteer—involves suicide prevention). It also gives the caregiver an understanding of who commits suicide and how to do a risk assessment. Participants have the chance to practice talking to a person at risk, using role play in which they follow the intervention model taught through ASIST.

5-Day Suicide Prevention Training for Aboriginal Communities

The 5-Day Suicide Prevention Training for Aboriginal Communities was commissioned by the Royal Canadian Mounted Police (RCMP) National Aboriginal Policing Services and was created by Suicide Prevention Training Programs (SPTP), a branch of the Centre for Suicide Prevention. The Centre for Suicide Prevention is a non-profit organization dedicated to providing information, research, and training regarding suicide prevention. SPTP developed a flexible, five-day workshop to address the issue of suicide in Aboriginal communities. The five-day workshop has been presented throughout Canada, in every province and territory. Many of the workshops have been conducted as part of a suicide prevention strategy of the RCMP National Aboriginal Policing Services Branch.

The ASCIRT Approach¹¹

Some First Nations and Aboriginal communities in British Columbia have adopted the Aboriginal Critical Incidence Response Team (AS CIRT) approach to suicide prevention and response. While the initial name for this type of approach is AS CIRT, each team has a unique name and have adapted this approach that fits their communities' needs. The teams are focused on building community capacity, mobilization, education and support. The goal of having a response team is not to replace what already exists, but to increase knowledge, awareness, capacity, and support a community in crisis.

The main objective is to have a community-based response team that will enhance primary suicide prevention efforts, and the existing community capacity to respond to community crises. The approach involves a cluster of communities or nations coming together and choosing members to participate in forming an incident response team. The members from each community obtain Band Council Resolutions (BCR) that stipulates the response team members are allowed up to 20 days during the year to be a part of the incident response team, while still maintaining their salary and job within their own community. The members from each community are then trained in mental health, the delivery of primary suicide prevention strategies, and critical incidence response to both suicide attempts and other crises within the community. The team includes many different types of responders such as clinical, knowledge keepers, Traditional healers, and youth support to name a few. The community-based AS CIRT team is trained within culturally based protocols. The teams are also a part of a circle of outside clinicians and responders that can work in cooperation with the traditional methods to provide a holistic path to healing.

11. ASCIRT Coordinator Gathering 2009, FNHC

In November 2008 the First Nations Health Council hosted the first AS CIRT Coordinators Gathering held in Kelowna. The Gathering was in response to the AS CIRT Coordinators desire to share their knowledge, challenges and best practices of their team's approach to suicide prevention, intervention and postvention. The Coordinator, Elder and two team members from each team participated in the two day Gathering which consisted of team building activities, self-care activities, workshops and a special meeting of the Coordinators.

On June 23rd, 24th, 25th, 2009 the First Nations Health Council facilitated the second gathering of the Aboriginal Suicide Critical Incident Response Team (AS CIRT) Coordinators in Courtenay. The AS CIRT team Coordinators shared their knowledge, challenges and best practices of their team's approaches to suicide prevention, intervention and postvention.

Physician and Health Professional Education

DEFINITION: Physician and health professional education on early recognition, risk assessment, clinical assessment, mental health conditions and comorbidities and treatment of suicidal behaviour and / or ideation across the lifespan. Education efforts include addressing depression, other mental health conditions and concurrent disorders as well as the interpretation of policies around treatment provision (BC Mental Health Act, Infants Act, Freedom of Information and Protection of Privacy Act)

Document Summary Findings:

There were no specific documents or reports provided that described or reported on physician and health professional education, however a schedule of available training opportunities for physicians and health professionals was sourced and is listed below.

- **ASIST (Applied Suicide Intervention Skills Training)** - 2 day workshop for health professionals who want to improve their ability to help prevent the immediate risk of suicide. See previous pages 57-58 for more detail.
- **Mental Health First Aid**, Mental Health Commission of Canada – a 12-14 hours (over 2-4 days) workshop to help health professionals support clients who may be developing a mental health problem or experiencing a mental health crisis.
- **Aboriginal Suicide & Trauma Prevention & Intervention**, Aboriginal Training & Consulting Services – a 3 day forum to learn strategies to deal with Aboriginal suicide and trauma; and network among other professionals dealing with these issues.
- **Suicide Intervention Training – Advanced**, Judy North – an 8 hour workshop for people with training/experience in suicide prevention, to build their suicide prevention/intervention competencies (exact content tailored to audience needs).

- ***Suicide Postvention Training, Judy North*** – an 8 hour workshop to assist service providers, spiritual leaders, and interested community members in preparing a culturally safe community suicide postvention response plan (exact content tailored to audience needs).
- ***River of Life: Aboriginal Youth Suicide Prevention***, Centre for Suicide Prevention - a 1-4 weeks (self-directed) online course to provide professionals with strategies to strengthen the protective factors of youth at risk, and train them to respond to youth at risk of suicide.
- ***Detection and Intervention Strategies Within First Nations and Inuit Communities***, Justice Institute of BC – a 14 hours classroom-based course designed to help professionals develop a greater awareness into the detection of children, youth and adults who are at risk for suicide and the significance of implementing sustaining long-term community-based strategies.
- ***Understanding the Role of Identity in Marginalized Youth***, Justice Institute of BC – a 14 hour classroom-based course designed to help professionals work more effectively with youth, and address some of the challenges they face in their lives today
- ***Ten Steps to Creating Safe Environments for Children and Youth: A Risk Management Road Map to Prevent Violence & Abuse***, Red Cross – a 2 day workshop for decision-makers/ executives on how their organizations/communities can prevent, mitigate and respond to interpersonal violence against youth.
- ***Walking the Prevention Circle***, Red Cross – a 3 day workshop for front-line staff working with First Nations/Inuit/Métis youth, on how to recognize and prevent violence against children and youth.
- ***The Cost of Caring***, Ross Priebe – a 3 hour self-care workshop for front-line staff.

As well as training opportunities there are also ***guidelines and toolkits*** that may be useful resources for physicians and health professionals:

- ***Promising Strategies – Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies***, Jennifer White and Nadine Jodoin, 2007 - Manual
- ***Men and Suicide: A High Risk Population***, Describes suicidality among men between the ages of 40-60; looks at stats, risk and protective factors, and programs for men in need of support, Centre for Suicide Prevention, 2011
- ***Practice Principles: A Guide for Mental Health Clinicians Working with Suicidal Children and Youth*** The Practice Principles document highlights evidence-based principles and is intended for practicing mental health clinicians with established clinical competencies working with suicidal children and youth in outpatient settings. Rod McCormick, 2001
- ***Working with a Client Who is Suicidal*** A toolkit that provides planners and direct care providers with recommended assessment and treatment practices for working with adults at risk for suicide.
- ***Working with the Suicidal Patient: A Guide for Health Care Professionals***, 2-page tool for the assessment and management of suicidality in adults, Assessment Tool

