A Suicide Prevention Resource

exploring strategies for
Northern Saskatchewan

Northern Human Services Partnership

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Executive Summary

Northern Saskatchewan is home to a young population, spread over a large territory of many small, remote communities. Northerners face many suicide risk factors at home including exposure to family violence, addictions and high unemployment rates. These factors lead to acute feelings of hopelessness resulting in high suicide rates across the north. There is a need to rekindle hope for the future and build upon community strengths in northern Saskatchewan. It is time to move from reactive processes to community stability by addressing the root causes of suicide. Suicide prevention is a long-term community support and engagement process with benefits that will be felt well into the future.

The purpose of this framework is ***to provide the general and specific best practices related to suicide prevention program implementation providing literature-based recommendations for promising projects and strategies to follow.***

This handbook is designed to support policy development as well as action-oriented community programs. It provides an overview of factors that influence suicidal behavior, prevention guidelines, best practices and challenges that face northern communities. Most importantly, it includes specific strategies than can be used in northern Saskatchewan. These include:

- focus on family health and well-being. Work with families to build parenting skills and to reduce addictions;
- promote activities that encourage high self esteem, self expression, and forward-thinking mindsets;
- support community and regional interagencies to problem solve, grow and work towards action-oriented prevention plans;
- revitalize public spaces to promote community engagement through intergenerational relationships and outdoor education;
- work with youth and their families to minimize the impact of potential trigger factors; and
- recognize the links between mental health and the non-medical determinants of health. Have a plan that promotes not only mental health but wellness, healthy families, improved living conditions and employment opportunities.

The Northern Human Services Partnership is proud to have undertaken the development of this handbook. It was written after extensive research of current suicide prevention initiatives around the world. Thanks to Haley Robinson, our summer student who worked on this document with the guidance of our coordinator, Karen Eckhart.

Background

Suicide is a global health concern; worldwide, suicide is among the top three leading causes of death between the ages of 15-44.[1] Globally, one million people die by suicide every year and it is estimated that for every suicide there are at least 20 suicide attempts.[2] Today, suicide affects mainly youth between the ages of 15-19, a change from the past when suicide was committed mainly by the old and ill. Suicide rates for Aboriginal youth are 5-7 times higher than non-Aboriginal youth.[3]

Aboriginal youth suicide victims are most often male and single. Alcohol intake is usually involved. Youth often use highly lethal means to commit suicide such as guns and hanging, and there is a tendency for youth suicides to occur in clusters. Clusters are when one suicide triggers a series of suicides and attempts in the same community in a short period of time.[4]

Northern Saskatchewan covers 46% of the province, but accounts for only 3.4% of the population. Home to a young population, 37% of northerners are under the age of 15. Almost 84% of northerners identify themselves as Aboriginal. The premature death rate in northern Saskatchewan is 1.8 times higher than the rest of the province with unintentional injuries and suicides accounting for most of the difference. Suicide is the third leading cause of premature death with the age groups of 15-19 and 20-24 having the highest hospitalization rates for self-inflicted injuries in the north.[5]

To prevent suicide, there is the need to take a holistic community-wide approach, focusing on well-being. Parents, Elders, leaders and service providers need to create stable environments full of opportunity so that youth have chances for expression and growth.

[1](WHO as cited in American Foundation for Suicide Prevention, 2009)

[2](WHO as cited in American Foundation for Suicide Prevention, 2009)

[3](Health Canada, 2006)

[4](White, J. & Jodoin, N., 2007)

[5](Irvine, J. & Stockdale, D., 2004)

Factors that Influence Suicidal Behavior

This section outlines the factors that influence suicide. These include risk factors, trigger factors, exacerbating factors and protective factors. Individuals may face multiple negative factors at once which lead to an increased risk of suicide. Risk and trigger factors can be minimized through protective factors such as mental health work, building self-esteem or individual resiliency and improving the non-medical determinants of health in the community. These protective factors are vital to minimizing the likelihood of suicide. Exacerbating factors heighten the likelihood of suicide. It is important to identify the unique factors that influence suicide in the community in order to build an effective prevention plan. This can only be done by getting to know the people in the community and gaining their trust. If the root factors of suicide in that particular community are not addressed, the underlying issues may be masked but are unlikely to disappear.