- ***Preventing Youth Suicide: A Guide for Practitioners***, Provides practitioners with information on the topic of youth suicide, Dr. Jennifer White (funded by MCFD), 2011
- ***Coping with Suicidal Thoughts*** - Brief worksheet intended for those who are experiencing suicidal thoughts, have a suicide plan, or who have recently attempted suicide.
- ***Success Stories from the Best Practices Registry for Suicide Prevention: Identifying Promising and Effective Suicide Prevention Programs*** - Provides a description of the Better Practices Registry, which is an online registry (American) of "best" practices in suicide prevention (over 80 programs currently listed), Phillip Rogers
- ***Teen Suicide Resource Toolkit*** - Provides information and statistics on youth suicide, with a Canada wide focus; highlights risk and protective factors, Centre for Suicide Prevention, 2012
- ***Raven's Children III*** - Provides data on protective factors for Aboriginal youth, Mc Creary Centre Society, 2012
- ***Suicide Prevention Guide for Practitioners***, MCFD (http://www.mcf.gov.bc.ca/suicide_prevention/for_practitioners.htm)



Coordination of Services

DEFINITION: Coordination of services for suicide prevention, intervention and postvention in the mental health system, health care system, school/post-secondary systems and community including:

- Interdisciplinary teams and case approaches such as active case management, assertive community teams and integrated case management
- Possible development of day programs to address suicidality and/or concurrent disorders and crisis stabilization teams/units to address people in acute crisis or suicide states and/or provide ongoing support
- Improved access to psychiatrists and psychiatric services
- Promoting a trauma informed response to suicidal people and their families

Document Summary Findings:

This element of the BC Suicide PIP framework is aimed at describing literature related to coordination and collaboration across various systems and within communities.

International Examples of Collaboration and Coordination

Submission to: *Select Committee on Youth Suicide in the Northern Territory, Australia,*
Submission by: *Megan Lawrance, PhD Student Menzies School of Health Research*

In 2007 the Northern Territory Suicide Prevention Coordinating Committee (NTSPCC or the Committee) was convened to establish a whole of government approach to suicide prevention. Led by the Mental Health Branch from the Northern Territory Department of Health and Families (DHF), the Committee's membership included 12 Northern Territory (NT) Government agencies and two Australian Government agencies. The NT Government representatives included the Department of Health and Families; Department of Education and Training, Department Local Government Housing, and Sport; Sport and Recreation; Office of Indigenous Policy; Police Fire and Emergency Services; Department of Justice Court Support Services and the Coroner's Office. The Australian Government (Commonwealth / Federal) agencies included the Department of Health and Ageing Darwin Office and Department of Families, Community Services and Indigenous Affairs Darwin Office. There was therefore State-wide representation as well as national (federal) representation.

The evaluation of the Committee's work and progress by the Menzies School of Health Research identified that the whole of government process was viewed a useful information sharing and networking opportunity. However it did not significantly impact on the activities of the agencies or the way they operated. Individuals within member agencies did develop a better understanding of their role in suicide prevention but this was not translated to the agencies at large. The dedicated Coordinator became overstretched with the considerable work this process required as well as the

other responsibilities of her position. After 3½ years she was burnt out. The whole of government approach had not changed the way suicide prevention was addressed across the member agencies. Funding came from DHF and was not indicative of a cross-government effort to address suicide prevention in terms of investment.

The first two objectives of the Committee to provide leadership and promote a whole of government approach for suicide prevention activities in the NT were not achieved by the Committee but rather by the lead agency and particularly the Coordinator. A whole of community approach was not fulfilled due to the lack of capacity within the community sector to participate. The final objective was to support a sound evidenced based approach for the development of programs and future policy directions. This separation between the day-to-day action and the formal organisational structures has been noted previously, particularly when the formally stated goals are ambiguous and/or unrealistic.

New Zealand Youth Suicide Prevention Strategy – Strengthening Youth Wellbeing, Ministry of Youth Affairs, Ministry of Health and Ministry of Maori Development, New Zealand

This strategy was the result of a joint collaboration led by the Ministry of Youth Affairs and in partnership with two other Government agencies – the Ministry of Health responsible for mental health and addiction services, and the Ministry of Maori Development (MMD) responsible for leading policy development affecting Maori as the indigenous people of New Zealand.

Fraser Region Collaborative Partnership Response to Youth Suicide

In response to an increase in youth suicides among Aboriginal communities in the Fraser Health region, a collaborative developed, inclusive of Health Authority staff, Ministry of Health staff, Ministry of Children and Family Development staff, First Nations Inuit Health, local Chiefs, the First Nations Health Authority, First Nations Community Engagement Hubs, First Nations Health Centre staff, Friendship Centre staff, Aboriginal youth, Fraser Region Divisions of Family Practice, municipal governments, academic researchers, RCMP, and local school districts. The mandate of this collaborative is to develop a common approach to Aboriginal youth suicide prevention, intervention, and postvention programs in the Fraser region. This document is a direct outcome of the collaborative.

Some of the early priorities identified by the collaborative are to (1) provide training programs for staff to increase awareness of the risk factors for Aboriginal youth suicide and enable partners to identify and support at-risk youth; (2) hold community-based Youth Empowerment events; and (3) reinstate an Aboriginal Youth Council in the Fraser region. The inclusion of Aboriginal youth in this collaborative ensures that the activities and discussions are grounded in their realities, and are relevant to their ongoing struggles and challenges.

The jointly developed strategy allowed for the agencies to work cross-sectorally and to allocate responsibility for certain elements of the strategy to each partner – as well as commit their joint resources to its implementation. The strategy continues to be implemented although since its introduction the Ministry of Youth Affairs has since been absorbed into the larger Ministry of Social Development or MSD (which also includes the Department of Child, Youth and Family) which now provides a broader scope to address social determinants and broader social / family issues.

The strategy implementation is now being coordinated by the Ministry of Health in partnership with MMD and MSD and resources continue to flow to invest in Suicide Prevention Coordinators across the country to work specifically with Maori communities.

National Examples of Collaboration and Coordination

Nunavut Suicide Prevention Strategy, September 17, 2010 Suicide Prevention Strategy Working Group

The Government of Nunavut (GN), Nunavut Tunngavik Inc. (NTI), the Embrace Life Council (ELC), and the Royal Canadian Mounted Police (RCMP), partners in the creation of the Nunavut Suicide Prevention Strategy, recognize the benefits of working together to prevent suicide in Nunavut, and acknowledge the contribution of each partner. Accordingly, they recommend a Strategy built around three core components - a full range of mental health services and supports; evidence-based interventions that have been shown in other jurisdictions to successfully decrease the rate of suicide and community-development activities (commonly known as “embrace life” or “celebrate life” activities) that promote individual and community mental wellness, build self-esteem and confidence, and give participants new skills to live healthier lives.

The working group and Government of Nunavut (GN) have made a number of commitments to suicide prevention activities and broken these into three separate but interrelated scopes of work: prevention, intervention, and postvention.

- **Commitment 1:** The GN will take a more focused and active approach to suicide prevention.
- **Commitment 2:** The Partners will strengthen the continuum of mental health services, especially in relation to the accessibility and cultural appropriateness of care.
- **Commitment 3:** The Partners will better equip youth to cope with adverse life events and negative emotions.
- **Commitment 4:** The GN will deliver suicide-intervention training on a consistent and comprehensive basis.
- **Commitment 5:** The Partners will support ongoing research to better understand suicide in Nunavut and the effectiveness of suicide prevention initiatives.
- **Commitment 6:** The Partners will communicate and share information with Nunavummiut on an ongoing basis.

- **Commitment 7:** The GN will invest in the next generation by fostering opportunities for healthy development in early childhood.
- **Commitment 8:** The Partners will provide support for communities to engage in community-development activities.

BC Examples of Collaboration and Coordination

There are a number of partnership agreements in place in BC that highlight a commitment by the Provincial and Federal Governments and Aboriginal groups to work together to address health issues, including mental health, addictions and suicide. These include the 2011: British Columbia Tripartite Framework Agreement on First Nation Health Governance; Consensus Paper: British Columbia First Nations Perspectives on a New Health Governance Arrangement; the 2007 Tripartite First Nations Health Plan; the 2006 TCA: First Nations Health Plan and the 2005: Transformative Change Accord. Signalled in these documents is a commitment to address youth suicide and to incorporate traditional methods of doing so.

As well as these health-specific collaborations / partnerships – there are also other partnerships and agreements that focus on the broader social determinants of health:

- **2011:** MOU between Metis Nation BC, MCFD, and Metis Commission for Children and Families of BC
- **2010:** First Nations Early Childhood Development Memorandum of Understanding; Procedures for Meeting Legal Obligations When Consulting First Nations, Ministry of Aboriginal Rights and Reconciliation
- **2009:** Tsawwassen Treaty; Recognition & Reconciliation Protocol on First Nations Children, Youth and Families
- **2008:** First Nations Housing Memorandum of Understanding
- **2007:** BC First Nations Education Act
- **2006:** Unified Aboriginal Youth Collective Memorandum of Understanding ; Metis Nation Relationship Accord
- **2005:** New Relationship Trust
- **1999– present:** Aboriginal Education Enhancement Agreements: Maple Ridge-Pitt Meadows; Mission; Fraser Cascade; Abbotsford; Coquitlam; Burnaby; Surrey; Chilliwack; Langley; Delta
- **1991:** Report of the Royal Commission on Aboriginal Peoples

All of these indicate a broader commitment to address some of the issues that affect health, mental health and suicide prevention.

Tripartite Working Group for Suicide Prevention, Intervention and Postvention – Terms of Reference: First Nations Health Authority

This Working Group is accountable to the “First Nations and Aboriginal Mental Wellness and Substance Use Strategy Council” a committee made up of representatives from the Federal and Provincial governments and First Nations Health Authority. This Council is one of several established after the signing of the Tripartite First Nations Health Plan (TFNHP). The TOR notes a time-limited purpose-driven body focused in particular on TFNHP Action Item # 8, which states: “*Adult mental health, substance abuse as well as young adult suicide will be addressed through an Aboriginal Mental Health and Addictions Plan.*” This plan is currently in development, and a proposed strategic direction speaks to addressing suicide prevention, intervention and postvention in First Nations and Aboriginal communities. The Working Group’s efforts are also informed by *Strengthening the Safety Net: a Report on the Suicide Prevention, intervention and Postvention Initiative for BC* (2009), and by the experience and wisdom of communities that have implemented holistic suicide prevention and response strategies.

The purpose of the Tripartite Working Group for Suicide Prevention, Intervention and Postvention is to coordinate the exchange of information and knowledge that will assist First Nations and Aboriginal communities in preventing and responding to issues of suicide. The Working Group approaches its various tasks and projects mindful of long-standing social and structural issues that have determined a heightened vulnerability to suicide and suicidal ideation for many Aboriginal people and communities in British Columbia.

BC Aboriginal Self-Harm Working Group : Report of Meeting July 2012

This working group includes Aboriginal Health representatives from BC’s Health Authorities; Ministry of Health (Aboriginal Healthy Living, Mental Health Promotion & Mental Illness Prevention); Ministry of Children and Family Development; First Nations and Inuit Health; Ministry of Aboriginal Relations and Reconciliation; and the First Nations Health Authority. The July 2012 meeting was the 3rd meeting of the group and a draft Resource List was developed and circulated to contribute to the goal of sharing best practices about suicide prevention.

Fraser Region Examples of Collaboration and Coordination

Partnerships & Collaborations

The Fraser Health Authority has partnered with First Nations at many levels but specifically two documents outline a more formal partnership - 2010: Document of Intent for Implementing the Health Actions from the Tripartite First Nations Health Plan (FHA and the former First Nations Health Society – now the First Nations Health Authority) and the 2012: Fraser Salish Partnership Accord which was signed with political representatives of First Nations in the Fraser region with the FHA.

These documents outline several commitments by FHA to First Nations including a commitment to work together in areas identified as high priority issues for First Nations in the Fraser region.

Sto:lo Youth Council

In 2006, the Sto:lo Nation created the Sto:lo Youth Council (SYC) which developed a Terms of Reference incorporating a mission statement that included:

- Working in cooperation with other Sto:lo and non-Sto:lo agencies on youth initiatives.
- Striving to develop and maintain a positive liaison with other individuals, groups, agencies, organizations who are addressing issues of concern of Aboriginal youth.
- Providing a forum on issues that concern youth and which gives an active voice for the Sto:lo youth
- Maintaining good networks with local schools and youth organizations
- Organizing and coordinating projects that take forward actions and priorities that are important to the youth.
- Ensuring that young people had the opportunity to take a leading role in participation and consultation activities on issues that affect their lives
- To raise awareness of the aspirations, needs and concerns of young Aboriginals
- Consult widely with young Aboriginal people in Sto:lo territory.

Membership is open to all youth in the Sto:lo territory aged between 13 and 25 years and is open to all Aboriginal youth. The SYC has an Executive Council comprising 3 youth from different Sto:lo communities who occupy their seats for two years. This Council could provide a suitable forum for ensuring a youth-led approach to suicide prevention.



PIP FRAMEWORK - POSTVENTION

Suicide postvention refers to support for those bereaved by a death from suicide. Postvention involves all activities undertaken after a death including addressing traumatic after-effects among survivors, bereavement and trauma recovery and education to reduce the risk of further suicides (Dafoe & Monk, 2005). Postvention approaches include but are not limited to:

1. Bereavement support (Families, Peers & Communities);
2. Postvention teams;
3. Postvention protocols and
4. Media reporting guidelines.

Postvention Programs, Services and Supports

DEFINITION: Development and enhancement of postvention bereavement programs, services and supports among persons touched by a suicide including:

- Educational workshops, support groups, group therapy and survivor groups for those bereaved by a suicide-related death
- Postvention response protocols involving referral practices, community response teams, critical incident management and treatment

Document Summary Findings:

Suicide Prevention Protocol: Thira Consulting

Thira Consulting serves as a community development/mental health consultant for many Aboriginal communities across Canada and offers training workshops and clinical consultation related to a variety of communications, trauma, and crisis-related fields. His doctoral dissertation related to Aboriginal suicide resilience and social activism and he is involved in further resilience research

at the University of British Columbia. He has previously served as a clinician with suicidal youth at Child and Youth Mental Health and as the Director of Community Education and Professional Development at the Vancouver Crisis Centre.