Risk Factors, or factors that increase risk of suicidal behavior

a) Mental disorders, including mood, anxiety and personality disorders and schizophrenia
b) Stigma attached to seeking help for mental illness and suicidal tendencies
c) Historical context:
    - Colonization which led to rapid socio-cultural change *i.e*. lost culture, language and traditions, or dual teachings that may conflict with each other
    - Forced relocation to reservations and residential schools which led to the loss of parenting and coping skills
d) Perceptions of being marginalized from mainstream society and community which leads to social isolation and feelings of hopelessness. Sexuality is a common reason for marginalization
e) Access to lethal means (e.g. guns, ammunition)
f) Substance abuse, addictions
g) Poor housing and unemployment[6]

Trigger Factors, or factors that when paired with risk factors in a predisposed individual greatly increase the risk of suicidal behavior

a) Death of a family member or friend, especially by suicide
b) Relationship ending
c) Media report on suicide or suicide methods
d) Conflict with law, incarceration[7]

[6](White, J. & Jodoin, N., 2007)

[7](Statewide Suicide Prevention Council, 2005)

Exacerbating Factors, or factors present in early childhood that negatively affect childhood development and increase risk of suicide

a) Abuse
    - Emotional: *recurrent humiliation*
    - Physical: *beating, not spanking*
    - Sexual
b) Household dysfunction
    - Mother treated violently
    - Household member was alcoholic or drug user
    - Household member was imprisoned
    - Household member was chronically depressed, suicidal, mentally ill or in a psychiatric hospital
    - Individual was not raised by both biological parents: *divorce most common reason*
c) Neglect
    - Physical
    - Emotional[8]

Protective Factors, or factors that promote mental health and decrease the risk of suicidal behavior

- Strengthening these factors will decrease the risk and the likelihood of trigger factors developing and can reduce the number of suicide attempts.
    a) Family, school and community support that encourages problem solving, conflict resolution and non-violent handling of disputes
    b) Strong inter-generational supports and families
        - Promote kinship through fun, recreational activities
    c) Easy access to mental health care and substance abuse programs and ongoing support from these programs
        - Use a broad-based approach for delivery of services
    d) Restricted access to lethal means of suicide, *e.g.* firearms and ammunition
    e) Cultural and religious beliefs that discourage suicide and support self-preservation - culture revitalization, spiritual healing practices
    f) Hope for the future - looking beyond today and next week to what can be achieved in the long-term
        - Promote forward-looking mindsets. Encourage personal goal development and support skill-building activities[9]

[8] (Felitti *et al.* as cited in Alberta Mental Health Board *Mending Minds*, 2007)

[9](White, J. & Jodoin, N., 2007)

Interestingly, a recent American study amongst Aboriginal youth who have attempted suicide found that increasing protective factors was more effective at reducing the probability of a suicide attempt than was decreasing risk factors … Preventative efforts should include the promotion of protective factors in the lives of all youth. (White & Jodoin, 2007)

Guidelines for Effective Suicide Prevention

Consider these four steps when creating and implementing a suicide prevention plan. Beginning with community asset mapping through assessment and planning, moving to wellness promotion, then healing actions and constructive project evaluation, these steps provide a structure for suicide prevention and community building. Each step contains action areas that affect both policy and community. A successful plan will involve the talents of a diverse group of people, from civic leaders and inter-sectoral committees to youth, their parents and community Elders.

These steps are adapted from *The Manitoba Suicide Prevention Framework.*[10]

1) Assessment and Planning

Potential Action:

a) Conduct a community assessment. Identify community strengths and resources, and what sectors/organizations will offer support. Assess opportunities to strengthen existing partnerships and to develop new ones. Identify the greatest needs and what actions will have the strongest impact.

b) Develop a suicide prevention community work-plan to achieve suicide prevention goals. Designate people responsible for activities.

- Incorporate existing community health programming into the suicide prevention plan.
- Plan for continuity after pilot projects end: Use pilot projects as stepping stones that can be used to guide subsequent program development.

c) Form a suicide prevention committee at an inter-agency/inter-jurisdictional level, with a diverse range of sectors, service providers, and representatives from high-risk groups such as youth.

- Youth involvement: Investing in youth develops capacity in communities. Consult with youth during the planning, implementation and evaluation of the suicide prevention plan.

[10](Manitoba Framework Provincial Committee, 2005)

d) Strategies should be sustainable at a community level.