In relation to suicide prevention, “Through the Pain” is a culturally driven community-based program has been used in over 40 Aboriginal communities across the country and is a national program in Australia. His program called “Opening the Circle” is designed to assist communities to develop their own crisis response team. “Choices”, his youth suicide awareness education video and seminar was used by more than 250 suicide prevention programs world-wide and he has collaborated on the production of a new version called “Reaching Out”. The “Community is the Medicine” workshop offers an introduction to the knowledge, skills, and strategies necessary for community-based suicide prevention. An interactive approach—including practice-circles, small and large group discussions, questionnaires, role-plays and other exercises—encourages the participants to share their experience and skills with one-another. Thira Consulting has developed a Suicide Prevention Protocol which is briefly described below – the full protocol is available from Thira Consulting.

Suicide Postvention Protocol

A death by suicide is a critical incident, because the whole community is impacted. Its resilience is threatened. That is, it has lost connection with one of its members, it has lost its empowerment as a suicide free community. In the event of a suicide, a *postvention protocol* can serve to coordinate an effective response to the community crisis. The *protocol* can act to build the self-esteem of the community as a whole: normalizing the bereavement process, ensuring that those who need support get it, and providing education. The following includes references to the roles of the *community postvention team* at each of the *levels of the community* – Family, Individual youth and adults, Community and the outside community.

Walking Forward

The Walking Forward grief & loss support program was developed in partnership by a core group of service providers from across disciplines and organizations in the Fraser Canyon. Built upon core Aboriginal cultural values, Walking Forward is designed to support Aboriginal children and youth to deal with grief and loss in a safe and healthy way.

The curriculum is divided into 12 one hour sessions delivered on a weekly or bi-weekly basis by trained facilitators. It is adaptable to any audience (age group/cultural traditions) and is based on the cultural values of wholeness and connectedness, balance, healing and respect. While the focus of the program is on loss and grief, it is complemented by teachings on and about the Medicine Wheel and Medicine Bags. In addition, it is informed by the work of Bendtro, Brokenleg and Bockern (2004) in the Circle of Courage and the four core values of belonging, mastery, independence and generosity.

Family:

- Ensure that support is offered to the whole family: In many cases families provide their own support system in the event of a death. However, a suicide can have a shattering effect on a family system which can lead to blaming, fear, hopelessness and disharmony.

Individual Youth and Adults:

- Offer assistance: Seek out and offer assistance to those close to the deceased as well as other individuals who may currently be in crisis. As well, ensure that friends of the deceased are interviewed to determine if there is a "suicide pact".
- Temporary counselling centre: For others who need support, it may be important to set up a temporary counselling centre (staffed by a counsellor and arranged by an organizer) to provide a safe place for grieving. This is particularly important for fellow students and school staff, if the deceased was attending a local school. In this event, a room in the school could be employed for this process.

Community:

- Memorials: Minimize the glamorizing effect of large memorials or school assemblies which may entice a suicidal person to make an attempt in order to receive the same validating attention.
- Guided sharing circles: When appropriate, encourage guided sharing circles in schools or community centres, particularly if the deceased was a child or youth.
- Factual information: Have a single spokesperson provide factual information about the suicide to prevent the spread of rumours and mis-information.
- Suicide prevention education: The tragedy can become an opportunity to offer basic suicide awareness/prevention information to the community. Have materials as well as educational events prepared ahead of time.
- Spiritual services: Community members and places identified as spiritually significant should be invited to participate in the process when appropriate.

Outside Community:

- Media coverage: Where possible, encourage the media to avoid sensational or romanticized accounts of the death.
- Outside services: In smaller communities, it can be useful to bring in counsellors and other services from the outside, as the human service workers in the community may, themselves, be too close to the deceased.

The use of a Critical Incident Response Protocol that incorporates these postvention recommendations can make a significant impact on reducing the risk of further suicides in the community. The protocol also provides guidance on dealing with a suicide pact and on responding to the media.

US Centre for Disease Control and Prevention (CDC) Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters, August 1988

The CDC protocol for prevention and containment of suicide clusters and pacts is well-acknowledged across most of the evidence and literature. They note that the response to the crisis should involve all concerned sectors of the community and should be coordinated by a Coordinating Committee, which manages the day-to-day response to the crisis, and Host Agency, whose responsibilities would include “housing” the plan, monitoring the incidence of suicide, and calling meetings of the Coordinating Committee when necessary. The relevant community resources should be identified. As well there should be a response plan that is implemented under either of the following two conditions: When a suicide cluster occurs in the community, or when one or more deaths from trauma occur in the community, especially among adolescents or young adults, which may potentially influence others to attempt or complete suicide. If the response plan is to be implemented, the first step should be to contact and prepare those groups who will play key roles in the first days of the response. The response should be conducted in a manner that avoids glorification of the suicide victims and minimizes sensationalism. Persons who may be at high risk of suicide should be identified and have at least one screening interview with a trained counselor; these persons should be referred for further counseling or other services as needed. A timely flow of accurate, appropriate information should be provided to the media. Elements in the environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed.

The Centers for Disease Control (CDC) has assisted several state and local health departments in investigating and responding to apparent clusters of suicide and suicide attempts. The recommendations should not be considered explicit instructions to be followed by every community in the event of a suicide cluster. Rather, they are meant to provide community leaders with a conceptual framework for developing their own suicide-cluster-response plans, adapted to the particular needs, resources, and cultural characteristics of their communities.

Chief Coroner Ontario: Report on Suicide Deaths at Pikangikum First Nation

In the years from 2006-2008, 16 children and youth between the ages of 10-19 killed themselves by hanging in the Pikangikum First Nation. The Office of the Chief Coroner undertook a review of these tragic deaths. The Pikangikum First Nation is a remote community approximately 100 kilometres north of Red Lake. Striking characteristics and details emerged as a result of this review:

- The suicides occurred largely in clusters;
- The youth were very young when they took their lives, many being less than 15 years of age;
- All of the deaths were due to hanging;
- None of the children had sought help from a trained professional in the month before they died;
- Many had a history of mental health problems;

- Almost all of the children were solvent abusers;
- Over half of the children had a history of exposure to suicide in their families, including parents and siblings;
- School engagement and attendance appears to have been very limited;
- Domestic violence was common in their families;
- Substance abuse in parents was common; and
- Being victims of violence, and/or perpetrating violence on others were common occurrences.