- Broad-based community programming**:** Incorporate a range of service providers within the community that cut across different sectors such as public health, the justice system, schools and social services. This will increase the impact of programming. Local inter-agencies are a good example of this system.
- Community-wide programs avoid the stigmatization of specific groups and ensure the entire population can be reached. No individual is immune to the risk of suicide; this approach ensures that all community members have equal opportunity to reach help, and be supported.
- Community designed and driven prevention programs are more likely to succeed as community members have a sense of control and self-determination.

2) Wellness Promotion

Potential Action:

a) Revival of culture, traditions and Elder involvement: Take a holistic, strength-based approach to preventing suicide, incorporating culture and traditional practices.[11] This encourages a stronger sense of identity, raises self-esteem and teaches important life coping skills that promote 'commitment to future-self'.[12] Community Elders play a key role in this process.
   - Suicide prevention strategies can double as programs designed to preserve culture and traditions for future generations.

b) Engage in community healing and recognizing community strengths. Work to merge new healing strategies with traditional practices.[13]

c) Promote resiliency. Encourage and support healthy families with parenting workshops and gatherings.

d) Ensure youth have long-term life plans, with future goals and recognition of past achievements and current strengths that can be built upon.

e) Work to improve the non-medical determinants of health (e.g. employment rates, housing, poverty) in the community.

f) Reduce stigma surrounding suicide. Make suicide a community-wide concern. Increase suicide awareness and the ability to seek help.

g) Implement media guidelines for reporting suicide and suicidal behavior. Educate the media on their role.

h) In schools, have a wellness component in the curriculum, promoting healthy lifestyles, coping strategies and conflict resolution.

[11](Suicide Prevention Advisory Group, 2001)

[12](Suicide Prevention Advisory Group, 2001)

[13](Kelly, F., 2007)

- Young children (under the age of 12 years) are an important target group for primary prevention.[14]

3) Prevention, Intervention and Postvention

- It is important to focus on prevention in the community; however, intervention and postvention plans should be in place to support those in need.
- 'Suicidal behaviors are symptoms, not a specific illness, therefore interventions have to be tailored to address the identifiable factors and underlying conditions.'[15]

Potential Action:

a) Strong focus on early childhood intervention, to reduce the number of exacerbating factors in the home environment. Work to reduce the impact of exacerbating factors to give all children a happy, healthy childhood that promotes mental well-being and life-skills.
   - *'Long-term evaluation in the United States concludes that a $1 investment in quality preschool child care saves $7 that would have been spent down the road on welfare, policing, social services and prisons.'*[16]
   - Encourage youth attachment to school activities and existing recreation programs.

b) Reduce access to lethal means and educate public *re.* dangers of having firearms or other common means of suicide readily available in household.

c) Train community members, youth and medical personnel to recognize the risk factors of suicide. Have an effective referral process so that at-risk individuals can easily access the level of health care and support they need.
   - Encourage family members and support workers to routinely assess the potential level of suicide risk in the home.

d) Have a crisis management plan and team prepared to act if a suicide or suicide-attempt occurs. This team should provide support to those impacted and identify those suffering from potential precipitating factors in order to avoid a suicide clustering effect.
   - Prepare for community-wide post-traumatic stress debriefing sessions.

e) Provide after-care and follow-up after a suicide attempt or mental health intervention. Support families living with at-risk individuals.

f) Have an established support network for the bereaved that includes age-specific sensitivity.

4) Data Surveillance, Research and Evaluation

Potential Action:

a) Develop evaluation criteria for all suicide prevention strategies.

[14](Suicide Prevention Advisory Group , 2001)

[15](Ashworth, J., 2001)

[16](*The Globe and Mail* as cited in National Crime Prevention Council Canada, 2008)

- Encourage the sharing of evaluation data so that comparisons can be made across communities and regions.
- Use evaluation findings to improve community awareness *re.* health and wellness issues.
- Ask: What is the potential impact of programs? Can impact be measured in the short, medium and long term?

b) Implement evidence-based practices and continue to build upon them.

c) Ensure accurate, easily accessible and widespread data are available *re.* factors impacting suicide, attempts, completions and trends.

Moving to Action

- 'Every single person has capacities, abilities and gifts. Living a good life depends on whether those capacities can be used, abilities expressed and gifts given.' [17]

Work to develop policies and programs based on the skills and capacities of community members so that people feel self-empowered and better connected to their community.[18] Taking this approach, the process of creating a suicide prevention plan will help to improve self-esteem and build forward-thinking mindsets. Provided is a broad set of best practices that allow for program growth into the long term. Challenges are also noted, in order to ensure they are addressed and do not endanger suicide prevention planning.