The Pikangikum First Nation has comprehensively reviewed the report and has identified seven main priorities for implementation. Some of these are briefly described below:

- Build a new school in Pikangikum as soon as possible including a gym and auditorium where community members can gather for traditional and cultural community events; and include a daycare facility
- Undertake a housing strategic study and ensure that all homes built in the future are connected to water for indoor plumbing, and the sewage disposal lagoon. Connect the First Nation to the hydro grid
- Develop a community Healing Treatment Centre to house multiple providers of health services under one roof including Tikinagan Child and Family Services, the community mental health workers, NNADAP workers and the solvent abuse workers.
- Develop a Comprehensive Mental Health and Addictions Program for children, youth and adults.
- Develop an antipoverty strategy for Aboriginal people, particularly focusing on those living in remote and isolated First Nations reserves such as Pikangikum.

It was also recommended that a Committee should be struck called the Pikangikum Steering Committee, to advance the recommendations included in the Coroner's report.

WORK TO DATE IN FRASER REGION

Fraser Region Suicide Prevention 'Collaborative'

Since late 2011, there has been a spike in youth suicides and self-harming activities among the Fraser region Aboriginal population especially in Fraser East. In response a collaboration of partners in the Fraser region has developed, including various community, government and health partners to work toward a jointly agreed regional approach to youth suicide prevention. FHA agreed to coordinate the meetings and act as Secretariat. The following highlights participants in these sessions:

Agency / Participants: NB: May be multiple reps from each in attendance at meetings	APR 25	MAY 7-9	JUN 25
Provincial Government			
Ministry of Health	•		
Ministry of Child and Family Development	•	•	•
B.C. Coroners Office			
Aboriginal Deputy Provincial Health Officer			
Health Authorities			
Fraser Health Authority			
Aboriginal Health (Secretariat)	•	•	•
Crisis / Child and Youth Mental Health	•	•	•
Addiction Services	•	•	•
Public Health / MHO			•
Provincial Health Services Authority	•		

Agency / Participants: NB: May be multiple reps from each in attendance at meetings	APR 25	MAY 7-9	JUN 25
First Nations / Aboriginal Organizations			
Tzeachten		•	•
Squiala	•	•	•
Seabird Island	•	•	•
Sts'ailes	•	•	
Sumas (ASCIRT)	•	•	
Matsqui	•		
Katzie		•	
Chawathil	•		
Sto:lo Health Services (ASCIRT)	•	•	
Spirit Bear Centre			•
Mission Friendship Centre		•	•
Mentis Nation B.C.			•
Xyolhemeylh - Fraser Valley Ab. C&F Serv Soc.	•		
Federal Government			
Health Canada - First Nations & Inuit Health	•		
RCMP / Police			
First Nations Health Council / FNHA			
FNHA - Community Engagement	•	•	
FNHC Representative(s) Fraser Region			•
Community Engagement Hub(s)	•	•	•
Education / Post Secondary Institutions			
Simon Fraser University	•		
School Representatives			

Feedback and Input from Stakeholders in the Fraser Region

April 25 meeting: Held at Seabird Island

The first Collaborative meeting was convened in April 2012 and included a number of First Nations representatives, Fraser Health Aboriginal Health / Mental Health & Substance Use, child and youth services, and other agency stakeholders. Priorities identified by the Collaborative include:

1. Training for peers, health professionals, community leaders, spiritual advisors, school workers and care providers
2. Funding for Applied Suicide Intervention Skills Training (ASIST) workshops (more detail on ASIST can be found on pages 57-58).
3. Youth Empowerment Days and gatherings – including cultural practice and engagement
4. Youth Council / Committee / Group

At this meeting a number of themes were identified and ideas, suggestions and concepts considered important for suicide prevention (intergenerational trauma and suicide; memorials / ceremonies; populations at risk; protocols for Communications; signs of Suicide – Teaching Youth; and youth-driven Processes and Engagement) were discussed. Within each of these a number of thoughts were expressed and these have been clustered into common themes:

Topic: INTERGENERATIONAL TRAUMA & SUICIDE

Implications for communities: Crosses all social layers; connection opportunities without an agenda, promoting belonging; protective versus risk factors; long term shame, lack of understanding, fear in the community; witnessing suicides and pacts; colonial processes and intergenerational effects have multiple symptoms; it takes a community to raise a child to teach coping skills not available; all of us must take responsibility (teachers, counselors); Support of the family/for the family, by the community;

Implications for Families: Suicide in multiple generations of one family; empowering families with support systems; family response or non-response; reciprocal discussion in families - not just youth sharing with parents; developing relationships rather than short individual sessions; family experience and history; traditional practices; addressing the grief of the family; emphasize families that have been able to break the cycle (who and how);

Prevention, Intervention and Postvention: being mindful of increases in family violence; increased risk of clusters; providing support for communications; shared sessions for counseling; group sessions include family and all other supports prior to crisis/suicide; gathering or retreat to build communications; community support skills; workshops incorporated in big events; Rapid Response

Intervention Teams; Train the Trainer for local responses; therapeutic services routinely available; Trauma counseling; identifying and screening higher risk groups; history of family member suicide;

Communications and Information: Honesty in communication versus messaging; fear of talking about it, open communication; how to openly discuss opportunities to express loss, value; family & community hear youth experience; identify & share about youth at risk; youth listen to youth – survival stories; passive / incidental sharing of coping and intervention stories; recovery approach, stories to separate illness from the individual, reduce labeling focus on strengths.

Topic: MEMORIALS AND CEREMONIES

Memorials and ceremonies were identified as ‘paying tribute to long gone people’ but participants noted that some ceremonies may not resolve the grief as some people got “stuck” in the grieving process. They determined that learning from Elders about traditional ways to handle grief would be useful such as traditional practices of ‘letting people go’.

In regard to memorials, some felt that youth may see memorials as a celebration to gain attention or to pay attention to what they have experienced, and that as a result this may be a trigger. There is some evidence that memorial/attention may be a factor in suicide. The process should be more about emphasizing and honouring youth in their lives such as sports tournaments. It was also felt that the focus needed to be balanced on the loved one lost versus ones still living.

Topic: POPULATIONS AT RISK

Two key population groups were considered to be most at risk – those suffering FASD and those who were associated with or had been affected by suicide clusters. For the FASD group, it was felt that there should be more advocacy for funding for diagnosis & assessment of FASD clients and potential clients for suicide risk. It was considered that people with FASD and mental illness were at higher risk and that interventions needed to take place before homelessness/addiction/MH disorders developed. Adult assessment should be done early and on-reserve as well as off-reserve, and many felt that early diagnosis was the key. It was also considered that there needed to be more supports for family – i.e. education, acceptance, counselling, for families who may have current addiction/misuse issues or history of same.

For those affected by or involved with suicide clusters, the participants felt that there were clear self-esteem issues, with people yearning a sense of belonging and not wanting to be alone. This group of the population was considered to be at risk since it only took one member to generate sufficient interest to solve the problem of isolation, loneliness and low self-esteem and self-worth. They felt that within schools these groups could be identified and key people who ‘led’ groups or ‘cliques’ within the school community. Using social media to create chatter about the potential for pacts and provide a safe place for revealing information was considered an important option.

A third group identified as being at risk were those with untreated mental illness. The participants considered that screening in schools should be undertaken, and training provided for teachers and parents to identify symptoms of mental illness. There should also be mental awareness incorporated into middle school / high school curriculum, including presentations by mental health professionals.

Topic: PROTOCOLS FOR COMMUNICATIONS

A priority was determined for a communication protocol between agencies, communities and schools with a central coordinating person or body identified. The group agreed that Fraser Health was appropriate to be this central point of communication. This should also include youth and young adults.

One of the goals for this group is to 'do a better job at transferring information for continuation of services' and providing after-hours support when people are discharged (e.g. transitions in care between MCFD, community services, Fraser Health services, the family physician or Nurse practitioner). A health liaison worker was considered a good idea to help undertake coordination across services as well as an after-hours and regular hours protocol for action. Another role for the group is reporting back to the community for follow-up after the crisis team or ASCIRT teams have dealt with a situation.

It was also considered that a communication protocol should reflect that education is needed in communities and that information about suicides 'trumps' confidentiality since information should be shared regardless of family's wishes (youth safety is paramount). Education could be developed around the theme of Mental Health month being in May, and use of internet and technology.

Areas where it was also felt that protocols could be reviewed and developed were in the area of:

- Fraser Health's clinical practice guidelines (including suicide management and response and clinical practice guidelines with an Aboriginal appendix)
- Communities – Council / Health portfolio holders manual
- First Nations Health Directors guidelines / protocols which could be developed with the FN Health Directors Association (FNHDA)

Topic: SIGNS OF SUICIDE: TEACHING YOUTH

Many ideas were generated by the participants about this area. Key themes were that:

- Youth (including role models) needed to be involved in the design, development and dissemination of information to recognize signs
- Schools needed to be involved
- Community workshops and gatherings were forums where information could and should be shared
- Training for youth to be peer mentors
- That ALL youth conferences should include suicide prevention as a standard component

- Parents and focusing on strengthening identity and connection early in life
- Use of technology (internet, facebook, twitter); online resources
- Use of heroes (e.g. sports) to speak about the topic
- Having a crisis line available where people can talk openly and honestly

Topics should include:

- Depression, teaching what it is
- Removing stigma
- Teaching identity and who we are as First Nations
- Surviving racism; bullying; discrimination
- Where to get help; having a plan of who to talk to
- Acceptance of self
- Homophobia
- Managing the after-effects
- Teaching about relationship break-ups; importance of relationships and having support systems in place; having someone to talk to
- Recognizing signs such as giving away stuff
- Having a plan, who can they talk to
- Peer interventions – how to get to them
- Relationship between alcohol & suicide
- Youth driven mental health literacy in schools

Topic: SUICIDE ~ TALKING ABOUT IT

Participants agreed that education is the key - for parents/families and in schools, so that people in the community become comfortable with using the words and talking about it. This should go along with discussions on meaningful relationships, sexuality and ensuring parents are ready and able to discuss these topics with their children.

Professionals and Social Workers need to talk about suicide prevention and be able to ask and answer questions honestly, in a sensitive manner. Having suicide information on the fridge and put in community newsletters was seen as a way of breaking down the stigma and encouraging discussion in the home. Availability of self-managed screening tools (such as that offered by www.mindcheck.ca) for youth to access information if they need it, was seen as a useful idea for encouraging discussion among youth.

Topic: YOUTH DRIVEN PROCESSES & ENGAGEMENT

Ideas that were generated for youth-driven processes and engagement included provision of training, peer training / peer support workers training, and development of a Youth Council.

Part of the role for youth engagement should include making connections between youth and elders and connecting with non-Aboriginal networks and resource people. Mental health literacy, diet nutrition and physical exercise were identified as key areas for discussion among youth. In addition youth added that learning and finding networks (e.g. primary care networks including physicians and community therapists) were vital.

Participants identified that family / parental involvement and having an Elders / Grandmother group would be useful. At the same time to provide avenues for anonymity, use of technology / social media to discuss suicide was something youth could lead. At the same time youth felt that committing to non-technology time with family was important (i.e. having dinner time together) and this was something youth could promote. Youth could also play a role in monitoring social media like facebook to identify risks.

May 7 – 9 meeting: Held at Squiala First Nation

Fraser Health Authority's Aboriginal Health Team has acted as Secretariat to the Collaborative to ensure stakeholders are brought together, and is leading the way in carrying out actions and decisions agreed by the group. Following the May meeting, FHA's Aboriginal Health Team requested resources for the Collaborative to help with the services of a Project Manager to prepare a Communications Strategy; develop a Terms of Reference for the group; prepare a Memorandum of Partnership between the stakeholders to coordinate region-wide initiatives and develop a specific Suicide Prevention Plan for the Fraser region (total cost expected to be around \$10,000).

June 25 meeting: Held at Squiala First Nation

Fraser Health Authority convened the 3rd Collaborative meeting¹² on June 25, 2012 to further the discussions and plans on suicide prevention in the Fraser region. One of the key objectives involved developing a shared understanding of the mandates of each partner with respect to youth suicide prevention. The forum also discussed other agencies or partners who should be involved in the work (and who had not participated yet) including:

- Divisions of Family Practice
- Local School Districts
- Municipal Governments
- RCMP

¹².PPT Fraser Health, June 25, 2012 + Attendance List + meeting notes

The group also discussed what “collaboration” looks like – and affirmed that a synergistic partnership means there is enhanced creativity, a more holistic view, practical solutions and transformative thought and action. Ultimately it was agreed that the “Collaborative” is “stakeholders with a common issue working together to plan and implement a comprehensive action plan not achievable by any single stakeholder”. The common goals for the Collaborative are through creating a ‘Call to Action’:

1. To stop suicides in all Aboriginal youth
2. To develop a common and shared approach
3. To demonstrate success by starting small and building on it
4. To endorse and allocate resources from funding partners

Ideas that were recommended as next steps included forming a Working Group; re-instating the Youth Council, developing a Stakeholder management plan and developing a training plan for gate-keepers, youth and schools. It was agreed to use and implement a response to Aboriginal youth suicide in the Fraser region based on the BC Suicide PIP Framework.

It was agreed from the June meeting that a summary of reports, documents and articles should be completed [this report] and a set of priorities, objectives and actions drafted for consideration by the Collaborative and that this should form the basis of an Action Plan to:

- Establish the Goal
- Define Target Audiences
- Identify Key Partnerships
- Define Key Activities at a systems level and a program level
- Document opportunities
- Define signs of success
- Define the request for resources

This last meeting also began working on #1. above and identified some key priority areas such as implementing training programs to raise the collective awareness of risk factors, and building skills to enable partners to identify at-risk youth and strategies for reducing that risk; provide appropriate prevention strategies and to work to strengthen a community-based safety net for Aboriginal youth.



PROPOSED ACTION PLAN

On behalf of the Collaborative, Fraser Health Authority was asked to identify three priorities based on the document / literature summary [in this report] and the BC Suicide PIP Framework, and provide associated objectives and action items for these.