Best Practices

These best practices can be incorporated into the development and delivery of any suicide prevention plan. They focus on community renewal and engagement, instead of reactive responses. This will help to improve future outlooks and reduce feelings of hopelessness. These practices strive to strengthen networks and build resiliency within northern communities. Taking a bottom-up approach means prevention work is initiated at the community level, with local people active throughout the planning and implementation processes. This promotes community wellness as people develop their potential and healthy living is encouraged. It is important to support programs that are inclusive and broad-based to help as many people as possible.

- Focus on community wellness
- Strength-based approaches – Build upon community strengths and existing networks
- Bottom-up approach – grassroots

[17] (Kretzmann, J., & McKnight, J., 1993)

[18] (Kretzmann, J., & McKnight, J., 1993)

- Not being exclusionary – develop strong inter-sectoral partnerships. These reduce overlap of services and gaps in service provision
- Services reaching broad-based population

Challenges

Active suicide prevention will come with challenges. To reduce these, an important first step is to strengthen and support a dedicated team of staff to ensure continuity in project delivery. Inter-sectoral partnerships will help to deliver specialized services and reduce barriers in service delivery, even in remote northern locations.

- Need for specialized services and adequate support in remote communities
- Jurisdictional and system barriers that impede the delivery of services
- Staff turnover in remote communities
- Ensuring staff are supported and frequently debriefed to prevent staff burnout

Promising Strategies for Northern Saskatchewan

These promising strategies can be used in prevention planning. They have the ability to be expanded from preventative to action plans. Currently, there are many existing programs in the north to support people of all ages which already follow these actions. These projects can be evaluated, and further supported. A primary focus within all these strategies is strengthening northern families, so that children are resilient, have developed life skills and have positive role models. Suicide prevention cannot and should not be contained to mental health offices. Instead, prevention must be supported in community recreation areas, schools, the streets and at home.

➢ With the goal to promote action, beginning at the community level

1) Focus on family health and well-being. Work with families to build parenting skills and to reduce addictions
    - Support early childhood intervention and education
    - Promote inter-generational activities and cultural continuity
    - Create change through promoting viable, fun alternatives to gambling, drinking, drug-use and watching TV. Address the root causes behind these behaviours
2) Promote activities that encourage high self-esteem, self-expression, and forward-thinking mindsets
    - Support existing school and community-based recreation programs. Promote the arts (*e.g.* drama, literature, painting, music, carpentry) with workshops and long-term programming

- Cultural activities as well as healing can be incorporated into art initiatives
- Promote sports as a way to develop self-worth and build friendships and peer supports

3) Support community and regional inter-agencies to problem solve, grow, and work towards action-oriented prevention plans
   - Support initiatives that can be sustained and expanded into the long term
4) Revitalize public spaces to promote community engagement and outdoor recreation
   - Celebrate volunteerism and tap into community capacity to improve community image and pride
   - Make the streets a safe place where young and old are encouraged to interact
   - Reduce the presence of gangs, if applicable
5) Work with youth and their families to minimize the impact of potential trigger factors
   - Support community healing initiatives
   - Foster peer-to-peer supports
   - Provide life-skills training and suicide prevention courses
   - Ensure that mental health professionals and crisis response teams are on call after-hours and on weekends in inclusive, accessible environments
6) Recognize the links between mental health and the non-medical determinants of health. Have a plan that promotes not only mental health but wellness, healthy families, improved living conditions and employment opportunities
   - Identify root causes of risk factors specific to the community, to orient goals in prevention planning

Towards a Brighter Future

It is time to celebrate current suicide prevention work and embark on creating new prevention initiatives and opportunities for northern communities. The Northern Human Services Partnership extends an invitation to all northerners to join in these efforts and form partnerships. Families, friends, service providers, and practitioners—all community members have the ability to join in action, produce results and foster hope.

Appendix A: Youth Response

- Current research done with youth in northern Saskatchewan regarding suicide prevention and youth engagement: the *La Loche Community Youth Surveys*[19], *Priorities That We Can Work on Together in Our Communities to Help Prevent Suicide*[20] and *The Northern Youth Strategic Action Plan*[21] were consulted.

- We recognize the limitations of this research. It does not contain the comprehensive depth required to make a detailed prevention plan. More consultation and work with northern youth needs to be done. However, common threads emerged from this initial research. These include:

1) Work with families and provide parenting supports to help create stable, loving home environments.

2) Engage in year-long recreation programming with leagues, tournaments and training camps.

    - Revitalize outdoor community sport facilities and open school gyms at night.

    - Include arts and drama components in programming as a means of self-expression.

3) Support youth centre initiatives so that youth have a safe, welcoming place where they can hang out, play games and learn new skills.

4) Organize culture camps on a regular basis.

    - Create opportunities to practice outdoor and traditional skills such as hunting, fishing and wilderness survival.

5) Address street crime such as drug dealing and graffiti to make the community a safer place.

    - Work together to build community pride, using creative, youth-driven initiatives.

6) Ensure mental health professionals take a client-centered approach, and youth have easy access to care.

    - See that mental health professionals are engaged in community activities year-round and present in public spaces such as school hallways and arcades.

[19](La Loche youth, 2009)

[20](Northern Saskatchewan Suicide Prevention Forum, 2009)

[21](New North-SANC Services Inc., 2006)

Appendix B: Literature Review

Strategy Reviews

1) A Framework for Suicide Prevention Planning in Manitoba (Manitoba Framework Provincial Committee, 2005)

This report provides an informative framework for preventing suicide at provincial, regional and community levels. Introducing the framework, factors influencing suicide and at-risk groups for suicide are identified. Also, a community needs assessment process is outlined to help with developing a suicide prevention workplan. The Framework contains five main components which are:

1) Assessment and Planning
2) Mental Health Promotion
3) Awareness and Understanding
4) Prevention, Intervention and Postvention
5) Data Surveillance, Research and Evaluation

Each component contains a list of achievable goals with objectives to focus on. Each goal is accompanied by a list of sample activities with links and contacts that a suicide prevention committee could implement. Examples specific to Aboriginal populations are given.

2) Canadian Association of Suicide Prevention Blueprint (Canadian Association for Suicide Prevention, 2004)

This blueprint was written in the hopes of providing enough information to initiate the development of a national suicide prevention strategy for Canada. The blueprint states 'Strategies must be humane, kindly, effective, caring and should be:

a) Evidence-based
b) Active and informed
c) Respectful of community and culture based knowledge
d) Inclusive of research, surveillance, evaluation and reporting
e) Reflective of evolving knowledge and practices'

The blueprint lays out a number of goals and objectives including reducing stigma, reducing access to lethal means, increasing training for recognition of risk factors and prioritizing service delivery for high-risk groups. In conclusion, there is a rationale for the need of a comprehensive strategy, which cites high suicide statistics for Canada and the world.

3) Living is for Everyone: A Framework for Prevention of Suicide in Australia (Living is for Everyone (LIFE), 2008)

Australia was one of the first countries to develop a national strategic approach to suicide prevention. The country has seen its suicide rate drop from 14.7 suicides per 100,000 people in 1997 to 10.3 suicides

per 100,000 people in 2005. This framework states that 'one of the main aims of suicide prevention… is to build resilience in individuals, their families and in whole communities to increase their capacity to respond to life's events, whatever they may be.' The framework underlines the importance of services being sensitive to social and cultural needs. Also, prevention activities should be delivered in easily accessible locations where at-risk groups feel comfortable. Local prevention efforts need to be sustainable and community support nets should be in place to help at-risk individuals should a prevention initiative finish.

The LIFE framework outlines six action areas that are the focus of prevention work:

1) Improving the evidence base and understanding of suicide prevention
2) Building individual resilience and the capacity for self-help
3) Improving community strength, resilience and capacity in suicide prevention
4) Taking a coordinated approach to suicide prevention
5) Providing targeted suicide prevention activities
6) Implementing standards and quality in suicide prevention

Each action area explains desired outcomes and strategies for taking action. The importance of evaluation is reiterated, and 11 evaluation indicators are provided.