The BC Suicide PIP Framework already establishes six main priority areas and therefore key actions have been identified for each of these six priority areas based on the findings of this report and the work already completed to date through the three Collaborative meetings held in 2012:

BC SUICIDE PIP FRAMEWORK SIX PRIORITY AREAS	KEY ACTIONS	OBJECTIVES / EXPECTED OUTCOMES / OUTPUTS
1. School-Based Strategies	a) Establish a Local School District Working Group (with Elders and youth representatives) to focus on developing school-based resources, training and a region-wide approach to school-based suicide prevention.	Resources and toolkits for school personnel developed and disseminated Resources and toolkits for youth in schools and their parents developed and disseminated
	b) Establish a Working Group to identify, document and share information on current mental health wellness and promotion programs in the School Districts	Directory of services (where to get help) disseminated within schools and in the wider community within school communities

2. Culturally appropriate Services	a) Seek shared commitment to funding from FNHA/FHA/FNIH for increased 'community-based suicide programs' in First Nations communities and with Aboriginal organizations.	Community-designed suicide prevention programs in all (or accessible to all) FN communities in Fraser region and in key urban areas with Aboriginal organizations
	b) Develop a Suicide PIP Service Directory for communities, service providers and contact people / information for the Fraser Region	On-Line Directory of Aboriginal / FN Services / Links for contact (help line, crisis response, assessment), FHA, other agency services available to wider community
	c) Develop 'Best Practice' directory of programs and examples used by other regions, Provinces and countries [some included in this report] for dissemination to all FNs and service providers	Best Practice information on models for suicide prevention available in the on-line directory
3. Gatekeeper Training (to identify at-risk individuals)	a) Seek shared commitment to funding from FNHA/FHA/FNIH for assessment and screening of at-risk population using tools and guidelines already available – led by FHA Child Youth Mental Health team in partnership with MCFD and working with communities and schools	Routine screening of at-risk youth occurs in all FN and Aboriginal communities and support provided for referral to support services
	b) Develop training programs for 'gatekeepers' including Health Care workers; Elders; Teachers; Chief and Council; community leaders; Service Leads) to provide information on how to identify at-risk Aboriginal individuals and improve access to resources available to others	Training Program for Gatekeepers is operational and accessible to all identified gatekeepers throughout the Fraser Region
4. Physician & Health Professional Education	a) Work with the local Divisions of Family Practice to share information and create information, resources and directories for physicians to access/refer services for supporting clients/ patients with suicide risks [including risk and clinical assessment tools]	On-line directory for physician guidelines and toolkits is available to all physicians in the region
	b) Develop training programs for physicians in the Fraser Region (working with Divisions of Family Practice) to provide information on screening for risk factors and providing support [including use of FHA clinical educators and experts from child and youth mental health]. This should include Privacy and Confidentiality policies.	Training Program for Physicians and Health Professionals in Suicide Prevention, Intervention and Postvention is operational and accessible to all physicians throughout the Fraser Region

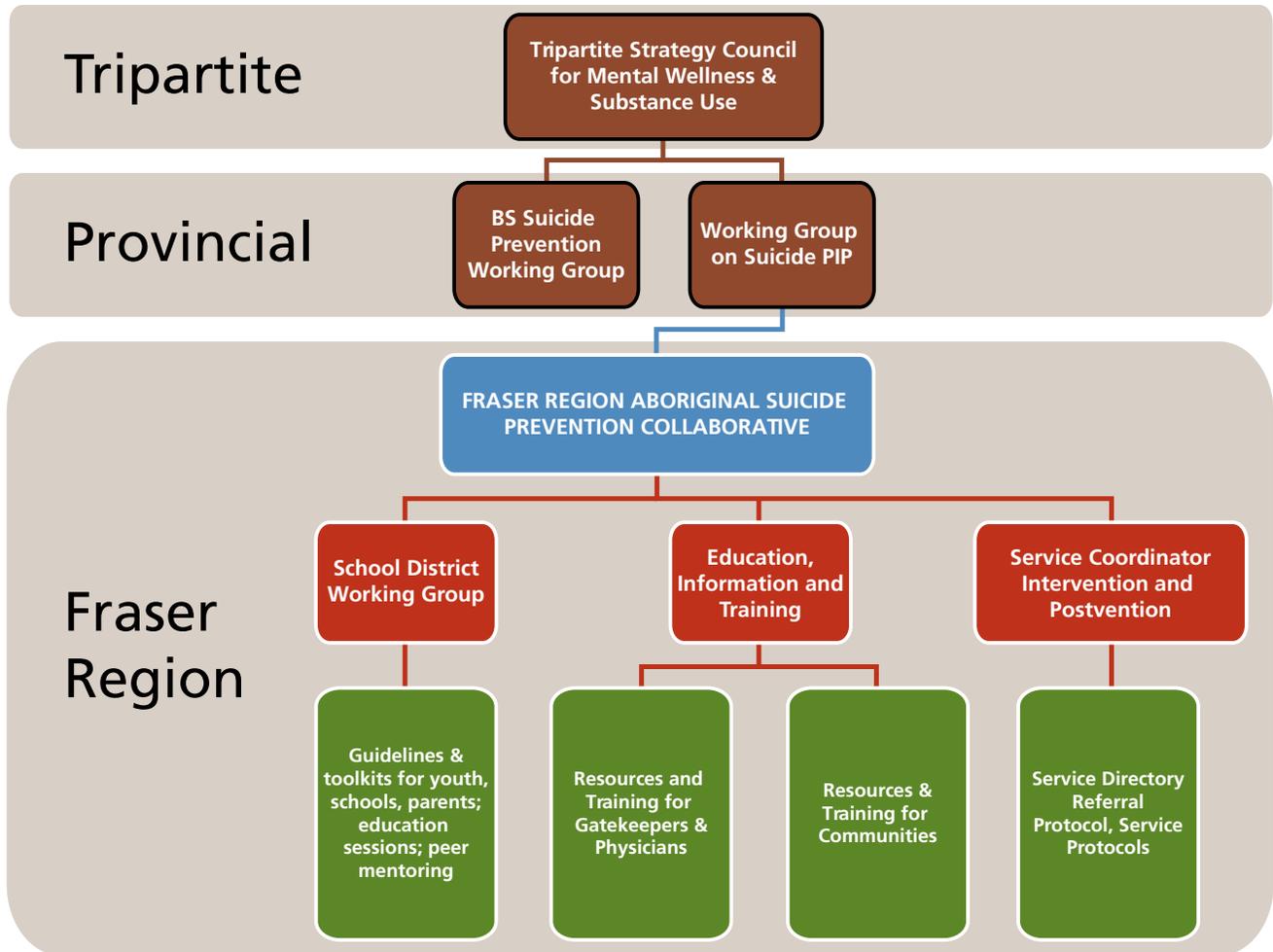
5. Coordination of Services	a) Formally establish the current informal 'Collaborative' as the 'Fraser Region Aboriginal Suicide Prevention Collaborative' ¹³ . Finalize TOR and key role; Secretariat (and resources) and meeting schedule. This group should be high level representatives who play an oversight and decision-making role and receive reports from Working Group(s) – see below for suggested structure	Collaborative is formally established as the over-arching body of inter-agency, community, school, physician and service provider partners to drive the agenda of youth suicide prevention and elimination in the Fraser Region; to report back to stakeholders and to the wider community; and to advocate for resourcing for this initiative in the Fraser Region.
	b) Develop Communication Protocol between service providers to ensure an agreed process is in place for responding to the identification of at risk individuals (or clusters) and including processes for connecting with crisis services	Communication Protocol is in place between health service providers (including Aboriginal service providers), schools and First Nations communities for action, referral and response in the case of identification of at-risk individuals; individuals attempting suicide and postvention responses.
	c) Establish an on-line/website for Suicide Prevention in Fraser Region including resources, links, guidelines, tools, youth help/mechanisms; information for schools and families – to be maintained by the Secretariat. Advocate for resources for maintaining the Secretariat, Working Groups and oversight committee.	On-line website for Fraser Region Suicide Prevention Collaborative for placement of all resources, links, directories and youth help/support mechanisms is operational
6. Postvention support & resources	a) Identify suicide survivor support groups (e.g. Survivors in Action) in the Fraser Region and disseminate information to the communities	Information on support groups is incorporated in the on-line resource directory
	b) Develop supports, information and resources on "returning to work" or "returning to school" after a suicide has occurred and disseminate through on-line directory (making printable versions available)	Information for post-suicide return is available to the wider community