Practice-Related Reviews

1) Acting on What We Know: Preventing Youth Suicide in First Nations (Advisory Group on Suicide Prevention, 2002)

This report outlines numerous short-, medium- and long-term recommendations for government and organizations to act upon to prevent Aboriginal youth suicide. The focus is on rural reserve communities. Recommendations are followed by a summary and objectives, and where possible the responsibilities are identified for existing organizations. The recommendations fall under four main categories:

1) Increasing knowledge about what works in suicide prevention
2) Developing more effective and integrated health care services at national, regional and local levels
3) Supporting community-driven approaches
4) Creating strategies for building youth identity, resilience and culture

The recommendations emphasize evidence-based decision making, and are designed to influence public policy on suicide prevention. This report does not examine community healing and health activities. Suicide prevention is promoted through the concepts of 'cultural continuity', 'commitment to future-self' and 'identity'. The report recognizes that suicide prevention strategies should be built as 'community wellness' strategies that promote all aspects of health.

The report finishes with the following three guiding principles for suicide prevention:

a) Engage community members

b) Ensure culture continuity: *transmission of knowledge, values and identity from one generation to the next, encourages belief in an optimistic future - 're-creating and re-inventing communal practices in ways that maintain connections, honour the past, and incorporate a sense of shared history'*.
c) Build capacity: *improves knowledge and skills of communities*

2) Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies (White & Jodoin, 2007)

This is a comprehensive manual written for all sectors of government, service providers and community members. It begins by outlining the problem of youth suicide in Aboriginal communities. It then presents a model for understanding youth suicide that includes all risk factors in order to be able to implement better prevention strategies. This manual focuses on prevention strategies and does not include treatment programs or crisis intervention strategies. There are 17 suicide prevention strategies aimed at Aboriginal youth given, along with examples of existing successful Aboriginal suicide prevention initiatives. Culturally relevant resources are suggested including workshops and organizations. For each strategy, short-, medium- and long-term indicators are given to serve as evaluation tools.

The 17 suicide prevention strategies are divided into four groups:

1) Community renewal strategies: *cultural enhancement, traditional healing practices, community development, interagency communication and coordination*
2) Community education strategies: *peer helping, youth leadership, community gatekeeper training, public communication and reporting guidelines, means restriction*
3) School strategies: *school gatekeeper training, school policy, school climate improvement*
4) Youth/family strategies: *self-esteem building, life skills training, suicide awareness education, family support, support groups for youth*

To finish, the manual provides a chapter on 'A Community-Wide Approach to Suicide Prevention'. This is designed to help communities begin to implement the 17 suicide prevention strategies. There are seven guidelines that frame this community-based approach:

1) Check out your community's assets
2) Capitalize on the expertise of a range of community partners
3) Gather pertinent information
4) Do your front-end work
5) Set up an interagency planning body
6) Develop an interagency action plan
7) Evaluate your suicide prevention efforts

3) Working with the Client who is Suicidal: A Tool for Adult Mental Health and Addiction Services (Monk & Samra, 2007)

This document was written as a tool for professionals who work with individuals who are at a risk for suicide. It states that 'the relationship between the clinician and the client is probably the most

important factor in the treatment of suicidal behavior'. This relationship is examined in depth, with the document divided into five sections:

1) Adult Suicidality - General Considerations: *Including the importance of family support and involvement during treatment*

2) Identifying and Assessing Suicide Risk

3) Managing Safety and Treatment Planning: *Including descriptions of mental disorders associated with suicide, and different therapeutic approaches as well as the documentation and evaluation guidelines for treatment plans*

4) Enhancing Linkages between Adult Mental Health and Addiction Services and the Community: *Building strong, proactive relationships between key service providers to build an integrated service delivery system to provide care for at-risk individuals*

5) Care for the Clinician: *Includes how to cope with occupational hazards such as burnout and compassion fatigue*

This prevention tool indicates 3 stages to build upon when working with an at-risk individual:

1) Stabilization and safety of the client

2) Assessment of temporal and distal risk factors

3) Ongoing management and active problem-solving of contributing factors

The clinician is advised to help the client understand their suicidal behavior so that they can begin to problem-solve and seek life-affirming alternatives. The importance of follow-up by the clinician is reiterated. This document is not a prescribed standard of care, and should only be used as reference and planning tool.

4) Practice Principles: A Guide for Mental Health Clinicians Working with Suicidal Children and Youth (Ashworth, 2001)

This guide is designed to support mental health clinicians by reviewing key practice principles, therapeutic tasks and treatment strategies that have been shown to work well with youth who are at a risk for suicide.

The practice principles are divided into five sections:

1. Introduction to child and youth suicidality
2. Overview of clinical care principles for treating child and youth suicidality
3. Model for identifying and assessing suicide risk
4. Suggestions for safety, treatment planning and ongoing monitoring of suicidality

5. Discussion and guidelines for linking child and youth mental health services with the community: *includes roles of media and schools*

Each section includes discussion points and informative tables including interview questions and how to conduct risk assessments.

There is also a section regarding cultural context when treating youth. There are four recommended focus points to consider when treating Aboriginal youth:

1) Teach positive self-image

2) Encourage and assist Aboriginal youth to explore traditional healing practices, if appropriate

3) Encourage and assist Aboriginal youth to explore traditional cultural activities, if appropriate

4) Utilize family and community-based approaches

Throughout the guide, there is a strong focus on the important role of the home and family environment, and steps to take to engage and support parents with at-risk children.

Research-Related Reviews

1) Mending Minds: 2007 AMHB Research Showcase Information Supplement (Alberta Mental Health Board, 2007)

This three-day showcase in Banff, Alberta focused on four identified mental health issues: the tragic imprint of childhood adversity; depression and the elderly; mental health in the workplace, and the case for early intervention. Many presentations were given by professionals, with the most compelling research in regards to suicide prevention done by Dr. Felitti and his colleagues and the long-term *Adverse Childhood Experience* (ACE) study.

The ACE study matches the current health of middle-aged, middle-class patients against 10 categories of childhood abuse, neglect and family dysfunction (for a complete list of the categories, please refer to *Exacerbating Factors*). 'The ACE study found a devastating link between childhood suffering and subsequent life experiences, including depression, alcoholism and suicide.' For each category experienced in their first 18 years of life, the patient scored a point, revealing their ACE score. Much childhood adversity was revealed; only one-third of patients had an ACE score of 0.

- Patients with an ACE score of 4 have an increased risk of attempting suicide by a factor of 1,250%. Also with an ACE score of 4, risk of becoming an alcoholic increases by 550%.

These findings reinforce the need for focus on early childhood intervention and prevention practices. In the closing address to the showcase the thought was reiterated – 'We can't afford to mend, so we must prevent'. [22]

[22](Andrews, G. as quoted by D. Hancock, Alberta Health and Wellness Minister, 2007)

2) Cultural Continuity as a Hedge against Suicide in Canada's First Nations (Chandler & Lalonde, 1998)

This report summarizes a study done in British Columbia of 196 Aboriginal bands. This report is based on the idea that anyone who experiences extreme personal or cultural change is at risk of losing their hope and goals for the future, which leads to a risk for suicide. To reduce the negative impact of sudden change, there is a need for cultural continuity, which is built by each individual community. Cultural continuity encourages a strong sense of identity and is defined by six protective factors:

1) Self-government
2) Land claims – title to traditional lands
3) Community control over education
4) Health services
5) Police and fire services
6) Established 'cultural facilities'

Each band in the study was analyzed for cultural continuity, scoring one point for each protective factor present. The results found that a high number in protective factors in the community resulted in low to non-existent suicide rates. This highlights the importance of community-based action to promote culture and reduce suicide.

Appendix C: Glossary

Community Wellness: Describes a state where the community works to improve resources that enable people to support each other and develop their maximum potential. Local capacity and ability is celebrated. The physical and social community environments encourage mental wellbeing and healthy living. (Centers for Disease Control and Prevention)

Cultural Continuity: 'Community control in the areas of self-government, land claims, education, health services, police and fire services and cultural facilities.' (Chandler & Lalonde as cited in Advisory Group on Suicide Prevention, 2002)

Non-Medical Determinants of Health: 'Basic factors and influences that shape or determine the health of individuals and communities. Health determinants can help identify the areas where action could improve health, approaches to improving health, and can serve as a basis for planning community or region initiatives. The determinants of health are interrelated and include income and social status, education, culture, and social support networks. These factors do not act in isolation from each other

but it is the interactions of these determinants that have an impact on the health of individuals and the community.' (Irvine & Stockdale, 2004)

Resiliency: 'Ability to 'bounce-back' from hardships and become stronger. Resilient people understand that life is full of challenges, joys, losses, disappointments, and unexpected events. They learn from their mistakes, get support from others, and keep a broader perspective.' (Statewide Suicide Prevention Council , 2005)

Suicidality: An individual's level of risk for suicidal behavior. (Ashworth, 2001)

Appendix D: Sources

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