13. Other Ideas: Name the group "FRASER" (Fraser Region Aboriginal Suicide Elimination Roundtable) or "FRASER-OK" (Fraser Region Aboriginal Suicide Elimination Roundtable creating Opportunities and Knowledge)

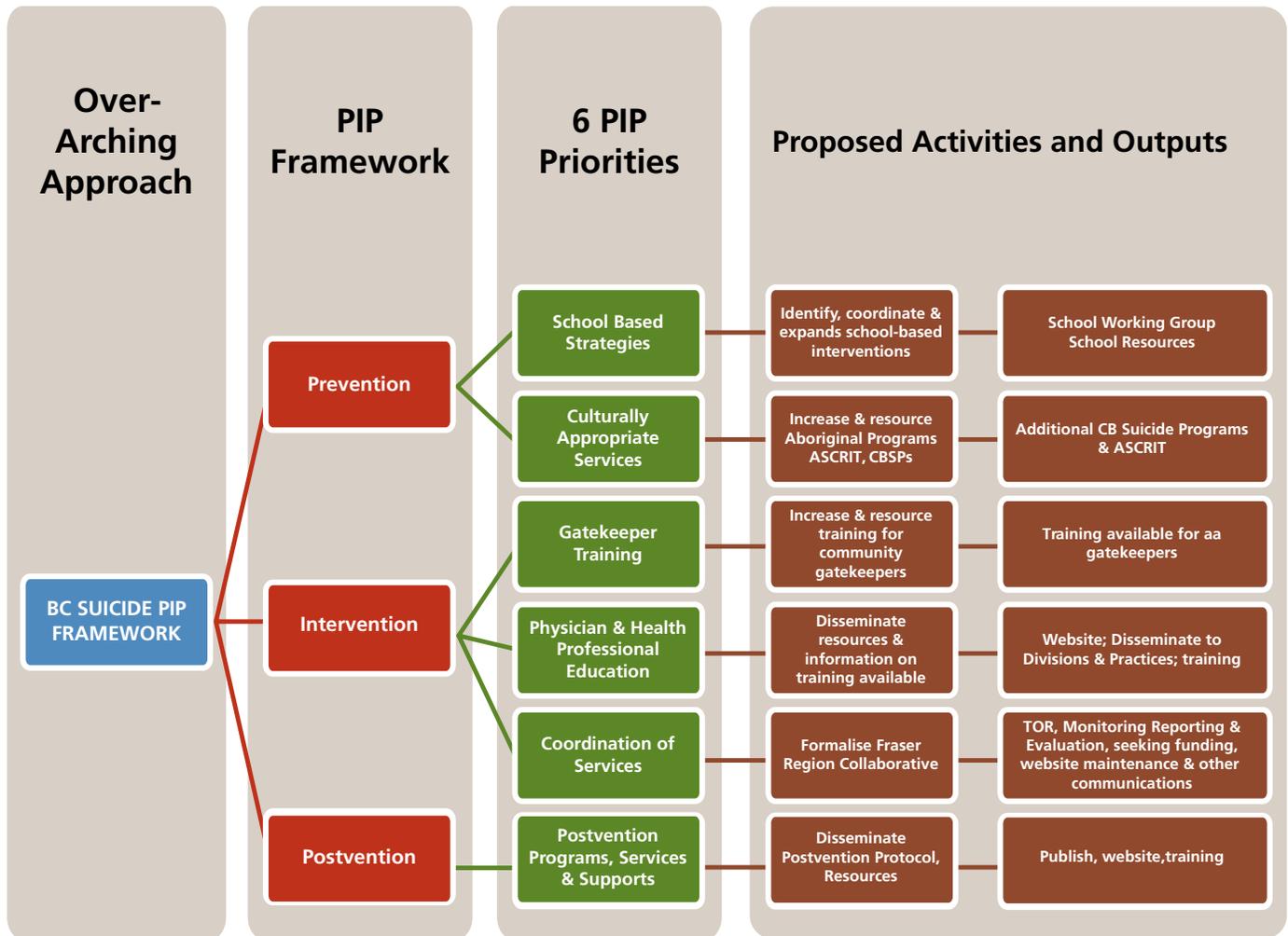
SUGGESTED BUDGET:

ITEM	DETAIL	ESTIMATED COST (p.a.)
"Collaborative"	Costs for hosting Collaborative Committee [venues, catering, travel expense]	20,000
Secretariat	Collaborative Suicide Prevention Coordinator (key lead for the Region) & administrative support	100,000
	Training & Education Coordinator for all aspects (gatekeepers and physicians/health professionals)	60,000
	On-Line Web Development & Maintenance with new resources and information, research, linkages	60,000
Working Groups / Youth Council	Meeting costs and administrative support	80,000
Community-Based Suicide Programs	Funding for additional AS CIRT and CBSPs in Aboriginal and FN communities across Fraser Region	500,000
Strengthen Crisis-Response	Including additional CY&F mental health services, clinicians, social workers to create an Aboriginal Crisis Response Team for Fraser region (networked across the region and FHA sites)	400,000
Resources	Printing and dissemination of suicide-related resources, pamphlets and materials; guidelines and toolkits for gatekeepers, physicians, schools, youth and communities	120,000
		\$1,340,000 per annum TOTAL

Possible 'Structure' of the Suicide Prevention Initiative



Visual of the Fraser Aboriginal Suicide Prevention Collaborative Action Plan (aligned to BC Suicide PIP Framework)



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Thank you to the members of the Fraser Region Aboriginal Youth Suicide Prevention Collaborative

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 Martin Bartel
 Tammy Bartz
 David Bayne
 Megan Bissky
 Leslie Bonshor
 Natasza Breitzkreuz
 Maureen Chapman
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 Julie Czerwinski
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